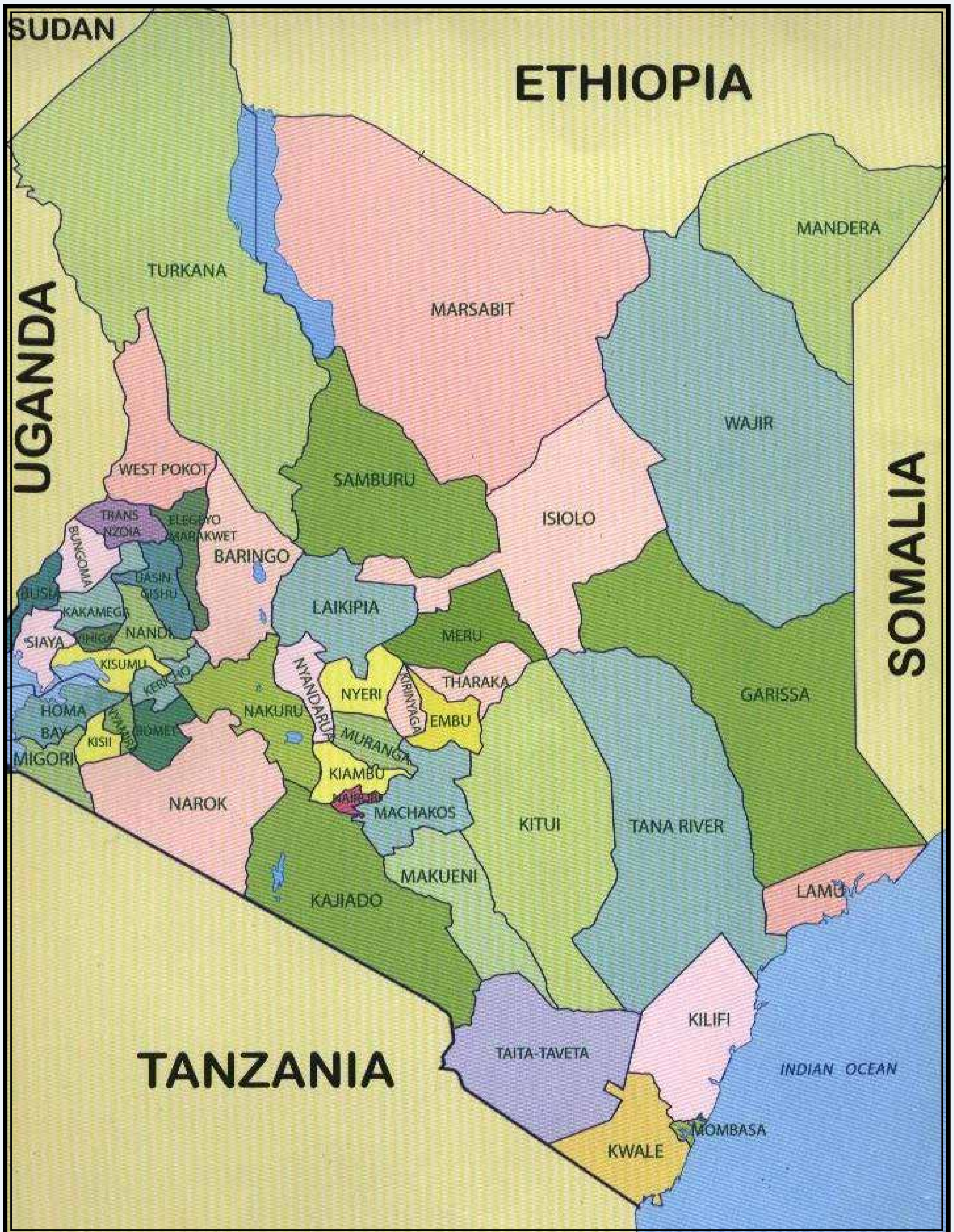
WHO COUNTRY COOPERATION STRATEGY KENYA

Medium - Term Support Strategy 2014 - 2019

MAP OF KENYA WITH THE 47 COUNTIES



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ACRONYMS

AfDB Africa Development Bank
CCS Country Cooperation Strategy
CDC Centres for Disease Control and Prevention
CF Clinton Foundation
DANIDA Danish International Development Agency
DaO Delivering as One
DFID Department for International Development
DHIS District Health Information System
DHS Demographic and Health Survey
DPHK Development Partners for Health in Kenya
DPR Disaster Preparedness and Response
EMMS Essential Medicines and Medical Supplies
EMONC Emergency Obstetric and Newborn Care
ERS Economic Recovery Strategy
EU European Union
FTCT Framework Convention on Tobacco Control
GAVI Global Alliance for Vaccines and Immunization
GDC German Development Cooperation
GFATM Global Fund to Fight AIDS, Tuberculosis and Malaria
HENNET Health Network for NGOs
HHA Harmonisation for Health in Africa
HRIS Human Resource Information System
HTC HIV Testing and Counselling
HSCC Health Sector Coordinating Committee
IDSR Integrated Disease Surveillance and Response
IHP International Health Partnership
IHR International Health Regulations
IFC International Finance Cooperation
IMF International Monetary Fund
IPT Intermittent Preventive Treatment
ITN Insecticide-treated Net
HMIS Health Management Information System
JICA Japanese International Cooperation Agency
KAIS Kenya AIDS Indicator Survey
KEMRI Kenya Medical Research Institute
KEPH Kenya Essential Package for Health
KHP Kenya Health Policy
KHSSP Kenya Health Sector Strategic and Investment Plan
MAL Malaria
MNH Maternal and Newborn Health
MTP Medium Term Plan
NCD Noncommunicable Disease
NTD Neglected Tropical Disease
OoP Out of Pocket
RMNCAH Reproductive, Maternal, Newborn, Child and Adolescent Health
RTIs Road Traffic Injuries
SDH Social Determinants of Health
TB Tuberculosis
UHC Universal Health Coverage
UNAIDS Joint United Nations Programme on HIV/AIDS
UNDAF United Nations Development Assistance Framework
UNICEF United Nations Children's Fund
UNDP United Nations Development Programme
UNESCO United Nations Educational, Social and Cultural Organization
UNHCR United Nations High Commission for Refugees
UNIDO United Nations Industrial Development Organization
UNOPS United Nations Office for Project Services
UNFPA United Nations Population Fund
UNWOMEN United Nations Women
USAID United States Agency for International Development
USG United States Government
VPD Vaccine-preventable Disease
WB World Bank
WFP World Food Programme
WHO World Health Organization

PREFACE

Third Generation – WHO Country Cooperation Strategy

The WHO Third Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly with a view to strengthen WHO capacity and make its deliverables more responsive to country needs. It reflects the WHO Twelfth General Programme of Work at country level, it aims at achieving greater relevance of WHO's technical cooperation with Member States and focuses on identification of priorities and efficiency measures in the implementation of WHO Programme Budget. It takes into consideration the role of different partners including non-state actors in providing support to Governments and communities.

The Third Generation CCS draws on lessons from the implementation of the first and second generation CCS, the country focus strategy (policies, plans, strategies and priorities), and the United Nations Development Assistance Framework (UNDAF). The CCSs are also in line with the global health context and the move towards Universal Health Coverage, integrating the principles of alignment, harmonization and effectiveness, as formulated in the Rome (2003), Paris (2005), Accra (2008), and Busan (2011) declarations on Aid Effectiveness. Also taken into account are the principles underlying the "Harmonization for Health in Africa" (HHA) and the "International Health Partnership Plus" (IHP+) initiatives, reflecting the policy of decentralization and enhancing the decision-making capacity of Governments to improve the quality of public health programmes and interventions.

The document has been developed in a consultative manner with key health stakeholders in the country and highlights the expectations of the work of the WHO secretariat. In line with the renewed country focus strategy, the CCS is to be used to communicate WHO's involvement in the country; formulate the WHO country workplan; advocate, mobilise resources and coordinate with partners; and shape the health dimension of the UNDAF and other health partnership platforms in the country.

I commend the efficient and effective leadership role played by the Government in the conduct of this important exercise of developing the CCS. I also request the entire WHO staff, particularly WHO Country Representative to double their efforts to ensure effective implementation of the programmatic orientations of this document for improved health outcomes which contribute to health and development in Africa.

Dr Matshidiso Moeti

WHO Regional Director for Africa

FOREWORD

This third generation WHO Country Cooperation Strategy (CCS) is being implemented during an interesting period for Kenya. Firstly, the Country is in the transition phase for the implementation of the 2010 constitution. Secondly, a new Government came into place in April 2013, whose structure and functioning is guided by the new constitution with health sector devolution in place. Thirdly, the United Nations started implementation of a new United Nations Development Assistance Framework (UNDAF) in 2014, based on the Delivering as One approach. Fourthly, the Country has in 2013 defined its overall strategic direction in the 2nd Medium Term Plan (MTP-2), and in 2014 its health strategic direction in the Kenya Health Sector Strategic and Investment Plan (KHSSP). These in-country changes have a direct implication on the structure and functioning of the WHO in Kenya.

In addition, the Country is facing unique health challenges that are different from what it is used to. There is evidence that efforts during the 2nd generation CCS period have led to a stagnation, and/or reduction in overall mortality and morbidity. This is contributed to, amongst other issues, by improvements in services for some communicable conditions like HIV/AIDS, TB and Malaria. However, a rising burden of non-communicable conditions and injuries, plus increasing health risks from new/re-emerging communicable conditions represent rising risks to health in Kenya.

The CCS priorities are therefore in response to this situation, taking into consideration the WHO/Kenya capacity and expectations. It builds on the spirit of strengthening health systems to attain primary health care ideals, and takes into consideration the changes in the country's political, economic and institutional context as defined above.

The WHO strategic agenda in the CCS III is defined across three levels: there are five (5) strategic priorities, with twenty-three (23) main focus areas across these priorities, with each main focus having 2 – 3 strategic approaches.. All the levels of WHO will support Kenya around this strategic agenda. By focusing on this agenda, we shall be able to contribute to the Country's health agenda, as expected of WHO.

Asante Sana

Dr Custodia Mandlhate

WHO Kenya Country Representative

EXECUTIVE SUMMARY

The WHO Country Cooperation Strategy III (CCS III) represents the medium-term strategy for the work of WHO in Kenya for the period 2014–2019 in support of the country's national health policy, strategies and plans. It is an important tool for harmonizing WHO cooperation with that of other UN agencies and development partners. The CCS III is anchored on three key planning frameworks, namely: (i) *the Twelfth General Programme of Work (GPW 2014-2019)* which is the high-level strategic vision for the work of WHO globally; (ii) Kenya's *Medium-Term Plan II (MTPII 2014-2018)* and *Health Sector Strategic and Investment Plan* (KHSSIP 2014-2018) which outline the country's development and health agenda; and (iii) the *United Nations Development Assistance Framework (UNDAF 2014-2018)* which outlines the framework for UN cooperation with the Government of Kenya.

The CCS III is the product of extensive consultations between WHO, the Government of Kenya and its partners. Hence, it is guided by the expectations of these stakeholders regarding WHO in the context of the roles and functions of WHO as a UN specialized agency for health.

This third generation CCS builds on the spirit of strengthening health systems to attain primary health care ideals, and takes into consideration the changes in the country's political, economic and institutional context, particularly in relation to the 2010 Constitution and its implications. The focus and priorities in this CCS III are guided by the expressed expectations of the Government of Kenya and its partners regarding WHO's support for the attainment of the country's health objectives.

Prior to this CCS III, the country has been registering improvements in some key development indicators, though disparities exist across population groups, geographical areas and gender. Life expectancy has also been improving, largely driven by improvements in infant, child and adult health. However, the country is impacted by a high double burden of disease with many communicable conditions not yet controlled and non-communicable conditions, including violence/injuries, rising exponentially. Kenya is also prone to natural disasters and emergencies mainly as a result of climate change.

The country has developed a number of strategies to address the health challenges. The Constitution of Kenya (2010) introduced a transformational change in governance and public administration, providing for the *Right to Health for every Kenyan*, and a devolved system of governance. The Kenya Health Policy (2014-2030) has defined a comprehensive set of policy objectives and orientations to be attained in order to accelerate improvements in the health of Kenyans. Its objective is to attain universal health coverage (UHC) with critical services that positively contribute to the achievement of the overall policy goal. It targets a 16% improvement in life expectancy; a 50% reduction in annual mortality from all causes; and a 25% reduction in time spent in ill-health.

The first strategic plan of the KHP and the Kenya Health Sector Strategic and Investment Plan (KHSSP – 2014 – 2018) further defines priorities and specific impact targets for the CCS III period.

The work of WHO during this period will be supported by a number of partners in health. There is a sector-wide approach to facilitate coordination of the efforts of partners. Within the United Nations, a United Nations Development Assistance Framework (UNDAF) 2014 – 2018 has been defined in the context of Delivering as One (DaO) to facilitate better harmonization of UN efforts in supporting the Government's agenda.

The WHO strategic agenda as defined in this CCS III is therefore based on these orientations. It is prepared across three levels: five (5) strategic priorities to be supported by the work of WHO; twenty-three (23) main focus areas to be prioritized by the work of WHO; and strategic approaches to be used by WHO to support the main focus areas.

The five strategic priorities to be supported by WHO are:

(i) Reduce the burden of **communicable diseases;**

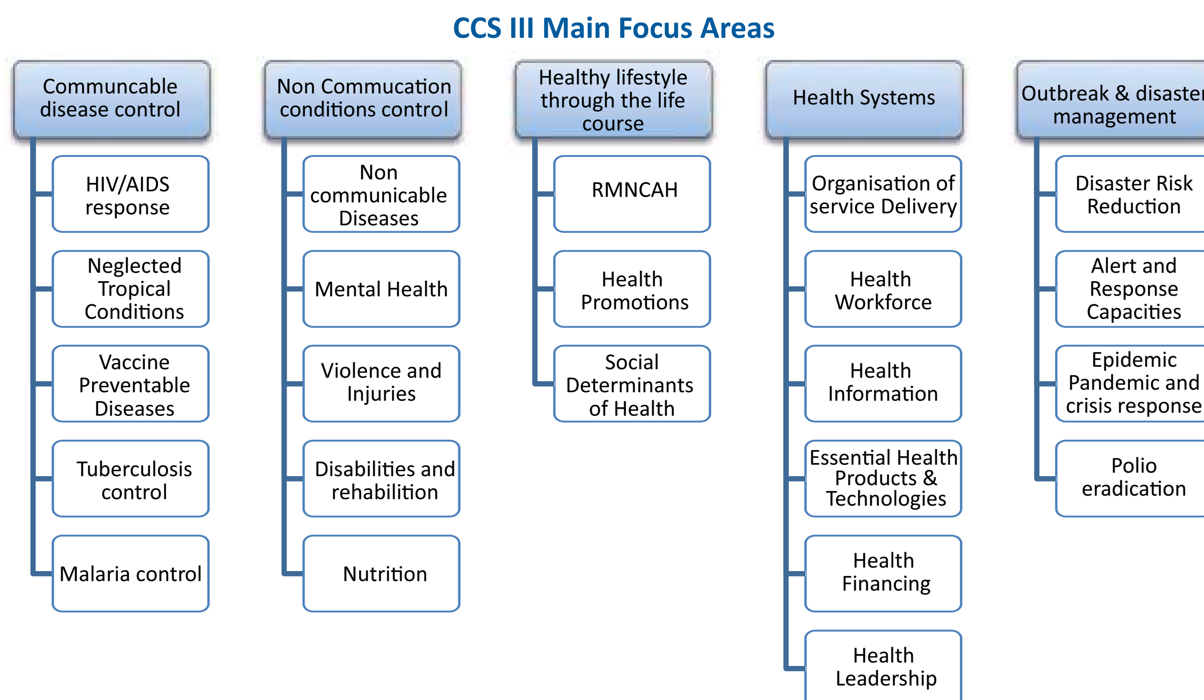
(ii) Halt/stabilize and reverse the rising burden of **non-communicable conditions**, injuries, violence and disability;

(iii) Improve health outcomes and embrace **healthy lifestyles** in a supportive and enabling risk-mitigating environment through the course of life;

(iv) Establish a responsive, client-centred, technology-driven and sustainable **health system; and**

(v) Have adequate capacity for **disaster preparedness, surveillance and effective response.**

The focus areas in each of these priorities are illustrated below.



The strategic approach in each of the main focus areas is defined, based on WHO's core functions as articulated in the Twelfth General Programme of Work.

The Kenya WHO Country Cooperation Strategy III (CCS III) document develops these orientations across six sections as follows:

Section 1: Sets out the principles underlying the CCS;

Section 2: Describes and analyses the country's health and development issues and challenges;

Section 3: Analyses the roles played by key development partners;

Section 4: Outlines WHO's cooperation with the country over the past CCS cycle;

Section 5: Outlines the strategic agenda in the CCS III; and

Section 6: Examines the implementation agenda for the CCS III.

01

Introduction

1: Introduction

The WHO Country Cooperation Strategy III (CCS III) is a medium-term strategic document that defines a broad strategic framework for WHO's work with the Government of Kenya for the period 2014–2019. It articulates a clear vision of how to improve the quality of WHO's work in Kenya with the aim of making the greatest possible contribution to health development. This third generation CCS builds on the spirit of strengthening health systems to attain primary health care ideals as outlined in the World Health Assembly Resolution 62.12[1] and on the foundation and implementation of previous Country Cooperation Strategies.

The overall goal of CCS III is to improve the quality of WHO's work in Kenya and make the greatest possible contribution to health development. It specifically aims to:

(i) Provide the strategic direction for WHO/Kenya in advancing thWe national health agenda for the six-year period;

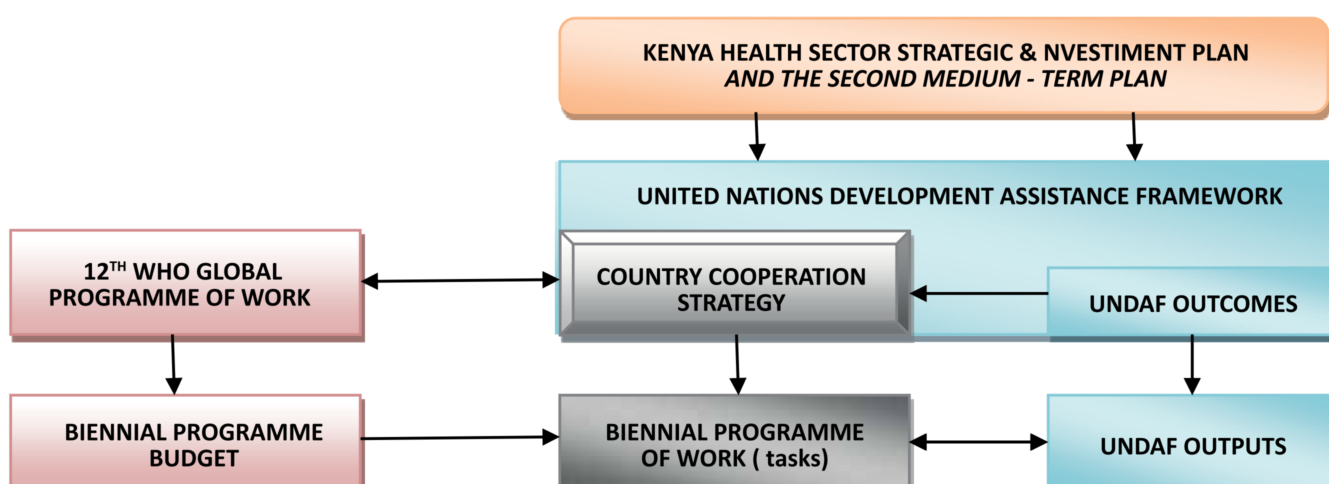
(ii) Provide a framework for WHO biennial work plans and budgets; and

(iii) Provide an institutional structure that reflects how the WHO office in Kenya will function and collaborate with the other levels of the Organization and country partners.

The CCS III takes into consideration the changes in the country's political, economic and institutional context. It examines the health situation in the country within a holistic approach that encompasses the health sector, socioeconomic status, the determinants of health and upstream national policies and strategies in health and health-related areas that have a major bearing on health. It also reviews current epidemiological and demographic trends in relation to the impact that these changes have on people's health and the country's health systems.

The CCS enables WHO in Kenya to respond to the various constituents it relates to. It draws on the Member States' expectations of WHO by aligning its focus and priorities with the Twelfth General Programme of Work [2]. As a Delivering as One self-starter country, the CCS is fully aligned with the United Nations Development Assistance Framework (UNDAF) for the corresponding period. Lastly, the CCS III is aligned with the country's strategic focus in health as defined in the Kenya Health Sector Strategic and Investment Plan (KHSSIP, 2013/14 – 2018/19) [3] and the second Medium-Term Plan[4]. The biennial budgets and plans will be guided and informed by the priorities in this CCS III.

Figure 1: WHO/Kenya planning framework



Source: Adapted by WHO/Kenya, from WHO Country Cooperation Strategies guide 2010 [5]

02 Health and Development Challenges, Attributes of the National Health Policy and Strategy

2: Health and Development Challenges, Attributes of the National Health Policy and Strategy

2.1 Macroeconomic, political and social context

Kenya is a country in the East Africa region. It is bordered by Uganda to the west, the Indian Ocean to the East Ethiopia and Somalia to the north and Tanzania to the south. Its population grew from 37.2 million in 2008 when the CCS II was developed to about 43.18 million in 2012 (+16% in four years, 4% annually)[6]. The country's population structure has remained largely constant since 2006, with the annual population growth remaining at 2.7%; the proportion of the population aged below 14 years was 42.37% and that of the total population aged 65 and above 2.64% in 2012.

Kenya is one the most developed countries in East Africa, with a GDP at current US dollars of $37.23 billion in 2012. Agriculture and fisheries is the largest sector of the economy and accounts for about 25% of GDP. Kenya's GDP growth rate averaged 1.15% from 2005 until 2013, reaching an all-time high of 3.50% in March 2010 and a record low of -2.40 % in March 2008.The proportion of the population with access to an improved water source rose from 56% in 2006 to 59% in 2012[6].

2.2 Other major determinants of health

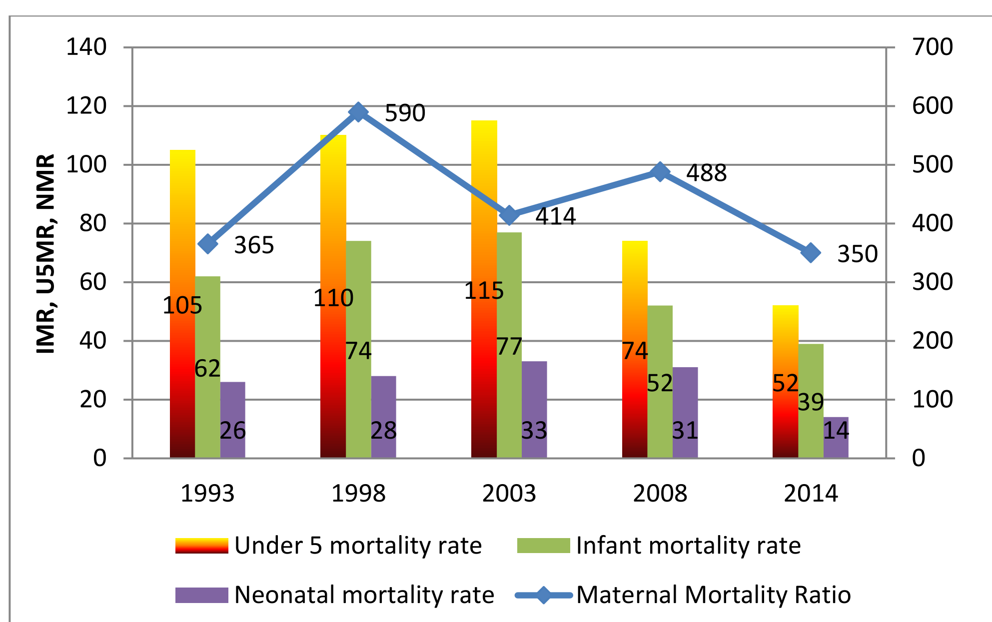
Kenya has registered remarkable improvements in some key development indicators. The country's Human Development Index (HDI) for 2012 was 0.519, ranking it 145 out of 187 countries with comparable data. According to UNDP, between 1980 and 2012, Kenya's HDI rose by 0.9% annually from 0.424 to 0.519 today. The HDI of sub-Saharan Africa as a region increased from 0.366 in 1980 to 0.475 today, placing Kenya above the regional average[7]. The country has witnessed some reductions in the population living in absolute poverty. The World Bank estimates that the poverty level in Kenya dropped from 47% in 2005 to between 34% to 42% in 2012 owing to Government's effort to expand infrastructure and improve living standards in the country. The drop has, however, been most remarkable in urban areas though the absolute poverty levels still remain high (46%)[8].

The population growth rate has remained high with a high young and dependent population that is increasingly urbanized. Literacy levels are fairly high at 78.1%, though inequities in age and geographical distribution persist. Gender disparities are also significant, particularly in the rural areas of the country, though some improvements are being noted as a result of improving opportunities for women. However, disparities exist and persist, with the GDI ranging from 0.628 (Central Province) to 0.401 (North Eastern Province). Lastly, security concerns persist in some areas of the country, making it difficult for communities to access and use existing services. Gender-related crime is also reported in urban areas, particularly in the informal settlements.

2.3 Health status of the population

The expectation of life at birth (Life expectancy – LE) in Kenya had improved from a low of 45.2 years in the 1990s to an estimated 60 years by 2009[9]. This improvement was particularly noted for persons under five years of age and adults due to improvements in health for these age groups. Some actual improvements in age-specific mortality rates are documented, as shown below.

Figure 2: Trends in health impact



'Source: Respective Demographic and Health Surveys. 2014 MMR data are MOH estimates'

2.3.1 Disease burden

Kenya faces a disease burden due to all major disease domains – communicable conditions, non communicable conditions and violence/injuries as shown in the table below.

Table 1: Leading causes of death and disabilities in Kenya, 2010

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

DALYs = Disability-adjusted life years – Time lost due to incapacity arising from ill-health

Source: Kenya Health Situation trends and distribution: 1994 – 2010, and projections to 2030[10]

HIV/AIDS is still estimated to cause the highest proportion of deaths and lost disability-adjusted life years. The overall HIV/AIDS prevalence is on a downward trend and is currently estimated to be 5.6% [11], attributable to implementation of an aggressive HIV control strategy. According to the National HIV/AIDS Estimates 2014, at the end of 2013, 81% of eligible adults were accessing antiretroviral therapy, thus improving their overall and disability-adjusted life expectancies. However, there are gaps, including the low ART coverage of 43% among children [12].

Perinatal conditions remain quite high, and are the major contributor to the high neonatal mortality rate, and therefore infant mortality rates. Efforts to improve these rates are ongoing, ranging from improving awareness in communities on the need for safe pregnancies to scaling up interventions associated with

antenatal and safe birth and improving neonatal care facilities across the country.

Lower respiratory infections are still a major cause of mortality and morbidity, particularly among under-five children in Kenya. Efforts to prevent these infections are being scaled up in the country. This age group is being immunized against *Haemophilus influenza* type B, measles, whooping cough and, more recently, pneumococcus. In addition, nutrition efforts, starting with exclusive breastfeeding, are helping to prevent infections and also to reduce the severity of illness.

Kenya is on track to meet the MDG target for reducing tuberculosis (TB) incidence (298 per 100,000 population) but is unlikely to achieve the targets for reductions in prevalence and mortality. Nonetheless, there has been substantial progress with a high estimated case detection rate (79%) and a high treatment success rate (88%). Kenya is one of the High Burden Countries (HBCs) making good progress in HIV testing of TB patients (94%) and provision of ART to HIV-positive TB patients (over 80%). Areas for improvement include expanded provision of intermittent preventive treatment (IPT) to people living with HIV and integration of new diagnostic tools into the laboratory network.

Diarrhoeal diseases remain one of the major causes of childhood morbidity and mortality in Kenya, particularly in areas where there is poor access to safe drinking water, inadequate sanitation, malnutrition, and pollution of food sources. Key ongoing efforts to address diarrhoeal diseases include scaling up hand washing with soap, zinc supplementation, exclusive breastfeeding and education on infection prevention and hygiene. In addition, the country is working to introduce rotavirus vaccine for under-five children.

Malaria accounts for 30% of total outpatient morbidity, and is the leading cause of mortality among under-fives. Significant efforts are ongoing to reduce this disease burden, through prompt and effective treatment with artemisinin–based combination therapies (ACTs), increased use of insecticide-treated nets (ITNs), improved epidemic preparedness and response and effective communication, monitoring and evaluation. At present, the epidemiology of malaria is changing, within a growing trend from holo- and meso-endemic patterns towards epidemic patterns. Malaria prevalence has been reduced significantly. By maintaining universal coverage with long-lasting insecticidal nets (LLIN) and providing quality-assured treatment for malaria (ACTs), Kenya expects to reduce malaria mortality by two-thirds by 2017.

Noncommunicable diseases (NCDs) are perceived to be on the increase in Kenya, though actual data on prevalence is scanty. According to the Health Management Information System (HMIS), cardiovascular diseases and cancer are the second and third leading causes of death respectively. In addition, the estimated prevalence of diabetes in the population aged between 20 and 79 years is 4.7%. Kenya has ratified the Framework Convention on Tobacco Control (FTCT), and has achieved some milestones in its implementation, especially in the areas of control of smoking in public places, and advertising, sponsorship and promotion. A STEPs Survey is planned, and is expected to provide comprehensive information on the magnitude of NCDs in the country. A global youth tobacco survey is also under way.

Kenya has high fatality rates due to road traffic crashes in excess of 3,000 deaths annually. The First Global Status Report on Road Safety 2009 (GRSS 2) estimates the death rates due to road traffic injuries (RTIs) to be 34.4 per 100,000 persons. Data from the Kenya Police reveals that RTIs increased at an annual rate of 1% between 2004 and 2009. Vehicle passengers account for half of all reported RTIs, followed by pedestrians. Notably, injuries to motorcyclists have increased by 29% annually; and RTI fatalities among motorcyclists have increased by 51% annually.

2.4 National responses to overcoming health challenges

The Constitution of Kenya (2010) introduced a transformational change in governance and public administration. From a health perspective, the Right to Health for every Kenyan is affirmed through a comprehensive Bill of Rights. Governance structures fundamentally changed from a previously centralized structure to a two-tier system comprising the National Government and 47 devolved County Governments[13]. The two levels of government are equal and distinct, and are required to work in collaboration, consultation and cooperation. The counties are the units of service delivery and resource allocation. These orientations require restructuring health governance and healthcare delivery systems to align them with the Constitution. A health bill is under development to consolidate, harmonize and update all health-related legislation and align it with the Constitution.

Vision 2030 is Kenya's political and economic blueprint through which the country aims to transform itself into a newly industrialized, middle-income country providing a high quality of life to all its citizens by the year 2030[14]. The Vision has three pillars - economic development, social development and political reform. It places a high premium on maintaining a stable macroeconomic environment, driven by constitutional and legal reforms as well as real time structural and institutional reforms, through which the country aims to increase annual GDP growth rates to an average of 10% over the Vision horizon. Vision 2030 is implemented through medium-term plans. The second Medium-Term Plan (2014-2018) aims to deliver accelerated and inclusive economic growth, higher living standards, better education and health care, increased job creation especially for youth, commercialized agriculture providing higher rural incomes and affordable food, improved manufacturing sector and more diversified exports[4]. The MTP II is also the framework through which Kenya aims to attain the MDGs.

Kenya is prone to many disasters and emergencies. A recent assessment of the country's preparedness for emergencies and disasters indicates that many gaps and weaknesses exist. These are at the level of policy, planning and coordination. A National Disaster Operation Centre (NDOC) exists, but it is not backed by a legal framework; hence, capacity enhancement is limited. Within the health sector, inadequate human resource (HR) capacity hinders effective DPR, including coordination with the NDOC. There are ongoing efforts to review the legal and institutional framework for DPR.

The Kenya Health Policy (2014-2030) defines the country's long-term intent in health. It is anchored on a health systems framework, defined in terms of six policy objectives to be achieved through investments across seven policy orientations. Its defined goal is **'attaining the highest possible health standards in a manner responsive to the population's needs'**[15]. It is designed to take the country beyond the traditional health services approach towards a focus on health, using a primary health care approach. The **target** of the policy is to attain a level of distribution of health commensurate with that of a middle-income country, with specific impact targets of attaining a 16% improvement in life expectancy; a 50% reduction in annual mortality from all causes; and a 25% reduction in time spent in ill-health.

The overall objective of this policy will be to **attain universal coverage with critical services that positively contribute to the realization of the overall policy goal.** It intends to attain this by focusing on the following six policy objectives:

(i) *Eliminate communicable conditions:* To force down the burden of communicable diseases, till they are not of major public health concern;

(ii) *Halt and reverse the rising burden of noncommunicable conditions*: By implementing clear strategies

to address all the identified noncommunicable conditions;

(iii) *Reduce the burden of violence and injuries*: By putting in place strategies that address each of the causes of injuries and violence;

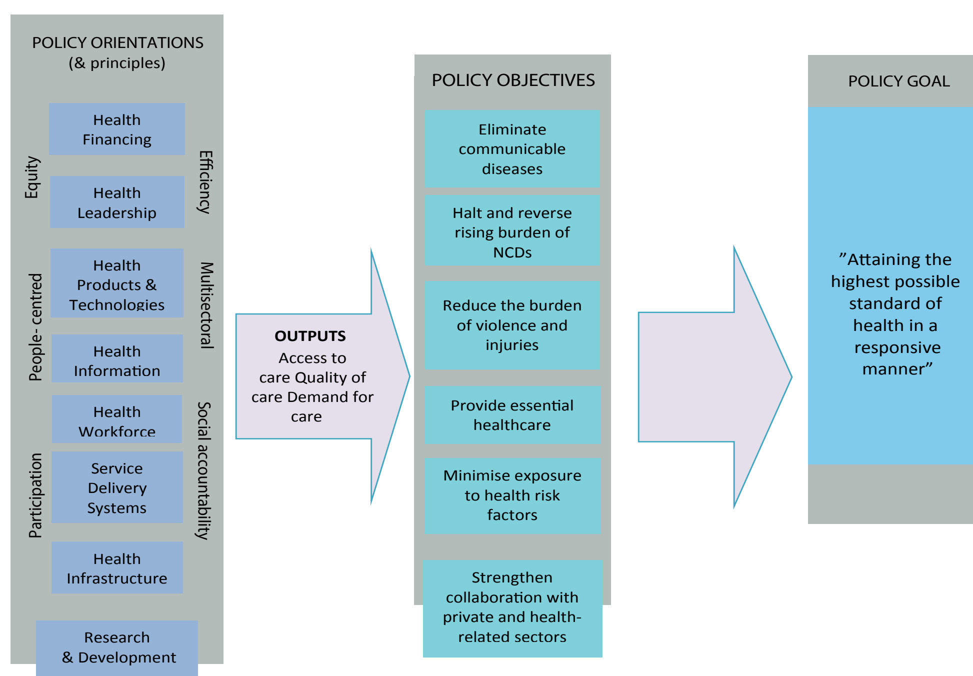
(iv) *Provide essential health care*: Through a focus on affordable, equitable, accessible and responsive health and related services;

(v) *Minimize exposure to health risk factors*: By scaling up health promoting interventions which address health risk factors, and facilitating the use of healthy behaviour-inducing products and services; and

(vi) *Strengthen collaboration with health-related sectors*: By adopting a 'Health in all Policies' approach.

The seven policy orientations represent distinct areas for health system investment, focused on attaining the policy objectives. Each investment area requires the development of a specific policy and strategic framework to guide the country on the nature, scope and rationale of the investment.

Figure 3: Framework for defining policy directions.



Source: Kenya Health Policy, 2014 - 2030

The health policy is implemented through medium-term (5-year) strategic plans outlining the strategic directions and investments required to attain the overall policy imperatives. The five-year plans are aligned with the Government's Medium-Term Plan (MTP) which is the implementation framework for Vision 2030. The Kenya Health Sector Strategic and Investment Plan (KHSSP III, 2014-2018) is the first medium-term plan of the Kenya Health Policy (2014-2030). It provides the strategic focus, objectives and priorities to enable the sector move towards the attainment of the Kenya Health Policy imperatives. Its stated goal is to accelerate the achievement of the country's health goals, with impact targets by 2018 of halving maternal and neonatal deaths; reduction by 25% of time spent in ill-health, and improvement by at least 50% of client satisfaction with health and related services[3]. It places great emphasis on implementing interventions and prioritizing investments relating to maternal and newborn health, which is the major impact area where progress was not achieved during the previous strategic plan.

The KHSSP adopts the health systems framework of the Kenya Health Policy, and also outlines the Kenya Essential Package for Health (KEPH) that defines the health and related services to be provided across four levels of care (community, primary, county and national levels) and for the five distinct cohorts of the human life cycle.

Table 2: Summary of KEPH for the Strategic Plan 2014 - 2018

Policy Objective	Services	Policy Objective	Services
Accelerate reduction of the burden of Communicable Conditions	Immunization	Provide essential health services	Outpatients
	Child Health		Emergency
	Screening for communicable conditions		Maternity
	Antenatal Care		In patient
	Prevention of Mother to Child HIV Transmission		Clinical laboratory
	Integrated Vector Management		Specialized laboratory
	Good hygiene practices		Radiology
	HIV and STI prevention		Operative services
	Port health		Specialized therapy
	Control & prevention neglected tropical diseases		Specialized services
Halt, and reverse the rising burden of non communicable conditions	Community screening for NCDs		Rehabilitation
	Institutional Screening for NCD's	Strengthen collaboration with health related sectors	Safe water
	Workplace Health & Safety		Sanitation and hygiene
	Food quality & Safety		Nutrition services
Reduce the burden of violence and injuries	Pre hospital Care		Pollution control
	Community awareness on violence and injuries		Housing
	Disaster management and response		School health
Minimize exposure to health risk factors	Health Promotion including health Education		Water and Sanitation Hygiene
	Sexual education		Food fortification
	Substance abuse		Population management
	Micronutrient deficiency control		Road infrastructure and Transport
	Physical activity		

Source: Kenya Health Sector Strategic and Investment Plan, 2014 - 2018

KEPH implementation aims to reduce the disease burden in the country, with specific targets defined for different causes of high disease burden as shown below.

Figure 4: KHSSP targets for different conditions contributing to the disease burden

CONDITIONS TARGETED FOR ERADICATION	CONDITIONS TARGETER FOR ELIMINATION
1. Polio 2. Guinea Worm Infestation	1. Malaria 2. Mother to Child HIV transmission, 3. Maternal and Neonatal Tetanus 4. Measles, 5. Neglected Tropical Conditions 6. Leprosy
CONDITIONS TARGETED FOR CONTROL	**RISK FACTORS TARGETED FOR CONTAINMENT**
1. HIV / AIDS 2. Conditions in the perinatal period 3. Lower Respiratory infections, 4. Tuberculosis 5. Diarrhoeal diseases in children, 6. Cerebrovascular diseases, 7. Ischaemic Health disease, 8. Road traffic accidents, 9. Violence including Gender Based Violence 10. Unipolar depressive disorders 11. Other Immunizable diseases 12. New / re-emerging infections	1. Unsafe Sex 2. Unsafe water, sanitation & hygiene 3. Suboptimal breastfeeding 4. Childhood and maternal underweight, 5. Indoor air pollution, 6. Alcohol use, 7. Tobacco use 8. Vitamin A deficiency, 9. High blood glucose, 10. High blood pressure, 11. Zinc deficiency, 12. Iron deficiency, 13. Lack of contraception

Source: Kenya Health Sector Strategic and Investment Plan, 2014 - 2018

To facilitate the attainment of these outcomes, the KHSSP further defines specific outputs relating to improvement in access, demand for services and quality of care that the sector needs to achieve. These outputs relate to different dimensions of access, quality of care and demand creation as shown below.

Table 3: Dimensions for output targets

Output area	Dimension
Improving access to services	Improvements in physical access
	Improvements in financial access
	Improvements in sociocultural access
Improving quality of care	Improving client experiences
	Assuring client / patient safety
	Ensuring effectiveness of care
Strengthening demand for services	Improving awareness
	Improving health-seeking behaviours

Source: Kenya Health Sector Strategic and Investment Plan, 2014 - 2018

2.5 Health systems and services, and the response of other sectors

The following is a summary of health systems status across the seven health sector investment areas, namely: Organization of Service Delivery; Human Resources for Health; Health Information; Health Infrastructure; Health Products and Technologies; Health Leadership and Governance; and Health Financing, highlighted in the KHSSP [3].

2.5.1 Investment area 1: Organization of Service Delivery

These are investments that relate to the organization and management of health services. The services addressed in this investment area include referral services, outreach services, community services, training and supervision, emergency preparedness, and facility master planning. At present, the sector has a referral strategy, although capacity building towards facilitating its implementation is not coordinated or adequate. Outreach services are currently provided in some areas of the country (for example, through mobile clinics in arid and semi-arid areas). The services are not uniform and are usually not integrated or coordinated. Efforts are being made to bring community services under the umbrella of a comprehensive community strategy. However, the implementation of the strategy is not uniformly supported and vertical community approaches continue to be used. Training and supervision are extensively ensured by different programmes depending on their specific needs. Lastly, although facility master planning is not prioritized at present, it is a recognized need.

Current sector efforts are aimed at scaling up referral services, establishing coordinated and harmonized outreach services, rolling out integrated community services, re-aligning training and supervision efforts, and improving emergency and disaster preparedness and response across all counties.

2.5.2 Investment area 2: Human Resources for Health

The health sector has experienced chronic HR shortages over the years owing to increased demand for services and the freezing of recruitments. In 2010, as part of the Economic Stimulus Package, there was significant recruitment of health workers to boost the health workforce. However, the number of workers, skills distribution and workforce management strategies remain a major challenge to service delivery.

Kenya has an estimated human resource for health (HRH) workforce of 67,075 persons (17 per 10,000 population) of which 56% are female. There are five medical staff per 10,000 population. The ratio of health workers per 10,000 population is generally low across all cadres, especially regarding key professionals, that is doctors (0.54), dentists (0.04) and pharmacists (0.13) and slightly higher regarding clinical officers (1.13) and nurses (3.41). There are critical shortages of HRH in some disciplines. For example, there are only six economists in the entire health sector. Furthermore, HR distribution remains skewed overall, with some areas of the country facing significant gaps while others have an optimum/surplus workforce.

A recent Health Workforce Forecast for Kenya (2013) highlights significant shortages in the number of clinical officers, general practitioners (doctors) and nurses. These gaps are too wide to be addressed in the near term through the existing training infrastructure alone and will require a strategic review of priorities and alternative short-term solutions.

With the establishment of the county as the health service delivery unit, there is a need for comprehensive guidance on HRH norms based on the expected services as defined in the KEPH. A staffing norm has therefore been defined for each level of service in order to outline the minimum number of health workers, by cadre, needed to ensure the provision of the KEPH. KHSSP health workforce improvement priorities include:

appropriate and equitable distribution of health workers, attraction and retention of health workers, institutional and health worker performance, and training, capacity building and development of health workers.

2.5.3 Investment area 3: Health Infrastructure

Kenya has a wide range of health facilities distributed all over the country and provided by the Government, faith-based organizations (FBOs), nongovernmental organizations(NGOs) and private institutions as shown in the table below.

Table 4: Distribution of health facilities by ownership and level of care

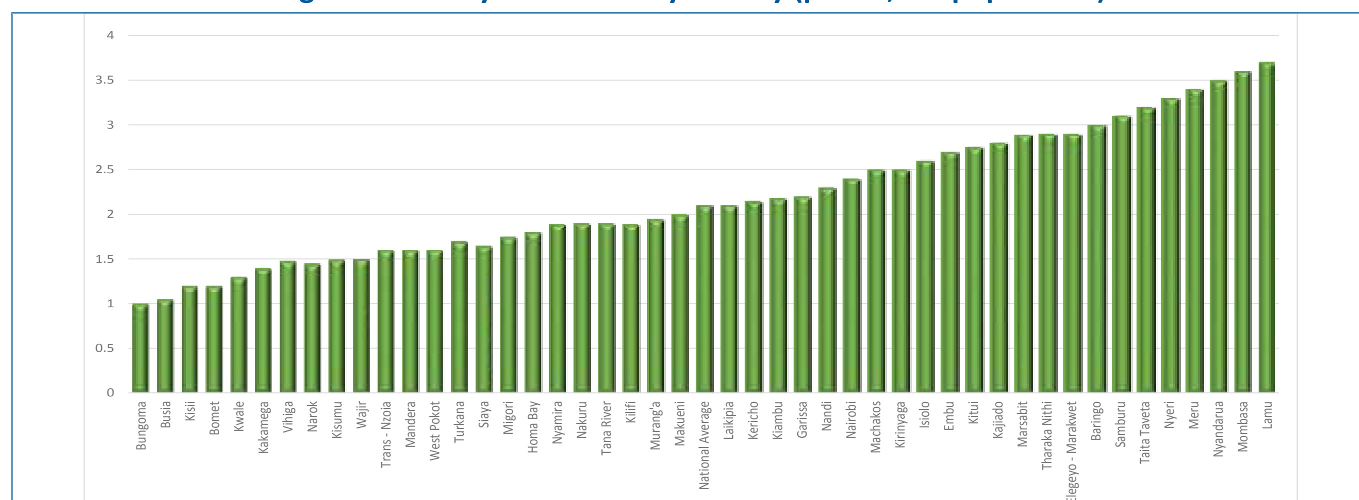
Ownership	Primary care facilities					County hospitals	National hospitals	Total
	Dispensaries	Health centres	Medical clinics	Maternity homes	Nursing homes			
Government	2954	682	35	1	0	268	16	3956
Faith-based organizations	561	166	61	3	11	79		881
NGOs	200	24	73	4	5			306
Private	196	60	2,098	32	150	116		2652
Total	3911	932	2267	40	166	463	16	7795

Source: Government of Kenya 2014. Service Availability and Readiness Assessment Mapping

The public health care system is the major provider of health services, but the non-state actors play a significant and growing role in health service delivery. The average facility density per 10,000 persons is 2.04, but wide disparities exist across the country, with a range of 1 to 3.5 facilities per 10,000 persons.

Wide disparities exist across the 47 counties in infrastructure for health service delivery. Over half of health facilities have old and dilapidated infrastructure. Most of the existing facilities do not conform to current norms and standards with respect to expected staffing, infrastructure and equipment. For example, availability of ambulances ranges from 0.09 to 5.23 per 100,000 persons. Infrastructure investment focus has been on the establishment of 201 model health centres under the economic stimulus package while more than 80 hospital projects are at various stages of completion. The medium-term focus to improve health infrastructure is the utilization of norms and standards and health infrastructure planning, maintenance and management.

Figure 5: County health facility density (per 10,000 population)



Source: Government of Kenya 2013. Service Availability and Readiness Assessment Mapping

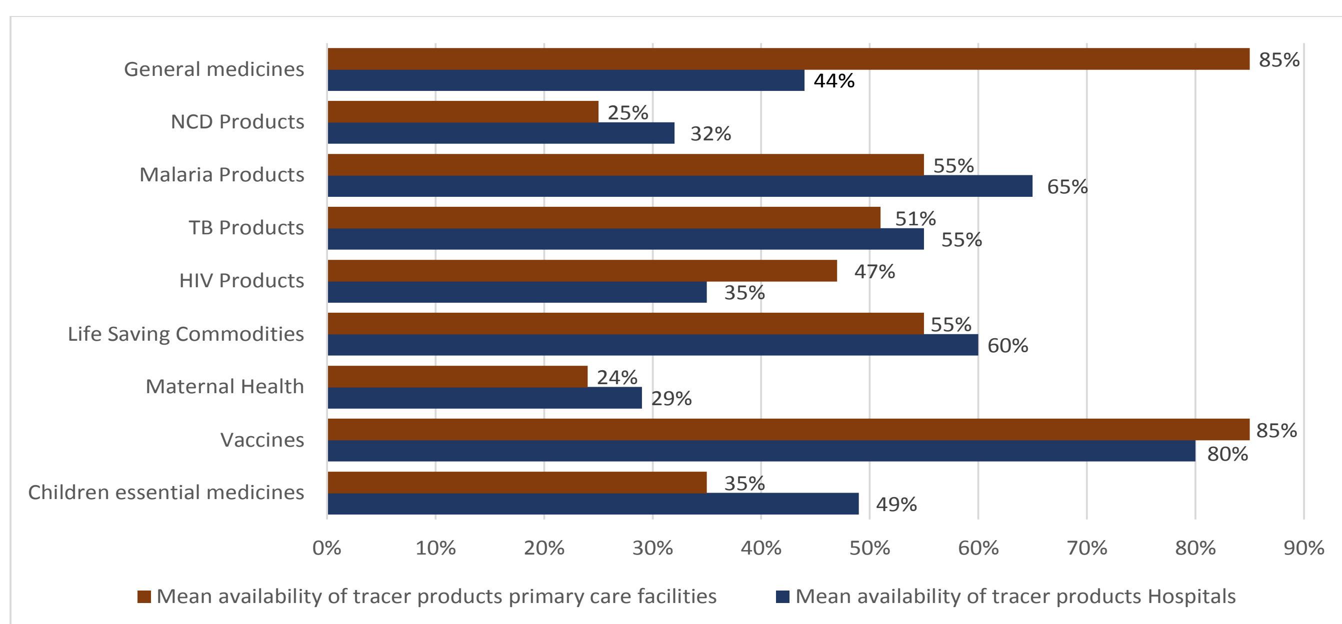
2.5.4 Investment area 4: Health Products and Technologies

The sector aspires to provide health products and technologies that are **available**, **affordable**, **safe**, **efficacious** and of **good quality** and **appropriately used.** Availability of essential medicines and health products is generally low, and shows wide variations across levels of care and within specific medicine groups. At the primary care level, essential medicines and vaccines are widely available (85%), but specific medicines for children and for communicable conditions are less available, ranging from 25% to 65% across all levels of care. Various systemic weaknesses contribute to low medicines availability, namely: inefficient public procurement and supply systems, inadequate financing, and inadequate utilization of existing supply chains.

Public funding for essential medicines and medical supplies (EMMS) is very inadequate, and can only assure a limited catalogue of supplies. The funding gap is covered by facility-generated cost-sharing (out-of-pocket user fees) which is an immediate barrier to access at the point of care, especially for the poor. Prices of medicines are generally high, and vary widely across sectors and regions of the country. Private sector prices of key essential medicines are unaffordable for the poor and a source of catastrophic expenditure. Expenditure on medicines accounts for 95% of out-of-pocket spending for the poorest households, compared to 50% for the wealthiest households Insurance coverage is very low (5%) across all households, and virtually non-existent in poor households (1%) compared to the wealthiest households (16%).

Data from various quality studies of malaria, TB and HIV medicines show high conformity with quality standards. However, the country is facing various threats which undermine treatment outcomes. These include substandard and counterfeit medical products, unregistered medicines, unlicensed pharmacies and unregulated prescribing and dispensing of medicines. Furthermore, the policy and strategic framework for medical devices and diagnostics is inadequate to ensure proper assessment, management and regulation thereof. Overall, there are ongoing legislative reforms to establish a harmonized regulatory system for health products and technologies (HPT).

Figure 6: Mean availability of commodities



Source: Government of Kenya 2013. Service Availability and Readiness Assessment Mapping

2.5.5 Investment area 5: Health Information

The country has witnessed significant efforts to improve the management and availability of health information. Various coordinated systems built around better and more efficient technologies are being established. These include the DHIS – 2 for routine information and HRIS for human resource management which, in the long run, should improve the effectiveness and efficiency of health information management. At present, however, many of these systems are not fully rolled out, and are, at times, not inter-operable. Information from vital events, surveillance, DHIS and system investments is not pooled to facilitate data use in a coordinated manner. The key priorities in improving health information are defined in relation to improvements in information generation and warehousing and information validation, analysis, dissemination and utilization.

2.5.6 Investment area 6: Health Financing

Investment in the health sector has increased steadily over the years. Total health expenditure increased from US$ 33.5 per capita in 2001/2002 to US$ 42.2 in 2009/2010. However, these increases are characterized by the following:

(i) Flat (slightly declining) share of government health expenditure of the total health expenditure

(ii) Increasing share of donors of total health expenditure;

(iii) Declining share of household out-of-pocket expenditure as a proportion of total health expenditure.

According to the most recent National Health Accounts (2009/2010), the country spent approximately 5.4% of its GDP on health (equivalent to US$ 42.2 per capita). Government health expenditure has been between 4 and 7 per cent of total Government expenditure, which is under half of the Abuja Declaration target of 15% and the Economic Recovery Strategy (ERS) target of 12% of total Government expenditure. Some 63.3% of total health expenditure is publicly funded, including external (donor) support and health insurance, the latter accounting for for 11% of total health expenditure. The remaining 36.7% is privately funded, with out-of –pocket (OOP) expenditure at the point of service being predominant. Private health insurance is limited – only an estimated 25% of the population is covered by any form of health insurance.

The country is prioritizing the development of a comprehensive health financing policy and strategy which would highlight the agreed health financing objectives (in relation to resource generation, equity and efficiency), institutional arrangements to manage available resources and the expected resources from different sources of financing.

2.5.7 Investment area 7: Health Leadership and Governance

Health Sector Leadership and Governance addresses three key objectives, namely: improving health stewardship, partnership and governance.

Stewardship encompasses the national and county governments, through the national Ministry of Health and the County Departments of Health respectively. The MOH management team was split across two ministries, and has just been reconstituted as one. In addition, the establishment of County Health Management Teams has just been undertaken.

Governance relates to the functioning of the institutions through which the authority of the State of Kenya is exercised. These institutions address the regulatory and legal functions that all actors in the sector have to

adhere to, and are built around the sector legal and regulatory framework. The devolved system of government has introduced fundamentally different governance systems across all sectors in Kenya. In the health sector, the 47 county executives, plus the national MOH leadership, constitute the intergovernmental forum for health which is a constitutional structure for health governance. The legal and regulatory framework for health has been extremely fragmented across numerous pieces of legislation and institutional mandates. The result was regulatory gaps and conflicting and overlapping mandates, leading to ineffective compliance and enforcement. Guided by the 2010 Constitution, efforts are ongoing to harmonize these under an updated Health Act and specialized acts relating to key investment areas such as HRH and health products and technologies.

Partnership relates to the interrelations and coordination of different actors working towards the same goals, and is built around the adherence to the sector partnership Code of Conduct. The partnership framework and instruments have been in existence for the past eight years, though adherence to them is poor. Furthermore, the devolved health system calls for review of these partnership structures across all levels of Government. They are, therefore, currently being reviewed to align them with the emerging stewardship and governance frameworks.

The key priorities to improve health leadership are the restructuring of the national Ministry of Health and establishment of County Health Management teams; coordinated transfer of functions to County Governments; establishing of functional partnership and coordination arrangements for health; and finalization of the legal framework harmonization efforts.

2.6 Kenya's contributions to the global health agenda

The country has a number of lessons that it can share with other countries as they address their health agenda. The significant improvements in health impact that it is currently witnessing are a testament to progress that countries not witnessing the same improvements can learn from. Under-one, under-five, and adult mortality improvements have lessons that can be shared.

Concerning outcomes, there have been improvements in selected health outcomes such as in communicable disease control (particularly HIV, TB and malaria control), where significant reductions in disease burden have been recorded. In addition, the sustained high levels of some of the health-related outcomes (access to safe water and sanitation, literacy, economic growth, improved housing and gender) are areas that other countries can learn lessons from Kenya.

Regarding outputs, the country has managed to attain high levels of access to health and related services through improvements in physical and financial access. The country has introduced numerous innovations to attain these outputs, from the use of Constituency Development Funding to improve physical access through application of voucher schemes and targeted free services to improve financial access with minimal stress to the health system. The health awareness and education programmes that have built up demand for health and related services, particularly for HIV and malaria, are also key lessons the country can share.

With respect to inputs, the country also has a number of lessons on interventions to improve availability and use of resources. The comprehensive referral strategy and emergency preparedness approach are good practices in organization of service delivery. The HRH strategy and its implementation are commendable, with the experience shared globally at the 2013 Global Health Workforce Alliance conference. The roll-out

nationally of electronic health information systems in low-income settings is novel, and an experience many other countries would benefit from. The capacity to mobilize significantly more resources for health is also a lesson that can be shared across other countries. Finally, the design and application of health partnership arrangements in a difficult environment has many lessons for peer countries.

Specifically, Kenya has unique capacity and expertise to contribute to the health agenda at regional and global levels. The country has been very instrumental in the negotiation for global resolutions and treaties[1]. Kenya is one of the selected countries for capacity building on Global health diplomacy through the University of Nairobi with the financial support of Rockefeller Foundation. Key institutions that serve regional needs include accredited reference laboratories, KEMRI, referral hospitals (public and private), training institutions for HRH and two WHO-prequalified quality control laboratories. Kenya also has HR expertise across various fields of health who actively contribute to regional and global health forums. Kenya has a vibrant private sector and is a strategic hub for communication, including logistics, and innovative ICT solutions across all sectors. These are serving regional and international needs in health and healthcare delivery; and are potential areas for future development and transfer of technology.

1 Framework Convention on Tobacco Control in 2003 (FCTC); International Health Regulations (IHRs 2005); Polio and Guinea-worm Eradication 2012; Consultative Expert Working Group on Research and Development 2012, among others.

03 Development Cooperation and Partnerships

3: Development Cooperation and Partnerships

3.1 The aid environment in Kenya

The country has, in the past, experienced relatively unpredictable flows of international aid. While the country had a dramatic increase in nominal aid in the 1980s (from US$ 393.4m in 1980 to US$ 1,120.5m in 1989/1990), aid decreased during the 1990s to a low of US$ 308.85m in 1999. These flows increased from 2002 in response to a new Government, but again fell sharply in 2008/2009 in response to the events related to the disputed presidential election of December 2008[8]. These ebbs and flows of aid are largely a reflection of the level of donor confidence in the Government's management of the economy and graft.

The increasing aid assistance since 2008/09 is not just a result of resumption of support from existing partners, but also a reflection of increasing support from non-traditional sources of aid, such as China, and other emerging economies. These are increasingly playing a larger role in aid, and focusing efforts more towards infrastructure projects (away from management and operational support favoured by traditional partners).

The country is not a high aid-dependent economy. At its peak in 1989-90, net ODA inflows averaged 14.6 per cent of the gross domestic income, declining to 2.52 per cent in 1999 and were 2.94 per cent in 2002, before increasing to 4 per cent in 2006. However, inflows had increased to 32% by 2011, showing a resurgent increase in the importance of ODA to the economy of late. However, at under 8% of GNI and with a high tax revenue base, Kenyan dependence on foreign assistance is low, compared to neighbouring countries.

Table 5: Key development assistance information

Indicator Name	2006	2007	2008	2009	2010	2011
General government final consumption expenditure (current US$)	3,953,574,184	4,871,204,771	5,020,027,387	4,962,340,198	5,671,098,402	6,063,915,448
General government final consumption expenditure (% of GDP)	17.6	17.9	16.5	16.2	17.6	18.0
Tax revenue (% of GDP)	17.4	17.8	18.8	18.8	19.5	19.9
IDA grants (current US$)	13,621,984	8,602,406	10,390,774	281,976	351,988	213,523
Net bilateral aid flows from DAC donors, Total (current US$)	833,340,000	965,260,000	1,047,360,000	1,308,720,000	1,260,810,000	1,697,360,000
Net official development assistance and official aid received (current US$)	946,700,000	1,326,780,000	1,365,960,000	1,776,200,000	1,628,570,000	2,474,230,000
Net ODA received (% of central government expense)	21.3	25.0	21.0	27.8	22.6	32.3
Net ODA received (% of GNI)	4.2	4.9	4.5	5.8	5.1	7.4
Net ODA received per capita (current US$)	26	35	35	45	40	59
Net official development assistance received (current US$)	946,700,000	1,326,780,000	1,365,960,000	1,776,200,000	1,628,570,000	2,474,230,000
Net official flows from UN agencies, Total (current US$)	41,040,000	48,980,000	69,560,000	49,240,000	47,610,000	67,880,000

Source: World Bank, 2013: World Development Indicators for Kenya

The Government, in its second Medium-Term Plan (MTP 2, 2014 – 2018) has highlighted the need to adhere to aid effectiveness and partnership principles[4]. The Government commits to:

(i) Setting the development objectives through a broad-based and inclusive process;

(ii) Translating its Vision 2030 into prioritized results-oriented operational programmes as expressed in the MTPs, MTEFs and annual budgets;

(iii) Taking the lead in coordinating ODA and across development partners, including civil society and the private sector;

(iv) Coordinating all development partners' joint missions;

(v) Adopting a participatory approach in formulating a mutual accountability framework;

(vi) Ensuring a smooth transition in DP engagement.

On the other hand, the development partners agree to:

(i) Align their assistance programmes to Vision 2030, the second MTP, the revised public procurement and disposal act and other relevant acts of Parliament;

(ii) Align their support through the use of Government's systems in budgeting, procurement, reporting, accounting, auditing and monitoring and have this monitored annually;

(iii) Ensure their support is integrated within the MTP framework and use SWAps and Sector Working groups in planning, budgeting and implementation of programmes;

(iv) Undertake division of labour as agreed on in the Mutual Accountability Framework;

(v) Work closely with the national treasury to ensure support is integrated into the MTEF to provide reliable indicative commitments of aid at least the three months prior to finalization of the preparation of the annual budget, and submit expenditure returns to the national treasury on resources channelled to non-state actors on a quarterly basis.

3.2 Stakeholder analysis

The health sector currently has a number of active partners supporting interventions in the country. Sector partners are categorized as:

- **State actors:** These are either agents of the National or County Governments. National Government agents include the National Ministry of Health (overall sector stewardship), parastatals and other health-related sectors. County Governments, on the other hand, are the 47 Counties.
- **International actors:** These are all international partners supporting the health sector. They are broadly categorized as technical partners and funding partners who support financing for health activities in the country either directly or indirectly by supporting implementing partners.
- **Non-state actors:** These are all the actors supporting the delivery of health services to Kenyans. They are broadly categorized as private for-profit organizations; private not-for-profit organizations (such as faith-based organizations), nongovernmental organizations and civil society organizations); and traditional practitioners (TPs).

Most of the partners provide off-budget financing, with resources from international and non-state actors reflected in the budget being a small percentage of the overall total[16].

Some of the key development partners, their respective areas of focus, and nature of engagement with WHO/Kenya are highlighted in the table below.

Table 6: Focus of support to the health sector in Kenya

Active Health Partners	Health Service Areas									Health System Areas						Related Services		
	HIV	TUB	MAL	NCD	NTD	RH	MCH	DPR	VPD	OSD	HRH	INF	FIN	L&G	HPT	NUT	HPR	WSH
AfDB																		
CF	✓						✓		✓			✓			✓			
DANIDA				✓		✓							✓	✓	✓			
DFID	✓		✓			✓	✓	✓		✓	✓	✓		✓				
EU						✓	✓				✓							
FRANCE																		
GAVI							✓		✓	✓			✓	✓				
GDC-GIZ													✓	✓	✓			
GDC-KFW						✓	✓										✓	
GFATM	✓	✓	✓															
IFC													✓					
ITALY																		
JICA	✓						✓		✓	✓				✓				
SWITZ							✓											
UNAIDS	✓																	
UNFPA						✓	✓											
UNICEF	✓					✓	✓	✓	✓									
WFP								✓										
WHO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
WORLD BANK	✓	✓	✓							✓			✓	✓	✓	✓		
USG-CDC	✓	✓	✓	✓				✓										
USG other																		
USG-USAID	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓		✓	✓	✓		
Total																		

Adapted from the Health Sector shadow budget, 2013/14

The non-state actors are quite many, and varied in the scope of work they are involved in. Most of the non-state actors are currently involved in HIV- TB- and malaria-related interventions.

3.3 Coordination and aid effectiveness in Kenya

The Government ensures overall development assistance coordination through an Aid Effectiveness Secretariat housed in the Ministry of Finance. Coordination is primarily focused on strengthening alignment of donor financing. The Ministry of Planning, however, focuses more on common planning and monitoring systems.

In the health sector, coordination has been ensured through a Health SWAp involving the state, non-state and international actors established formally in 2006. A Sector Code of Conduct and joint planning, budgeting and monitoring tools have been adopted[17], [18]. In addition, a Joint Funding Agreement has been concluded to facilitate the pooling of resources by like-minded partners. Coordination structures have been established for different constituents (non-state actors – HENNET; development partners – DPHK), and for the overall sector (HSCC and ICC's).

In the health sector, the development partners (DPs) are organized around the 'Development Partners for Health – Kenya (DPH-K)' group. WHO/Kenya is officially the secretariat for this group. Membership is open to

representatives from all organizations/agencies whose function is primarily to provide development support to the health sector. They include bilateral and multilateral development partners as well as foundations and global initiative partners. Representatives from other stakeholder groups, such as from the Government of Kenya, and implementing partners are constantly engaged.

Guided by the sector's Code of Conduct and the Paris Declaration on Aid Harmonization and Alignment, the objectives of the DPH-K are to support the health sector in achieving the objectives set out in the NHSSP II, and include:

(i) Strengthening coordination and coherence among DPs working in health;

(ii) Reducing transaction costs for the agencies and Government;

(iii) Efficient engagement;

(iv) Improving the quality of dialogue between MoH and DPs;

(v) Strengthening the harmonization and alignment of DP support; and

(vi) Facilitating support within the context of the SWAp process.

The Code of Conduct also guides engagement of DPs in international partnerships such as the recently launched programmes for International Health Partnership (IHP), and the Harmonization for Health in Africa (HHA).

However, alignment with obligations in the SWAp has not been adequate, as documented in a June 2013 assessment. Systems and processes have been developed, but adherence by Government and partners to these systems and processes is still weak. This has made it difficult for the sector to reap the benefits of a good coordination process.

3.4 UN reform status and the UNDAF process

The presence of the United Nations in Kenya is quite extensive, with a number of agencies having country and regional presence in the country.

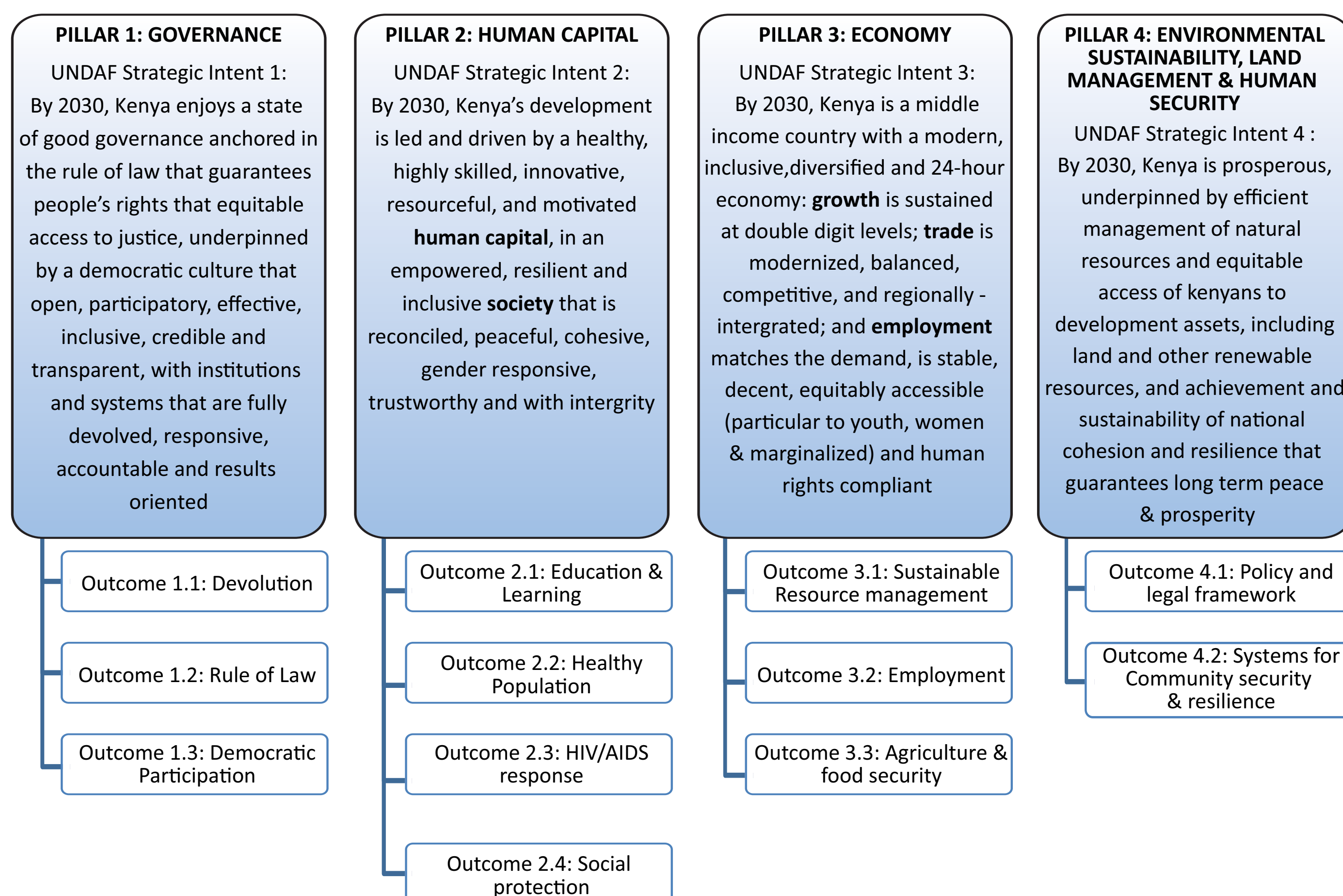
Table 7: United Nations agencies in Kenya

AGENCIES HEADQUARTERED IN KENYA
United Nations Environment Programme (UNEP)
United Nations Human Settlements Programme (UN-Habitat)
UNITED NATIONS COUNTRY TEAM FOR KENYA
Food and Agriculture Organization of the United Nations (FAO)
International Civil Aviation Organization (ICAO)
International Labour Office (ILO)
International Maritime Organization (IMO)
International Monetary Fund (IMF)
United Nations Children's Fund - Kenya Country Office (UNICEF-KCO)
United Nations Development Fund for Women (UNIFEM/UN WOMEN)
United Nations Development Programme (UNDP)
United Nations Drug Control Programme (UNODC)
United Nations Educational, Social and Cultural Organization (UNESCO)
United Nations High Commission for Refugees (UNHCR)
United Nations Industrial Development Organization (UNIDO)
United Nations Office for Project Services (UNOPS)
United Nations Population Fund (UNFPA)
United Nations Programme on HIV/AIDS (UNAIDS)
United Nations Women (UNWOMEN)
World Bank
World Food Programme (WFP)
World Health Organization (WHO)
United Nations Centre for Regional Development (UNCRD)

Source: Adapted from United Nations website (http://www.unicnairobi.org/unagencies.asp)

The country has formally notified the United Nations of its intention to become a Delivering as One self-starter country with the UNDAF 2014 – 2018[19]. The emerging UNDAF for the period was developed within this framework. Its respective strategic intents and outcomes are shown in the figure below.

Figure 7: UNDAF 2014 – 2018 pillars and outcomes



The respective UNDAF outputs are derived from each of the outcomes. Most of WHO activities are reflected in outcome 2.2 (healthy population). Within this context, the UN will work towards supporting the country to have a healthier population that is progressively realizing universal health coverage for health and related services; and adopting healthier lifestyles. The focus of the UN will be on the following outputs:

(i) Output 2.2.1: Health system

(ii) Output 2.2.2: WASH, environmental conservation, food availability and nutrition

(iii) Output 2.2.3: Reproductive, maternal, newborn, child and adolescent health

(iv) Output 2.2.4: Communicable and noncommunicable conditions control

In addition, WHO would directly contribute to UNDAF outcomes 1.1 (devolution), 2.1 (education and learning), 2.3 (HIV/AIDS response), 2.4 (social protection), 3.2 (employment), 3.3 (agriculture and food security), 4.1 (policy and legal frameworks), and 4.2 (systems for community security and resilience).

04

Review of WHO Cooperation over the Past CCS Cycle

4: Review of WHO Cooperation over the Past CCS Cycle

4.1 Introduction

WHO cooperation in Kenya for the period 2008-2013 was guided by Country Corporation Strategy II (CCS II) [20]. CCS II focused WHO's support to the country centred around the scale-up of priority essential health interventions, advocacy on the need to address the determinants of health, health systems strengthening for universal health access and promotion of partnerships and networking. Specific issues addressed in each area are presented below:

Scale-up of priority essential health interventions in routine and emergency situations at the household, community and national levels with specific focus on preventing and reducing the health, social and economic burden of communicable and noncommunicable conditions; reducing morbidity and mortality and improving health during key stages of life, while promoting active and healthy ageing for all individuals; and reducing the health consequences of emergencies, disasters, crises and conflicts and minimizing their social and economic impact.

Advocacy for policies and strategies to address determinants of health with specific focus on addressing the underlying social and economic determinants of health; and improving nutrition and food safety throughout the life-course and in support of public health and sustainable development.

Supporting governance and facilitating the strengthening of health systems for universal and equitable access to quality health services with focus directed towards improving governance, financing, staffing, organization and management of quality and accessible health services informed by evidence and research; and ensuring improved access and quality of medical products and technologies, including appropriate traditional medicines regulation, safety and standards.

Providing technical leadership on matters of health and promoting partnership and networking focusing on providing leadership, based on WHO norms and standards, fostering partnership and collaboration in health to advance health development; and strengthening capacities of the country office to enable it to carry out its mandate efficiently and effectively.

CCS II served to implement WHO's medium-term agenda for the period 2008 – 2013 at the country level through three Biennial Plans of Action (BPOAs). It was developed through a consultative process with Government, the UN and other health sector development partners in the health sector. It was guided by the Kenya Government's Vision 2030, the National Health Sector Strategic Plan II (NHSSP II) and the United Nations Development Assistance Framework (UNDAF).

4.2 External review of CCS II implementation

WHO in Kenya commissioned an independent evaluation of the implementation of CCS II[21]. Through this independent review, a document/reports review was undertaken and supplemented by interviews with ministry of health (MOH) and development partners for health in Kenya (DPHK) officials. The results of the document review and interviews were collated and fed back to MOH/DPHK for validation before presentation to the WHO office in Kenya along with relevant recommendations.

The consultant conducted key informant interviews and focus group discussions with Development Partners in Health Kenya (DPHK) members, ministry of health (MoH) officials and nongovernmental organizations

(NGOs). Key informants from DPHK and NGOs included heads of agencies and health programme officers. Key informants from the MoH included the director of public health and various heads of departments. The interviews sought to enlist partners' knowledge, perceptions and expectations of WHO in Kenya.

4.2.1 WHO strengths

WHO's leadership and development of technical support policies and guidelines in health were pointed out by most partners as a key strength of the organization. Respondents appreciated the role WHO played in defining the Kenya Essential Health Package (KEPH) and ongoing advocacy towards the development and implementation of various guidelines. Communicable disease control programmes in particular were singled out as having benefited more than any other intervention area from WHO support. WHO's strength in influencing policy uptake was said to be enhanced by its close relationship with the Ministry of Health.

It was acknowledged that policy-makers do readily accept WHO recommendations and advice compared with any other partner in health. WHO is therefore better placed to facilitate national uptake of globally recommended policies and guidelines for health care. WHO is also in a position to influence leadership and management in the Ministry of Health and thus advocate for interventions to strengthen health systems.

Table 8: Areas of WHO strength as perceived by partners

Area of Strength	N	%
Policies and guidelines	12	60
Close relationship with Government	10	50
Communicable disease control	9	45
Technical support and guidance	8	40
Immunization programmes	6	30
Health systems strengthening	5	25
Procurement of emergency commodities	4	20
Disease outbreaks response	4	20
Advocacy for NCD	4	20

Source: CCS II review consultant's report, 2013

Kenya's relative success in communicable disease control and immunization for vaccine-preventable diseases was attributed to collective support from WHO and other partners. Furthermore, WHO's existing technical capacity was considered credible, responsive and timely. WHO was well regarded and respected as an important convener within the health sector and this role had been used positively to foster adoption of policies and guidelines and to engender collaboration between partners in the sector including around IHP+ principles of aid effectiveness. Government and two donor partners mentioned WHO's support in the procurement of emergency supplies for disaster response as a particular strength.

4.2.2 Weaknesses

NGO partners felt that WHO at times tends to overlook the inputs of other partners when providing guidance on policy matters in health due to its close relationship with Government. The UN health sector agencies also noted that while WHO represented all health sector UN agencies at key forums, they were rarely consulted on pertinent health issues and when consulted, their views were not always taken forward.

Other areas of WHO's weakness listed by consulted partners include perceived ad hoc/reactive response to humanitarian disasters, non-attendance of meetings convened by development partners, understaffing

in HIV/AIDS, maternal health, disaster response and laboratory accreditation services areas, lack of regular briefings to funding partners and shying away from taking a position on sensitive issues.

4.3 Internal review of CCS II implementation

The internal review encompassed WHO internal desk reviews of all CCS II objectives and expected outcomes. CCS II outcomes were health sector-wide results to which the CCS II contributed towards. Hence, the review of the CCS II outcomes was derived from health sector strategic plan II review which WHO supported the Ministry of Health to conduct in 2011. The other dimension of the review of CCS II results involved reviewing BPOAs for the years of 2008-09, 2010-11 and 2012-13.

4.3.1 Health sector achievement during CCS II period

There are indications of notable health status improvements during the CCS II period. According to DHS (2009), infant and under-five mortality improved from 77 and 115 to 52 and 74 per 1000 live births respectively. Many interventions were introduced during this period to address the burden of communicable diseases. As a result, substantial investments in HIV, malaria and tuberculosis control as well as maternal and child health were made. Furthermore, the country introduced notable initiatives to start dealing with health risk factors, such as tobacco and alcohol abuse.

Owing to the investments made, the country registered significant malaria incidence and prevalence reduction as confirmed by the 2010 community survey. Malaria parasitemia among children under five years of age in the lake endemic areas declined by over 80% between 2002 and 2010 to 38%% primarily as a result of increased ITN coverage.

With regard to HIV/AIDS, major progress has been made with HIV prevalence declining from 7.1% [22] to 5.6%[11]. This resulted from increased knowledge of HIV status by nearly 80% of adults; sustained awareness of HIV at above 90% of the population; continued increase in condom use to over 61.5% for men, scale-up of antiretroviral therapy to 81% of those in need of treatment by end-2013 and reduction in estimated rate of mother-to-child transmission of HIV to 14% at the end of 2013[12]. WHO played an important role in the Joint UN Theme Group on HIV/AIDS.

Estimated TB incidence also came down from the peak of 450 cases per 100,000 population in 2005 to 200 per 100,000 population in 2010. The country also managed to maintain its achievement of 70% case detection rate and 85% treatment success rate since 2006.

4.3.2 WHO specific contribution to health outcomes

During the CCS II period, WHO supported the Government of Kenya in rolling out the RED (Reaching Every District) strategy for EPI. Furthermore, the EPI cold chain was strengthened with additional equipment. New vaccines, including PCV10, were introduced. Polio and measles outbreak response campaigns were conducted following respective outbreaks.

A national integrated plan for elimination and control of NTDs was developed for a coordinated NTDs control in Kenya. National IDSR guidelines were revised and training was carried out in 80% of the districts. IHRs 2005 was implemented through a 2010 -2012 plan. However; the plan had to be extended to 2014 since the minimum core capacities were not met by the end of 2012 as earlier planned. Responses to various epidemics including cholera outbreaks, pandemic influenza H1N1 of 2009 and dengue were supported. A Yellow Fever Risk assessment was conducted in 2013.

In the areas of HIV, TB and malaria, WHO supported continued scale-up and strengthening of the health sector interventions through the provision of programming, resource mobilization and implementation support. Guidelines/strategies were developed to extend HIV interventions for ART, PMTCT, RH/HIV integration, TB/HIV 5Is and HTC. Male circumcision was introduced as an additional HIV prevention intervention and scaled up. National malaria policy 2010, national malaria strategy 2009-2017, national IVM policy and IRS business plan were developed. Malaria RDTs were introduced, LLINs were supplied and IRS was conducted in epidemic-prone regions.

A five-year strategic plan for TB control, TB drug-resistant policy and Practical Approach to Lung Health (PAL) guidelines were developed. TB treatment guidelines were updated; GeneXpert and Fluorescent microscopy diagnostic technologies were introduced. WHO also supported the generation of strategic information through surveys and surveillance; therapeutic efficacy testing and the mobilization of resources from the Global Fund, DFID, UG government and others towards the national HIV, TB and malaria programmes. WHO was also at the centre stage in facilitating partner collaboration, including joint UN working around the three diseases.

WHO also supported the country in progressively strengthening its programming for control of non-communicable diseases and strengthening Mother and Newborn Health (MNH) interventions. National policies and strategies were developed on risk communication and health promotion including healthy diets and physical activity. Health promotion officers were trained and district plans developed. A child survival strategy was developed. A national MNCH Roadmap and national MNH and FP guidelines were developed. Procurement of essential MNH equipment including training mannequins and training of health workers, lecturers/tutors and professional association members was also supported. A service provision assessment, EmONC assessment surveys, a YFS model review and a review of the cervical cancer control programme were also conducted.

Advocacy, technical, financial and logistical support was provided to the national level in the development and implementation of the national platform for disaster risk reduction; strengthening of health and nutrition sector coordination through the MOH; drafting of a health sector component of the national disaster management bill; and strengthening of national capacities for early warning, disease surveillance, outbreak investigation and health emergencies response at district level. Technical, financial and logistical support was provided to counties to develop/implement contingency and response plans for different disasters including post-election violence experienced in 2008; disease outbreaks such as measles, polio and cholera; displacement of populations due to floods, mudslides and internal conflicts; fire disasters, food security emergencies, disease outbreaks and others. The implementation of a Turkana human health security project was also commenced.

Support was provided towards generating health impact analyses on Health in All Policies approach and in establishing a MOH department dedicated to gender mainstreaming. WHO also supported the development of the environmental sanitation and hygiene (ESH) policy, strategy and roadmap including a communication strategy on household water treatment and safe storage. A healthy cities/urban HEART initiative was implemented. Advocacy was conducted on public health problems resulting from climate change, the Libreville Declaration on Health and Environment was operationalized and food-borne surveillance tools were incorporated into the HMIS system.

WHO supported the development of the Kenya Health Policy (2014 -2030) and its first strategic plan (2014 – 2018) in line with the country's Vision 2030. WHO has also advocated for social determinants of health towards addressing health inequities, improving daily living conditions, empowering communities and fostering environmental preservation. Clinical management and referral guidelines and an HRH strategic plan were also developed. WHO also supported capacity building for mid-level health managers, the implementation of annual clinical audits for all hospitals, the client satisfaction survey and the review of sector partnership.

Furthermore, WHO supported the generation of national health accounts for 2009/10 and the strengthening of the legal and institutional framework for KEMSA, in line with the Kenya National Pharmaceutical Policy (Sessional Paper No. 4 of 2012). Access to Essential Medicines surveys were conducted and a pharmaceutical country profile for Kenya was developed. Medicines registration was streamlined, a regulatory unit for medical devices established and Kenya Essential Medicines List (KEML 2010) developed.

4.4 WHO capacity during the CCS II implementation period

The WHO country office is located in the ACK Garden house, close to the Ministry of Health and related health partners. There is also a field office based in Garissa County.

The following is the current staff mix, to facilitate its activities:

- 8 internationally-recruited staff: The WHO Representative, medical officers for HIV, Malaria, Health Systems, road safety, disaster preparedness, immunisation together with the Operations Officer;
- 19 National professional officers for disease prevention and control, immunization and vaccine development, health promotion, integrated disease prevention and control, noncommunicable conditions, tuberculosis, water and hygiene sanitation, road safety, family and community health, essential drugs and medicines, health economics, statistics and health information, and information and communication technology;
- 24 general service staff in the Country Support Unit covering finance, human resources, logistics management, drivers, and administrative assistants.

Organizationally, the staff is grouped into four clusters: WHO Presence; Programme Support; Health the through Life-course & Health Systems; and Disaster Management and Outbreak. Revisions of the organogram will be guided by any future changes in the priorities of the country office.

During the just ended biennium, the total Programme Budget (PB) for Kenya was USD 10,758,000 (AC was USD 2,524,000 and the VC USD 8,234,000). Up to 98% of the AC funds were used to cover staff salary, with VC funding primarily for activities.

Regarding ICT, the country office has standardized the equipment it uses, with regular updates of software and hardware carried out to ensure proper office functioning. The server capacity is currently adequate, to allow smooth uninterrupted functioning of the Global Management System (GSM). The office also has a fleet of 15 vehicles in Nairobi and 3 field vehicles, which are regularly maintained and replaced when they become inefficient.

05 The Strategic Agenda for WHO Cooperation

5: The Strategic Agenda for WHO Cooperation

5.1 Introduction

The work of WHO is interpreted in different ways by different stakeholders. Consequently, WHO is generally expected to support every area that affects health, irrespective of its capacity to do so. There is, however, a need to prioritize a strategic agenda which takes into consideration WHO's capacity to respond to needs and stakeholder expectations. This is a delicate balancing process, but one which defines the eventual usefulness of WHO – focus on too few areas and WHO is perceived as ineffectual, while focus on many areas and WHO capacity becomes too stretched to be effective.

The strategic agenda **defined herein** therefore attempts to strike a balance between these competing needs. Prioritization is based on a clear set of variables defined herein. The absence of an action from the priorities defined does not mean that WHO is not interested in it. It rather implies that WHO would rather focus more on building required partnerships with institutions and organizations that could provide a comparable level of support in the area, to ensure that its objectives are still attained.

In this CCS, WHO/Kenya will be guided by the priorities of the Twelfth General Programme of Work (GPW) defined around six categories of work: five programmatic and one corporate services categories as follows:

(i) **Communicable diseases**: reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria and neglected tropical diseases.

(ii) **Noncommunicable diseases**: reducing the burden of noncommunicable diseases, including heart disease, cancer, lung disease, diabetes and mental disorders, as well as disability and injuries, through health promotion and risk reduction, prevention, treatment and monitoring of noncommunicable diseases and their risk factors.

(iii) **Promoting health through the life-course**: reducing morbidity and mortality and improving health during pregnancy, childbirth, the neonatal period, childhood and adolescence; improving sexual and reproductive health; and promoting active and healthy ageing, taking into account the need to address determinants of health and internationally-agreed development goals, in particular the health-related Millennium Development Goals.

(iv) **Health systems**: supporting the strengthening of health systems with a focus on the organization of integrated service delivery; financing to achieve universal health coverage; strengthening human resources for health; health information systems; facilitating transfer of technologies; promoting access to affordable, quality, safe and efficacious health technologies; and promoting health systems research.

(v) **Preparedness, surveillance and response**: supporting preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and effective management of health-related aspects of humanitarian disasters in order to contribute to health security.

(vi) **Corporate services/enabling functions**: organizational leadership and corporate services that are required to maintain the integrity and efficient functioning of WHO.

These categories of work were translated, based on the UNDAF and KHSSP priorities, into CCS III priorities based on the following criteria:

(i) Whether the issue is a national health challenge;

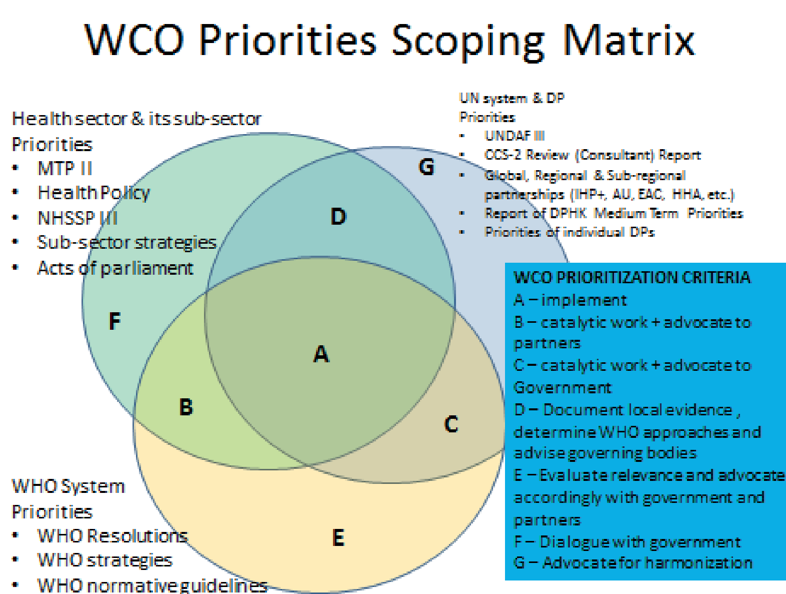
(ii) Whether there is alignment of key actors to support the area of focus;

(iii) Internationally-agreed instruments that involve or impact health such as declarations and agreements, as well as resolutions, decisions and other documents adopted by WHO's governing bodies at the global and regional levels;

(iv) The existence of evidence-based, cost-effective interventions and the potential for using knowledge, science and technology for improving health;

The figure below illustrates the overlapping considerations that are taken into account for identification of CCS III priorities.

Figure 8: WHO priorities scoping matrix



Activities that were in category **A** were awarded highest priority for inclusion in this CCS III. All the activities that fell outside this category are not considered for implementation during the CCS III.

5.2 The strategic agenda

As a result, the defined strategic agenda for WHO in Kenya, during the period 2014 – 2019, is developed across strategic priorities, main focus areas and strategic approaches.

(a) **Strategic priorities:** The outcomes towards which the WHO/Kenya office will contribute. These are five for the CCS III.

(b) **Main focus areas:** These will be the outputs on which WHO/Kenya will focus, in facilitating attainment of the above five outcomes.

(c) **Strategic approach:** The priorities on which WHO/Kenya will focus in each of the main focus areas, based on WHO core functions.

The subsequent tables elaborate on these three levels of the strategic agenda.

5.2.1 CCS III strategic priorities

CCS III STRATEGIC PRIORITIES

STRATEGIC PRIORITY 1: Reduce the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases, using disease control strategies including prevention, treatment, elimination and eradication.

STRATEGIC PRIORITY 2: Halt /stabilize and reverse the rising burden of noncommunicable conditions, injuries ,violence and disability through comprehensive sector-wide evidence-based policy options and strategies coupled with robust monitoring and evaluation systems informed by a continuous research agenda.

STRATEGIC PRIORITY 3: Improve health outcomes and embrace healthy lifestyles in a supportive and enabling risk-mitigating environment through the course of life for improved quality of health and increased health-adjusted life expectancy.

STRATEGIC PRIORITY 4: Put in place a responsive, client-centred, technology-driven and sustainable health system that facilitates movement towards universal access to demand-driven quality health and related services, with protection from catastrophic health expenditures.

STRATEGIC PRIORITY 5: Have adequate capacity for disaster preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and effective management of health-related aspects of humanitarian disasters in order to contribute to health security.

5.2.2 CCS III main focus areas

The main focus areas in each of these strategic priorities are defined in the table below.

Table 9: CCS III main focus areas

Strategic priorities	Main focus areas
STRATEGIC PRIORITY 1:Reduce the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases, using disease control strategies including , prevention, treatment, elimination and eradication	HIV: Support the development and implementation of national policies, strategies and programmes for HIV prevention, testing, treatment and care services to ensure universal access to HIV services.
	Neglected tropical diseases (NTDs): Support the elimination or eradication of selected NTDs by 2019 and beyond.
	Vaccine-preventable diseases (VPDs): Support efforts to increase coverage of vaccination services.
	Tuberculosis (TB): Support Stop TB Strategy in the detection and successful treatment of tuberculosis, including drug-resistant tuberculosis and multidrug-resistant tuberculosis, through integrated services and community, civil society and private sector engagement.
	Malaria: Support the development and implementation of national policies, strategies and approaches to malaria prevention, control and elimination, including the generation and use of strategic information for antimalaria agenda setting and evidence-based targeting of antimalaria interventions towards a malaria-free Kenya.
STRATEGIC PRIORITY 2:Halt/ stabilize and reverse the rising burden of noncommunicable conditions, injuries ,violence and disability through comprehensive sector-wide evidence-based policy options and strategies coupled with robust monitoring and evaluation systems informed by a continuous research agenda.	Noncommunicable diseases (NCDs): Support the development and implementation of sector-wide policies, strategies and programmes, including research and evidence generation, monitoring and assessing the health situation and trends to prevent and control noncommunicable conditions together with their risk factors in order to halt and reverse the rising burden of noncommunicable conditions in Kenya.
	Mental health: Support the development and implementation of strategies, including early diagnosis and data systems which ensure access to services for mental health and substance use disorders.
	Violence and injuries: Support the development and implementation of comprehensive multisectoral national policies, strategies and plans on violence and injury prevention and control, including the generation and utilization of research and information for violence &injury prevention agenda setting and evidence-based options to reduce the burden of injuries and violence in Kenya.
	Disabilities and rehabilitation: Support the development and implementation of evidence- based policies, legislation and strategies to increase access to services for people with disabilities by providing norms and standards on rehabilitative services and monitoring access to services.
	Nutrition: Improve nutrition and food safety through the life-course in support of public health and sustainable development.

STRATEGIC PRIORITY 3: Improve health outcomes and embrace healthy lifestyles in a supportive and enabling risk mitigating environment through the course of life for improved quality of health and increased health-adjusted life expectancy.	Reproductive, maternal, newborn, child and adolescent health (RMNCAH): Support National and County Governments to build capacity to expand access to quality evidence-informed interventions to improve maternal, newborn, child, adolescent and reproductive health, whilst securing the health of older people through healthy behaviours.
	Health promotion: Support health and development, and prevent or reduce risk factors for health conditions using evidence-based and ethical policies, strategies, recommendations, standards and guidelines at national and subnational levels.
	Social determinants of health (SDH): Facilitate the development and implementation of policies and programmes to enhance health equity through strengthened intersectoral collaboration and partnerships for coordinated actions addressing social determinants of health (SDH).
STRATEGIC PRIORITY 4: Put in place a responsive, client-centered, technology-driven and sustainable health system that facilitates movement towards universal access to demand-driven quality health and related services, with protection from catastrophic health expenditures.	Organization of service delivery: Support National and County Governments' in efforts to improve the organization of devolved service delivery to improve physical, financial and sociocultural access to health and related services, with a focus on the organization of the health service package, the health system, health infrastructure, community health, facility management, emergency / referral, outreach and supervision services.
	Health workforce: Support National and County Governments' efforts to improve the production, productivity, motivation, retention and distribution of the health workforce required to attain universal health coverage.
	Health information: Support National and County Governments' efforts to generate, analyse, disseminate and use comprehensive health information from routine health statistics, vital statistics, surveys, census and research.
	Essential health products and technologies: Support National and County Governments' to improve access to essential medicines and health technologies; and to strengthen national and regional regulatory capacity.
	Health financing: Assist the country in defining, applying and monitoring approaches to ensure efficient and equitable use of health finances, in a manner that ensures social protection.
	Health leadership: Support National and County Governments to build capacity for leading the health agenda, in order to attain the policy and strategic objectives of health.
STRATEGIC PRIORITY 5: Have adequate capacity for disaster preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and effective management of health-related aspects of humanitarian disasters in order to contribute to health security.	Disaster risk management: Support the development of national capacities for disaster risk management, including the effective management of health-related aspects of humanitarian disasters.
	Alert and response capacities: Support and focus will continue towards developing, maintaining and implementing policies, strategies and technical guidance, information management, communication and operational systems needed at national and county levels to detect, verify, assess and coordinate the response to serious public health hazards , risks and events as and when they arise, according to 2005 International Health Regulations (IHRs) requirements.
	Epidemic, pandemic and crisis response: Focus support towards (i) implementing relevant international frameworks for pandemic influenza preparedness and sharing influenza viruses and access to vaccines and other benefits; (ii) establishing mechanisms for response to emerging, re-emerging and established epidemic-prone diseases /conditions.
	Polio eradication: Support the complete eradication of polio and attainment of polio-free certification status.

5.2.3 CCS III strategic approaches

The strategic approaches represent the priority actions on which WHO will focus, in support of each of the main focus areas. The strategic approach for each strategic priority in the respective focus areas has been developed.

Table 10: Strategic approaches for attaining strategic priority 1 focus areas

1. STRATEGIC PRIORITY (COMMUNICABLE CONDITIONS) Reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases, using disease control strategies including prevention, treatment , elimination and eradication.		
1.1 Main focus area: HIV/AIDS control (HIV) Support the development and implementation of national policies, strategies and programmes for HIV prevention, testing, treatment and care services to ensure universal access to HIV services.		
1.1.1 Strategic Approach	**1.1.2 Strategic Approach**	**1.1.3 Strategic Approach**
Support **capacity building** for HIV prevention, diagnosis, treatment and care outcomes	Provide **norms and standards** for defining and operationalizing integrated delivery of HIV/AIDS services	Provide **monitoring and evaluation** for HIV/AIDS strategic interventions
1.2 Main focus area: Neglected tropical diseases (NTDs) Support the elimination or eradication of selected neglected tropical diseases (NTDs) by 2019 and beyond, focusing on increasing access to essential medicines for neglected tropical diseases, expanding preventive chemotherapy and innovative and intensified disease management including strengthening national capacity for disease surveillance and certification and verification of the elimination of selected neglected tropical diseases.		
1.2.1 Strategic Approach	**1.2.2 Strategic Approach**	**1.2.3 Strategic Approach**
Provide technical support for the roll-out of preventive chemotherapy and case management of targeted NTDs	Facilitate the strengthening of national NTDs monitoring and evaluation frameworks and reporting thereon	Provide norms and standards for the implementation of strategies and plans for NTD interventions

Support efforts to increase coverage of vaccination services.		
1.3.1 Strategic Approach	**1.3.2 Strategic Approach**	**1.3.3 Strategic Approach**
Provide the evidence base needed to guide policy decisions regarding the introduction of new vaccines and technologies	Provide technical assistance for accelerated control initiatives and scaling-up of the coverage of VPD vaccines	
1.4 Main focus area: Tuberculosis control (TB) Support Stop TB Strategy in the detection and successful treatment of tuberculosis including drug-resistant tuberculosis and multidrug-resistant tuberculosis, through integrated services and community, civil society and private sector engagement.		
1.4.1 Strategic Approach	**1.4.2 Strategic Approach**	**1.4.3 Strategic Approach**
Build capacity for intensified implementation of Stop TB Strategy to scale up care and control of tuberculosis	Provide evidence-based policy guidance on addressing emerging areas in TB control, particularly TB-HIV, MDR/XDR TB, screening for high-risk populations, and integrated community-based TB management	Support operational research to accelerate TB care, particularly in relation to new approaches to managing TB in Kenya
1.5 Main focus area: Malaria Support the development and implementation of national policies, strategies and approaches on malaria prevention, control and elimination, including the generation and use of strategic information for antimalaria agenda setting and evidence-based targeting of antimalaria interventions towards a malaria-free Kenya.		
1.5.1 Strategic Approach	**1.5.2 Strategic Approach**	**1.5.3 Strategic Approach**
Build capacity for targeting feasible cost-effective malaria prevention and control /elimination interventions	Provide norms and standards for strengthening malaria service delivery systems, integrated vector management and quality case management	Improve the monitoring of malaria control by promoting generation and use of strategic information for evidence-based malaria policies and strategies

Table 11: Strategic approaches for attaining strategic priority 2 focus areas

2. STRATEGIC PRIORITY (NONCOMMUNICABLE CONDITIONS) By 2019, the country will have halted/stabilized and reversed the rising burden of noncommunicable conditions, injuries ,violence and disability through comprehensive sector-wide evidence-based policy options and strategies coupled with robust monitoring and evaluation systems informed by a continuous research agenda.		
2.1 Main focus area: Noncommunicable diseases (NCDs) Support the development and implementation of sector-wide policies, strategies and programmes, including research and evidence generation, monitoring and assessing the health situation and trends to prevent and control noncommunicable conditions together with their risk factors in order to halt and reverse the rising burden of noncommunicable conditions in Kenya.		
2.1.1 Strategic Approach	**2.1.2 Strategic Approach**	**2.1.3 Strategic Approach**
Provide technical assistance to engage in multisectoral and policy dialogue to establish policies and plans and implement the 'best buy' interventions to prevent and manage the major noncommunicable diseases, including measures to reduce exposure to their risk factors	Strengthen national capacity for operational research for early detection, diagnosis and use of cost-effective treatment interventions for non-communicable diseases and for the promotion of health-in-all policies and whole-of-government approaches and multisectoral action	Support the establishment and application of a framework for monitoring progress in the prevention and control of non-communicable conditions
2.2 Main focus area: Mental health Support the development and implementation of strategies, including early diagnosis and data systems which ensure access to services for mental health and substance use disorders.		
2.2.1 Strategic Approach	**2.2.2 Strategic Approach**	**2.2.3 Strategic Approach**
Provide technical support to ensure increased access to services for mental health and substance use disorders	Scale up research on prevention and management of mental health conditions	Support the building and strengthening of country capacity to implement strategies for early detection and prevention of mental disorders and suicides
2.3 Main focus area: Violence and injuries Support the development and implementation of comprehensive multisectoral national policies, strategies and plans on violence and injury prevention and control, including the generation and utilization of research and information for violence and injury prevention agenda setting and evidence-based options to reduce the burden of injuries and violence in Kenya.		
2.3.1 Strategic Approach	**2.3.2 Strategic Approach**	**2.3.3 Strategic Approach**

<table>
<tr><td>Provide leadership in supporting the Government to develop policies, strategies, plans and programmes to prevent injuries and violence</td><td>Support research on violence and injuries, in order to provide adequate guidance on appropriate strategies to prevent them.</td><td>Develop norms and standards for addressing violence and injury prevention</td></tr>
<tr><td colspan="3">2.4 Main focus area: Disabilities and rehabilitation

Support the development and implementation of evidence- based policies, legislation and strategies to increase access to services for people with disabilities by providing norms and standards on rehabilitative services and monitoring access to services.</td></tr>
<tr><th>2.4.1 Strategic Approach</th><th>2.4.2 Strategic Approach</th><th>2.4.3 Strategic Approach</th></tr>
<tr><td>Provide technical support in the implementation of disability and development strategies</td><td>Strengthen capacity to develop evidence-based policies and strategies and plans addressing disabilities and rehabilitation.</td><td>Provide norms and standards to address disability and rehabilitation.</td></tr>
<tr><td colspan="3">2.5 Main focus area: Nutrition

Improve nutrition and food safety throughout the life-course in support of public health and sustainable development.</td></tr>
<tr><th>2.5.1 Strategic Approach</th><th>2.5.2 Strategic Approach</th><th>2.5.3 Strategic Approach</th></tr>
<tr><td>Provide leadership for multisectoral policy dialogue addressing food and nutrition primarily for maternal, infant and young child nutrition</td><td>Provide norms and standards on population dietary goals, nutritional status and breastfeeding and policy options for effective nutrition actions for stunting, wasting and anaemia</td><td>Provide technical support to improve capacity to address the double burden of malnutrition included in global food and nutrition security initiatives</td></tr>
</table>

Table 12: Strategic approaches for attaining strategic priority 3 focus areas

<table>
<tr><td colspan="3">3. STRATEGIC PRIORITY (PROMOTING HEALTH THROUGH THE LIFE-COURSE)

Improve health outcomes and embrace healthy lifestyles in a supportive and enabling risk-mitigating environment through the course of life for improved quality of health and increased health-adjusted life expectancy.</td></tr>
<tr><td colspan="3">3.1 Main focus area: Reproductive, maternal, newborn, child and adolescent health (RMNCAH)

Support National and County Governments to build capacity to expand access to quality evidence-informed interventions to improve maternal, newborn, child, adolescent and reproductive health, whilst securing the health of older people through healthy behaviours.</td></tr>
<tr><th>3.1.1 Strategic Approach</th><th>3.1.2 Strategic Approach</th><th>3.1.3 Strategic Approach</th></tr>
<tr><td>Provide leadership in improving the national and county capacity for defining evidence-informed policies and strategies through the life-course.</td><td>Provide technical support to build capacities at national and county levels for implementation of comprehensive integrated packages of interventions that address equity at the primary health care level, including strengthening community participation</td><td>Enhance accountability through strengthened monitoring of RMNCAH interventions defined by related global initiatives (e.g. COIA; Ending preventable maternal & child deaths; every newborn action plan; eliminating new HIV infections among children)</td></tr>
<tr><td colspan="3">3.2 Main focus area: Health promotion

Support health and development, and prevent or reduce risk factors for health conditions using evidence-based and ethical policies, strategies, recommendations, standards and guidelines at national and subnational levels.</td></tr>
<tr><th>3.2.1 Strategic Approach</th><th>3.2.2 Strategic Approach</th><th>3.2.3 Strategic Approach</th></tr>
<tr><td>Strengthen capacity to address major health risk factors through the development of evidence-based strategies and legislation</td><td>Provide leadership in the establishment of effective and comprehensive multisectoral and multidisciplinary collaboration for health promotion to prevent and reduce the occurrence of major health risk factors</td><td>Strengthen monitoring for major health risk factor surveillance through developing, validating and disseminating frameworks, tools and operating procedures</td></tr>
<tr><td colspan="3">3.3 Main focus area: Social determinants of health (SDH)Facilitate the development and implementation of policies and programmes to enhance health equity through strengthened intersectoral collaboration and partnerships for coordinated actions addressing social determinants of health (SDH).</td></tr>
<tr><th>3.3.1 Strategic Approach</th><th>3.3.2 Strategic Approach</th><th>3.3.3 Strategic Approach</th></tr>
<tr><td>Provide leadership in re-orienting the health sector towards promoting health and reducing health inequities</td><td>Strengthen capacity for ensuring inter-sectoral collaboration at national and subnational levels to address social and economic determinants of health</td><td>Facilitate the monitoring of progress and the improvement of accountability through the collection, collation, analysis and dissemination of disaggregated social and economic data relevant to health</td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

Table 13: Strategic approaches for attaining strategic priority 4 focus areas

4. STRATEGIC PRIORITY (HEALTH SYSTEMS) By 2019, the country has a responsive, client-centred, technology-driven and sustainable health system that facilitates movement towards universal access to demand-driven quality health and related services, with protection from catastrophic health expenditures.		
4.1 Main focus area: Organization of service delivery Support the National and County Governments in efforts to improve the organization of devolved service delivery to improve physical, financial and sociocultural access to health and related services, with a focus on the organization of the health service package, the health system, health infrastructure, community health, facility management, emergency / referral, outreach and supervision services.		
4.1.1 Strategic Approach	**4.1.2 Strategic Approach**	**4.1.3 Strategic Approach**
Provide technical support for the development of tools and processes required for appropriate organization of health and related services	Monitor and review country efforts to improve the organization of health and related services	Develop norms and standards for improving the organization of health and related services
4.2 Main focus area: Health workforce Support National and County Governments' efforts to improve the production, productivity, motivation, retention and distribution of the health workforce required to attain universal health coverage.		
4.2.1 Strategic Approach	**4.2.2 Strategic Approach**	**4.2.3 Strategic Approach**
Provide leadership in defining evidence-based strategies for improving the production, productivity, retention and distribution of the health workforce	Monitor the production, productivity, retention and distribution of the health workforce	Define evidence-based norms and standards for guiding investments in the health workforce
4.3 Main focus area: Health information Support National and County Governments' efforts to generate, analyse, disseminate and use comprehensive health information from routine health statistics, vital statistics, surveys, census and research.		
4.3.1 Strategic Approach	**4.3.2 Strategic Approach**	**4.3.3 Strategic Approach**
Provide leadership in developing approaches to generate, analyse, disseminate and use health information from all sources	Provide technical support for the development of appropriate tools and guidelines for the generation, analysis, dissemination and use of health information	Support the comprehensive monitoring of health status and trends, guided by tools and frameworks
4.4 Main focus area: Essential health products and technologies Support the National and County Governments to improve access to essential medicines and health technologies; and to strengthen national and regional regulatory capacity.		
4.4.1 Strategic Approach	**4.4.2 Strategic Approach**	4.4.3 Strategic Approach
Articulate and monitor comprehensive policies and strategies to promote access to essential health products and technologies; and provide technical support to strengthen demand-driven procurement and supply systems	Support the building of institutional capacity for a comprehensive regulatory framework for health products and technologies; and actively contribute to regional regulatory harmonization	Provide technical support to institutionalize the evidence-based selection of medicines and health technologies; to adapt WHO norms and standards for HPTs; and to promote their appropriate use within the context of evidence-based health care
4.5 Main focus area: Health financing Assist the country in defining, applying and monitoring approaches to ensure efficient and equitable use of health finances, in a manner that ensures social protection.		
4.5.1 Strategic Approach	**4.5.2 Strategic Approach**	**4.5.3 Strategic Approach**
Provide leadership in defining appropriate health financing strategies that ensure social and financial risk protection	Support capacity strengthening in health financing at national and county levels of Government	Facilitate the monitoring of health financing trends, and implications for efficiency, equity and social protection
4.6 Main focus area: Health leadership Support National and County Governments to build capacity for leading the health agenda, in order to attain the policy and strategic objectives of health.		
4.6.1 Strategic Approach	**4.6.2 Strategic Approach**	**4.6.3 Strategic Approach**
Support capacity strengthening in improving health leadership and governance at the national and county levels	Provide norms and standards for appropriate leadership and governance for national and county levels of Government	Support the monitoring of the effects of leadership and governance on health outcomes, particularly in relation to principles of aid effectiveness

Table 14: Strategic approaches for attaining strategic priority 5 focus areas

<table>
<tr><td colspan="3">5. STRATEGIC PRIORITY (PREPAREDNESS, SURVEILLANCE AND RESPONSE)

By 2019, the country has adequate capacity for disaster preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and effective management of health-related aspects of humanitarian disasters in order to contribute to health security.</td></tr>
<tr><td colspan="3">5.1 Main focus area: Disaster risk management

Support the development of national capacities for disaster risk management, including the effective management of health-related aspects of humanitarian disasters.</td></tr>
<tr><th>5.1.1 Strategic Approach</th><th>5.1.2 Strategic Approach</th><th>5.1.3 Strategic Approach</th></tr>
<tr><td>Provide norms and standards and develop capacity for disaster risk management, including vulnerability and risk analysis and mapping (VRAM), hospital safety assessment and training programmes to build human resource capabilities for DRM</td><td>Build capacity for disaster preparedness and response planning at national and county levels.</td><td>Strengthen the readiness of WHO country office for WHO and international emergency response in support of national response capacities</td></tr>
<tr><td colspan="3">5.2 Main focus area: Alert and response capacities

Support and focus will continue towards developing, maintaining and implementing policies, strategies and technical guidance, information management, communication and operational systems needed at national and county levels to detect, verify, assess and coordinate the response to serious public health hazards , risks and events as and when they arise, according to 2005 International Health Regulations (IHRs) requirements</td></tr>
<tr><th>5.2.1 Strategic Approach</th><th>5.2.2 Strategic Approach</th><th>5.2.3 Strategic Approach</th></tr>
<tr><td>Support capacity building for strengthening national systems for IHRs (2005) , in surveillance of and response to public health emergencies and events, including targeting capacities for specific hazards like zoonosis, chemical, radiological and nuclear hazards and points of entry</td><td>Provide leadership to monitor, review, analyse and use national information and ensure adequate annual reporting on implementation of the International Health Regulations (2005) and to support reporting on progress made</td><td>Develop norms, standards and SOPs for IHRs (2005) events (public health emergencies, including specific hazards like zoonosis, chemical, radiological and nuclear hazards and points of entry)</td></tr>
<tr><td colspan="3">5.3 Main focus area: Epidemic, pandemic and crisis response

Focus support towards (i) implementing relevant international frameworks for pandemic influenza preparedness and sharing of influenza viruses and access to vaccines and other benefits; (ii) establishing mechanisms of response for emerging, re-emerging and established epidemic-prone diseases /conditions.</td></tr>
<tr><th>5.3.1 Strategic Approach</th><th>5.3.2 Strategic Approach</th><th>5.3.3 Strategic Approach</th></tr>
<tr><td>Support the setting of norms and standards on management of epidemic and pandemic diseases and advocate for intersectoral collaboration to prevent and control outbreaks and epidemic diseases and ensure antimicrobial resistance monitoring</td><td>Provide leadership to coordinate actions among many stakeholders; access to global technical assistance, knowledge and guidance; and surge capacity (mobilizing expert staff and materials rapidly); and information for epidemic and pandemic response for control of epidemic diseases</td><td>Support national research initiatives to advise on adaptation of regional good practices for epidemic preparedness and response, and application of international standards for epidemic diseases; routine and event-based surveillance; early warning; and risk assessment</td></tr>
<tr><td colspan="3">5.4 Main focus area: Polio eradication

Support the complete eradication of polio and the attainment of polio-free certification status</td></tr>
<tr><th>5.4.1 Strategic Approach</th><th>5.4.2 Strategic Approach</th><th>5.4.3 Strategic Approach</th></tr>
<tr><td>Provide norms and standards, and build capacity to boost population immunity through enhanced routine and supplemental immunization activities, focusing on special populations (hard to reach, hard to convince, mobile, urban informal populations)</td><td>Support monitoring and surveillance efforts for detection, notification, investigation, confirmation and reporting of polio virus</td><td>Provide leadership, build capacity and monitor activities towards polio eradication (endgame) by 2018</td></tr>
</table>

5.3 Validation of the CCS III agenda

5.3.1 Validation against the country's strategic priorities

The CCS III is aligned with the country's KHSSP priorities as shown in the table below.

Table 15: CCS III main focus areas, and related KHSSP priorities

CCS III Strategic Priorities	CCS III Main Focus Areas	KHSSP Priority Areas												
		Health Outcomes						Health Investments						
		1	2	3	4	5	6	1	2	3	4	5	6	7
STRATEGIC PRIORITY 1: Communicable disease control	HIV	✓												
	NTDs	✓												
	VPDs	✓												
	TB	✓												
	Malaria	✓												
STRATEGIC PRIORITY 2: NCD control	NCDs		✓											
	Mental health		✓											
	Violence and injuries			✓										
	Disabilities and rehabilitation			✓										
	Nutrition		✓											
STRATEGIC PRIORITY 3: Risk factor mitigation	RMNCAH	✓												
	Health promotion					✓								
	SDH						✓							
STRATEGIC PRIORITY 4: Health systems	Organization of health services							✓		✓				
	Health workforce								✓					
	Health information										✓			
	Essential health products											✓		
	Health financing												✓	
	Health leadership													✓
STRATEGIC PRIORITY 5: Outbreak and disaster management	Disaster risk management				✓									
	Alert and response capacities				✓									
	Epidemic, pandemic and crisis response				✓									
	Polio eradication	✓												

NB: Service delivery outcomes: 1 – Communicable disease control; 2 = Noncommunicable conditions control; 3 = violence and injury prevention; 4 = essential health services; 5 = risk factor mitigation; 6 = health-related sector collaboration. Health Investments: 1 = Organization of health services; 2 = Health workforce; 3 = Health infrastructure; 4 = Health information; 5 = Health products; 6 = Health financing; 7 = Health leadership

5.3.2 Validation against UNDAF 2014 – 2018 priorities

The CCS III is aligned with the country's UNDAF priorities as shown in the table below.

Table 16: CCS III main focus areas, and related UNDAF priorities

CCS III Strategic Priorities	CCS III Main Focus Areas	UNDAF Priority Areas												
		Governance				Human capital			Economy				Environment & security	
		1.1	1.2	1.3	1.4	2.1	2.2	2.3	2.4	3.1	3.2	3.3	4.1	4.2
STRATEGIC PRIORITY 1: Communicable disease control	HIV						✓		✓					
	NTDs						✓							
	VPDs						✓							
	TB						✓							
	Malaria						✓							
STRATEGIC PRIORITY 2:NCD control	NCDs						✓							
	Mental health						✓							
	Violence and injuries						✓							
	Disabilities and rehabilitation						✓							
	Nutrition						✓							
STRATEGIC PRIORITY 3: Risk factor mitigation	RMNCAH						✓							
	Health promotion						✓							
	SDH							✓			✓	✓		
STRATEGIC PRIORITY 4: Health systems	Organization of health services			✓			✓		✓					
	Health workforce						✓		✓					
	Health information						✓		✓					
	Essential health products						✓		✓		✓			
	Health financing						✓		✓					
	Health leadership						✓		✓					
STRATEGIC PRIORITY 5:Outbreak and disaster management	Disaster risk management													✓
	Alert and response capacities													✓
	Epidemic, pandemic and crisis response													✓
	Polio eradication						✓							✓

NB: UNDAF outcomes: 1.1 = Governance Policy & Institutional framework; 1.2 = democratic participation & rights; 1.3 = devolution & accountability; 1.4 = evidence & rights-based decision making; 2.1 = education and learning; 2.2 = health; 2.3 = HIV; 2.4 = social protection; 3.1 = business environment; 3.2 = productive sector & trade; 3.3 = job creation; 4.1 = policy & legal framework; 4.2 = peace and security

5.3.3 Validation against WHO GPW priorities

Lastly, the CCS III is aligned with the WHO Twelfth Global Programme of Work priorities as shown in the table below.

Table 17: CCS III main focus areas, and related WHO Twelfth GPW priorities

CCS III Strategic Priorities	CCS III Main Focus Areas	GPW Categories					
		1	2	3	4	5	6
STRATEGIC PRIORITY1: Communicable disease control	HIV	✓					
	NTDs	✓					
	VPDs	✓					
	TB	✓					
	Malaria	✓					
STRATEGIC PRIORITY 2: NCD control	NCDs		✓				
	Mental health		✓				
	Violence and injuries		✓				
	Disabilities and rehabilitation		✓				
	Nutrition		✓				
STRATEGIC PRIORITY 3: Risk factor mitigation	RMNCAH			✓			
	Health promotion			✓			
	SDH			✓			
STRATEGIC PRIORITY 4: Health systems	Organization of health services				✓		
	Health workforce				✓		
	Health information				✓		
	Essential health products				✓		
	Health financing				✓		
	Health leadership				✓		
STRATEGIC PRIORITY 5: Outbreak and disaster management	Disaster risk reduction					✓	
	Alert and response capacities					✓	
	Epidemic, pandemic and crisis response					✓	
	Polio eradication					✓	

NB: 12th GPW categories: 1 = Communicable disease control; 2 = Noncommunicable condition control; 3 = health in the life-course; 4 = health systems; 5 = disaster preparedness & response; 6 = corporate functions

06 Implementing the Strategic Agenda: Implications for the Entire Secretariat

6: Implementing the Strategic Agenda: Implications for the Entire Secretariat

6.1 The role and presence of WHO according to the strategic agenda

WHO/Kenya views its role as that of a policy and technical advisor, trusted broker and convenor that:

- facilitates the partners' contributions towards supporting the KHSSP implementation, and
- plans and leads the international response to public health emergencies as they emerge in the country.

WHO/Kenya will exercise this mandate through focusing activities on six core areas/functions as articulated in the Eleventh GPW, and reiterated in the Twelfth GPW. These are:

(i) Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;

(ii) Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;

(iii) Setting norms and standards, and promoting and monitoring their implementation;

(iv) Articulating ethical and evidence-based policy options;

(v) Providing technical support, catalysing change and building sustainable institutional capacity;

(vi) Monitoring the health situation and assessing health trends.

The human resource base will continue to be better aligned to enable support towards implementing the agenda as defined in section 5. Any human resource re-profiling during the CCS III implementation period will be driven by this over-arching goal. Human resources improvements will not only focus on improving the numbers, but also ensuring that adequate skills and capacities exist in the country office to facilitate implementation of this strategic agenda. At present, there are internal capacities to focus on each of the identified focus areas, though in many areas these capacities are inadequate in relation to the effort required to provide the support. Resource mobilization efforts will therefore prioritize the building of the existing capacities, to ensure all the main focus areas have adequate capacities to facilitate their implementation.

The WHO representative (WR) carries overall responsibility for the work of WHO in Kenya, and therefore for implementation of this strategic agenda. The WR's functions are coordinated through the WR's office.

The strategic agenda will be coordinated through four clusters in the WHO/Kenya office, namely:

(i) Programme support cluster: It will coordinate the implementation of strategic agenda 1 and 2;

(ii) Life-course and health systems cluster: It will coordinate the implementation of strategic agenda 3 and 4;

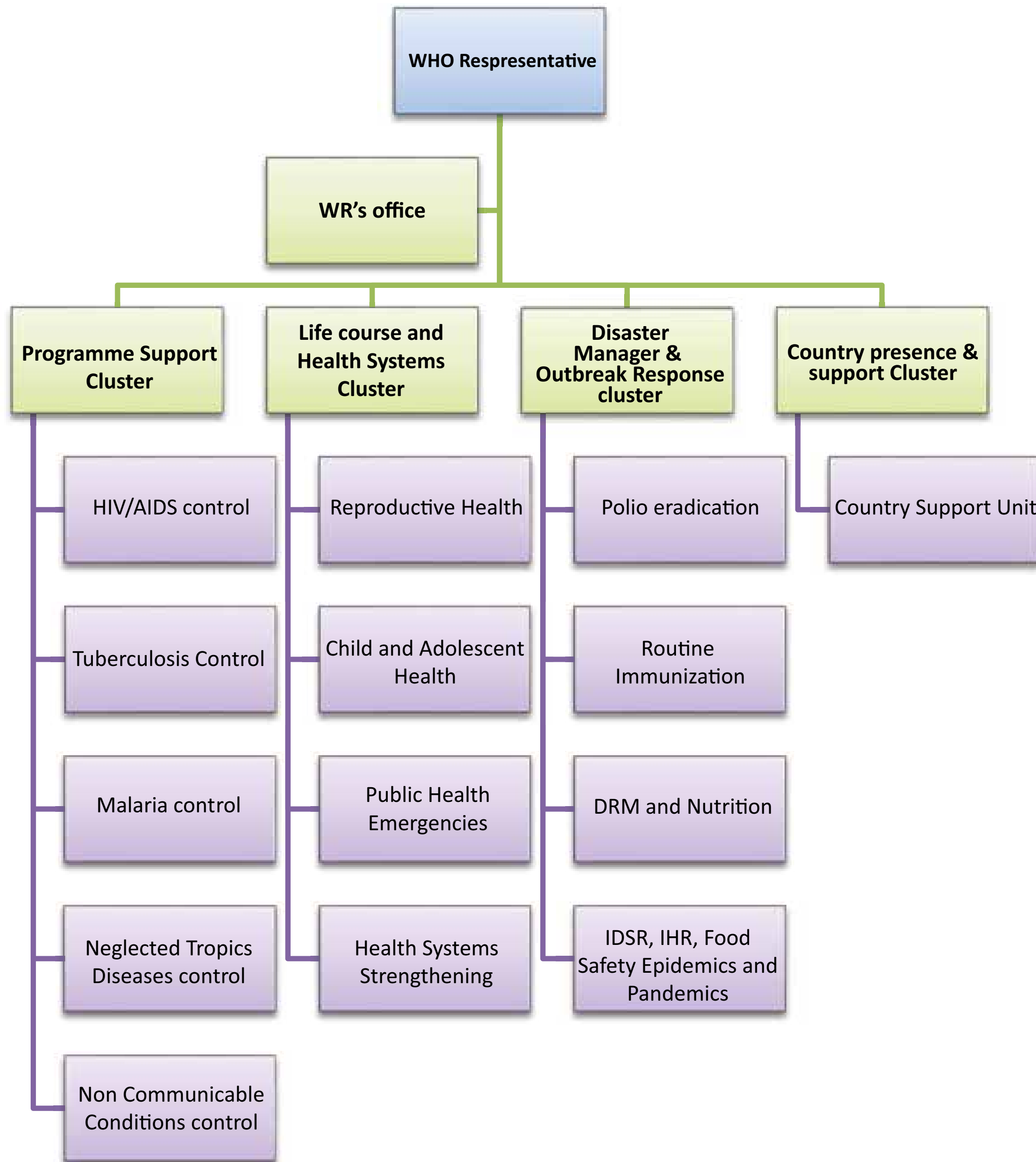
(iii) Disaster reduction and outbreak response cluster: It will coordinate the implementation of strategic agenda 5;

(iv) Country presence and support cluster: It will provide administrative and operations support for implementation of the strategic agenda.

It is expected that the technical programmes in WHO/Kenya will continue to receive support from the other levels of the Organization (IST/ESA, WHO Regional Office and Headquarters).

The country office organizational structure is designed in a manner to facilitate implementation of the strategic agenda, as shown in the figure below.

Figure 9: WHO/Kenya organogram for implementation of the CCS III



The budgets for implementing the strategic agenda will be derived from the World Health Assembly. The country office will take the lead in mobilizing the required resources based on the budgets provided for each of the elements of the strategic agenda. Biennial plans of action will then be developed, based on the known / probable resources.

6.2 Using the CCS

To enable adequate follow-up and implementation of the CCS, the WHO in Kenya will have a clear review and monitoring mechanism to ensure that planned support is maintained. The process will focus on ensuring appropriate linkages to national and WHO monitoring and review processes, as opposed to establishing new mechanisms.

The CCS will be widely disseminated to the national and county governments and other partners in the country to ensure that WHO plans and strategies are clearly understood.

CCS briefs will be produced annually, to provide continuous updates on the work of WHO.

6.3 Monitoring and evaluation of the CCS

The monitoring and evaluation process will focus on demonstrating results. It is envisioned that the outputs from such efforts will continuously guide any re-alignments that may be required for the remaining period of CCS III implementation. Such changes will be appropriately incorporated into subsequent biennial plans and budgets.

This monitoring and review process is both at the operational and strategic levels, and its implementation will be guided by the basic principles of efficiency, equity and effectiveness.

At each level, existing monitoring and review systems will be used. The monitoring process will entail:

(a) Periodic monitoring of progress toward outcomes;

(b) Factors contributing to or impeding progress of the outcomes;

(c) Main focus and how their implementation is contributing to the strategic priorities; and

(d) Contribution of partnerships towards the achievement of the main focus.

At the operational level, CCS III will be implemented and monitored through the Biennial Plans of Action (BPOA's) processes. The focus at this level will be on ensuring that the Organization is supporting the implementation of the appropriate results for each of the objectives it is planning to support. These results will form the basis of the Office-Specific Expected results in the BPOA. Process and output level achievements supporting the achievement of the respective OSERs will be monitored at the semi-annual and annual processes, with the biennial process setting the expected results and products for focus during the biennium.

A mid-term review of the CCS III implementation will be carried out at the strategic level, to review progress, and re-align the CCS III priorities with the country's priorities as this will be the end of the devolution transition period. In addition, the post-MDG agenda will just have been defined, and WHO/Kenya would need to ensure that it is aligned with the agreed agenda.

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ANNEX 1

DEVELOPMENT OF THE KENYA THIRD GENERATION CCS FOR THE PERIOD 2014-2019

THE ROAD MAP

Milestone	Responsible person(s)	Month 2013										Month 2014	
		M	A	M	J	J	A	S	O	N	D	J – M	April
Identification of CCS 3 drafting team ***This was the beginning of the process _March 2013***	WR	✓											
Drafting of CCS evaluation: Status of achievement of deliverables	ALL WCO			✓	✓								
Independent consultation of health stakeholders on WHO expectations, with clear TORs	Consultant Dr Elizabeth Juma			✓	✓	✓							
Drafting team consolidation of CCS 3 outcomes and outputs (26 – 30) ***in a retreat***	WCO drafting team under WR leadership						**26- 30**						
UNDAF Strategic Prioritization Retreat (11 – 13)	WCO under WR leadership							**11 -13**					
UNDAF lessons learnt M&E one day meeting (3 October)	RCO								**3**				
UNDAF Writing Team Retreat Week 7 to 10 October	RCO								**7-10**				
UNDAF development process, ***New UN Resident Coordinator****	RCO									✓	✓	✓	✓
Stakeholder consultation to discuss the draft CCS ***Very important milestone***	All WCO								**22-25**				
Drafting team finalization of CCS 3	WCO drafting team											✓	
Signing of final UNDAF by UNCT and Gov. of Kenya, 26 March 2014 ***Very important milestone***	RCO. UNDAF launch by His Excellence President H. Kenyatta											**26 March**	
Submission of the draft CCS 3 to the Regional Office (CAS) for Steering Committee comments - 25 March 2014	WR											**25 March**	
Comments from the Steering Committee at different levels of the Organization incorporated	WCO under WR leadership												**15-20**
Final submission of the CCS document to RO/CAS, together with CCS Briefs	WR												**20 April**

*** The Road Map was adjusted to respond to the UNDAF development process. In October 2013, a New Resident Coordinator assumed duty and the UNDAF development process experienced some adaptations.*

ANNEX 2

STAKEHOLDERS, ORGANIZATIONS AND INDIVIDUALS CONSULTED

CCS II INDEPENDENT CONSULTANCY REVIEW. List of Key Informants and Group Discussion Participants

Key Informants

Shanaz Sharif	Director of Public Health, Ministry of Health
Tomohiko Sugisita	Health Programmes Advisor, JICA
Willis Akhwale	Head, Department of Disease Prevention and Control, Ministry of Health
Annah Wamae	Head, Department of Family Health, Ministry of Health
Samuel Were	Head, Department of Technical Planning, Ministry of Health
Titus Katembu	Health Education and Gender Focal Person, EU Delegation
Abbas Gullet	Director General, Kenya Red Cross Society
Sylvia Khamati	Health Advisor, Kenya Red Cross Society
Sammy Mahugu	Head, Department of International Health Relations, Ministry of Health
Ramana Gandham	Lead Health Specialist, World Bank Africa Region

Group Interviews

Group 1: World Food Programme (WFP)	
Pippa Bradford	Deputy Director, WFP Kenya
Yvonne Forsen	Lead, Vulnerability Assessment Mapping Programme
Group 2: United States Agency for International Development (USAID)	
Jerusha Karuthiru	Project Management Specialist
Tara Simpson	Deputy HIV/AIDS Team Leader
Rene Berger	HIV/AIDS Team Leader
Group 3: United Nations Population Fund (UNFPA)	
Stephen Wanyee	Deputy Director, UNFPA Kenya
Matilda Musumba	Humanitarian Affairs
Ruben Vellenga	Humanitarian Affairs
Lister Chapeta	Gender and Equality
Group 4: Pharmacy and Poisons Board	
Stephen Kimatu	Director, Medicines and Information Services
Ambrose Kyalo	Department of Drug Registration
Jacinta Wasike	Director of Inspections and Surveillance
James Owuor	Department of Inspections and Surveillance
Group 5: United Nations Children's Fund (UNICEF)	
Marcel Rudasingwa	Country Representative
Awadu Tinorgah	Health Programmes Coordinator
Madhavi Ashok	Deputy Representative and Coordinator of Cluster Activities
Group 6: UNAIDS	
Maya Harper	Country Representative
Guru Rangaiyan	Health Programmes Coordinator
Group 7: German Society for International Cooperation	
Heide Richter-Airijoki	Principal Advisor
Atia Hossain	Health Financing Advisor
Thomas Dammrich	Senior Health Systems Advisor
Group 8: Centers for Disease Control and Prevention (CDC), Kenya	
Kevin DeCock	Director and Head, Division of Global HIV/AIDS (DGHA)

Jennifer Galbraith	DGHA Prevention Services
Evelyne Ngugi	DGHA Care and Treatment Services
Meghna Desai	Malaria Branch Chief & Acting Director KEMRI/CDC Programme
Emmanuel Okumu	WHO-CDC Cooperative Agreement Coordinator
Joel Montgomery	Global Disease Detection (GDD) and Emergency Response Programme
Group 9: Kenya Medical Research Institute	
Solomon Mpoke	Director
Elizabeth Bukusi	Deputy Director, Research and Training
Rosemary Sang	Centre for Virus Research
Peter Borus	Centre for Virus Research/WHO
Group 10: African Medical and Research Foundation	
Lennie Kyomuhangi	Country Director
Meshack Ndirangu	Coordinator, Health Programmes
Peter Ofware	Malaria Programme Manager
George Kimathi	Water and Sanitation Programme Manager
Group 11: UN Office for the Coordination of Humanitarian Affairs (OCHA)	
Gabriella Waaijmang	Humanitarian Coordinator
Lucy Dickinson	Programme Advisor, OCHA

Stakeholder Consultative Meeting, October 2013 CCS 2014-2019 - List of Participants

No.	Name	Organization	Title
1	Mr Mathew Kipturgo	Kenya Medical Training Center	Deputy Registrar
2	Dr Joyce Lavussa	WHO/Kenya country office	NPO/FRH
3	Mr Chris Ouma	UNICEF	Program Officer
4	Dr Simon Njuguna	Ministry of Health	Mental Health
5	Dr A. Tinorgah	UNICEF	Chief CSD
6	Dr Humphrey Karamagi	WHO/Kenya country office	HSS
7	Syphrine Wanyonyi	WHO/Kenya country office	Procurement Assistant
8	Mr Eric Manas	WHO/Kenya country office	Protocol Assistant
9	Dr David Soti	Ministry of Health	Head of Information, M&E
10	Dr James Teprey	WHO/Kenya Country Office	DPR
11	Dr Joseph Sitienei	Ministry of Health	Head, DPPC
12	Dr Lennie Kyomuhangi	AMREF, Kenya	Country Director
13	Dr Okumu Co	UNFPA	Program Specialist
14	Mr Benjamin Murkomen	Ministry of Health	SPHO
15	Mr Nzoya Munguti	Ministry of Health	DLE
16	Manaseh Bocha	Ministry of Health	DCCO
17	Dr Kevin De Cock	CDC	Director
18	Dr Duncan Kibongong	WHO/Kenya country office	NPO/Road Safety/VIP
19	Dr Elizabeth Juma	KEMRI	Research Scientist
20	Dr Ian Njeru	Ministry of Health	SADMS
21	Dr Samuel Ongwae	NBTS-Ministry of Health	NTD
22	Dr Joyce Nato	WHO/Kenya country office	NPO/NCD

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23	Dr Gladwel Gathecha	Ministry of Health	Head Injuries Unit
24	Mr Gurumultey Rangaiyan	UNAIDS	Senior Advisor
25	Ms Nancy Mwema	WHO Kenya country office	Events Assistant
26	Mr Alex Amiani	WHO Kenya country office	Information Assistant
27	Mr Hilary Kipruto	WHO Kenya country office	SHI
28	Dr Juliet Bataringaya	WHO Uganda country office	NPO/OSD Facilitator of the meeting
29	Mr Elijah Kinyangi	JICA	NPO
30	Dr Joyce Onsongo	WHO Kenya country office	NPO/DPC
31	Mr Charles Njuguna	WHO	NPO/IDSR
32	Dr Maurice Maina	USAID	HIV Care Support
33	Dr Nollascus Ganda	WHO Kenya country office	NPO DPR
34	Dr Regina Mbindyo	WHO Kenya country office	NPO/HTC
35	Dr Joel KANGANGI	WHO Kenya country office	NPO/TUB
36	Bouri Jean Victor Sanhouini	UNFPA	Acting Representative
37	Dr Custodia Mandlhate	WHO Kenya country office	Representative
39	Mr Stephen Cheruiyot	WHO Kenya country office	HEC
40	Dr Hellen Mbugua	Ministry of Health	International Health Relations
41	Dr I. B. Amira	Ministry of Health	SDDMS
42	Dr Njeri Mucheru	Ministry of Health	Deputy Chief Pharmacist

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