World Health Organization
REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2008-2013

KENYA

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ABBREVATIONS

ADB	:	African Development Bank
AFRO	:	Regional Office for Africa
AIDS	:	Acquired Immunodeficiency Syndrome
AMREF:		African Medical Research Foundation
ARVS	:	Antiretrovirals
CBO'S	:	Community-based Organizations
CCA	:	Common Country Assessment
CCS	:	Country Cooperation Strategy
CDC	:	Centres for Disease Control
CDF	:	Constituency Development Fund
CHAK	:	Christian Health Association of Kenya
CIDA	:	Canadian International Development Agency
DANIDA	:	Danish International Development Agency
DfID	:	Department for International Development
DG	:	Director-General
DOTS	:	Directly-Observed Treatment, Short-course
DP	:	Development Partner
DPH-K	:	Development Partners for Health – Kenya
EB	:	Extrabudgetary
EHA	:	Emergency and Humanitarian Action
EC	:	European Commission
EPI	:	Expanded Programme on Immunization
ERS	:	Economic Recovery Strategy
FGM	:	Female Genital Mutilation
FP	:	Family Planning
GAVI	:	Global Alliance for Vaccines and Immunization
GDC	:	German Development Cooperation
GF	:	Global Fund
GPW	:	General Programme of Work
GTZ	:	Germany Technical Cooperation
HENNET	:	Health Network for NGO's

HDI	:	Human Development Index
HHA	:	Harmonization for Health in Africa
HIV	:	Human Immuno deficiency Virus
HMIS	:	Health Management Information System
HPR	:	Health Information and Promotion
ICC	:	Interagency Coordination Committee
IDSR	:	Integrated Disease Surveillance and Response
IEC	:	Information Education and Communication
HSSF	:	Health Sector Services Fund
ICT	:	Information and Communication Technology
IDSR	:	Integrated Disease Surveillance and Response
IHR	:	International Health Regulations
IMCI	:	Integrated Management of Childhood Illness
ITN	:	Insecticide-Treated Nets
JAR	:	Joint Annual Review
JICA	:	Japan International Cooperation Agency
JICC	:	Joint Interagency Coordination Committee
JPWF	:	Joint Programme of Work and Funding
JRM	:	Joint Review Mission
KDHS	:	Kenya Demographic Health Survey
KEPH	:	Kenya Essential Package for Health
KHDR	:	Kenya Human Development Report
KEMRI	:	Kenya Medical Research Institute
KEMSA	:	Kenya Medical Supply Agency
KES	:	Kenya Shillings
KHSWAp	:	Kenya Health SWAp
KIHBS	:	Kenya Integrated Household and Budget Survey
KJAS	:	Kenya Joint Assistance Strategy
KNASP	:	Kenya National AIDS Strategic Plan
KSPA	:	Kenya Service Provision Assessment
LLIN	:	Long-Lasting Insecticidal Net
M&E	:	Monitoring and Evaluation
MDG	:	Millennium Development Goal
MDR/TB	:	Multi-Drug Resistant TB
MMR	:	Maternal Mortality Ratio

MOH	:	Ministry of Health
MOMS	:	Ministry of Medical Services
MOPS	:	Ministry of Public Health and Sanitation
MSP	:	Ministerial Strategic Plan
MTSP	:	Medium-Term Strategic Plan
NASCOP	:	National AIDS and STI Control Programme
NACC	:	National AIDS Control Council
NCD	:	Noncommunicable Diseases
NGO	:	Nongovernmental Organization
NHSSP	:	National Health Sector Strategic Plan
NLTP	:	National Leprosy and Tuberculosis Programme
NPO	:	National Professional Officer
RB	:	Regular Budget
SIDA	:	Swedish International Development Agency
SWAp	:	Sector-wide Approach
TB	:	Tuberculosis
UNAIDS	:	United Nations Programme on AIDS
UNDAF	:	United Nations Development Assistance Framework
UNDP	:	United Nations Development Programme
UNFPA	:	Untied Nations Population Fund
UNHCR	:	United Nations High Commission for Refugees
UNICEF	:	United Nations Children's Education Fund
UNRC	:	United Nations Resident Coordinator
USAID	:	United States Agency for International Development
VPD	:	Vaccine-Preventable Disease
WB	:	World Bank
WHO	:	World Health Organization
WFP	:	World Food Programme
WRA	:	Women of Reproductive Age
XDR/TB	:	Extensively Drug-Resistant TB

EXECUTIVE SUMMARY

This Country Cooperation Strategy (CCS) for WHO/Kenya sets forth how the country office will support the implementation of WHO's strategic agenda in the context of the country's priorities and WHO capabilities. It draws on a series of changes in international health, and on expectations on WHO, guided by recommendations and lessons learnt during implementation of CCS1 (2002 to 2005).

This second generation CCS for Kenya (CCS 2) outlines key features through which WHO intends to make the greatest possible contribution to heath in Kenya. The activities of the WHO Secretariat in Kenya (WHO/Kenya) during the lifespan of CCS 2 are based on the 11th General Programme of Work which is elaborated in the Medium-term Strategic Plan for the period 2008 to 2013. The Kenya office will focus on supporting the achievement of the country's health objectives in line with the WHO expectations as outlined in the MTSP.

The national health sector priorities have been used to crystallize the focus of WHO support to the sector during the period of the CCS 2. The areas where WHO/Kenya has a comparative advantage have been identified and the results have been translated into four Strategic Priorities which will guide this Country Cooperation Strategy. The four strategic priorities and their main areas of focus are set forth below:

Strategic priorities, and areas of focus during CCS 2

	STRATEGIC PRIORITY	MAIN FOCUS
1.	To support the scale up of priority essential health interventions in routine, and emergency situations at the household, community and national levels;	To prevent and reduce the health, social and economic burden of communicable and noncommunicable conditions.
		To reduce morbidity and mortality and improve health during the key stages of life, while promoting active and healthy ageing for all individuals.
		To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimise their social and economic impact.
2.	To advocate for policies and strategies to address the determinants of health;	To address the underlying social and economic determinants of health.
		To improve nutrition, and food safety throughout the life-course and in support of public health and sustainable development.
3.	To support governance and facilitate the strengthening of health systems for universal and equitable access to quality health services;	To improve governance, financing, staffing, organisation and management of quality and accessible health services informed by evidence and research. Ensure improved access and quality of medical products and technologies, including appropriate regulation, safety and standards on traditional medicines.
4.	To provide technical leadership in matters of health; and to promote partnership and networking.	Provide leadership, based on WHO norms and standards, foster partnership and collaboration in health to advance health development. Strengthen the capacities of the country office to enable it carry out its mandate efficiently and effectively.

Specific Expected Results (ERs) are defined for each focus area. These Expected Results form the basis for the biennial planning and budgeting.

Institutional Strengthening

The results elaborated in this CCS 2 as well as the objectives outlined will be achieved if the correct investments are made available. These investments relate to human resources, institutional support and financial support. During the lifespan of CCS 2, WHO/Kenya will ensure that these investments are made available in the most effective manner to enable achievement of the expected results. The quantities, qualities and mix of these investments will be dynamic and adjusted based on changing expectations in the course of implementation of CCS 2.

The necessary human resource, institutional and financing layout have been elaborated to guide the development of appropriate programmatic framework that will ensure the achievement of the expected results.

Monitoring and Evaluation

A robust monitoring and evaluation mechanism is essential to ensure effective implementation of the CCS. The process will focus on ensuring appropriate linkages to national and WHO monitoring and review processes, as opposed to establishing new mechanisms.

At the operational level, the monitoring of the CCS 2 shall be through the existing semi-annual, annual and biennial monitoring processes. The focus at this level shall be on ensuring that WHO is supporting implementation of appropriate results for each of the focus areas. Monitoring at this level is based on follow up of process and output achievements.

At the strategic level, the emphasis of monitoring and review processes shall be on how well the expected results are supporting achievement of the main focus of the Strategic Priorities, and will mainly address outcome and impact level indicators. In this context, a major review of outcome and impact shall be done at the Mid-term point of implementation of the CCS 2 in 2010, and at the end term in 2013. It is worth noting that the Mid-term review of CCS2 will coincide with the end-term reviews of the National Health Sector Strategic Plan (NHSSP II), Ministerial Investment Plans, and the Kenya National HIV/AIDS Strategic Plan (KNASP). Therefore, it is expected that a lot of synergies and lessons shall be shared during these reviews for the benefit of both WHO and the health sector in Kenya.

Indicators and milestones to be achieved are elaborated for each main focus in the CCS 2 to guide and support the quantification of achievements in health. The indicators to be used here are all health sector based, and not necessarily WHO-specific. To a large extent, therefore, the role of WHO should be seen as supporting the realisation of national health sector targets. In this way, WHO will associate itself more closely with any progress in national health development, as opposed to creating its own niche and thus fulfilling the ultimate aim of the Organization which is to facilitate achievements of improvements in health. As highlighted in the expected results, WHO will work to influence the achievement of these outcomes directly or indirectly, through building effective partnerships with development and implementing partners to support Government's effort in achieving the health outcomes.

PREFACE

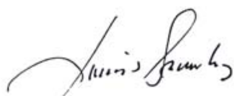
The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.



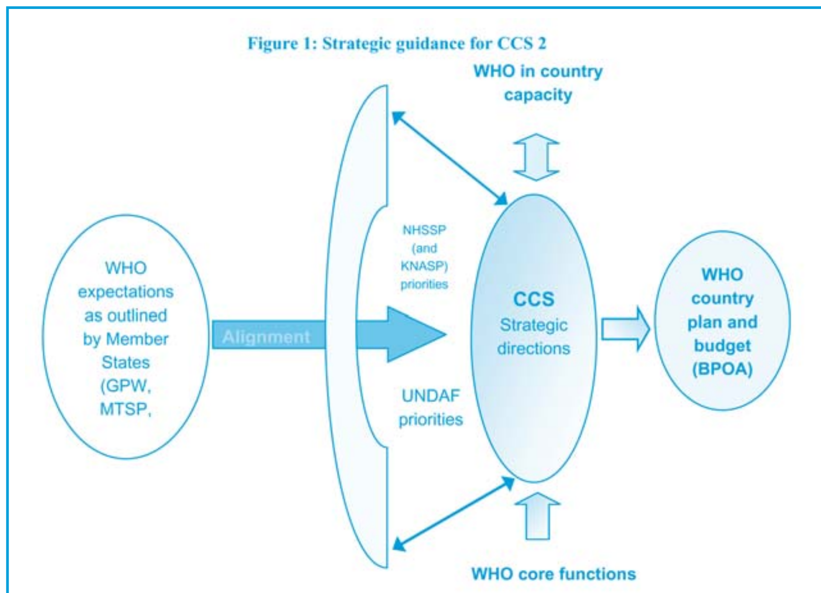
Dr Luis G. Sambo
WHO Regional Director for Africa

SECTION 1

INTRODUCTION

The World Health Organisation (WHO) Country Cooperation Strategy (CCS) is a key component of the Organization's Results-Based Management Framework (RBMF). The CCS guides the strategic direction and medium-term agenda of WHO at the country level, and is operationalised through Biennial Plans of Action (BPOA). The CCS has been developed based on extensive internal consultation, and external discussions with Government and WHO partners in the health sector. Its guidance is illustrated in Figure 1 below.

Figure 1: Strategic guidance for CCS 2



The CCS elaborates how WHO in Kenya will support the implementation of the Organization's strategic agenda, in the context of the country priorities and WHO capabilities. It outlines how WHO in Kenya will contribute to achievement of expectations on the WHO secretariat by the Member States, as elaborated in the 11th General Programme of Work (GPW, 2006-2015), and its strategic plan, the Medium-term Strategic Plan (MTSP, 2008-2013). These are translated at the regional level to strategic directions for the Africa Region.

Prioritization of strategies is guided by expectations of WHO, the Government, the UN and other partners in health towards achievement of their respective strategies. Government strategic approach is outlined in its Vision 2030, and the National Health Sector Strategic Plans (NHSSP's), the UN's in the United Nations Development Assistance Framework (UNDAF), and the health partners in the Kenya Joint Assistance Strategy (KJAS).

This second generation CCS (CCS 2) is for the period 2008–2013. It draws on a series of changes in international health, and on expectations on WHO, guided by recommendations and lessons learnt during implementation of CCS 1 (2002 to 2005). It is designed to enable WHO/Kenya re-align its functioning with the changes in the Health Sector, and in the Aid architecture and its instruments like the Paris Declaration on Aid Effectiveness, International Health Partnership, and the Harmonization for Health in Africa.

Finally, the country is now in a phase of accelerating implementation of interventions that will enable it to achieve its objectives in health, and so achieve the MDGs.

The CCS 2 will therefore aim to:

- Provide the strategic direction for WHO/Kenya in advancing the national health agenda for the five-year period;
- Provide a framework for WHO biennial work plans and budgets; and
- Provide an institutional structure to reflect how the WHO office in Kenya will function and collaborate with the other levels of the Organisation and in country partners.

SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

This section sets the context of the national development agenda and the health sector framework to guide the focus of the CCS 2.

2.1 NATIONAL DEVELOPMENT CHALLENGES

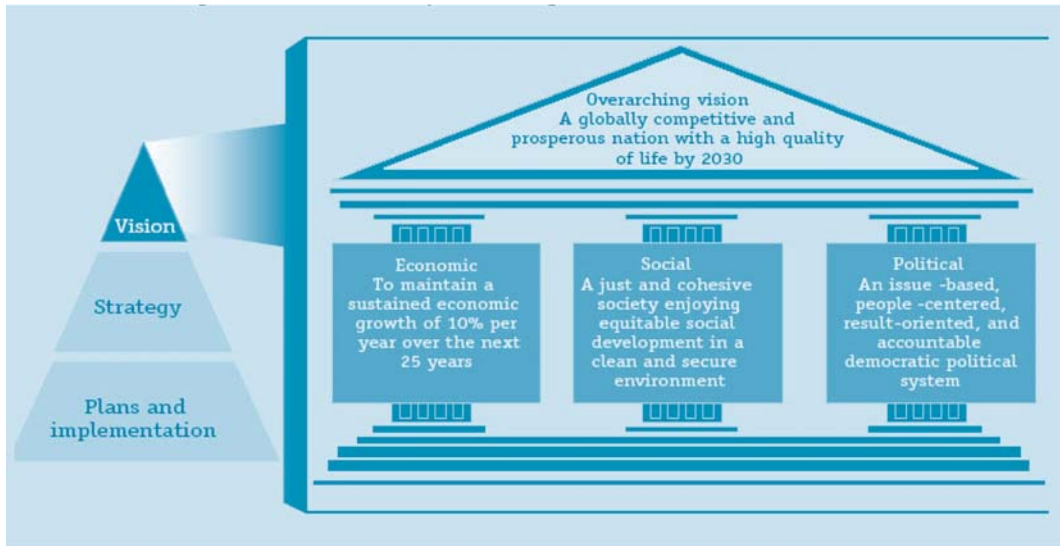
Having experienced two decades of low economic performance, the Kenya Government has been committed to undertaking significant public sector reforms for improved service delivery. The country began an ambitious economic reform Programme that has seen improved public sector management, including public procurement and financial management practices. The health sector has embraced and accelerated these reforms for improved service delivery. By the end of 2006, the country had experienced three years of consecutive growth of over 5% in the face of drought, floods and rising oil prices. The Government increased its budget to strategic priorities for development such as health, infrastructure, education, agriculture and rural development.

Although social indicators are improving, in order to accelerate growth, major challenges must be overcomed. These challenges include: improving governance and reducing corruption, strengthening public safety and rule of law, increased investment in infrastructure, completing the restructuring of parastatals and reducing administrative barriers to doing business in the country.

The period following the elections in December 2007 was characterised by disturbances to the social structure in a number of areas in the country. The implication of this on the economy, health, and social welfare of the different populations in the country will be debated for a while, but will undoubtedly call for a re-examination of strategic interventions in many areas of service delivery.

Kenya's development strategy is laid out in the Vision 2030. This was prepared to guide the development of the medium-term framework to succeed the IPERS. The Kenya Vision 2030 aims to transform Kenya into a middle-income country in 25 years. It specifies its economic, social, and governance goals as shown in Figure 2.

Figure 2: Pillars of Kenya's Development Framework – Vision 2030



Source: Kenya National Economic and Social Council

The country recognizes that achieving the development goals outlined in Vision 2030 will require a stable macroeconomic environment, supported by real time structural reforms. Such reforms would focus on accelerating the rehabilitation and expansion of infrastructure; developing quality human capital to raise productivity and to enhance global competitiveness; maximizing economic opportunities for all Kenyans through targeted programmes to reduce inequality and poverty; encouraging growth of business through improved governance; reducing the inequalities in the economic and social improvements; and developing a more targeted approach to improving overall welfare of the population.

It should be noted that the country draws up Medium-Term Plans (MTPs) every 5 years to guide the prioritization of key activities that will facilitate the attainment of Vision 2030. The CCS 2 time frame is aligned to the time frame of the first MTP, 2008-1013.

2.2 HEALTH STATUS AND HEALTH SECTOR CHALLENGES

2.2.1 Analysis of current national health status

There has been a downward trend in health according to the Demographic and Health Survey of 2003. The country's Human Development Index in 2004 was 0.491, with a rank of 152. Life expectancy at birth for the same year was estimated at 47.5 years, and the Healthy Life expectancy (2002) was 44/45 for males and females, respectively. Maternal, newborn and child health indicators have been stagnating or declining (see Table 1).

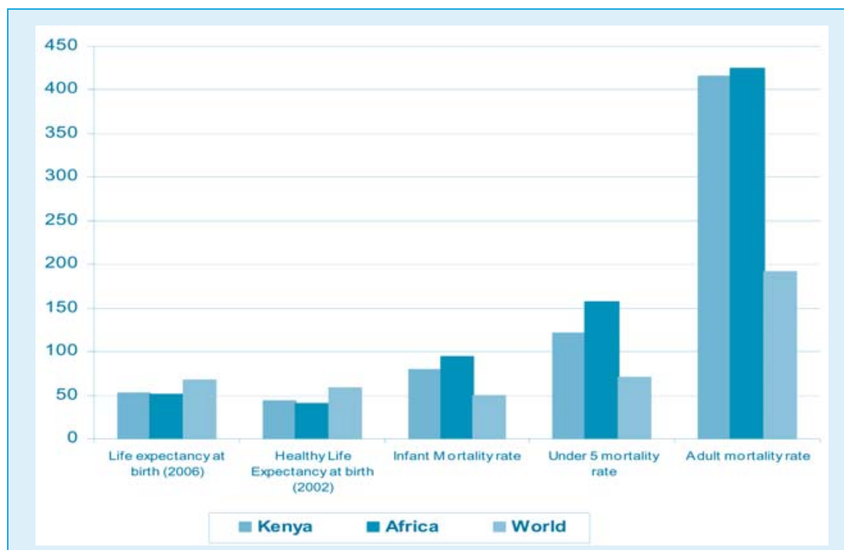
Table 1: Kenya's status with respect to the Millennium Development Goals (selected indicators)

MDG Goal No	Target	Baseline MDG 1990	Baseline NHSSP I 1999/2000	Output NHSSP I 2003	Current estimate 2007	Target MDG 2015
	Kenyan Population	21.4		28.7		NS
	MDG Development Outcomes / Outputs					
4.Child Health	Prevalence underweight children < 5 yrs (%)	32.5	33.1	28	11	16.2
	Reduce IMR/1000 by 2/3 between 1990 and 2015	67.7	73.7	78		25
	Reduce UFMR /1000 by 2/3 between 1990 and 2015	98.9	111.5	114		33
	Proportion 1 year old immunised against Measles (%)	48	76	74	80	90
	Proportion of Orphans due to AIDS	27.000	890.000	1.2 M		
5. Maternal, Sexual Reproductive Health	Reduce MMR /100.000 by ¾ between 1990 and 2015	590	590	414		147
	Proportion of births attended by skilled health staff %	51	NA	42	37	90
	Coverage of Basic Emergency Obstetric Care (BEOC)		24			100
	% WRA receiving FP commodities	—	—	10	43	70
	HIV prevalence among 15-24 yr old pregnant women	5.1	13.4	10.6		NS
6 Disease Control	Malaria Prevalence of persons five yrs and above	NA		30%	14%[2]	NA
	Malaria In-patient Case Fatality Rate[1]	NA		26%		NA
	Pregnant women / children <5 sleeping under ITN %	NA		4 / 5	40/39[2]	80/80[3]
	TB Case Detection Rate (%)	NA		47		60
	Treatment Completion Rate (Smear +ve cases) (%)	75		80		90
7	Access to safe water (National) (%)	48	55	48		74
8	Access to good sanitation (%)	84	81	50		NS
9	% Population with access to essential drugs	NA		35%		NA

Source: Adapted from the National health Sector Strategic Plan II (NHSSP II), 2005 – 2010, and mid-term review of the NHSSP II, 2007. NHSSP I outcomes serve as NHSSP II baselines.

[1] This includes all fever cases treated as malaria. Malaria sentinel surveillance report of 2002 estimated it at less than 5%.
[2] This data is from the malaria indicator survey 2007.
[3] This is the new expected values after adoption of targets to universal coverage.

Figure 3: Health impact in Kenya, compared to Africa and the rest of the world



Source: *WHO: World Health Statistics, 2008*

Figure 3 shows that the values of impact indicators in Kenya are comparable to the rest of Africa, but are generally lower than the global averages. According to the Health Management Information System in Kenya, the leading causes of morbidity in 2007 were malaria (30.8%), diseases of the respiratory system (24.5%), skin diseases (6.1%), diarrhoeal diseases (4.7%), and intestinal worms (4.3%)[2].

The causes of morbidity and mortality in the country are largely driven by the underlying determinants of health that relate to factors in the household/individual, environment, and the health system. The values for key indicators for the underlying determinants of health are well elaborated in the 2006 Kenya Integrated Household and Budget Survey (KIHBS)[3]. Individual/household factors include the low level of maternal education (74% female literacy, as compared to 85% for males), poor nutritional status (34.7% of children stunted), and gender inequalities. On the other hand, factors of environmental deficiencies include poor access to clean water (57% coverage) and adequate sanitation (85.2% coverage of households), environmental degradation and its resultant stresses, presence of vectors, and other disease-carrying variables. Health system factors relate to the weak availability and use of health services, and will be elaborated more in subsequent sections. However, the 2004 Kenya Service Provision Assessment Survey[4] found that 57% of existing facilities could provide a basic package of child, maternal, reproductive health and HIV/AIDS services, even though only 10% of clinics are able to provide 24-hour delivery services. There is a high distance decay factor, with some areas, particularly the pastoral areas with low population densities having very few people living within 5km of facilities.

The weak value of the impact indicators in Kenya is made worse by high levels of disparities in their distribution across the country. The UNDP human development report of 2006[5]

[2] Ministry of Health: Facts and figures on health and health-related indicators, 2008.
[3] Central Bureau of Statistics, 2006. Kenya Integrated Household and Budget survey.
[4] Ministry of Health: Kenya Service Provision Assessment Survey, 2004.
[5] UNDP 2006. Human Development Report.

showed that Kenya had a gini index of 42.5%, which indicates a skewed distribution of development in the country with a quite high value compared to a similar country like Tanzania whose gini index was 34.6%. Marked disparities are also seen across many of the direct and underlying causes of ill-health and death in the country. Data derived from the 2003 Demographic and Health Survey[6] show that in the lowest socio-economic quintile, infant and child mortality rates were up to 50% higher than in the richest quintile, and the incidence of moderate and severe malnutrition was almost four times greater.

The root causes of the weak values of impact indicators are closely linked to high levels of poverty and underdevelopment. Poverty in Kenya is a factor encompassing broad issues of consumption, poverty, powerlessness, exclusion, lack of opportunity, discrimination, marginalization, deprivation of basic services and disparities in infrastructure investments. Other root factors in Kenya include social conflict, and displacement of populations.

2.2.2 Current Policy Response

The Kenya Health Policy Framework is the overarching health policy in the country. It sets out six policy imperatives in health that the Government will focus on for the period of 1994 to 2010. To support the implementation of the strategic imperatives, the sector develops five-year strategic plans (NHSSP's) which outline the medium-term objectives for the sector.

The implementation of the first National Health Sector Strategic Plan (NHSSP I) did not achieve all the targets and indicators of health and socioeconomic development. As a result, health outcomes stagnated or worsened as shown by the increase in infant and child mortality and the stagnation of other key indicators of health. There was also declining utilisation of health services in public facilities, inadequate number of health workers, and low contributions from the public sector to health (from US$ 12/per capita in 1990 to US$ 6/per capita in 2002).

The second National Health Sector Strategic Plan (NHSSP II: 2005 - 2010) was developed with the aim of reducing health inequalities and reversing the downward trends in health-related outcome and impact indicators observed during the implementation of the NHSSP I. The policy objectives of the NHSSP II are to:

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

Plans for implementing the priorities to attain the strategic objectives are set out in the respective investment plans of the sector constituents. These are the Ministerial Strategic Plans (MSPs) for Government, United Nations Development Assistance Framework (UNDAF) for the UN partners, and the Kenya Joint Assistance Strategy (KJAS) for the development partners.

[6] Ministry of Planning, 2005. Kenya Demographic and Health Survey, 2003.

2.2.3 Challenges in Health Sector Delivery

The mid-term review of the NHSSP II was carried out in October 2007. This revealed improvements in specific areas of service delivery due to universal access to targeted interventions. But the health sector still faces many challenges.

Service Delivery

The sector has defined an essential package of care, the Kenya Essential Package for Health (KEPH), that is based on a life cycle approach to delivery of a comprehensive package of care across the different levels of care. However, there is a need for harmonization of services around the implementation of the KEPH approach, and ensuring its universal roll out particularly at the community level.

Child Survival

Significant progress was noted in child survival, particularly as a result of the targeted interventions in malaria, HIV and TB control. However, infant and under-five mortality is still very high. This is due to lack of a comprehensive implementation approach to delivery of effective health and nutrition interventions and practices for children. Various system weaknesses relating to access and availability of key resource inputs (human resources, commodities, infrastructure) hamper the efforts to improve child survival.

Furthermore, adolescent health and child rights remain largely unaddressed. Furthermore, to achieve MDG4 on child survival with a continuum of care approach, it is essential to link maternal and newborn health.

Maternal Health

Maternal mortality is the leading cause of death in women of a childbearing age (15%). An estimated 14,700 women die annually due to pregnancy and its related complications particularly in adolescents (between the ages of 15 to 24 years). The HIV/AIDS pandemic has compounded this problem. Other indirect causes of death during pregnancy include malaria and TB – which are avoidable if women receive antenatal and delivery care from skilled health personnel.

Lack of resources for scaling up evidence-based interventions is the primary obstacle to the implementation of Making Pregnancy Safer Programmes. This is due to inadequate national resource allocation; dependency on unpredictable external funds; poor harmonisation and alignment to national priorities; weak delivery mechanisms, including those for human resources, infrastructure and essential equipments and supplies; inadequate coordination between concerned parties; weak management and monitoring of progress; and inequitable distribution of services.

Combating HIV/AIDS, Malaria and TB

There has been remarkable progress in scaling up HIV and AIDS interventions through support from the Global Fund (GF) and other partners. The current support for the HIV Programme is guided by the country's five year strategic plan, 2006 to 2010. However, there are concerns about the sustainability, due to the government's meagre contribution and over-reliance on external partners. As such, scaling up of ATM efforts towards universal access needs aggressive advocacy with government and partners.

A number of interventions for malaria control have been scaled up, such as vector control through Indoor Residual Spraying in 16 malaria epidemic prone districts, mass

distribution of free long lasting insecticidal nets (LLINs) to under 5's and distribution of highly subsidised insecticide treated nets (ITNs) to under 5's and pregnant women; Intermittent Preventive Treatment for pregnant women; Provision of an effective medicine for case management through introduction of artemether-lumefantrine in public health facilities. However, challenges exist in supporting the scaling up of the interventions. These challenges include weak health systems, inconsistent flow of funds and limited human resources.

Kenya has continued to record an increasing TB burden - registering over 116 723 new TB cases in 2007. Since inception of DOTS in 1994 in Kenya, over ½ million TB patients have been successfully treated. TB/HIV collaborative activities expanded, reaching 79% screening of TB patients for HIV and 37% of them benefiting from ARV in 2007. Almost all districts offering a form of community-based TB care services with 30% of them providing intensive community involvement in TB care. The co-infection rates of TB with HIV continue to increase with a prevalence of 53% in the same period. There is also a threat of MDR-TB and XDR-TB. The National Leprosy and Tuberculosis Programme in conjunction with partners have started new initiatives to address the TB burden such as Community TB care, TB/HIV Collaboration, Prevention and Control of MDR/XDR-TB, TB management in congregate settings, advocacy, communication and social mobilisation among other initiatives.

Noncommunicable Conditions (NCDs)

The country is experiencing a growing threat of noncommunicable diseases. Studies indicate that the prevalence of diabetes has grown from 1% of the population to 3.3% over the last ten years, with up to 10% in the urban areas. Global youth tobacco survey indicates that 13% of the school-going children aged 13-15 years are active smokers of cigarettes. Road injuries are also on the increase. The ministry has established the division of NCDs to address the major NCDs. Human and financial resources are, however, a challenge in undertaking this effectively.

Challenges in Health Security

Kenya has experienced several outbreaks of emerging and re-emerging diseases. The Government has put in place systems for early detection through the Integrated Disease, Surveillance and Response strategy (IDSR). The country has initiated strategies to implement the International Health Regulations (IHR) for public health emergencies of international concern (PHEIC). Other threats to health security arise from conflicts and natural disaster, which Kenya continues to experience.

Cross-border Health

Kenya is prone to a number of disease outbreaks due to the dynamic populations affected by the insecurities and insurgencies in the region. For example, in 2006, there was a polio outbreak in North-Eastern Kenya caused by importation of the polio virus from Somalia. Likewise, in late 2005/early 2006, there was a measles outbreak. The index case was traced to Somalia.

The clashes and conflict that arose as a result of the elections in December 2007 highlighted the need to have the health sector coordinate and manage humanitarian interventions. While the Government has traditionally left management of this humanitarian response largely in the hands of its field partners, its quick and sustained coordination of health response in this case enabled a fast and well-managed intervention. Lessons from this should be strengthened, with the Ministry of Health encouraged to play a more leading role during such humanitarian situations.

Neglected Tropical Diseases. Pockets of Neglected Tropical Diseases such as lymphatic filariasis, leishmaniasis, schistosomiasis, HAT and soil-transmitted helminths exist in Kenya. While these do not represent a significant disease burden, effort to eliminate or contain them are necessary, but are not prioritised in the country's operational approaches.

Health, Environment and Sustainable Development

The country needs to pay more attention to addressing the social determinants of health including education, water and sanitation, and human settlements.

The growing education sector is characterised by gender and geographical disparities which have resulted in low literacy rates and poor health. According to the WHO/UNICEF Joint Monitoring report (JMR) of 2004, 60% of the population had access to safe drinking water and 43% had access to safe sanitation. This has resulted in sanitation-related illnesses. The growing poverty levels are affecting the health of the population in the country.

Service Delivery Inputs (Human Resources, Infrastructure and Commodities)

Inequalities and disparities in the distribution of inputs are due to lack of enforcement of the existing framework which guides appropriate balance in investments needed for delivery and coordination of services.

The human resource situation is not adequate, with only half the nurses needed to implement the KEPH available in the Ministry of Health (MoH). The MoH personnel establishment of 44,813 has up to 80% of staff posts filled – with gross imbalance across cadres and severe rural-to-urban disparities. Human resource deployment mechanisms are inadequately structured and training is not aligned with the sector needs.

Infrastructure is poorly distributed in terms of the numbers and types of facilities. In addition, there is a lack of defined standards for infrastructure and equipment guidelines developed in line with expected functions and human resources. As a result, a high proportion of health infrastructure is not functioning. There is lack of basic technical and administrative equipment to support service delivery including communication, ICT and transport. The introduction of a constituency level decentralized development fund namely, the Community Development Fund (CDF), has led to an increase in health facilities in the country. This expansion has not been entirely guided by need, hence may compound inequality.

Sector Governance, Partnership and Stewardship

The framework to guide the sector governance and stewardship is still evolving. There is, however, a lack of appreciation of the requirements for effective stewardship (a government function) and technical governance (a process that involves all sector actors). There is lack of a framework to guide public/ private partnerships and this constrains the engagement of partners in the sector.

Common Management Arrangements

There are weaknesses in the procurement function relating to the organisational setting, structures, competencies, procedures for good practice, policy and planning. As a result, commodities are not obtained efficiently, transparently, in a timely basis and in sufficient amounts.

The financial management system is ineffective. Resources required for implementation of activities are tardy and existing account codes, budgeting and reporting formats are not suitable for MoH management information needs. Outdated auditing and internal control

arrangements also hamper effective delivery of services. Efforts to strengthen the financial management mechanisms are ongoing through the Government-wide Integrated Financial Management Information System (IFMIS). The sector is also working on the elaboration of a Health Facility Fund; a mechanism to enable direct funding to facilities.

Information management is inadequate. The arrangements for monitoring and evaluation (M&E) and for Health Management Information (HMIS) are highly fragmented and not geared towards performance assessment. In spite of the multiple M&E frameworks in place, reports are hardly shared among the partners. Institutional arrangements are ineffective and despite an emphasis on collection and reporting on patient activity data and surveillance, data entities as a tool for managerial decision-making are poorly managed. More attention is needed for other aspects of the health information platform such as the health system resource-data bases (for human resources, for health accounts and standard supplies). The competencies for managing the system are low and the systems are inadequately resourced.

Sector Financing

Health services and Programmes are financed from Government through the exchequer both directly to the Ministry of Health and indirectly to other sectors with health-related functions (NCPD, MWD, MHCSS), development partners who fund MOH Programmes, the private sector and NGOs. Government financing represents close to 30% of sector financing, second only to household direct out-of-pocket expenditures (see Table 2).

Table 2: Key financing sources from the National Health Accounts

Sources of finances	1994/95	2001/2002	2005/06
Households	53%	51%	39.3%
Government	28%	30%	29.3%
Development partners and International NGOs.	8%	16.4%	31.0%
Private companies	2%	2.3%	
Local NGOs	0.9%	0.7%	
Source not specified	0.4%	0.1%	0.4%

Source: *NHA 2001/02 and preliminary findings for 2005/06*

Government spending on health increased by 37%, between 2002 and 2006. This is in absolute terms (from KES 15 billion to KES 23 billion overall, and from US$ 6.29 to US$ 10.03 per capita spending). However, in relative terms, spending has reduced as a proportion of overall Government expenditure and as a proportion of GDP. Table 3 depicts health expenditures from all sources for the period 2002/03 to 2006/07.

Table 3: Health expenditures (all sources) – in Kshs Million

	2002/03		2003/04		2004/05		2005/06		2006/07	
	Amt	%	Amt	%	Amt	%	Amt	%	Amt	%
Budgetary	15,351	46%	16,441	47%	19,158	51%	23,007	50%	23,178	50%
FIF	1,871	6%	2,432	7%	2,474	7%	2,592	6%	3,151	7%
Development partners	16,000	48%	16,000	46%	16,000	43%	20,000	44%	20,000	43%
Total	33,222	100%	34,873	100%	37,632	100%	45,599	100%	46,329	100%
$ per capita	14.3		15		16.2		19.7		20	
MOH expenditure as % of total Government expenditure	8.33		6.99		6.1		5.73		7.0	

Source: Public Expenditure Review, 2007

The declining pattern in health spending as a proportion of government expenditures shows the risk health faces because of factors and decisions that take place outside the sector especially the macroeconomic trends and government-wide fiscal policy objectives.

The amount of resources from development partners has also increased in the past few years. The known health expenditures from development partners have increased from 16 billion to 20 billion Kenya Shillings in the same period.

Development partner financing represents a small proportion of the known health expenditures as reflected in the official statistics. However, a large proportion of development partner resources are spent off-budget. This implies such expenditures are not reflected in the official expenditures, giving an under-estimation of their contribution, and making it difficult to ascertain the extent to which such expenditures are in line with the sector's priorities. Estimates from the health-sector shadow budget for 2007/08 in Table 4 below indicate the levels of funding from different sources.

Table 4: Sources of funds for different levels of the Health Sector, 2007/08 (US$)

Level of care	Requirements, 2007/08	MTEF resources	Cost sharing	Expected DP support (Indicated by programmes)	Indicative funding gaps	% funding gap
National Level	4 360 029	3 082 456	-	238 912	1 038 661	24%
L-6 National Services	7 330 705	4 455 477	-	138 000	2 737 228	37%
L-5 Provincial Services	11 366 867	3 441 032	359 096	841 808	6 724 931	59%
L-4 District Services	33 040 209	10 422 079	892 625	4 678 450	17 047 055	52%
L-2/3 Rural Services	18 267 419	4 478 478	367 560	4 547 113	8 874 268	49%
L-1 Community Services	608 000	-		-	608 000	100%
Total	74 973 229	25 879 522	1 619 281	10 444 283	37 030 143	49%
Percentage		35%	2%	14%	49%	

Source: Health Sector Shadow budget, 2007/08

2.3 THE CURRENT STRUCTURE OF THE HEALTH SYSTEM IN KENYA

The Health System is defined in line with the need to efficiently, and effectively deliver health services to the population in Kenya. The health system functions both at the national, and sub-national levels.

The national level focus is on coordination of overall guidance for the sector. The functions of the national level are:

(i) strategic planning and policy formulation;

(ii) ensuring commodity security;

(iii) performance monitoring;

(iv) capacity strengthening;

(v) resource mobilization, and

(vi) operational and other researches.

At this level is the Ministry Headquarters, plus various Semi Autonomous Government Agencies like the Kenya Medical Research Institute, Kenya Medical Supplies Agency, Kenya Medical Training College, National Hospital Insurance Fund, and National Referral Centres.

The sub-national level focus is on provision of defined medical services. These are coordinated through 8 provincial levels. Within each province are districts. Medical services also have zonal units that coordinate provision of clinical services across a small number of districts. In Each district are facilities, which provide actual care. These are either provincial hospitals, district/sub-district hospitals or rural facilities (dispensaries and health centres). Below these are community units.

The system is therefore a 6-tier health system. Level 1 is the community units; level 2 is the dispensaries, or basic health facilities; level 3 is the health centres; level 4 is the district level; level 5 is the provincial level, and level 6 is the national level.

Following a dispute over the results of the Presidential and parliamentary elections held in Kenya on December 27, 2007, violence and destruction of properties erupted in many parts of the country, leading to an emergency and humanitarian situation. Estimates suggest over 500 000 persons were affected including those displaced from their homes and unable to access health services, and a number of people sustained injuries.

In an effort to address the post-election challenges to the health sector, a 'Post-election Recovery Plan for the Health Sector' was developed to outline strategies, interventions and outputs needed to restore the capacity of national institutions and communities to restore health services to the level of achieving the goal of the NHSSP II as part of the 'Roadmap for acceleration of the implementation of interventions to achieve the objectives of the NHSSP II'.

The political settlement that resolved the crisis was legalized through the National Accord and Reconciliation Act, 2008. This political settlement necessitated the creation of two Ministries in Health: (i) the Ministry of Public Health & Sanitation, and (ii) the Ministry of Medical Services. Their respective roles and functions have been defined and are set forth in Table 5.

Table 5: Health functions of the various ministries as stipulated by Government in circular No 2/2008

Ministry of Medical Services	Ministry of Public Health and Sanitation
1. Medical services policy	1. Public health and sanitation policy
2. Curative services	2. Preventive and promotive health services
3. HIV/AIDS and other sexually-transmitted infections (STI) treatment and management	3. Community health services
4. Maternal services	4. Health education
5. Rural medical services	5. Reproductive health
6. Clinics and hospitals	6. Food quality and hygiene
7. Registration of doctors and paramedicals	7. Health inspection and other public health services
8. Nurses and midwives	8. Quarantine administration
9. National hospital insurance fund	9. Oversight of all sanitation services
10. Clinical laboratory services	10. Preventive health Programme including vector control
11. Kenya Medical Training College	11. National public health laboratories
12. Kenya Medical Supplies Agency	12. Government chemist
13. Government Chemist	13. Dispensaries and health centres (i.e. Levels II & III)
14. Kenya Medical Supplies Agency (KEMSA)	14. Kenya Medical Research Institute (KEMRI)
15. Regulatory bodies for pharmacy and medicine	15. Radiation Protection Board
16. Member of KEMRI board	16. Member of KEMSA Board
	17. Member of KMTC Board

Each of the Ministries has an investment plan that, based on its mandate, guides its support towards attaining the main focus of the sector set out in the NHSSP II.

SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIPS

3.1 STAKEHOLDER ANALYSIS

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

- **Government of Kenya**, including institutions, sectors and parastatals;
- **Implementing partners**, including all the actors supporting delivery of health services to Kenyans. These 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 Health Practitioners (TP).
- **Development partners**, including all international partners supporting the health sector. These are broadly categorized as: technical partners and funding partners who support financing for health activities in the country either directly or indirectly through supporting implementing partners.

WHO engagement with the development partners is both on financial and technical arrangements in support of the health sector. In addition, WHO also does a lot of networking, advocacy, collaboration and facilitation for health development.

The country has evolved a Sector-Wide Approach (SWAp) to improve the coordination of support received in the health sector. The major development partners including DANIDA, DfID, GDC, Italian Cooperation, SIDA, USG, the World Bank and UNICEF came together under the Joint Support programme to design areas of focus for their support. Coordination mechanisms are continuously being strengthened between the implementing partners. There is active engagement with the formal faith-based service providers (through the Christian Health Association of Kenya (CHAK) and Catholic Health Commission), and the NGO's (through the Health Network for NGO's, HENNET umbrella). However, the private-for-profit providers, and traditional practitioners are not yet appropriately engaged with the sector.

Some of the key development partners, their respective areas of focus, and nature of engagement with WHO/Kenya are highlighted in Table 6 below.

Table 6: Level of support to the Health Sector in Kenya

Agency	Proposed support, 2008 – 2011 (US$)			Notes on funding
	2008/09	2009/10	2010/11	
ADB	-	-	-	No information on specific health sector inputs and funding, not currently engaged with DPHK
Clinton Foundation	21 000 000	27 000 000	35 000 000	Majority of budget is for paediatric ARV procurement and services.
DANIDA	16 118 394	16 324 774	13 277 462	Estimated inputs based on Nov-07 projections. Main components support to HSSF and EMMS (46% of 2008/09 budget), HRH contracting (37%), HMIS, NEP, SWAp support, TA to MOH
DFID	54 153 751	54 756 164	73 827 431	Main components ITNs (41% of 2008/09 budget), HIV/AIDS (18%), condoms (14%), flexible funding (11%) - not yet approved, EHS Project (9%), malaria control (5%).
EU	5 704 257	377 930	1 921 188	Ten projects through NGO implementing partners and UNICEF. General budget support to GOK.
French Embassy	-	-	-	All sector funding channeled through GFATM at global level.
Gates Foundation	-	-	-	Proposing support to malaria - details not available.
GAVI	41 136 526	41 136 526	41 136 526	Projections based on MOH estimated inputs for 2008/09.
GDC	19 307 575	17 854 168	16 531 296	Main components RH (33% of 2008/09 budget), sector governance (16%), sector financing (16%), GBV (16%), PPP (10%), standards/QA.
GFATM	60 910 374	60 910 374	60 910 374	Projections based on inputs for 2008/09.
Government	519 156 071	530 197 120	542 545 944	
Irish Aid	-	-	-	Proposing project-based support to clinical training - details not available.
Italian Cooperation	9 337 920	9 337 920	9 337 920	Main components debt relief flex funds MOH (40% of 2008/09 budget), PPP (33%), projects through NGOs (27%).
JICA	17 184 000	5 587 200	931 200	Estimated inputs based on Nov-07 projections. Main components infrastructure / equipment (58% of 2008/09 budget), HIV prevention and testing (25%), projects through IPs (15%).
Netherlands	-	-	-	No information on health sector inputs, not currently engaged with DPHK.
SIDA	-	-	-	Has withdrawn from health sector effective 2007/08.
UNAIDS	-	-	-	*No information submitted.*
UNFPA	3 079 500	3 079 500	3 079 500	Projects on obstetric fistula, community midwifery, SRH-HIV/AIDS, RH commodity security, safe motherhood, GBV, gender mainstreaming.
UNICEF	4 000 000	4 000 000	4 000 000	Estimated inputs based on Nov-07 projections. Main components child health IMCI, Malezi Bora, KEPI, NEP RH services, emergency health and nutrition.
USG	573 000 000	573 000 000	573 000 000	Projects on global aids programme (PEPFAR), malaria (PMI), TB, child and maternal health, family planning, disease detection.
WFP	3 169 670	3 449 884	3 730 293	No information on specific components.
WHO	7 061 000	7 061 000	7 061 000	Main inputs technical assistance and support to MOH on sector planning, RH, malaria, child health, HIV/AIDS, TB, service delivery.
World Bank	15 000 000	28 000 000	28 000 000	Estimated inputs based on Nov-07 projections. Main components support to health SWAp / KEPH (66% of 2008/09 budget) - NOT YET APPROVED, and TOWA commodities 33%.
TOTAL	1 369 3.19 038	1 385 469 561	1 414 290 134	

Source: *Adapted from the draft Health Sector shadow budget, 2008/09 and the MTEF 2008 – 2011. Does not include estimated resources from cost sharing*

3.2 DEVELOPMENT PARTNER COORDINATION AND UNDAF

The Kenya Joint Assistance Strategy (KJAS) presents the core strategy of 17 development partners for the period 2007 to 2011 and provides the basis for their support for the implementation of the Government's development strategy, including the Vision 2030. These partners are Canada, Denmark, the European Commission (EC), Finland, France, Germany, Italy, Japan, Netherlands, Norway, Spain, Sweden, United Kingdom, United States, African Development Bank, United Nations and World Bank Group.

The UN partners are recognised in the KJAS as one entity, coordinating their support to the country through the UNDAF. The UNDAF describes the collective response of the UN to the country priorities. Priorities in the UNDAF are negotiated among the UN agencies, in collaboration with other partners and the Government of Kenya. Implementation of a new generation of UNDAF commenced at the beginning of 2009, and CCS 2 has clearly elaborated areas where WHO will make its contribution.

In the health sector, Development Partners (DPs) are organised 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 organisations/agencies whose function is primarily to provide development support to the health sector. This includes bilateral and multilateral development partners as well as foundations and global initiative partners. Representatives from other stakeholder groups such as the Government of Kenya, and implementing partners, are constantly engaged.

Guided by the sector's Code of Conduct and the Paris Declaration on Aid harmonisation and alignment, the objectives of the DPH-K are to support the health sector in achieving 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 harmonisation 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).

SECTION 4

WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

This section outlines the overall policy and strategic framework within which WHO is operating. It acts as a guide for the focus and expectations of WHO at the global and regional level, setting the stage for the prioritization process.

WHO has been –and is still –undergoing significant changes in the way it operates, with the ultimate aim of improving its performance in support to Member States, to address key health and development challenges and the achievement of the health-related MDGs. The organizational change process has, as its broad frame, the WHO Corporate Strategy.[7]

4.1 GOAL AND MISSION

The mission of WHO remains "the attainment by all peoples, of the highest possible level of health" (Article 1 of WHO Constitution). The Corporate Strategy, the 11th General Programme of Work 2006-2015[8] and the Strategic Orientations for WHO Action in the African Region 2005-2009[9] outline the key features through which WHO intends to make the greatest possible contribution to health. The Organization aims at strengthening its technical and policy leadership in health matters, as well as its management capacity to address the needs of Member States including the Millennium Development Goals (MDGs).

4.2 CORE FUNCTIONS

The work of the WHO is guided by a set of core functions which are:[10]

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
2. Shaping the research agenda, and stimulating the generation, dissemination and application of valuable knowledge;
3. Setting norms and standards, and promoting and monitoring their implementation;
4. Articulating ethical and evidence-based policy options;
5. Providing technical support, catalysing change and building institutional capacity; and
6. Monitoring the health situation and assessing health trends.

[7] WHO EB 105/3: A corporate strategy for the WHO Secretariat
[8] 11th General Programme of Work 2006-2015. A Global Health Agenda
[9] Strategic Orientations for WHO Action in the African Region 2005-2009
[10] 11th General Programme of Work 2006-2015. A Global Health Agenda

4.3 GLOBAL HEALTH AGENDA

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the WHO Global Health Agenda is always defined and adjusted in line with emerging global health challenges. Recently, the current Director-General of WHO, Dr Margaret Chan, outlined a six-point agenda to guide the work of the Organization. These are:

(i) Promoting Development;

(ii) Fostering Health Security;

(iii) Strengthening Health Systems;

(iv) Harnessing Research, Information and Evidence;

(v) Enhancing Partnerships; and

(vi) Improving the performance of WHO.

In addition, the WHO Director-General pledged that success during her tenure of office should be measured in terms of results on the health of women and the African population.

4.4 GLOBAL STRATEGIC PRIORITIES

The Global Strategic Priorities have been outlined in the 11th General Programme of Work[11]. They include:

1. Providing support to countries in moving to universal coverage with effective public health interventions;
2. Strengthening global health security;
3. Generating and sustaining action across sectors to modify the behavioural, social, economic, and environmental determinants of health;
4. Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health; and
5. Strengthening WHO's leadership at global and regional levels and supporting the work of governance at country level.

4.5 REGIONAL STRATEGIC PRIORITIES

The regional priorities have taken into account, the global documents and the resolutions of the WHO governing bodies, the health millennium development goals, and the NEPAD health strategy, resolutions on health adopted by Heads of State of the African Union and the organizational Main focus which are outlined in the Medium-Term Strategic Plan (MTSP) 2008-2013.[12] These regional priorities have been expressed in the "Strategic Orientations for WHO Action in the African Region 2005-2009". They include prevention and control of communicable and noncommunicable diseases, child survival and maternal health, emergency and humanitarian action, health promotion, and policy making for health and environment, food and safety and nutrition, health systems (policy, service delivery, financing, technologies and laboratories), governance and partnerships, and management and infrastructures.

[11] 11th General Programme of Work 2006-2015. A Global Health Agenda

[12] Medium Term Strategic Plan 2008-2013, Strategic Direction 2008-2013, P. 4, Paragraph 28

In addition to the priorities mentioned above, the Region is committed to support countries to attain the health MDG goals, and assist in addressing its human resource challenge. In collaboration with other agencies, the problem of how to assist countries to source financing for the goals of the countries will be addressed under the leadership of the countries. To meet these added challenges, one of the important priorities of the Region is that of decentralization and the establishment of Intercountry Support Teams to further support countries in their own decentralization process, so that communities may benefit maximally from the technical support provided to them.

To effectively address the priorities, the Region is guided by the following strategic orientations:

1. Strengthening the WHO country offices;
2. Improving and expanding partnerships for health;
3. Supporting the planning and management of district health systems;
4. Promoting the scaling up of essential health interventions related to priority health problems; and
5. Enhancing awareness and response to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT THE COUNTRY LEVEL

The outcome of the expression of WHO's cooperate strategy at country level will vary from country to country depending on the country-specific context and health challenges. But building on WHO's mandate and its comparative advantage, the six critical core functions of the Organization as outlined in section 4.2 and the relevant regional orientations, have all been adjusted in this CCS 2 to suit the needs of Kenya.

SECTION 5

CURRENT WHO COOPERATION

This section outlines the current WHO support to the country, outlining form of support, and key challenges in providing this support.

5.1 REVIEW OF WHO COOPERATION IN KENYA

5.1.1 Framework for Support

The previous WHO cooperation in the country was guided by the CCS 1. It was based on five programme components, based on WHO's comparative advantage and Areas of Work. These were health systems development; disease prevention and control; reproductive and child health; health promotion and environmental health as illustrated in Table 7 below.

Table 7: CCS1 components

Major component	Sub component
Health Systems Development	Health Sector Stewardship and Financing
	Health care quality and efficiency
	Coordination of partners
	Human Resource development and management
Disease prevention and control	Vaccine-preventable diseases
	Diseases of poverty
	Noncommunicable diseases
	Integrated Disease Surveillance and Response
Reproductive and child health	Making pregnancy safer
	Child and Adolescent health
Health Promotion	Health Promotion Strategy
	School Health
Environmental health and sustainable development	Environmental sanitation and hygiene
	Water quality control
	Food safety

The CCS 1 was developed in line with the Kenya Health Policy Framework (KHPF) and was to be operationalised in biennial plans and budgets. Operations during the CCS 1 were over the whole range of health interventions being provided in the country. The focus was on:

- Leverage policy and technical direction in the health sector as a whole, and for different interventions areas.
- Initiation and strengthening of service delivery strategies. For example, initiation and scale up of different interventions has been supported in TB (DOTS, MDR/TB), malaria (new interventions for Indoor Residual Spraying, Insecticide Treated Materials, Intermittent Preventive Treatment for pregnant mothers, use of Rapid Diagnostic

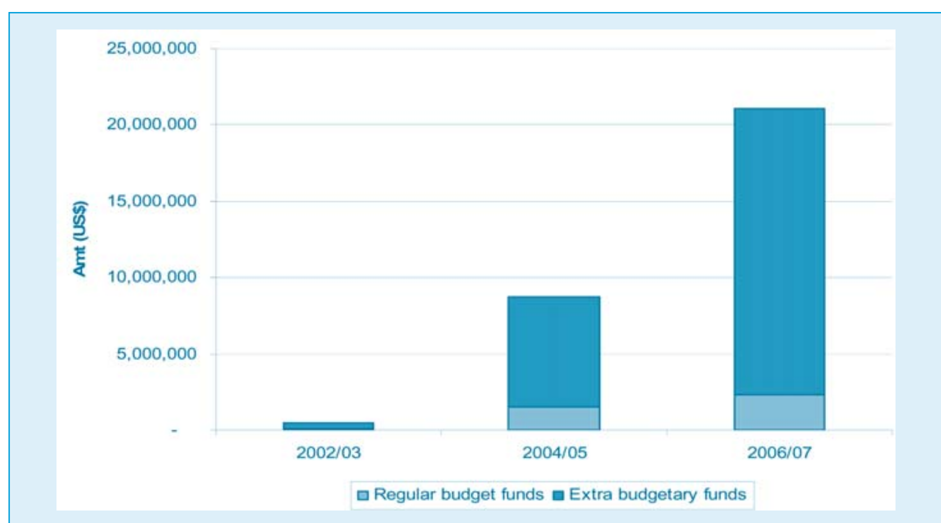
Test's, drug policy change and introduction of artemether combined therapies), HIV/AIDS (3 by 5 policy implementation, leading to rapid ART use, Provider-Initiated Testing and Counselling), EPI (new vaccines, safe injection), IDSR and other health determinants (water / sanitation, nutrition), NTDs, NCDs, etc.

- Systems support at programme, and sector-wide levels particularly in planning, monitoring, governance, partnership strengthening, etc.
- Resource mobilization for support to the health sector, both globally and in country. This has been in Malaria (Global fund, DfID, PMI, World Bank, etc); HIV (Global Fund, Italian Cooperation, OGAC, etc); NTDs; EPI (GAVI); RH; EHA; IDSR (CDC, Africa Development Bank); etc.

5.1.2 Financial Resource Levels

Resource flows to support the Organisation's activities in Kenya have evolved over the period. Overall expenditure on activities by the Organisation during the recent past is illustrated in Figure 4 below.

Figure 4: Actual WHO/Kenya expenditures on activities, 2002-2007



Source: *WHO expenditure records; 2002/03, 2004/05 and 2006/07*

Resource flows to the office increased from under US$ 500,000 in 2002/03 to over US$ 21 million by 2006/07 biennium. The increase is more noted with the extrabudgetary funds and resources mobilised by WHO to complement its regular funds. The increases in these extrabudgetary resources have enabled the expansion of WHO support in line with the country needs.

Additional resources were provided from other levels of WHO to support activities in Kenya. These resources have been increasingly channelled to Strategic Priorities identified by the country. The major areas of financing in the 2006/07 biennium were Malaria, EPI, EHA and HIV.

5.1.3 Human Resource Levels

WHO's core functions revolve around leadership in health, primarily through the provision of evidenced-based policy guidance and technical support. It is important to note that WHO's primary function is not financial contributions to the health sector or at implementation level.

These core functions rely on the availability of a skilled, high quality human resource. The WHO CCS determines the human resource needs. Therefore there was an increase in technical staff in 2003 to support implementation of the previous CCS.

After 2003 there has been a small increase in technical staff relating to human resource needs and re-profiling the country office. Recently, the office was strengthened with the addition of international officers for HIV, Malaria and Health Systems Support. In the last year, most of the posts have been made permanent (from short-term contracts), giving a more predictable and stable human resource base for the Country Representative to manage and deploy.

The country office has changed its organisational structure, shifting from disease-based Programmes to cluster working, whereby teams of staff concentrate on cross-cutting issues to improve WHO harmonised support.

The overall staffing levels of WHO in Kenya are illustrated below.

Table 8: Overall staffing in WHO Kenya

	2002	2003	2004	2005	2006
Technical staff	15	22	25	26	27
Support staff	16	20	20	22	25
Total staff	**31**	**42**	**45**	**48**	**52**

A significant added value of WHO is the availability of specialised skilled technical support at the regional and at headquarters levels. In the last two years, this resource has been further decentralised to subregional offices or intercountry support teams.

5.1.4 Recommendations from the CCS 1 Review

The five components of support in CCS are as follows:

Disease Prevention and Control

This domain focused on diseases of poverty, noncommunicable diseases, integrated disease surveillance and response, diseases targeted for eradication and elimination and health environment and sustainable development.

Vaccine-preventable Diseases (VPDs)

The programme contributes to the achievement of the MDG targets in Kenya. Interventions are highly cost-effective and the WHO has a visible downstream presence. However, financial support comes largely from voluntary contributions which are unpredictable and unsustainable. As Kenya strengthens the sustainability of interventions and introduces additional interventions beyond the traditional focus of VPDs, it is imperative that WHO continues to support this area of work.

Other Diseases Targeted for Eradication and Elimination

WHO has invested in the acceleration of disease control towards the elimination of targeted Neglected Tropical Diseases (NTDs). However, there is limited partner involvement and government investment in the management of the NTDs. There are significant expectations on WHO input in this area. However, additional financial and technical resources will be needed to maintain adequate response.

Diseases of Poverty

HIV, TB and Malaria are recognised as major causes of ill-health and poverty in Kenya. WHO is supporting the scale up of a number of interventions. These include intensified case finding for TB among vulnerable groups such as in the networks of persons living with HIV/AIDS, slum dwellers, mobile population in the manyatta's and prison inmates; increasing treatment access by providing free medicines and free laboratory services; decentralisation to community-based care services to reduce transport costs; HIV prevention and treatment scale up; and use of ITN's and strengthened malaria management. Human resource review for this area shows a need to strengthen the WHO country office with additional staff to support the accelerated scaling up of the interventions. Financial support through WHO in this area comes largely from external sources which are unpredictable and not sustainable. There are other players in the sector who support these interventions through other mechanisms that complement WHO efforts.

Noncommunicable diseases

The threat of NCDs is growing and is increasingly contributing to morbidity and mortality, leading to a double burden of disease as communicable diseases are not yet fully addressed. NCDs are not given adequate priority due to limited data and lack of national policies on major NCDs. Financial and human resources are also a major challenge and have limited WHO support in this area. Technical inputs have been available, but have been piecemeal due to the wide scope of the work and interventions that are required to address the NCDs agenda. WHO's comparative advantage in technical leadership and coordination needs to be strengthened, particularly as there are a number of players in this field.

Integrated Disease Surveillance and Response (IDSR)

IDSR is the backbone for communicable disease prevention and control in Kenya. WHO provides most technical support upstream and has provided guidance to scale up the programme. It is a low-cost intervention area and WHO's technical lead is well recognised by supporting partners. However, financial limitations have prevented the country from implementing the strategy in all districts.

Continued support is needed to incorporate International Health Regulations (IHR), emerging conditions and diseases, based on priorities especially malnutrition. To sustain the gains and ensure sustainability, WHO is consolidating surveillance functions and recourses of VPDs and IDSR into one Main focus.

Maternal and Child Health

Child and Adolescent Health

This area is a defined priority for Kenya and a key focus area for WHO. WHO has supported the adoption of the IMCI strategy and its adaptation to Kenya and advocates for scaling up the efforts and additional partner support. In addition, WHO has supported the implementation of various key packages of other cost-effective interventions. Scaling up of

interventions requires significant resources. However, financial support for child survival has been low. In addition, the support for adolescent health interventions has also not been prioritised. There is a need for enhanced advocacy and improved resource mobilisation for WHO to meet expectations in child and adolescent health. New or refined strategies to ensure sustainability of interventions, such as integration and coordination with other related programmes, need to be explored.

Making Pregnancy Safer

Reproductive health continues to be a major challenge area and a core area of WHO technical support. WHO is supporting Kenya in the implementation of a number of strategies to reduce maternal and newborn mortality and morbidity. However, financial and human resources constraints have limited WHO support in this area. Technical inputs have been available, but have been piecemeal due to the wide scope of the work and interventions needed to address the reproductive health agenda. WHO's comparative advantage in technical leadership and coordination needs to be strengthened, particularly as there are a number of players in this field.

Health Systems Development

The health system domain focused on health system strengthening; health care equity; coordination of partners; and human resource development. This is a priority focus area for WHO and support continues to evolve with the changing needs of the country's health systems. Specific areas of support include: health system policies, poverty and health, essential drugs and medicines, health financing and social protection, and human resources for health. The area of health systems strengthening is a key priority of the health sector in Kenya, with high level of expectation of WHO participation by the Government and all partners. WHO is expected to provide leadership and technical guidance. Therefore, WHO/Kenya needs to build its capacity to adequately respond to the sectors' expectations.

Health Promotion

Kenya has strengthened the role of health promotion in its strategic approach and the service delivery approach is outlined in the KEPH. These strategies have been incorporated as part of the implementation approach in many of the intervention areas supported by the need to follow up and monitor the level of implementation and the impact of health promotion activities. WHO did not have the additional capacity needed to provide this level of support during the CCS1. Instead, WHO support for health promotion for focused on the communication function, in line with the regional health promotion strategy.

There is an expectation for WHO to provide a leadership role in health promotion. Therefore, WHO needs to focus on strengthening the implementation and follow up of health promotion-related activities across the different intervention areas. The capacity of WHO in Kenya needs to be strengthened to provide this support. Additional skills, coordination and management support are needed through availability of additional human resources.

Health, Environment and Sustainable Development

There is a high risk of environment-related diseases in Kenya. WHO has provided continuous support in this area at a relatively low cost. However, as the country continues to implement new interventions and technologies, and is faced with climatic changes, urbanisation and associated challenges of unplanned settlement, the scope of work will widen, increasing the need for additional technical assistance. WHO's comparative advantage in technical leadership and coordination needs to be strengthened, particularly as there are a

number of players in this field. In particular, WHO should take on the leadership of the multisectoral coordination mechanism to address multiple demands.

Specific recommendations by area of work are included in Appendix A. However, the key issues emerging from the CCS 1 include:

- Strengthening the advocacy role of WHO through ensuring adequate provision of information to all partners in the sector in order to influence policy;
- Fortifying the stewardship function of the MoH through the development of comprehensive policy frameworks in respective areas of focus;
- Increasing emphasis on building partnerships across the sector within areas of focus;
- Institutionalising operational mechanisms and support for integration of activities;
- Targeting interventions to support equitable access and delivery of services;
- Mainstreaming gender issues in health; and
- Supporting the integration of joint planning, monitoring and review.

These recommendations have been considered in the development of the Strategic Priorities for the WHO Office in Kenya. The key changes to be highlighted in this CCS 2 as a result of lessons learnt during the CCS 1 implementation are as follows:

- The need for better alignment of the needs of different constituencies. The WHO in Kenya needs to respond to the expectations the Government, the World Health Assembly, and other partners with whom it is working in health. As such, this CCS 2 strategic approach is designed to respond to the expectations of each of these constituencies.
- More detail is provided on the actual results and objectives to be achieved. This makes it easier to monitor and follow up on planned achievements.

A stronger Monitoring, Review and Evaluation component has been included, to ensure that the WHO in Kenya is constantly guided, and follows up on a defined strategic approach, allowing for re-alignment of planned interventions during the course of implementation to ensure its input is always relevant. This allows for emerging issues to be incorporated in the implementation of the strategic approach.

SECTION 6

STRATEGIC AGENDA: PRIORITIES FOR WHO/KENYA COOPERATION

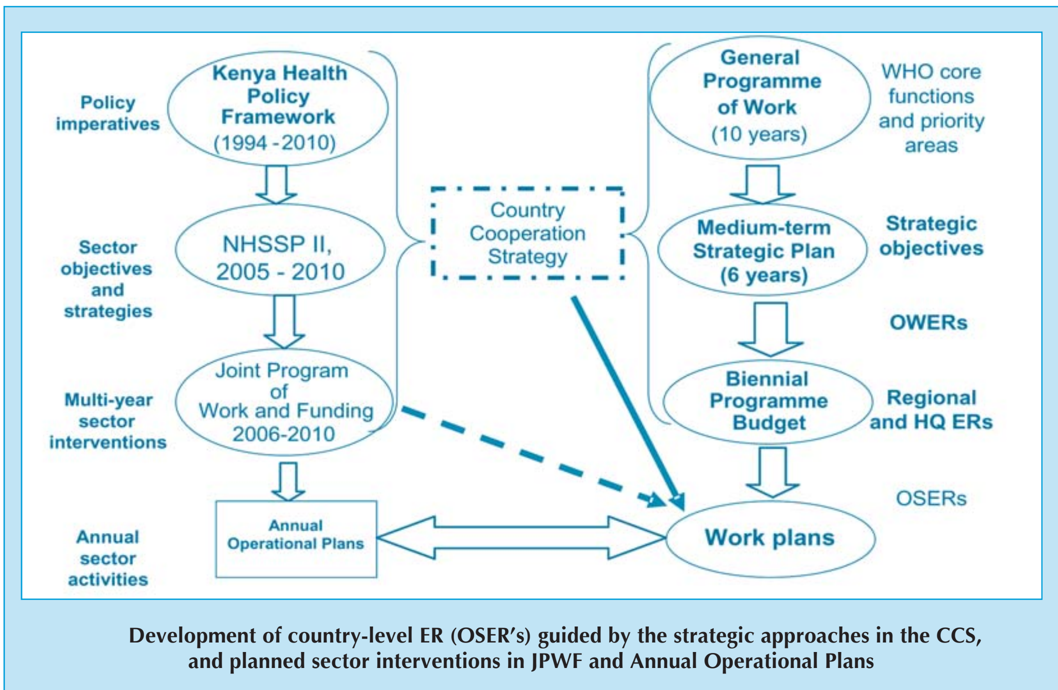
This section highlights the overall strategic focus of WHO in Kenya, based on analysis of expectations on it and the lessons learnt during implementation of CCS 1. The overall focus of the Organization during this period is elaborated.

6.1 PROCESS OF ELABORATION OF THE CCS 2

CCS 2 outlines key features through which WHO intends to make the greatest possible contribution to heath in Kenya.

The activities of WHO/Kenya are based on the 11th General Programme of Work, which is elaborated in the Medium Term Strategic Plan for the period 2008 to 2013. The Kenya office will focus on supporting the achievement of the country's health objectives in line with the WHO expectations as outlined in the MTSP. The linkages between these two planning processes are outlined in Figure 5 below.

Figure 5: Strategic linkages between Kenya and WHO planning process



Development of country-level ER (OSER's) guided by the strategic approaches in the CCS, and planned sector interventions in JPWF and Annual Operational Plans

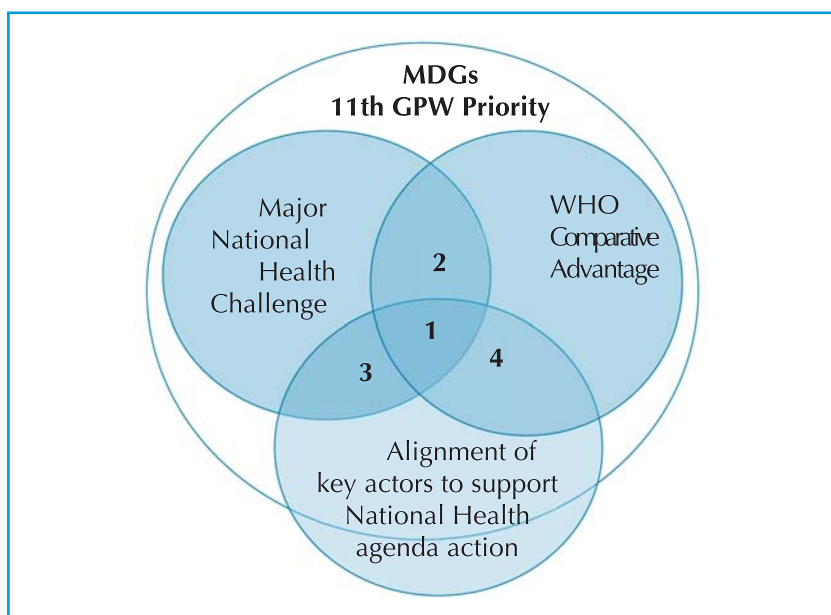
This CCS 2 has been developed in a process that aims to operationalise the partnership and coordination principles of Government ownership, alignment, harmonization and shared responsibilities. Its priorities were identified through a process of adaptation of the UNDAF prioritisation mechanism, and guided by the following three-point criteria:

Whether the issue is a national health challenge;

- Whether WHO/Kenya has a comparative advantage in supporting the priority; and
- Whether there is alignment of key actors to support the area of focus.

Figure 6 illustrates the overlapping considerations that are taken into account for identification of CCS 2 priorities.

Figure 6: Identification of Strategic Priorities



1. **Top strategic priority**
2. **Potential high priority: use negotiation/consensus building to seek alignment**
3. **Potential high priority: draw on regional/global UN capacity where feasible**
4. **Lower priority: does not meet major national challenge**

The top priorities for WHO/Kenya are those that fall under all the three areas (shaded area 1), i.e. the issue is a national health challenge, WHO has a comparative advantage in offering services and there is an alignment of key supporting actors.

The next level of priority includes issues which fall under two of the three areas, i.e. the issue is a national health challenge where WHO has a comparative advantage. However, as support from key actors is lacking, the WHO will focus on negotiation and consensus building initiatives to garner support from other partners.

Third in priority are the issues that are only national health challenges. In such areas where WHO does not have a comparative advantage, it shall draw on global and regional capacities where feasible.

WHO/Kenya recognises that, for it to have a comprehensive CCS, the health sector needs to first have a comprehensive plan that outlines its objectives and priorities to achieve the health outcomes the country needs. As such, support was provided to the country to identify the strategic areas it needs to focus on to achieve its medium-term health objectives. These are set out comprehensively in the National Health Sector Strategic Plan II (NHSSP II). Priorities are also elaborated in the investment plans of the different constituents of the sector. Each ministry has set out its priorities in an investment plan, as has the UN (in the United Nations Development Assistance Framework, UNDAF) and the partners (in the Kenya Joint Assistance Strategy, KJAS).

Based on these priorities, WHO Kenya identified the key result areas it could support within its mandate, but guided by its current and potential future institutional capacity and the lack of key actors supporting the result areas. Concurrence was sought with the Government, and other sector partners on the appropriateness of these proposed results, before they were completed.

As a result, the CCS 2 sets forth key priorities that the sector (Government and partners) feels WHO should focus on to support attainment of its strategic objectives and priorities.

6.2 STRATEGIC FOCUS

The sector priorities have been used to crystallize the focus of WHO support to the sector during the period of the CCS 2. The areas where WHO has a comparative advantage have been identified and the results have been translated into four Strategic Priorities which will guide this Country Cooperation Strategy. These are as follows:

STRATEGIC PRIORITY 1:	**To support the universal scale up of priority essential health interventions in routine, and emergency situations at the household, community and national levels;**
STRATEGIC PRIORITY 2:	**To advocate for policies and strategies to address determinants of health;**
STRATEGIC PRIORITY 3:	**To support governance and facilitate the strengthening of health systems for universal and equitable access to quality health services; and**
STRATEGIC PRIORITY 4:	**To provide technical leadership in matters of health and promote partnership and networking.**

These priorities aim to address all the constituents to which WHO/Kenya is responding. These constituents are the World Health Assembly (through the MTSP); the Health Sector in Kenya (through the NHSSP II); the UN in Kenya (through the UNDAF 2). The linkages to these constituents are highlighted in Table 9 below.

Table 9: Highlights of contribution of CCS 2 priorities to key health development strategies

Strategic area	Strategic Objectives	Priority 1	Priority 1	Priority 1	Priority 1
National Health Sector Strategic Plan II goal: Reduce health inequalities and reverse the downward trend in health-related outcome and impact indicators	Objective 1: Increase equitable access to health services	++	+		
	Objective 2: Improve the quality and responsiveness of services in the sector	+		+	
	Objective 3: Improve the efficiency and effectiveness of service delivery			+	
	Objective 4: Foster partnerships in improving health and delivering services		+	++	++
	Objective 5: Improve financing of the health sector			+	
WHO Medium-term Main focus	Objectives 1 – 6	+			
	Objectives 7 – 9		+		
	Objectives 10 – 11			+	
	Objectives 12 – 13				+
UNDAF Strategic Priority 1: Improving good governance, realization of human rights and gender equality	Outcome 1.1: Good governance, human rights and gender equality progressively accelerated and realized			+	
UNDAF Strategic Priority 2: Empowering people who are poor, and reducing disparities	Outcome 2.1: Increasing equitable access and use of quality essential social services and protection services with a focus on marginal and vulnerable groups	++	++	++	++
	Outcome 2.2: Humanitarian impact and risk of natural and human-made disasters reduced	+			
	Outcome 2.3: Evidence – informed and harmonized national HIV response to delivering sustained reduction in new infections, scaled up treatment, care, support and effective impact mitigation	++			
UNDAF Strategic Priority 3: Promoting sustainable and equitable economic growth for poverty and hunger reduction with a focus on vulnerable groups	Outcome 3.1: Equitable livelihood opportunities and food security for vulnerable groups enhanced and sustained	+			
	Outcome 3.2: Enhanced environmental management for economic growth with equitable access to energy services and response to climate change		+		

6.3 MAIN FOCUS, AND EXPECTED RESULTS

As highlighted in section 2, a key difference between CCS 2 and CCS 1 relates to how the strategies outlined will be implemented and monitored. To be able to respond to the expectations of the different constituents as outlined in the previous section, clear objectives to be achieved for each Strategic Priority, plus information on results to be achieved for each objective need to be elaborated. This section therefore aims to 'un-package' the different Strategic Priorities of the CCS 2, in terms of what exactly will be sought for as regards objectives and results to enable achievement of the Strategic Priority in a manner responding to the respective constituent partner expectations. The result is elaboration of Main focus to guide achievement of each of the four Strategic Priorities.

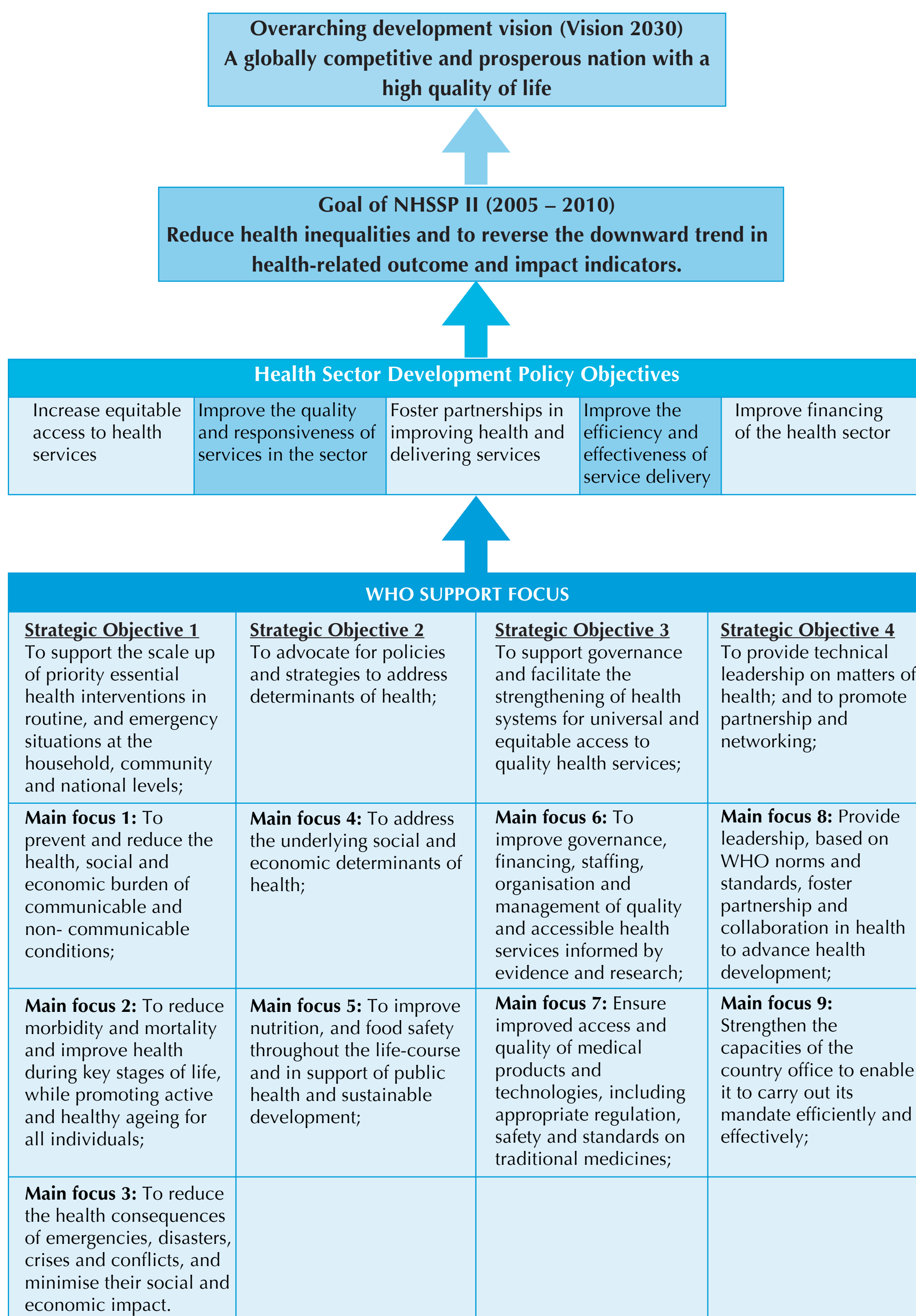
The Main focus is designed to address broad health goals that WHO, together with other partners in the sector, will work to achieve. Their implementation will be followed up through monitoring of the implementation of a set of expected results for each Main focus. These expected results directly relate to the operational results the sector is striving to achieve in its Operational planning process. Any new/emerging expected results that come up during the implementation of the CCS 2, that would contribute to achievement of the Main focus will also be included and supported by the WHO in Kenya. This is to ensure the CCS 2 remains a dynamic document, taking into consideration new innovations and approaches, but maintaining a clear strategic direction provided by the Main focus and Priorities.

The scope of work possible under each Strategic Priority is potentially very broad. Without adequate prioritization, WHO/Kenya would risk spreading its abilities too thinly to have a meaningful impact. As already highlighted, prioritization is done in the context of ensuring adequate response to the expectations of constituents in health. WHO/Kenya has avoided prioritising its objectives and results by intervention area; rather, the priorities are selected based on filling gaps in which WHO/Kenya has a comparative advantage. In this way, WHO/Kenya can respond to a wide range of expectations placed on it.

The subsequent section in this document outlines the key approaches to be used to support the realisation of the CCS Main focus, as well as the expected results. As indicated already, in each expected result, the focus of WHO's contribution is highlighted based on appropriate WHO core function.

Table 10 below lists the Main focus corresponding to each Strategic Priority of the CCS 2. These priorities and Main focus are designed to support achievement of the country's overall development agenda.

Table 10: Main focus to guide support to the Strategic Priorities



Overarching development vision (Vision 2030)
A globally competitive and prosperous nation with a high quality of life

Goal of NHSSP II (2005 – 2010)
Reduce health inequalities and to reverse the downward trend in health-related outcome and impact indicators.

Health Sector Development Policy Objectives				
Increase equitable access to health services	Improve the quality and responsiveness of services in the sector	Foster partnerships in improving health and delivering services	Improve the efficiency and effectiveness of service delivery	Improve financing of the health sector

WHO SUPPORT FOCUS			
Strategic Objective 1 To support the scale up of priority essential health interventions in routine, and emergency situations at the household, community and national levels;	**Strategic Objective 2** To advocate for policies and strategies to address determinants of health;	**Strategic Objective 3** To support governance and facilitate the strengthening of health systems for universal and equitable access to quality health services;	**Strategic Objective 4** To provide technical leadership on matters of health; and to promote partnership and networking;
Main focus 1: To prevent and reduce the health, social and economic burden of communicable and non- communicable conditions;	**Main focus 4:** To address the underlying social and economic determinants of health;	**Main focus 6:** To improve governance, financing, staffing, organisation and management of quality and accessible health services informed by evidence and research;	**Main focus 8:** Provide leadership, based on WHO norms and standards, foster partnership and collaboration in health to advance health development;
Main focus 2: To reduce morbidity and mortality and improve health during key stages of life, while promoting active and healthy ageing for all individuals;	**Main focus 5:** To improve nutrition, and food safety throughout the life-course and in support of public health and sustainable development;	**Main focus 7:** Ensure improved access and quality of medical products and technologies, including appropriate regulation, safety and standards on traditional medicines;	**Main focus 9:** Strengthen the capacities of the country office to enable it to carry out its mandate efficiently and effectively;
Main focus 3: To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimise their social and economic impact.			

Strategic Priority 1: To support the scale up of priority essential health interventions in routine, and emergency situations at the household, community and national levels.

Main focus 1: To prevent and reduce the health, social and economic burden of communicable and noncommunicable conditions.

The main strategic approach of WHO will be to provide technical guidance, and leadership towards introduction, scale up, strengthening of strategies and interventions for prevention, early detection, diagnosis, management and control of communicable, noncommunicable and emerging conditions. This includes strategies that will promote healthy lifestyles and reduce risk factors to disease, in line with the country's strategic approach.

Expected results	WHO Core functions					
	1	2	3	4	5	6
Strengthened immunization services and supported introduction of new technologies through district-based monitoring and integrated services	√					
Strengthened VPD Surveillance and prompt response for outbreaks						√
Capacity strengthened in control efforts for defined NTDs					√	
National capacity for IDSR strengthened and monitored						√
International Health Regulations minimum core capacity built					√	
National capacity for prevention and response to major epidemics and pandemic-prone diseases strengthened					√	
Policy framework to support prevention, treatment and care of malaria, TB and HIV/AIDS strengthened	√					
Strengthened ATM laboratory capacity and networking					√	
Delivery of integrated prevention, treatment and care interventions for HIV/AIDS, Malaria and TB is expanded and strengthened			√			
Equitable access to essential medicines for the prevention, treatment and care of ATM conditions strengthened	√					
Availability of HIV/AIDS, malaria and TB information through national surveillance, monitoring and evaluation systems strengthened						√
Political commitment and partnership strengthened and sustained for HIV/AIDS, malaria and tuberculosis prevention and control through appropriate advocacy	√					
Advocacy and support provided to increase political, financial and technical commitment in Kenya in order to address chronic noncommunicable conditions (including mental and behavioural disorders, violence, injuries and disabilities)	√					
Enhanced national capacity to collect, analyze, disseminate and use data on the magnitude, causes and consequences of chronic noncommunicable conditions (including mental and behavioural disorders, violence, injuries and disabilities)						√
Guidance and support provided to national authorities for development and implementation of policies, guidelines, strategies and regulations for chronic non-communicable conditions, mental and behavioural disorders, violence, injuries and disabilities			√			
Health promotion capacity improved					√	
Capacity to address/prevent public health problems associated with tobacco enhanced.					√	

Main focus 2: To reduce morbidity and mortality and improve health during key stages of life, while promoting active and healthy ageing for all individuals.

The strategic approach of WHO will focus on supporting the country in scaling up interventions towards attaining universal access for effective public health interventions to promote maternal, newborn, child and adolescent health.

Expected results	WHO Core functions					
	1	2	3	4	5	6
Policy framework and capacity for implementing child survival strategies strengthened				√		
National capacity to implement initiatives to ensure skilled care for pregnant women and newborns enhanced			√			
Monitoring and evaluation of reproductive health strengthened						√
Child health development interventions strengthened					√	
Implementation of adolescent-friendly health services scaled up					√	
National capacity in the screening and management of reproductive tract cancers enhanced					√	
National capacity to carry out RH and child health research, surveys and evaluations enhanced		√				
Gender and reproductive rights in service delivery mainstreamed into the National Reproductive Health Strategy				√		

Main focus 3: To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimise their social and economic impact.

Strengthening health response in emergencies by enhancing coordination of partners in joint planning, response and information management.

Expected results	WHO Core functions					
	1	2	3	4	5	6
National capacity to coordinate detection, confirmation, risk assessment and response to epidemics and other public health concerns enhanced					√	
Emergency Preparedness and Response at provincial and district levels in the high-risk and vulnerable districts strengthened					√	

Strategic Priority 2: To advocate for polices and strategies to address determinants of health.

Main focus 4: To address the underlying social and economic determinants of health

WHO will support the country to align its health interventions and overall national development agenda to ensure social and economic determinants are appropriately addressed, and in the context of a human rights, and gender-based approach. This will involve strengthening of partnerships with all actors that have an eventual bearing on health impacts, including NGO's, parliament, media, human rights commission, and others.

Expected results	WHO Core functions					
	1	2	3	4	5	6
Information on impact of social and economic determinants of health on health outcomes used to guide intersectoral interventions in health		√				
Mainstreaming of gender and human rights in operational approach for the health sector strengthened			√			
Policy framework on priority environmental health risks strengthened		√				
Implementation of primary prevention interventions that reduce environmental health risks strengthened					√	
Occupational health policy framework strengthened	√					

Main focus 5: To improve nutrition, and food safety throughout the life-course and in support of public health and sustainable development.

WHO will build capacity to establish, promote and implement a food safety, nutrition, and environmental health agenda that facilitates creation of necessary intervention synergies and linkages between Programmes and partners.

Expected results	WHO Core functions					
	1	2	3	4	5	6
Coordination and networking on nutrition and food safety strengthened	√					
Strengthen national capacity on food safety and nutritional requirements for specific populations in need (such as pregnant and breastfeeding mothers, orphans, adolescents and the elderly etc) and key food safety actions of importance.					√	
Establishment of systematic monitoring of nutrition activities and surveillance systems including early warning systems for nutrition						√
Implementation and monitoring of nutrition intervention strengthened through development and updating of policies, strategies, guidelines, tools and development of operational plans			√			
Strengthening the implementation of micronutrient strategies through the revision/updating and dissemination of policies, guidelines, tools and manuals and monitoring of its implementation			√			
Food-borne disease surveillance, prevention and control systems strengthened					√	

Strategic Priority 3: To support governance and facilitate strengthening of health systems for universal and equitable access to quality health services.

Main focus 6: To improve governance, financing, staffing, organisation and management of quality and accessible health services informed by evidence and research.

This will focus on technical guidance and leadership support to revitalise and strengthen the different elements of the health system.

Expected results	WHO Core functions					
	1	2	3	4	5	6
Implementation of the primary care approach in Kenya enhanced	√					
Governance, partnership and stewardship in health enhanced	√					
Performance monitoring process for the sector enhanced						√
Utilisation of research to inform and guide policy strengthened		√				
Equitable distribution of health workers enhanced					√	
Availability of information on equity of health care financing increased		√				

Main focus 7: Ensure improved access and quality of medical products and technologies, including appropriate regulation, safety and standards on traditional medicines

This objective will focus on support development of relevant policies and strategies of ongoing scale up towards universal access to health care and elaborate policy framework for appropriate use of traditional medicines and facilitate integration within the EAC, harmonisation of medicines regulation and procurement systems.

Expected results	WHO Core functions					
	1	2	3	4	5	6
Systems for Good Pharmaceutical Procurement and Supply Management strengthened				√		
National policy framework on medicines, including traditional medicine enhanced			√			
National medicines regulatory systems strengthened					√	
Quality and Safety of medical products & technologies improved					√	
National guidance on appropriate medicines use, including use of traditional medicine enhanced			√			
National guidance on standard treatments enhanced			√			

Sategic Priority 4: To provide technical leadership on matters of health; and promote partnership and networking.

Main focus 8: Provide leadership, based on WHO norms and standards, foster partnership and collaboration in health to advance health development.

This will focus on promoting the visibility and presence of WHO in the country, through strengthened coordination, leadership and partnership building in the health sector.

Expected results	WHO Core functions					
	1	2	3	4	5	6
Alignment and re-profiling of WHO/Kenya enhanced	√					
Increased financing of WHO/Kenya	√					
Monitoring of implementation of WHO/Kenya Strategic approach strengthened	√					

Main focus 9: Strengthen the capacities of the country office to enable it to carry out its mandate efficiently and effectively.

This objective will focus on strengthening the management and development of resources in WHO/ Kenya, to be able to efficiently respond to the expectations of Ministry of Health and its cooperating partners.

Expected results	WHO Core functions					
	1	2	3	4	5	6
Alignment of country office activities and plans with country priorities strengthened	√					
Strengthened financial management activities in the Country office	√					
Harmonisation of planning and management systems improved	√					
Strengthened mainstreaming of Human Resources in WHO/Kenya	√					
Strengthened information management in WHO/Kenya	√					
Strengthened managerial and administrative support in WHO/Kenya	√					
Improved working environment in WHO/Kenya	√					

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

This section describes capacity building actions required for the WHO in Kenya to achieve the expectations as outlined in the CCS previous section

The elaborated results and objectives can only be achieved if the correct quantities, qualities and mix of inputs are available to support WHO in Kenya. The inputs needed relate to human resources, institutional support and financial support. The WHO in Kenya will work during the CCS 2 to ensure these inputs are made available in the most effective manner to enable support to achievement of the expected results, and subsequently the Main focus and priorities. Numbers, and mix of these inputs will also be dynamic, following the changes in expectations of WHO during the implementation of the CCS 2.

7.1 HUMAN RESOURCE STRENGTHENING

The WHO views human resource skills as its major resource for supporting achievement of health sector objectives in a country. The WHO in Kenya does not view itself as a parallel Ministry of Health, with all the technical expertise in MOH represented in WHO/Kenya. It rather views itself as a unit that is able to ensure that the technical expertise the sector requires is made available as and when it is needed. This expertise is not only that existing in the WHO Office, but also includes the vast technical support it has at the regional and global levels both in WHO and in its collaborating centres, in addition to the wide array of consultants it is able to draw upon for any specific technical input needed.

The human resources required to support implementation of the CCS 2 were reviewed against the existing human resources in WHO/Kenya. The complete human resource plan is provided in Appendix D. It is based on ensuring that key human resources are available within the country to support achievement of the results and objectives as outlined in CCS 2. However, there are key skills and competencies that need to be strengthened to align WHO/ Kenya human resource capacity with the expectations of the country. These are:

- **Technical skills** in laboratory services management; research; and additional capacity in health promotion; health economics; financial management and procurement systems support.
- **General skills** in project management i.e. coordination of interventions within a focus area; communication i.e. advocacy and communication of specific issues relating to focus areas.
- **Additional administrative skills** needed include secretarial support; personnel management; knowledge management; and transport management.

Technical support currently forms the backbone of WHO's support to the country. This shall continue to be the case in the period of CCS 2. Resource mobilization efforts shall focus on ensuring that adequate human resources are made available to address national health development challenges.

7.2 INSTITUTIONAL STRENGTHENING

To ensure effective delivery of the Main focus, the organisational design of the country office in Kenya has been refined. The technical coordination of the programmes will be managed through two technical clusters, namely: targeted intervention support and cross-cutting programme support. The 13 Main focus outlined in the MTSP have been assigned to their respective clusters and the programmes relating to each Main focus have been accordingly mapped. The country office organogram is provided in Appendix E.

It is expected that the technical programmes in WHO/Kenya will continue to receive support from the WHO Regional Office and headquarters. In addition, WHO will continue to play a major role in resource mobilisation, advocacy, communication and logistics, networking and working with other partners to enforce coordination, harmonisation and alignment of national policies.

To facilitate the work of the country office, WHO needs to acquire new technology and upgrade the existing infrastructure. The IT infrastructure should be in harmony with Global Management System software.

7.3 FINANCING OF THE CCS 2

The financing of CCS 2 will focus on ensuring that appropriate technical support skills are made available. The budget and plans are derived from the Biennial Plan and Budget processes, based on Organization-wide allocations for Kenya. Usually, these allocations have assessed contributions and Voluntary contributions components. The Assessed contributions, also sometimes referred to as the 'Regular Budget', are drawn from Member States' assessed contributions, and are allocated through the World Health Assembly. Voluntary contributions relate to extrabudgetary funds mobilized from 'donor' countries and external contributors to support planned interventions. There is a crucial shift from the predominant reliance on the regular budget to greatly increased dependence on extra-budgetary funding. Already, extrabudgetary funds represent nearly 60% to 70% of the total country office budget. This trend may pose a potential risk of donors influencing the policy direction of the country office. These resources will be mobilized at the global, regional and country levels.

For the first biennial plan of action of CCS 2 (BPOA 2008/ 2009), the total budget provided for WHO in Kenya is highlighted in Table 11 below.

Table 11: Biennial Budget for 2 years: 2008–2009 for WHO/Kenya (US $)

	Strategic Priority	Related MTSP Main focus	Assessed Contribution	Voluntary Contribution	Total
1	To support the scale up of priority essential health interventions in routine, and emergency situations at the household, community and national levels;	1 – 6	1 012 000	12 574 000	**13 586 000**
2	To advocate for policies and strategies to address determinants of health;	7 – 9	231 000	785 000	**1 016 000**
3	To support governance and facilitate the strengthening of health systems for universal and equitable access to quality health services; and	10 – 11	361 000	2 901 000	**3 262 000**
4	To provide technical leadership on matters of health; and to promote partnership and networking.	12 – 13	1 418 000	582 000	**2 000 000**
	Total		**3 022 000**	**16 843 000**	**19 865 000**

7.4 MONITORING AND EVALUATION

A robust monitoring and evaluation mechanism is essential to ensure effective implementation of the CCS. To enable adequate follow up and implementation of this strategy, the WHO in Kenya will have a clear review and monitoring mechanism to ensure 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 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 2 implementation. Such changes will be appropriately incorporated in the 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:

- Periodic monitoring of progress toward outcomes;
- Factors contributing to or impeding progress of the outcome;
- Main focus and how their implementation is contributing to the Strategic Priorities; and
- Contribution of partnerships towards the achievement of the Main focus.

At the operational level, CCS 2 will be monitored through the existing semi-annual, annual and biennial monitoring processes. The focus at this level shall be on ensuring the Organization is supporting the implementation of the appropriate results for each of the objectives it is planning to support. These results shall form the basis of the Office-Specific Expected results in the BPOA. Process, and output level achievements supporting achievement of the respective OSER's shall be monitored at the semi-annual and annual processes, with the biennial process setting the expected results, and products for focus during the biennium.

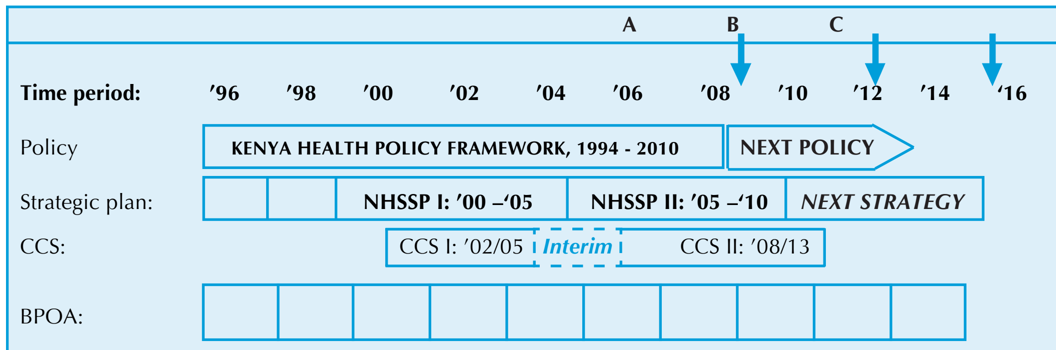
At the strategic level, the focus of the monitoring and review process shall be on how well the expected results being implemented are supporting the achievement of the Strategic Priorities. This shall be at the outcome and impact level. It shall be done at the Mid-Term of the implementation of the CCS 2 (2010) and at its end-term (2013). The Mid-Term review will coincide with the end-term reviews of both the National Health Sector Strategic Plan (NHSSP II), and the Kenya National HIV/AIDS Strategic Plan (KNASP). The focus of this review will be:

- To review progress and identify challenges to date in the implementation of the CCS 2;
- To review the CCS 2 strategic priorities and results in line with any modifications made in the revised Kenya health sector policy framework and strategic plan; and
- To implement any changes in strategic direction that may be prompted by the WHO review of the MTSP.

Strategic changes prompted by these reviews will be incorporated into the mid-term review recommendations on strategic shifts required in CCS 2 implementation to ensure WHO remains relevant and focused on priorities. The end-term review of the CCS 2 shall likewise be done at the Mid-Term review of the subsequent NHSSP and KNASP. It shall evaluate the status of outcomes, factors influencing the outcomes and the contribution of WHO and other partners to the achievement of CCS 2 objectives and priorities.

In line with this, the key performance monitoring events during the period of CCS 2 are highlighted below.

Figure 7: Key performance review events during CCS 2



Key timelines

A: MTR of NHSSP II, and elaboration of CCS 2 and MSP's

B: MTR of CCS II, and elaboration of the next country policy framework and strategic plan

C: End-term of CCS II and MSP's

Indicators and milestones to be achieved are developed for each of the Main focus in the CCS 2, to guide, and support the quantification of achievements in the monitoring process. These indicators are highlighted in Table 12. The indicators to be used here are all health sector-based, and not necessarily WHO-specific. To a large extent, therefore, the role of WHO should be seen as supporting the realisation of national health sector targets. In this way, WHO will associate itself more closely with any progress in national health development, as opposed to creating its own niche; and thus fulfilling the ultimate aim of the Organization which is to facilitate improvements in health. As highlighted in the expected results, WHO will work to influence the achievement of these outcomes, directly or indirectly, through building effective partnerships with development and implementing partners to support Government's effort in achieving the health outcomes.

Table 12: Key indicators for monitoring CCS 2 progress

	Focus area	Country Level Indicators	Value	
			Baseline	Target (2013)
1	To prevent and reduce the health, social and economic burden of communicable and non-communicable conditions	Proportion of 1 year old immunised against measles	80%	90%
		Coverage of interventions targeted at the control, elimination or eradication of tropical diseases.		90%
		Reduction of malaria morbidity (fever) in the community by 30% of current levels	14%	9%
		% reduction in the prevalence rate of tobacco use.		10%
2	To reduce morbidity and mortality and improve health during key stages of life, while promoting active and healthy ageing for all individuals	Reduction in under-five mortality by two-thirds from 1990 levels	115 per 1000 life births	32 per 1000 life births
		Reduction in maternal mortality by three-quarters from 1990 levels	414 per 100.000 life births	147 per 100.000 life births
3	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimise their social and economic impact	Proportion of emergencies where daily mortality of populations affected is maintained below 1 per 10 000 during initial emergency response phase		90%
		Proportion of emergencies with 90% of affected populations having levels of access similar to, or better than, pre-emergency conditions within one year		
		Proportion of emergencies with less than 10% of the affected population having a weight-for-height measurement that is below 80% of the standard value.		80%

	Focus area	Country Level Indicators	Value	
			Baseline	Target (2013)
4	To address the underlying social and economic determinants of health	Proportion of national health indicators disaggregated by sex and age and at least two other determinants	–	40%
		Number of policies and work plans of priority non-health sectors (e.g. agriculture, energy, education, finance, transport) that have incorporated health targets	–	80%
5	To improve nutrition, and food safety throughout the life-course and in support of public health and sustainable development	Access to safe drinking water	50%	70%
		Access to improved sanitation	43%	48%
		Prevalence of underweight children (<5’s)	28%	16.2%
		Number of food safety policies, plans and strategies developed and implemented	–	80%
		% of districts with population living within 5km of facility below 2008 national average	–	10%
		% of indicators for monitoring Code of Conduct adherence showing improvement	–	80%
6	To improve governance, financing, staffing, organisation and management of quality and accessible health services informed by evidence and research	% of districts with nurses / 10 000 population below 2008 value	–	10%
		Number of scientific platforms for health research and policy		1/year
		Timeliness and completeness of health information		80%
		Household expenditure on health as % of total health expenditure	29.3%	25%
7	Ensure improved access and quality of medical products and technologies, including appropriate regulation, safety and standards on traditional medicines	Percentage of population with access to essential drugs		
		Availability of and median consumer price ratio for 30 selected generic essential medicines in the public, private and nongovernmental sectors.		80%
		Proportion of vaccines and medicines that are of assured quality.		100%
		Percentage of prescriptions in accordance with current national or institutional clinical guidelines.		70%
8	Provide leadership, based on WHO norms and standards, foster partnership and collaboration in health to advance health development Strengthen the capacities of the country office to enable it to carry out its mandate efficiently and effectively	Proportion of health resolutions of the World Health Assembly and the Regional Committee appropriate to Kenya that are implemented		100%
9	Strengthen the capacities of the country office to enable it to carry out its mandate efficiently and effectively	Proportion of overall budget spent on this Main focus relative to the total WHO budget	30%	20%
		Proportion of Main focus that have spent 80% to 120% against the Programme budget	70%	100%
		Proportion of human resource gaps (numbers and skills) identified through the human resource plan that are addressed	50%	80%

SECTION 8

APPENDICES

8.1 APPENDIX A: SPECIFIC RECOMMENDATIONS BY AREA OF WORK FROM REVIEW OF CCS 1.

Table 13 below outlines the specific recommendations by areas of focus from the CCS review.

Table 13: Key recommendations emanating from CCS 1 review by areas of focus

Cluster	Area of Focus	Final recommendations from CCS 1 review
Maternal and Child Health	Child Health	• Strengthen policy framework for implementation of child health interventions • Build integration and partnership efforts to facilitate child health initiatives in a sustainable manner • Facilitate integration of child health in level 1 interventions, and implementation of services • Advocate for rational resource allocation initiatives for child health interventions
	Adolescent Health	• Support a multi-sectoral approach in addressing issues relating to the health of adolescents • Facilitate development of comprehensive policies, and implementation of services for adolescent health • Capacity building for services to adolescents health
	IVD-EPI	• Support advocacy efforts in resource mobilisation for immunisation services • Strengthen support to surveillance team at national level to ensure data is monitored and acted on • Institutionalise Programme reviews e.g. coverage surveys, EPI reviews, in National Monitoring and Review processes
	MPS	• Strengthen partnerships in reproductive health • Scale up monitoring and follow up of interventions, with a focus on maternal audits • Undertake advocacy for resource mobilisation, and provide support for an integrated community approach
	Health Systems Strengthening	• Need to strengthen support to MOH stewardship of sector to enable uptake of system strengthening initiatives • Support development of tools and guidelines for capacity strengthening particularly in planning, organisation and management of services in line with the new strategic directions
	Health Care Equity	• Support evolution of a comprehensive approach to planning, and monitor equity in service delivery to ensure service delivery covers disparities across the country • Support evolution of an equity-guided resource allocation framework

Health Systems	Coordination of partners	• Elaborate mechanisms for guiding different evaluation and review mechanisms for use in the joint sector mechanisms • Support different sector actors and constituencies to operationalise their expectations in the partnership
	Human resource development and management	• Undertake advocacy and technical support to strengthen the HRH policy environment • Support generation of an evidence base on rationalised human resource management approaches
	Additional (EDM)	• Support the regulatory framework for essential health technologies including medicines
	Health Promotion	• Enhance advocacy for health promotion • Support development of health promotion, and communication strategy • Manage health information and its dissemination
Disease Prevention and Control	Health and Environment	• Support development of health and environment policies and strategies • Support strengthening of primary prevention interventions to reduce the environmental health risks in specific settings and vulnerable populations • Support scaling up of existing strategies to reduce the environmental health risks, enhance safety, and promote public health • Strengthen monitoring and evaluation in public health and sanitation
	NCD's	• Generate evidence for focus on NCD's, particularly in light of the double disease burden • Support strengthening of the policy environment relating to NCD's • Support integration of NCD interventions in service delivery
	Communicable disease surveillance & IDSR	• Support scaling up of IDSR as a strategy in the country • Build partnerships for IDSR
	Malaria	• Advocate for stronger partnerships in malaria control • Support scaling up of existing strategies in malaria control • Carry out integration of malaria control interventions
	EHA	• Strengthen preparedness and response plans, guidelines and tools • Strengthen capacity for coordination and response at all levels
	Communicable Diseases for Eradication and Elimination (CPC)	• Support development of a comprehensive strategy for neglected diseases as the way forwards in mobilising support. • Strengthen partnership building in eradication and elimination efforts • Strengthen integration of efforts in eradication and elimination
	HIV Tuberculosis	• Advocacy for stronger partnerships, and integrated partner programming for HIV interventions in the health sector • Support strengthening of HIV surveillance, monitoring of health sector interventions and generation and dissemination of evidence • Support development of strategies, guidelines and tools for decentralised and integrated HIV service delivery, M&E, and quality assurance • Support scaling up of HIV health sector strategies • Advocate for increased funding to embrace the other 5 components contained in the global plan to stop TB in addition to DOTS strategy • Strengthen surveillance in the prevention of drug-resistant TB particularly MDR/XDR-TB. • Increase support for the implementation of ACSM and M&E development strategies • Advocate for strengthened and focused partnership in addition to TB/HIB collaboration.

8.2 APPENDIX B: CORRESPONDING MAIN FOCUS OF THE WHO MEDIUM-TERM STRATEGIC PLAN.

The Main focus areas for the four strategic priorities and their relation to the WHO Medium-Term Strategic Plan 2008-2013 are as follows:

Strategic Priority 1: To build health security at the household, community and national levels.

Main focus	Corresponding Main focus in the MTSP 2008-2013
1. Prevent and reduce the health, social and economic burden of communicable and noncommunicable conditions	1. Reduce the health, social and economic burden of communicable diseases 2. Combat HIV/AIDS, tuberculosis and malaria 3. Prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries 4. Promote health and development and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical activity and unsafe sex
2. Reduce morbidity and mortality and improve health during key stages of life, while promoting active and healthy ageing for all individuals	5. Reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, improve sexual and reproductive health and promote active and healthy aging for all individuals
3. Reduce the health consequences of emergencies, disasters, crises and conflicts, and minimise their social and economic impact	6. Reduce health consequences of emergencies, disasters, crises and conflicts, and minimise their social and economic impact

Strategic Priority 2: To advocate for polices and strategies to address determinants of health

Main focus	Corresponding Main focus in the MTSP 2008-2013
4. Address the underlying social and economic determinants of health	7. Address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-sensitive, and human rights-based approaches
5. Improve nutrition, and food safety throughout the life-course and in support of public health and sustainable development	8. Promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health 9. Improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development

Strategic Priority 3: To support governance, and facilitate strengthening of health systems for universal and equitable access to quality health services

Main focus	Corresponding Main focus in the MTSP 2008-2013
6. Improve governance, financing, staffing, organisation and management of quality and accessible health services informed by evidence and research	10. Improve health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research
7. Ensure improved access and quality of medical products and technologies, including appropriate regulation, safety and standards on traditional medicines	11. Ensure improved access, quality and use of medical products and technologies

Strategic Priority 4: To provide technical leadership on matters of health; and promote partnership and networking

Main focus	Corresponding Main focus in the MTSP 2008-2013
8. Provide leadership, based on WHO norms and standards, foster partnership and collaboration in health to advance health development	12. Provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system and other stakeholders in order to fulfil the mandate of WHO in advancing the global health agenda as set out in the Eleventh GPW
9. Strengthen the capacities of the country office to enable it to carry out its mandate efficiently and effectively	13. Develop and sustain WHO as a flexible, learning organisation, enabling it to carry out its mandate more efficiently and effectively

8.3 APPENDIX C: HUMAN RESOURCE SUMMARY PLAN AND BUDGET

Table 14 describes the human resources required for each Main focus and their availability over the defined period.

Table 14: CCS 2 Human Resource Plan

Italics: Staff covering more than one SO in the workplan
Bold, and blue: Staff to be recruited, source of funds not yet identified

CCS 2 Strategic Priority	MTSP Main focus support	Position Title	Position Grade	2008 – 2009	2010-2011	2012-2013
Strategic Priority 1	SO 1	National Programme Officer, VPD	XKE OC	Yes	Yes	Yes
		National Programme Officer, DPC	XKE OC	Yes	Yes	Yes
		Routine Immunization Officer	XKE OC	Yes	Yes	Yes
		Disease Surveillance Officer	XKE OC	Yes	Yes	Yes
		Disease Surveillance Officer	XKE OC	Yes	Yes	Yes
		Laboratory Scientific Officer, KEMRI	XKE OC	Yes	Yes	Yes
		Disease Surveillance Officer	XKE OC	Yes	Yes	Yes
		Programme Assistant, VPD	NA -6	Yes	Yes	Yes
		Programme Assistant (IDSR)	NA-7	Yes	Yes	Yes
		Data Manager (SO 1, plus support to office)	XKE OB	Yes	Yes	Yes
		Data Manager (SO 1, plus support to office)	XKE OB	Yes	Yes	Yes
		Secretary	NA - 5	Yes	Yes	Yes
		Driver	NA - 2	Yes	Yes	Yes
		Driver	NA -2	Yes	Yes	Yes
		Driver	NA -2	Yes	Yes	Yes
		Driver	NA -2	Yes	Yes	Yes
		Driver	NA -2	Yes	Yes	Yes
		Driver	NA-2	Yes	Yes	Yes
	SO 2	Technical Officer, HIV	P 4	Yes	Yes	Yes
		Technical Officer, MAL	P 4	Yes	Yes	Yes
		National Programme Officer, HIV	XKE OC	Yes	Yes	Yes
		National Programme Officer, MAL	XKE OC	Yes	Yes	Yes
		National Programme Officer, TB	XKE OC	Yes	Yes	Yes
		Programme assistant (Biostatician)	NA - 7	Yes	Yes	Yes
		Programme Assistant (Lab technologist)	**NA - 7**	**Yes**	**Yes**	**Yes**
		Secretary	NA - 4	Yes	Yes	Yes
		Driver, HIV	NA - 2	Yes	Yes	Yes
		Driver, MAL	NA - 2	Yes	Yes	Yes
		Driver, TB	NA - 2	Yes	Yes	Yes

CCS 2 Strategic Priority	MTSP Main focus support	Position Title	Position Grade	2008 – 2009	2010-2011	2012-2013
	SO 3	National Programme Officer	XKE OC	Yes	Yes	Yes
	SO 4	National Programme Officer, SRH	XKE OC	Yes	Yes	Yes
		National Programme Officer, CAH	XKE OC	Yes	Yes	Yes
		National Programme Officer, MPS	XKE OC	Yes	Yes	Yes
		Associate Programme Officer, CAH		Yes	Yes	Yes
		Programme Assistant, MPS	NA - 6	Yes	Yes	Yes
		Driver (SO 4, 6)	NA - 2	Yes	Yes	Yes
		Secretary (SO 4, 6)	NA - 4	Yes	Yes	Yes
	SO 5	Technical Officer, EHA	P 4	Yes	Yes	Yes
		National Programme Officer, EHA	XKE OC	Yes	Yes	Yes
		Secretary	NA 4	Yes	Yes	Yes
		Secretary	NA 4	Yes	Yes	Yes
		Driver	NA 2	Yes	Yes	Yes
		Driver	NA 2	Yes	Yes	Yes
	SO 6	National Programme Officer	XKE OB	Yes	Yes	Yes
		National Programme Officer, TOB	**XKE OC**	**Yes**	**Yes**	**Yes**
		Programme assistant (Communication specialist)		**Yes** **Yes**	**Yes** **Yes**	**Yes** **Yes**
Strategic Priority 2	SO 7	Technical Officer, Health Systems	P 4	Yes	Yes	Yes
	SO 8	National Programme Officer	XKE OB	Yes	Yes	Yes
	SO 9	*Covered by SO 5 Nutritionist*		Yes	Yes	Yes
		Covered by SO 4 CAH NPO		Yes	Yes	Yes
Strategic Priority 3	SO 10	*Same staff as SO 7*		**Yes**	**Yes**	**Yes**
		National Programme Officer (Health Economist)		**Yes**	**Yes**	**Yes**
		National Programme Officer, Research		**Yes**	**Yes**	**Yes**
		Secretary (Support to SO 8, 9, 10, 11)		**Yes**	**Yes**	**Yes**
		Driver (Support to SO 8, 9, 10, 11)	NA 2	Yes	Yes	Yes
	SO 11	National Programme Officer, EDM	OKE OC	Yes	Yes	Yes
		Procurement specialist		**Yes**	**Yes**	**Yes**
Strategic Priority 4	SO 12	*Covered by SO 7*		Yes	Yes	Yes
		Covered by SO 13 (Administrative Officer)		Yes	Yes	Yes
	SO 13	WHO Representative	P-5	Yes	Yes	Yes
		WR Secretary	NA-6	Yes	Yes	Yes
		Driver	NA -3	Yes	Yes	Yes
		Administrative Officer	P-3	Yes	Yes	Yes
		ICT Assistant	NA-7	Yes	Yes	Yes
		Administrative Assistant	NA-7	Yes	Yes	Yes
		Finance Assistant	NA-6	Yes	Yes	Yes
		Administrative Assistant, MAL	NA - 6	Yes	Yes	Yes
		Logistician (including transport coordination)	NA 6	Yes	Yes	Yes
		Personnel assistant		**Yes**	**Yes**	**Yes**
		Library Assistant	NA - 5	Yes	Yes	Yes
		Country Team Secretary	NA-5	Yes	Yes	Yes
		Administrative Secretary	NA-5	Yes	Yes	Yes
		Registry Clerk	NA-4	Yes	Yes	Yes
		Junior Clerk	NA-3	Yes	Yes	Yes
		Distribution Clerk	NA-2	Yes	Yes	Yes
		Driver	NA-2	Yes	Yes	Yes
		Driver	NA-2	Yes	Yes	Yes
		Messenger	NA-1	Yes	Yes	Yes
		Messenger	NA - 1	Yes	Yes	Yes
		Messenger-Garissa	NA - 1	Yes	Yes	Yes

8.4 APPENDIX D: WHO KENYA COUNTRY OFFICE ORGANOGRAM

REPRESENTATIVE

Overall Technical and Administrative Coordination

TARGETED PROGRAMME SUPPORT CLUSTER

Coordinator: Medical Officer, HIV/AIDS

1. **SO 1 coordination**
   - *Communicable disease support*
   - *Surveillance support*
   - *Immunization support*
2. **SO 2 coordination**
   - *HIV programme support*
   - *TB programme support*
   - *Malaria programme support*
3. **SO 3 coordination**
   - *NCD programme support*
4. **SO 4 coordination**
   - *RH programme support*
   - *Child Health programme support*
   - *MPS programme support*
5. **SO 5 coordination**
   - *EHA programme support*

TOB programme support ***(part SO 6)***

SYSTEMS SUPPORT CLUSTER

Coordinator: Technical Officer, Health Systems Development

1. **SO 6 Coordination**
   - *HPR programme support*
   - *Communication support*
2. **SO 7 Coordination**
   - *Social Determinants Support*
   - *CWS programme support*
3. **SO 8 Coordination**
   - *CWS programme support*
4. **SO 9 coordination**
   - *CWS programme support*
   - *Nutrition programme support*
5. **SO 10 coordination**
   - *Health Systems Support*
6. **SO 11 Coordination**
   - *EDM programme support*

ADMINISTRATIVE & FINANCE SUPPORT

Coordinator: Administrative Officer

1. ***SO 12 Coordination***
   - *Coordination of WHO presence*
2. ***SO 13 Coordination***
   - *Personnel management*
   - *Finance management*
   - *Logistics and transport mgt*
   - *IT support*
   - *Secretarial support*
   - *Information management*
   - *Registry management*
   - *Office maintenance*
   - *Public relations*