CHRISTIAN HEALTH ASSOCIATION OF KENYA

PROMOTING ACCESS TO QUALITY HEALTH CARE

STRATEGIC PLAN

2011 - 2016

Christian Health Association of Kenya

Strategic Plan
2011 - 2016

Promoting universal access to quality health care in Kenya

through advocacy, capacity building, health systems strengthening,
networking and innovative health programs

Christian Health Association of Kenya
P.O. Box 30690, GPO 00100, Nairobi, Kenya
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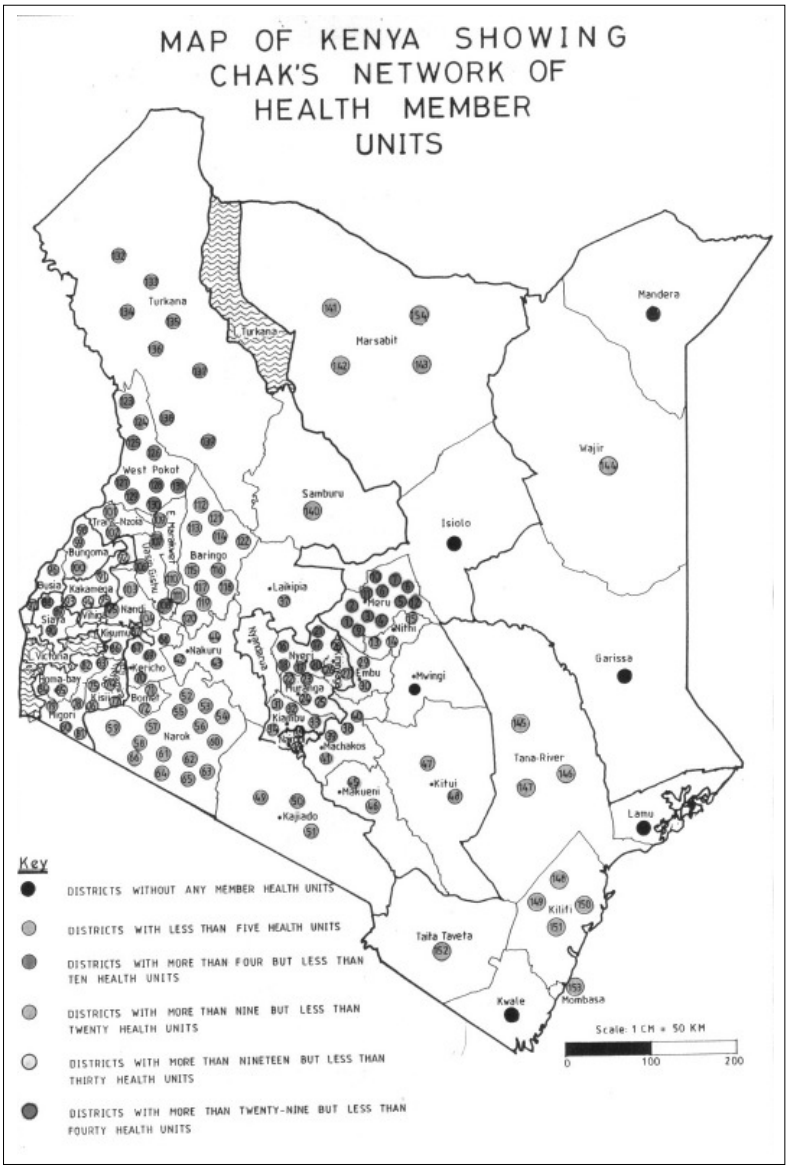
National network of membership

CHAK is a national network of Protestant Churches' health facilities and programmes from all over Kenya



The CHAK Constitution allows membership to *"Any Protestant Church or church sponsored or related non-profit making organization or community group with the objective of promoting health and health service within the Republic of Kenya"*.

CHAK's foundation

Revelation 22:1-2 "...the River of the water of Life…flowing from the throne of God ...down the middle of the great street of the city. On each side of the River stood the tree of life bearing twelve crops of fruit, yielding its fruit every month. And the leaves of the tree are for the healing of the nations"

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Acknowledgements

The General Secretary and CHAK Secretariat staff wish to express their gratitude to all those who supported and contributed to the end-term external evaluation of the Strategic Plan 2005 - 2010 and the development of this Strategic Plan 2011 - 2016.

We thank all CHAK Member Health Units who gave their feedback in the evaluation process. Special thanks to all those who found time to come and share with us their views and recommendations in the CHAK Strategic Plan 2005 – 2010 regional evaluation workshops held in Kisumu and Embu in July 2010. Their input has been very valuable in informing the focus of this new strategic plan.

CHAK Secretariat staff have worked tirelessly to facilitate the evaluation of the previous strategic plan and the development of this one. The Chairman and EXCO have given us support and inspiration. We thank them for allowing the necessary resources and their individual and collective input to the development of this strategic plan.

We thank the external evaluation consultants from CORAT Africa for their facilitation of the end-term external evaluation process and their recommendations.

The ministries responsible for health in Kenya have steered the health sector through critical reforms since the launch of National Health Sector Strategic Plan II (NHSSP II) 2005 – 2010 whose theme is 'Reversing the trends'. The development of several new health sector policies has created new demands and opportunities in the health sector. Notable among these is the Sector Wide Approach Strategy (SWAps) which has created more structured opportunities for sector collaboration in planning, implementation and monitoring. We thank the ministries for their leadership role in the health sector and for the recognition, involvement and support to CHAK in the new policy developments. This has increased our knowledge of health sector issues and created impetus for the development of this strategic plan.

We cannot forget to thank our dependable development partner EED who provided resources for the evaluation. We thank EED for its long-term partnership with CHAK which has contributed tremendously to the organisation's development. We also thank them for supporting the core budget during the implementation of the CHAK Strategic Plan 2005-2010.

Additionally, we sincerely thank our other partners IMAWH, Kerkinactiel and ICCO, Global Fund, CDC, UNICEF and USAID for supporting the implementation of specific components of the strategic plan 2005-2010.

It is our prayer and hope that we shall continue to partner in the implementation of this new strategic plan over the period 2011 - 2016.

May God bless you all.

Dr Samuel Mwenda
General Secretary

Foreword

Implementation of CHAK Strategic Plan 2005-2010 came to an end in December 2010. During this period, CHAK made major strides in organisational development and programmes. Institutional capacity was enhanced through the development of a new office, guest house and conference centre. Through partnerships, CHAK was able to expand the breadth and scope of HIV and health programmes.

Advocacy was a key area of CHAK work with the notable achievement of an MoU between Government and Faith Based Health Service providers which would guide partnership and collaboration. In the area of partnerships, CHAK was mandated to establish a secretariat for the Africa Christian Health Associations Platform which has opened up opportunities for regional networking, information sharing, peer learning and provided visibility and opportunities for advocacy in the international arena.

The external evaluation of CHAK Strategic Plan 2005-2010 conducted by CORAT Africa identified organisational strengths and environmental opportunities which we need to build on. It, however, also pointed out internal capacity gaps and external threats. Sustainability, staff motivation and retention have been identified as key challenges facing MHUs in health service delivery. These have been compounded by political and social economic reforms taking place in Kenya.

Kenya has adopted major political, institutional and legal reforms through the adoption of a new Constitution following a national referendum held on August 4, 2010. The country's political structure is to be devolved into a national government and county governments. The national government will be responsible for health policy and national referral hospitals while the county governments will be responsible for primary health care and health service delivery by dispensaries, health centres and district hospitals. There will be devolution of resources and decision making.

CHAK will restructure its Regional Coordinating Committees (RCCs) to create County Coordinating Committees (CCCs) to coordinate members' engagement with county government structures. We shall build on the existing MoU partnership framework to sustain gains in advocacy.

CHAK Strategic Plan 2011–2016 whose theme is *"promoting access to quality health care"* has been developed through a participatory process that involved member health units, EXCO and all secretariat departments and technical staff. The strategic plan vision is "*All member health units providing efficient and high quality health care that is accessible, equitable, affordable and sustainable, as a witness to the healing ministry of Christ"*. The mission statement that will guide secretariat programmes towards the realization of these aspirations is *"To facilitate member health units in their provision of quality healthcare services through advocacy, health system strengthening, networking and innovative health programs"*.

To maximize efficiency, CHAK has adopted a strategy of integration. The strategic plan priority areas have been grouped in seven strategic directions, namely, health service delivery, health systems strengthening, governance and accountability, research, advocacy and communication, health care financing and sustainability, Human Resources for Health (HRH) and grant management.

The organizational structure has been refined to integrate HIV&AIDS programmes with health services. Human resource management and M&E have been given special focus as a support function to all programmes. During the implementation of this plan, CHAK will embrace technology to enhance efficiency in the management of MHUs. The CHAK HMIS software will be rolled out in MHUs to enhance resource management and report generation for informed decision making.

As we roll out this ambitious plan, we have faith in God who has called us to this healing ministry because He has given us assurance in 1 Thessalonians 5:24 which states: "The one who calls you is faithful and He will do it." God has a plan for us as recorded in Jeremiah 29:11 which states: "For I know the plans I have for you…plans to prosper you and not to harm you, plans to give you hope and a future".

We invite you to partner with and support us in the implementation of this Strategic Plan. We have faith that through our collective action, God who has called us to this ministry will enable us to accomplish it in the service of the people of Kenya.

Rt. Rev. Michael Sande
Chairman

List of abbreviations

ABC model..... Abstinence, Be Faithful, use Condoms
ACHAP..... Africa Christian Health Associations Platform
AGM..... Annual General Meeting
AHC..... Annual Health Conference
AOP..... Annual Operational Plan
ART..... Antiretroviral Therapy
ARV..... Anti-retroviral
BQ..... Bills of Quantities
CBHC..... Community Based Heath Care
CBHFA..... Community based Health Financing Association
CBO..... Community Based Organisations
CCC .... County Coordinating Committee
CCIH..... Christian Connections for International Health
CCM..... Country Coordinating Mechanism
CDF..... Constituency Development Fund
CHAS..... Christian Health Associations
CHC..... Catholic Health Commission
CHEW..... Community Health Extension Workers
CHSCC..... Church Health Services Coordinating Committee
CME..... Continuing Medical Education
CMMB..... Catholic Medical Mission Board
CORPS..... Community Own Resource Persons
CPD..... Continuous Professional Development
CPR..... Contraceptive Prevalence Rate
DHP..... District Health Plan
DHSF..... District Health Stakeholders Forum
DMOH..... District Medical Officer of Health
DSRS..... Department of Standards and Regulatory Services
EXCO..... Executive Committee
ESP..... Economic Stimulus Plan
FBHS..... Faith Based Health Services
FBO..... Faith Based Organisation
FAD..... Finance and Administration Department
FAM..... Finance and Administration Manager
GFTAM..... Global Fund to fight Tuberculosis, AIDS and Malaria
GIS..... Geographical Information Systems
GOK..... Government of Kenya
GPS..... Global Positioning Systems
GS..... General Secretary
HAPD..... HIV/AIDS Program Department
HBC..... Home based Care
HCTS..... Health Care Technical Services
HENNET..... Health NGOs Network
HIS..... Health Information Systems
HMIS..... Health and Management Information Systems
HIV..... Human immunodeficiency Virus
HMU..... Hospital Maintenance Unit
HSCC..... Health Sector Coordinating Committee
HRH..... Human Resources for Health
HRIS..... Human Resource Information Systems
HRM..... Human Resource Management
HSSD..... Health Services Support Department
HSSF .... Health Sector Service Fund
HSSM..... HSSD Manager
HSSTO..... Health Services Training Officer
ICC..... Inter Agency Coordinating Committee
ICT..... Information Communication Technology
IODM..... Institutional/Organizational Development Manager
IEC..... Information Education and Communication
IMAI..... Integrated Management of Adult Illnesses
IMCI..... Integrated Management of Childhood Illnesses
IMF..... International Monetary Fund
INFAMED..... Institute of Family Medicine
IT..... Information Technology

JRM ..... Joint Review Mission
KCS ..... Kenya Catholic Secretariat
KEBS..... Kenya Bureau of Standards
KEC ..... Kenya Episcopal Conference
KEMSA. ..... Kenya Medical Supplies Agency
KENAAM..... Kenya NGOs Alliance Against Malaria
KEPH..... Kenya Essential Package for Health
KMA..... Kenya Medical Association
KQM ..... Kenya Quality Model
LATF..... Local Authority Transfer Fund
LAN..... Local Area Network
MCH ..... Maternal and Child Health
MEDS..... Mission for Essential Drugs and Supplies
MHU..... Member Health Unit
MIS..... Management Information Systems
MLTTB ..... Medical Laboratory Technicians and Technologists Board
MOH..... Ministry of Health
MOH-FBHS-TWG ..... Ministry of Health-Faith Based Health Services-Technical Working Group
MoMS .... Ministry of Medical Services
MoPHS ..... Ministry of Public Health and Sanitation
MOV..... Means of Verification
MP&DB..... Medical Practitioners and Dentist Board
MT ..... Management Team
MTP. ..... Medium Term Plan
NACC..... National AIDS Control Council
NASCOP ..... National AIDS Control Program
NCCK..... Nation Council of Churches of Kenya
NCK ..... Nursing Council of Kenya
NGO..... Non Governmental Organisation
NHIF ..... National Hospital insurance Fund
NHSSP ..... National Health Sector Strategic Plan
NSHIS ..... National Social Health Insurance Scheme
OJT..... On-job Training
PCMA..... Protestant Churches Medical Association
PDA ..... Personal Digital Assistants
PEP..... Post-exposure prophylaxis of HIV/AIDS
PEPFAR ..... Presidential Emergency Plan on AIDS Relief
PHC ..... Primary Heath Care
PLWHA..... People Living with HIV/AIDS
PIM ..... Presidential Initiative on Malaria
PMCT..... Prevention of Mother to Child Transmission of HIV/AIDS
PMOH..... Provincial Medical Officer of Health
RCC..... Regional Coordinating Committee
RH..... Reproductive Health
STI..... Sexually Transmitted Infections
SWOT ..... Strengths, Weaknesses, Opportunities and Threats
SWAPs ..... Sector Wide Approach Strategy
TA ..... Technical Assistance
T&D ..... Training and Development
TNA ..... Training Needs Assessment
TOR ..... Terms of Reference
TWG ..... Technical Working Group
UNAIDS..... Joint United Nations Program on HIV/AIDS
USG. ..... United States Government
VCT..... Voluntary Counselling and Testing
VSC..... Voluntary Surgical Contraception
WAD..... World AIDS Day
WCC ..... World Council of Churches
WHO ..... World Health Organization

Executive summary

CHAK Strategic Plan 2011–2016 has been developed at a time when Kenya has adopted a new Constitution which is expected to birth key political, social and administrative reforms. The health sector is expected to undergo major decentralization reforms.

CHAK will play its role in supporting MHUs to align their services to the new Government arrangement. Some key challenges to be addressed in this plan include HRH development, motivation and retention and health care financing for sustainability. The theme of this strategic plan is *"promoting access to quality health care" and it shares a vision with the health sector which states ""All member health units providing efficient and high quality health care that is accessible, equitable, affordable and sustainable, as a witness to the healing ministry of Christ"*.

The core activities in this six-year plan have been organized in seven strategic directions as below:

Strategic direction 1: Health service delivery
- HIV& AIDS programs
- Health Programs and policy
- Essential drugs access and rational drug use
- Coordination of capacity building
- Technical support to MHUs
- Disaster preparedness and emergency response in MHUs
- Primary Health Care through implementation of the Community Strategy

Stragetic direction 2: Health systems strengthening
- Enhanced participation of MHUs in health sector joint planning and monitoring (AOPs & District Health Sector Stakeholders Forums)
- Establishing specifications for medical equipment and consumables for the health sector in Kenya (HCTS and KEBS/GOK)
- Mobilisation of resources in response to relevant specific areas of felt needs by MHUs (projects)
- Responding to requests from MHUs for technical support in architectural services, project formulation and proposal writing (technical assistance)
- Health Care Technical Services available for all church health units (HCTS)
- Governance and management support for MHUs
- Enhanced support to MHUs by empowered RCCs (further devolved to CCCs in line with the new Constitution)

Strategic direction 3: Governance and accountability
- Support to CHAK governance structures
- Financial management and reporting
- Internal and external audit
- Donor compliance and reporting
- Legal/statutory compliance
- Support MHUs in the implementation of financial management policies
- CHAK secretariat administration, procurement and logistic support
- Assets maintenance and management

Strategic direction 4: Research, advocacy and communication
- Conduct operational research to inform programmes improvement and document best practices and lessons
- M&E for projects and programmes
- HMIS for health service and systems data and resource management
- ICT to enhance information retrieval, processing, dissemination and storage
- Publications and resource centre for information storage and dissemination
- Conduct advocacy for the implementation of the MoU between Government and Faith based health services

Strategic direction 5: Human resources for health
- HRM Policy Manual implementation
- HRM capacity building
- Support to HRH training institutions
- HRH motivation and retention strategies

- Performance based management systems
- Work climate improvement initiatives

Strategic direction 6: Health care financing and sustainability
- Costing study of health services for evidence based service pricing
- Efficiency in resource management through HMIS software
- NHIF inpatient and outpatient insurance medical cover including support for health facilities in compliance and mobilization of communities for NHIF enrolment
- Innovative income generating activities
- Capacity building in proposal writing for fundraising
- Support CHAK Guest House and Conference Centre in the development of a business strategy

Strategic direction 7: Grant management
- Disbursement of HSSF funds and reporting
- AIDSRelief transition project and site management
- Global Fund sub recipient role
- Technical assistance/capacity building in financial management
- Other projects grants management

Detailed activities and M&E indicators have been presented in the logframe at the end of this plan. The implementation management structure has been drawn under three departments and a supportive unit with HR, M&E, ICT and HMIS.

1 Context

New Constitution and political reforms

Kenya experienced a rebirth following the adoption of a new Constitution which received majority endorsement at a national referendum held on August 4, 2010. The Constitution creates a framework for major political and institutional reforms in Government which should enhance human rights, security, public service and accountability.

One drastic reform is the creation of county governments under the leadership of elected governors and county assemblies. The Constitution provides for the devolution of public funding with 15 per cent of the national budget being allocated to counties and an equalization fund being created for counties that lag behind in economic development.

Health as a right for every Kenyan is now enshrined in the Constitution which provides that no person should be denied emergency medical treatment. The counties are responsible for the provision of primary health care through health facilities up to district level hospitals. The national government has been assigned the responsibilities of health policy and running national referral hospitals. It is expected that several laws will be legislated to operationalize the new Constitution.

CHAK will need to keenly follow developments in legal and political reforms to reposition itself strategically to be relevant in the new political dispensation and ensure participation in development of new health policies, particularly in areas touching on the devolved health sector coordination structure, health care financing at the county level and health services regulation.

Social-economic context

Kenya continues to record steady economic growth. The global economic downturn of 2009 and the post election violence experienced in 2008 had major impact on the country's economic performance. The economic growth rate dropped to less than 2 per cent in 2009. The country's economy has however been predicted to grow at over 3 per cent in 2010. The adoption of a new constitution is expected to provide stability and an enabling environment that would spur investment and economic growth. The country however continues to experience high poverty levels with 46 per cent of the population living below one dollar a day (poverty line).

a) Kenya Vision 20/30

The Government's Vision 20/30 is a long-term economic development plan that aims to produce an economic growth rate of 10 per cent. The aim of Vision 20/30 is to create a globally competitive and prosperous country with high quality of life by 2030 by transforming Kenya from a third world country to a middle level income country. The vision calls for a series of five year medium-term plans.

Vision 20/30 has three pillars: economic, social and political. Health is one of the key components of the social pillar. The vision aims to provide equitable and affordable health care at the highest affordable standard to all citizens by restructuring health care delivery systems to shift emphasis to preventive and promotive health care. The emphasis will be on access, equity, quality, capacity and institutional framework.

The first Medium-Term Plan (MTP) is the Economic Recovery Strategy of 2008 – 2012. The MTP has stipulated the following health objectives:

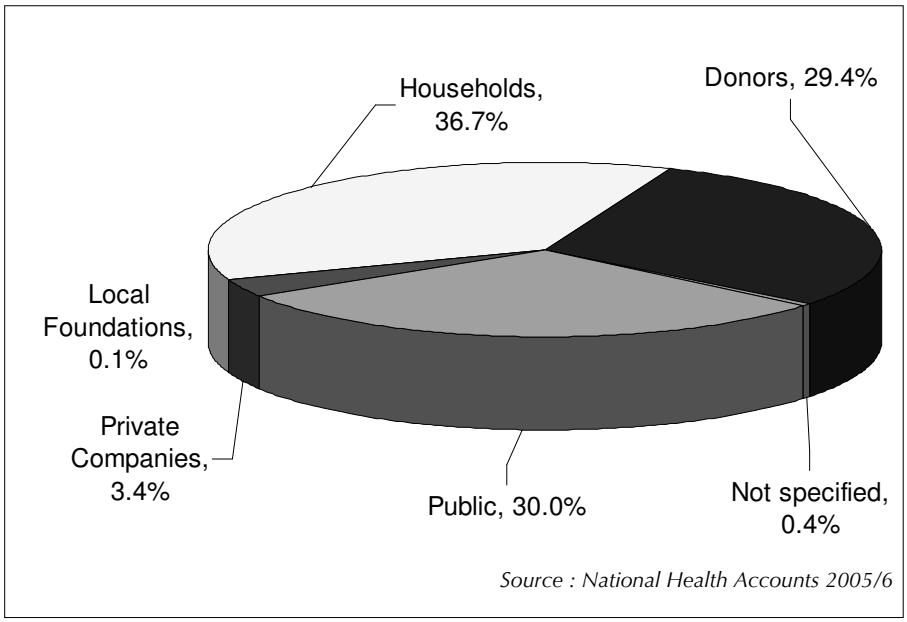
i. Reduce under five mortality from 120 to 33 per 1,000 live births
ii. Reduce the maternal mortality ratio (MMR) from 410 to 147 per 100,000 live births
iii. To increase the proportion of deliveries by skilled personnel from the current 42 per cent to 90 per cent
iv. To increase the proportion of immunized children below one year from 71 per cent to 95 per cent
v. Reduce the number of cases of TB from 888 to 444 per 100,000 persons
vi. Reduce the national adult HIV prevalence to less than 2 per cent
vii. To reduce the proportion of in-patient Malaria fatality to 3 per cent

b) Health care financing

The move towards the development of a mandatory National Social Health Insurance has been revived. A pilot study for the introduction of out-patient cover by NHIF has been conducted from which lessons have been learnt to inform national roll-out. This development creates an opportunity for CHAK member health facilities to get accredited as service providers.

Health care financing in Kenya is largely dependent on out-of-pocket payment by households for routine health services and donor funding for special programmes such as HIV, Malaria and TB treatment. According to the National Health Accounts of 2005/6, the national budget accounts for 30 per cent of health funding.

Sources of health care financing in Kenya



Source : National Health Accounts 2005/6

Although the budgetary allocation to health has increased to Ksh34.4b in the 2007/8 financial year, this is only 8 per cent of the National Budget which is below the Abuja Declaration target of 15 per cent. The per capita expenditure on health in Kenya is US$12.

c) Impact of HIV/AIDS

The HIV epidemic in Kenya peaked in the late 1990s with an overall prevalence 14 per cent in adults. This declined over the next decade, with the national HIV prevalence currently estimated at 7.4 per cent in the age group 15-49, and at 7.1 per cent in the age group 15-64 years in 2007.

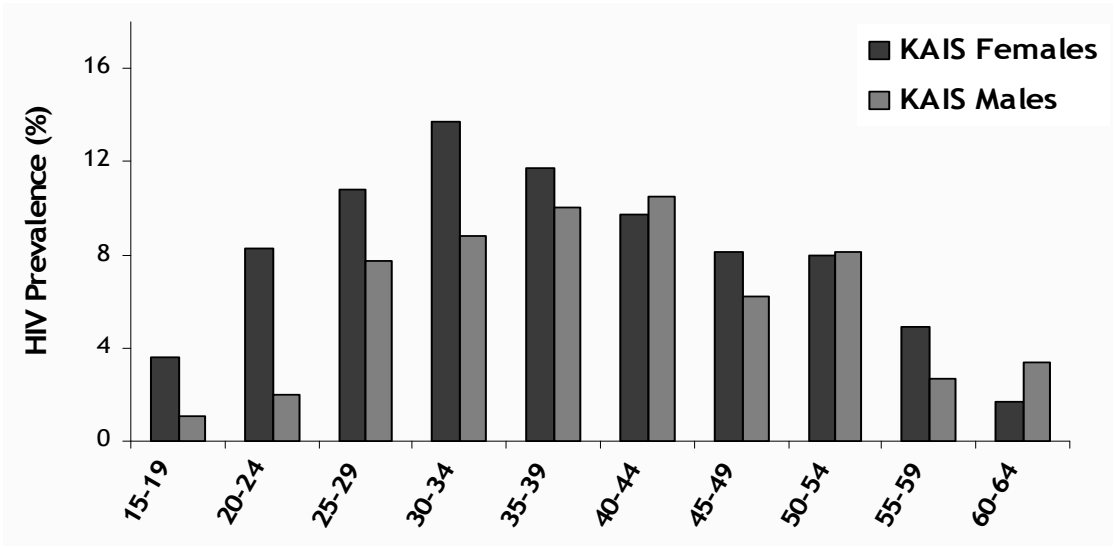
KAIS Results on HIV status

The 2008 KAIS indicates that 7.4 per cent of Kenyans aged 15-64 are infected with HIV. This means that about 1.4 million adults are living with HIV. More women are infected with HIV (8.7 per cent) compared to men (5.6 per cent).

The country has recorded significant gains in HIV/AIDS management through a multi-sectoral response with the Government providing leadership through the National AIDS Control Council (NACC). The Government's National AIDS and STI Control Program (NASCOP) provides technical leadership in producing technical guidelines in prevention, care and treatment which include VCT, PMCT, DCT, ART (adult and paediatric), Voluntary Male Medical Circumcision (VMMC) and Home Based Care (HBC).

A national framework known as the Kenya National AIDS Strategic Plan III (KNASP) 2010–2015 has been developed through partner collaboration to guide the response. In addition, a Monitoring and Evaluation (M&E) framework has been developed. These strategy documents follow the UNAIDS recommended "Three ones" – one National Strategy, one Coordinating Agency and one M&E Framework. In addition, the country has established a legal framework for HIV/AIDS management through the enactment of the Kenya HIV/AIDS Prevention and Control Act 2006.

HIV prevalence by age and sex



Source: KAIS Report 2008/9, NASCOP

d) Health status in Kenya

Kenya has recorded some gains in the national health indicators according to the 2008/9 Demographic and Health Survey. The infant mortality rate has improved from 77 to 52 per 1000 live births and under five mortality rate has dropped from 115 to 74. However there has been little gain in newborn mortality and pregnant women delivery in health facilities which still stands at 43 per cent while maternal mortality stands at 410 per 100,000 deliveries. The country has made good progress towards the attainment of the HIV related MDG but little progress towards the maternal and child health MDGs.

Health status in Kenya

Health indicator	2003 DHS result	2008/9 DHS result
Infant mortality rate /1000	77	52
Under five mortality rate/1000	115	74
Newborn mortality rate/1000	33	31
Delivery in a health facility	40%	43%
FP contraceptive prevalence rate	39%	46%
Unmet FP need	24%	25%
Maternal mortality ratio/100,000	414	410

Source: KDHS 2008/9

e) Changes in donor environment

The traditional ecumenical development partners from Europe who have been long-term partners of CHAK have been restructuring their operations. Introduction of more stringent requirements with emphasis on impact, accountability and mutual partnership are some of the key elements emphasised. Global financing initiatives present new funding opportunities in health care. These include Global Fund to Fight AIDS, TB and Malaria (GFTAM), US

Presidential Emergency Plan on AIDS Relief (PEPFAR) and Presidential Initiative on Malaria (PIM). The International Health Partnerships and the Paris Declaration on AID effectiveness have provided guidance on donor harmonization that should support country developed strategic plans and assist to strengthen country systems.

The Sector Wide Approach Strategy (SWAPs) has created a policy framework for improving coordination and collaboration in planning, implementation, financing and monitoring.

A Code of Conduct (CoC) for SWAps has been developed and signed by Government, development partners and implementing partners to guide health sector partnership.

Development Partners for Health in Kenya (DPHK) has created a coordination forum for health sector donors.

f) Technological advancement

Kenya is experiencing rapid developments in information technology. The arrival of fibre-optic cable and expansion of mobile technology has opened up great opportunities in telecommunication.

Mobile phone service providers have introduced internet access and data transfer solutions which are facilitating communication to most areas of Kenya. CHAK Secretariat and several member hospitals have VSAT for internet access which has greatly enhanced communication. CHAK Secretariat will need to install fibre-optic internet connectivity which has higher speeds and lower costs. Telemedicine may become more accessible following these developments.

CHAK has developed a Health Management Information Systems (HMIS Software) built on an open source system. The HMIS software will be installed in MHUs to enhance efficiency in resource management and generate timely reports to support decision making.

Health sector policies

a) National Health Sector Strategic Plan (NHSSP)

The NHSSP II 2005-2010 was developed as a whole sector plan and includes all implementing partners such as FBOs, NGOs and the private sector. The plan has the theme 'Reversing the trends' while its vision is 'An efficient and high quality health care system that is accessible, equitable and affordable for every Kenyan".

The mission statement is 'To promote and participate in the provision of integrated and high quality promotive, preventive, curative and rehabilitative health care services to all Kenyans'.

NHSSP II objectives are to:

- Increase access to services
- Improve service quality and responsiveness
- Improve efficiency and effectiveness of services
- Enhance the regulatory capacity of MOH
- Foster partnerships
- Improve health sector financing

The NHSSP has been implemented through Annual Operational Plans which are developed from the district level with the participation of the various stakeholders. CHAK has played a key role in mobilizing member health facilities to participate in the development of District Health Plans. The secretariat participates in the consolidation of the Annual Operational Plan (AOP) at the national level.

Following the formation of the Grand Coalition Government after the 2007 General Election, the Ministry of Health was split into two: Ministry of Medical Services (MoMS) and Ministry of Public Health and Sanitation (MoPHS). The roles of the two ministries have been defined and each ministry has developed its own strategic plan. The MoMS is responsible for health policy and service delivery in level 4 – 6 health facilities (District, Provincial and Referral Hospitals). It also oversees institutions training health workers, NHIF and medical commodity logistics through KEMSA. The MoPHS is responsible for public health policy, preventive and promotive services and community strategy implementation. CHAK continues to partner with both ministries and the institutions they supervise to support its MHUs in health service delivery.

The Sector Wide Approach Strategy (SWAPs) has promoted partnership in health and provided a framework for coordination. This partnership has been formalized through a Code of Conduct signed between MOH, develop-

ment partners and implementing partners. CHAK is a signatory to the SWAps COC. SWAPs seek to achieve better planning, implementation coordination and joint performance review. It also seeks to provide guidelines on financing mechanisms and common management arrangement.

b) Kenya Essential Package for Health (KEPH)

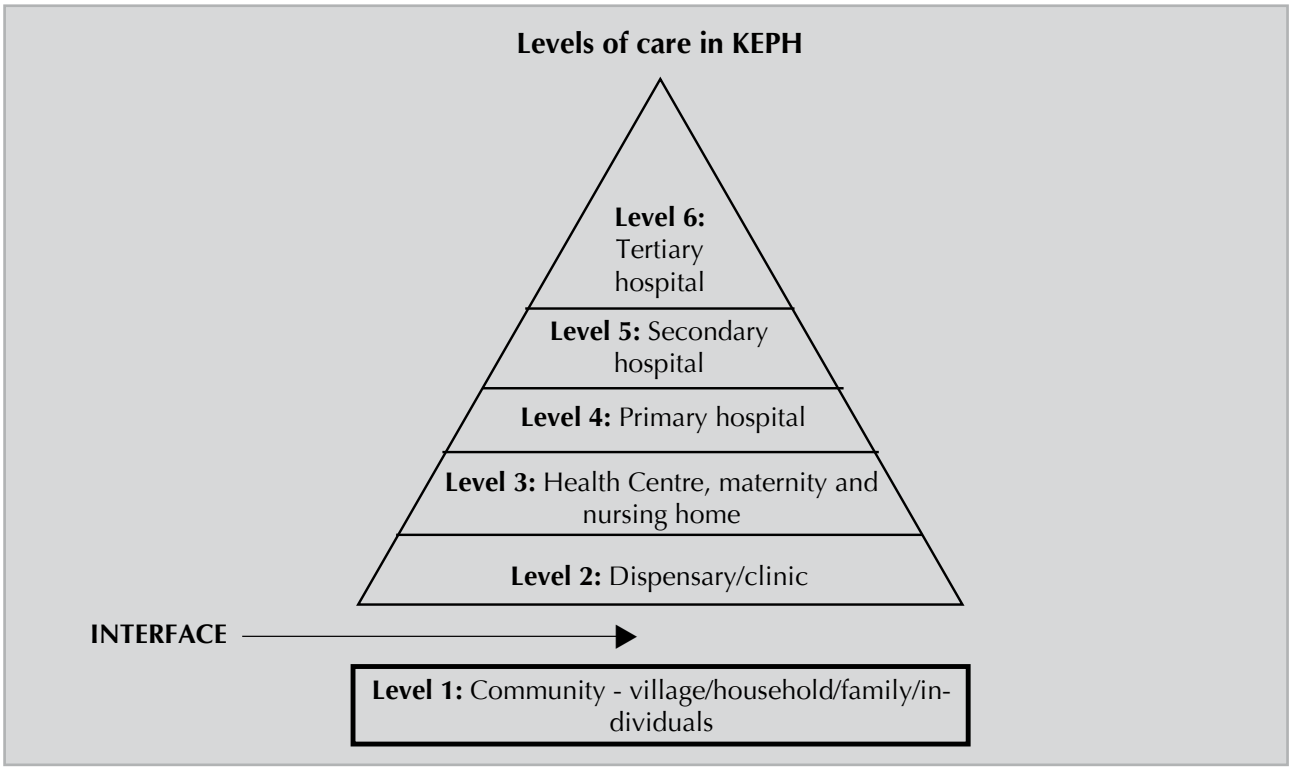
KEPH integrates all health programmes into a single package focussing on improving health in all stages of the human life cycle. The NHSSP II therefore adopts a broader approach that entails moving emphasis from disease burden to promotion of healthy lifestyles for individuals with attention to the various stages of the human life cycle.

KEPH distinguishes six distinct life cycle stages (cohorts):

- Pregnancy, delivery and the newborn child (up to 2 weeks of age)
- Early childhood (3 weeks to 5 years)
- Late childhood (6 to 12 years)
- Adolescence (13 to 24 years)
- Adulthood (25 to 59 years)
- Elderly (60 years and over)

The KEPH approach also defines six service delivery levels:

- Level 1, which is the community, is the foundation of service delivery as it allows the community to define its own priorities so as to develop ownership and commitment to health services. Communities are empowered with information and skills.
- Levels 2 and 3 are dispensaries and health centres respectively and maternity/nursing homes, which primarily handle promotive and preventive care, but also some curative services.
- Levels 4-6 are the primary, secondary and tertiary hospitals, which focus mainly on the curative and rehabilitative aspects of the service delivery package.



The 'minimum KEPH' interventions include:

- Safe motherhood and reproductive health
- Child health promotion and IMCI
- Malaria control
- HIV/AIDS/STI & TB control
- Sanitation and food safety

Health systems in support of KEPH

Improvement in health service delivery depends on support systems that function efficiently and effectively so that funds, human resources, drugs and commodities, infrastructure and other essentials are available in a timely manner. Such systems also ensure that available resources are better managed. .

c) Millennium Development Goals (MDG)

The Millennium Development Goals (MDGs) are eight goals to be achieved by 2015 that respond to the world's main development challenges. The MDGs are drawn from actions and targets contained in the Millennium Declaration that was adopted by 189 nations and signed by 147 heads of state and government during the UN Millennium Summit in September 2000.

A summary of the eight MDGs is as below:

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

The NHSSP II, MoMS Strategic Plan and MoPHS Strategic Plan have incorporated the MDG targets relevant to health. Thus, by aligning CHAK's strategy to the NHSSP, the organisation will be able to make a contribution towards the country's attainment of health MDGs.

c) Memorandum of Understanding (MOU) between Faith Based Health Services and Government

A memorandum of understanding (MoU) has been signed between Government and Faith Based Health Service providers in Kenya to provide a structured framework for enhancing partnership and collaboration. The MoU has been signed by the Ministry of Medical Services (MoMS) and Ministry of Public Health and Sanitation (MoPHS) on the side of Government and Christian Health Association of Kenya, Kenya Episcopal Conference of the Catholic Church and Supreme Council of Kenya Muslims (SUPKEM) for faith based health services. The MOU development process was coordinated by the MOH-FBHS-TWG and CHAK facilitated the process in its role as the secretariat for the TWG.

The MoU secures the recognition of FBOs' contribution in health service delivery and commits Government support. It defines a mechanism for scaling up support to FBO health facilities in cash and kind from Government and Development Partners. The support will however be linked to performance against service delivery targets set out in annual work plans submitted through the District Health Management Teams (DHMTs), which would be included in the District Health Plans (DHP). Performance would be monitored through submission of service statistics to the MOH through District Medical Records Officers.

All FBO health facilities would be grouped into three categories of support guided by defined criteria. These support categories are:

1) Minimal support
2) Partial support
3) Maximum support

The level of Government involvement in governance, staffing and resourcing of FBO health facilities increases progressively from minimal to maximum support. However, in all situations, a partnership shall be maintained between the owning church and Government. Each health facility will be accredited into the appropriate partnership status following a joint assessment and a commitment signed by the church/health facility and MOH and witnessed by the respective Secretariat.

The MoU recognizes a health financing mechanism from the following sources:

i. User fees
ii. NHIF (National Hospital Insurance Fund)
iii. Government grants though the Health Sector Services Fund (HSSF)
iv. Donor funding

Financial management systems should ensure adequate accountability with periodic reports submitted to Government through the Secretariats. Human resource support through secondment of health workers from Government will be better structured, coordinated and managed. The MOH-FBOs-TWG will coordinate and provide oversight to the implementation of the MoU.

2 Background information and overview

Organisational development

Christian Health Association of Kenya (CHAK) was established in the 1930s as a Hospitals' Committee of the National Christian Council of Kenya (NCCK). In 1946, the Committee was changed to the Protestant Churches Medical Association (PCMA) which acquired autonomous legal registration. Its mandate was limited to the distribution of Government grants to protestant churches' health facilities in Kenya. In 1982, the Association changed its name to the Christian Health Association of Kenya (CHAK) with the broader mandate of facilitating the role of the Church in health care and healing.

Restructuring

Availability of donor funds enabled CHAK to implement many projects, resulting in rapid growth and expansion of the scope of activities and the Secretariat. However, this growth was not adequately matched with strengthening of CHAK's management, coordination systems and capacity. An external evaluation by CORAT Africa done in 1995 revealed some weaknesses and formed the basis for a major restructuring.

In 1996, CHAK EXCO and AGM made a decision for a paradigm shift, changing CHAK's role from that of frontline implementer to facilitator. This shift has increased the dependence of the Association on its members for support and direction. The MHUs participate in development of CHAK strategic plans and in policy making through the AGM and representation in EXCO. Operationally, CHAK Secretariat plays a facilitative role by providing technical support, capacity building, coordination, advocacy and networking for its members rather than front-line implementation of health services. The MHUs' core function remains health service delivery.

CHAK's organizational development has stabilized through the implementation of two strategic plans for the periods 1998 – 2004 and 2005 – 2010. CHAK has embraced a learning culture and utilizes lessons pointed out by evaluation reports to strengthen systems.

Each strategic plan undergoes a mid-term evaluation and an end term evaluation which generate valuable recommendations on organizational development. In addition, CHAK engages in partnerships with various national, regional and international organizations which provide experiences and technical support in organisational development and health systems strengthening.

During the period of the CHAK Strategic Plan 2005 – 2010, CHAK facilitated study tours to five African countries for a combined team from MOH, NGOs and FBOs from Kenya. The tours picked important lessons on public-private partnership which were utilised in the development of an MoU between Government and faith based health services providers.

In 2007, CHAK was mandated to establish the secretariat for the Africa Christian Health Associations Platform (ACHAP). The ACHAP facilitates communication, networking and sharing of lessons and experiences among CHAs in Africa and also provides an avenue for joint advocacy. CHAK hosts the platform and has evolved to become a leader among Africa Christian Health Associations, a role which has opened up numerous opportunities for international advocacy.

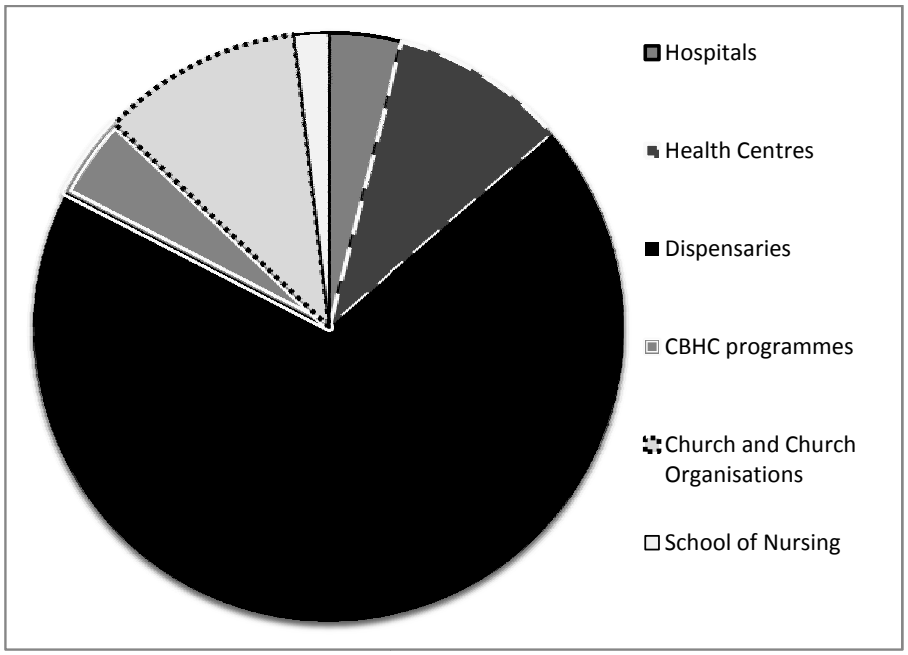
CHAK has developed notable competences in advocacy, health systems strengthening which include medical equipment maintenance services, architectural services for infrastructure design and development, HMIS software, governance and management policies, capacity building, communication and networking. A new office block, Guest House and Conference Centre (www.chakguesthouse.org) has been developed at the Musa Gitau Road property in Nairobi.

This has provided infrastructure for the secretariat, conference facilities for meetings and income generation opportunities.

CHAK membership

CHAK has a large membership that is growing steadily. The CHAK Constitution provides that "Any Christian church or church sponsored or related non-profit making organisation or community group with the objective of promoting health and health service within the Republic of Kenya shall be eligible for membership of the Association".

The total membership as at August 1, 2010, was 528, comprising 21 hospitals, 51 health centres, 364 dispensaries, 58 churches/church organizations, 24 community-based health care programs and 10 Schools of Nursing. These members are drawn from 43 church denominations and are located all over Kenya.



Membership by Category	No.
Hospitals	21
Health Centres	51
Dispensaries	364
CBHC programmes	24
Church and Church Organisations	58
School of Nursing	10
Total	528
Church Affiliations	43

The CHAK membership is grouped into four regions covering the whole country. These are:

- Eastern/North Eastern region
- North/Central/South East & Coast region
- Western/North Rift region
- Nyanza/South Rift region.

CHAK is unique due to its ecumenical nature and nationwide network providing comprehensive quality health services to needy and vulnerable communities who would otherwise be inadequately served. Some hospitals within the CHAK membership have evolved as teaching and referral centres offering highly specialized services.

3 Mission, vision, values and purpose

Identity
CHAK is a national network of Protestant Churches' health facilities and programs from all over Kenya.

Vision
All member health units providing efficient and high quality health care that is accessible, equitable, affordable and sustainable, as a witness to the healing ministry of Christ

Mission
To facilitate member health units in their provision of quality healthcare services through advocacy, health system strengthening, networking and innovative health programs.

Values
- Christian values guided by Biblical teaching on health and healing following the example of Christ.
- Transparency and accountability to members and partners
- Adherence to professional ethics and operating within National Health Sector policies and guidelines
- Promotion of equity
- Gender responsiveness and promotion of human rights
- Embrace creativity and innovation in service delivery
- Fostering partnership with other health sector stakeholders
- Recognition of human resource and investment in their development, motivation and teamwork.

Purpose
The purpose of CHAK is to facilitate member health facilities to deliver accessible, comprehensive, quality health services to Kenyans in accordance with Christian values and professional ethics guided by the national health sector policies.

4 SWOT analysis

A SWOT analysis reviewing CHAK's internal strengths and weaknesses and the external opportunities and threats was conducted through a participatory approach in regional review workshops attended by key stakeholders. The Secretariat technical staff and EXCO also gave their input in the environmental analysis using both the SWOT and PESTEL tools.

Strengths, weaknesses, opportunities and threats (SWOT) analysis

	Existing strengths	Existing weaknesses	Opportunities	Threats
Human Resources for Health	• CHAK has training institutions for HRH (10 schools of nursing and two universities). • CPD through seminars and other short-term CMEs • Internship training for doctors • Skilled and committed workforce • Volunteer mission professionals working in CHAK MHUs • Existing HR policy documents • Support from committed partners to fill existing HR gaps • Regional and local HR advisors • Christian values attract staff to our MHUs	• Non-competitive terms and conditions of service • Perceived job insecurity • Limited avenues for career progression • Minimal capacity of training institutions in terms of numbers, diversity in training courses. • Slow adoption of HR policies	• Secondment of staff by GOK • MOU for advocacy to access more HR support from GOK • Training opportunities by other players	• Competitive HR packages by other players such as CDF, ESP and GOK • Migration of health workers
Health system/sector	• Existing heath systems structures • HMIS reporting tools • Equipment • Infrastructure • Financial systems • Operating within the national health sector plans • Representation in govt policy agencies including the NHIF board, CCM, NCK, ICCs • MHUs accredited	• Inadequate information sharing with stakeholders • Inadequate health system structures at the lower level facilities • Inadequate participation in health sector planning in some regions • Insufficient documentation and reporting on	• Roll out of NHIF outpatient cover • Sector Wide Approach (SWAP) • Specific donor interest in Health Systems Strengthening (HSS) funding • Roll out of HSS Fund	• Economic Stimulus Package leading to recruitment of health workers from our MHUs by the Government • Inadequate funding especially to small health facilities • Competition for space and representation

SWOT analysis

	to NHIF • Availability of highly specialized services in facilities • Some CHAK facilities are national referral hospitals	service delivery for advocacy		by CSO networks
	Existing strengths	**Existing weaknesses**	**Opportunities**	**Threats**
Health service delivery	• National network coordinating health services delivery • Major stakeholder in heath sector delivery contributing above 20 per cent of health services in the country • Specialized and quality health services e.g. eyes, open heart surgery, rehabilitative • Experienced, skilled expatriates and volunteer professionals • National coverage even in marginalized areas • Holistic approach to health care meeting also emotional and spiritual needs • Emergency response to outbreak of diseases	• In adequate staff • Competition for limited donor funding by many players • Inadequate medical supplies and equipment • Poor documentation of service delivery statistics	• Opportunities for secondment of specialized personnel from the Government e.g. surgeons • Networking with national referral centres and higher institutions of learning	• Economic Stimulus Package leading to recruitment of health workers from CHAK facilities • High costs of services delivery • High poverty levels in the country • Shortage of specialized personnel in the job market • Poor infrastructure e.g. roads, electricity, ICT • competition from public and private health services
Health promotion, disease prevention and management	• Existing outreach services and CBHC programmes • Availability of IEC materials and guidelines from MOH • Trained volunteer CHWs • Capacity to develop proposals addressing health promotion, prevention and management at	• Inadequate equipment • Inaccessibility of MHUs due to poor infrastructure • Weak communication strategy • Irregular supply of commodities from the MOH • Inadequate staff	• Restructuring of KEMSA leading to efficiency in drugs' distribution • Restructuring of the supply systems of commodities - Roll out of the pull system • Commodities provided by the	• Heavy burden of HIV overshadowing other diseases, hence resources are diverted to it • Emerging epidemics and natural disasters • Competition for limited donor and Government resources

SWOT analysis

	secretariat • Availability of KEMSA supplies and drugs to FBO facilities • Large membership hence a wide coverage		Government (nets, vaccines, anti–TB drugs and anti -malaria drugs, IEC materials e.t.c) • Available funding opportunities for HIV/AIDS, Malaria and TB programmes • Collaboration with GOK • Health days – WAD, Malaria day, and TB day	• Staff migration
	Existing strengths	**Existing weaknesses**	**Opportunities**	**Threats**
Partnership, networking and coordination	• Partnership and networking with the following bodies: GOK/MOH, International NGOs, bilateral partners such as USAID, multilateral partners such as UNFPA and UNICEF, communities, MEDS, ACHAP, Provincial Administration, Ministry of Education, churches and church institutions • MoU with GoK • Occasional secondment of staff to FBO health facilities • Use of FBO facilities for internship training • Well established advocacy taskforce called the Church Health Services Coordinating Committee • Membership to HENNET and KENAAM • Regional Coordinating Committees (RCCs)	• Uncoordinated communication of activities to MHUs • Gaps in management and governance • Inadequacy of funds leads to FBOs being unable to meet their part of partnership bargains • Networking among the MHUs is not as much as expected	• MOU with Government provides a forum for advocacy and collaboration • AOPs, District Health Stakeholders Forums provide platforms for advocacy • The EAC common market is an opportunity for expansion of networks and information sharing • Trust capital/goodwill with donors • Sector Wide Approach (SWAPs)	• Shift in Political will • Uncertainty of impact of new constitution on health service delivery • Takeover of MHUs by GOK due to continual institutional support • Emergence of other health care networks claiming FBO space • Donor dependency

SWOT analysis

	that aid networking and coordination within the CHAK network			
	Existing strengths	**Existing weaknesses**	**Opportunities**	**Threats**
ICT/Technology	• Development and ongoing implementation of Hospital management information systems at MHU and secretariat level • ICT infrastructure in place in a few sites • ICT technical capacity at secretariat level for oversight exists • Improvement of service delivery at MHU level due to good ICT infrastructure • Existing medical maintenance equipment unit at the secretariat	• Insufficient funds to support ICT development and maintenance in MHUs • Reports sent rarely reach the target • Reports from MHUs take time to reach the Secretariat • Insufficient ICT skills at MHUs • Resistance to technological change	• Expansion of fibre optic cable network • Improved/ increased diagnostic equipment • VAT Exemption on medical equipment and zero rating of tax on computers • Changes in technology	• Flooding of counterfeit equipment in the market • Limitation in resources to keep up with changes in technology
Institutional development and management	• Accountable and functional governance structures • Sound governance and management policies and guidelines in place • Nationwide spread of membership • Qualified human resources • We have both local and international partners • Strong collaboration with the Government, national, regional and international partners • The Secretariat and MHUs stand on their own properties	• Inadequate capacity in implementing governance, finance and management policies and guidelines • Insufficient staffing numbers at all levels • Sustainability challenges • High staff turnover	• Recognition of CHAK as a key health sector player • WHO Prequalification of MEDS quality control laboratory • New NHIF cover for both inpatient and outpatient services	• CDF facilities • Improved terms and conditions of service in the Government • Shifting focus by donors • Perceived low cost health care services from the Government

SWOT analysis

	• Church Health Services Coordinating Committee commissioned by Bishops for advocacy purposes • CHAK is represented in the NHIF Board			
	Existing strengths	**Existing weaknesses**	**Opportunities**	**Threats**
Church support and relations	• Goodwill from both local and international Churches • Support from key church leaders in advocacy • Spiritual nature of our services	• Weak church support in the management of MHUs	• Expansion of networks with other church networks	• Competition for resources from church networks that previously operated from the North
Community strategy and linkages	• Existing church health programmes targeting communities and run by CHWs • Well established linkages between most CHAK MHUs and the community • Grassroots representation on the facility management committees • Rich history of the church in implementing community activities	• Reliance on volunteers to serve as CHWs • Insufficient feedback mechanisms between MHUs and the community • Inadequate mechanisms for motivation and involvement of CHWs	• Existence of a national community strategy	• Provision of incentives to CHWs by private practitioners and NGOs • Influence of alternative medicine

4 Implementation approach

CHAK has an organisational work culture characterised by participatory planning, focused implementation and monitoring. This culture will be central in the implementation of the Strategic Plan 2011-2016.

The organisational structure will be redefined to ensure optimal efficiency and effectiveness in the plan's implementation. The strategic plan has identified strategic directions, priorities and defined a framework for their implementation and monitoring. A three-year program proposal will be developed with more specific details of activities and resource needs and used for fundraising. Implementation will be achieved through annual operational plans that will be further broken down to specific quarterly departmental and individual work plans

In response to the wishes of its members, CHAK Secretariat will maintain a facilitative approach that incorporates elements of accompaniment/implementation especially for innovative projects/programs that address the identified priorities. CHAK will also retain its role as a resource organisation for its members. Deliberate effort will be made to ensure equitable allocation of Secretariat staff time and resources in serving the diverse membership, while bearing in mind that the demand-driven approach disadvantages smaller MHUs.

The strategies to be engaged include:

- Participation in health sector coordination structures for joint planning and review
- Empowering MHUs through health systems strengthening and capacity building
- Networking, establishment of linkages and collaboration
- Advocacy through both proactive engagement in policy development, dialogue for opportunities and resources and building on the opportunity created by the MoU between Government and Faith Based Health Services. The Church Health Services Coordinating Committee (CHSCC) will be used to strengthen the advocacy role of Churches in health.
- CHAK will endeavour to establish strategic partnerships for technical assistance, resource sharing and fundraising both locally and internationally.

CHAK has evolved as a key implementing partner in the health sector in Kenya and is a signatory to the SWAps Code of Conduct. In the implementation of the Sector Wide Approach strategy (SWAps), CHAK has been included in various coordinating structures of the health sector including the HSCC, ICC, CCM and DHSF. Additionally, CHAK has a leadership role in the functioning of the MOH-FBHS-TWG by serving as its secretariat. This creates a structured forum for engagement between FBOs and MOH. CHAK will continue to take advantage of this representation to proactively articulate issues from MHUs.

CHAK will restructure to facilitate engagement with county government structures that have been created by the new Constitution. County Coordinating Committees will be established to coordinate MHUs advocacy and participation in annual planning at the district and county level.

The CHAK Secretariat will seek to maintain a human resource compliment that is lean, efficient and cost effective. Full time core staff under the leadership of General Secretary will be maintained, developed and motivated by promoting a team spirit. The core staff will be supported by project staff who may be recruited to support implementation of funded projects for the life of such projects. The regular staff will be provided with relevant technical assistance by external consultants drawn for specific assignments with mutually agreed TOR and performance standards. It is recognised that the CHAK network has human resources with varied skills, expertise and experience from whom we shall draw technical support for capacity building, mentorship and monitoring.

CHAK will give priority to the health sector coordination structures and opportunities and build capacity of its membership in KEPH implementation and health systems strengthening guided by the National Health Sector Strategic Plan. Governance, management and planning in MHUs will receive special attention in capacity building.

The implementation of this strategic plan will be monitored and backed by operational research, data gathering, processing, dissemination and management. This will create an evidence base for advocacy as well as for process and impact assessment.

5 End-term external evaluation of Strategic Plan 2005-2010

End-term evaluation of the Strategic Plan 2005 – 2010 was conducted by CORAT Africa. The evaluation involved desk review of various reports and documents and interviews with key stakeholders. CHAK MHUs were engaged in the evaluation process through regional workshops held in Kisumu and Embu.

The evaluation observed that CHAK had done well in institutional capacity building having completed the construction of the new office block, Guest House and Conference Centre. These had been well equipped while the Guest House and Conference Centre staffing and operational guidelines have been put in place.

CHAK had done well in advocacy with Government having led the development process of an MoU between Government and faith based health services providers. The advocacy efforts opened up space for CHAK inclusion in policy organs such as CCM for Global Fund and NHIF Board. The MOH-FBHS-TWG provided an important structured forum for ongoing engagement and dialogue. CHAK visibility and advocacy went beyond the borders of Kenya with the establishment of the Africa CHA Platform which is hosted and managed by CHAK. Through the platform, CHAs acquired advocacy space in the international arena.

CHAK recorded significant growth in its HIV&AIDS programmes ranging from prevention to treatment, care and support. This included an innovative health and human rights project that provides capacity building and empowerment for PLWHA.

The development of a HMIS software for hospital management is a strategic development towards supporting MHUs to improve efficiency and performance. The architectural technical services to members, secretariat and MEDS generated high demand which outstrips the available capacity.

The RCC structure has potential for strengthening CHAK engagement at the provincial and district level. The RCCs require strengthening to support members more effectively. In view of the devolved government in the new Constitution which has created county governments, CHAK should re-structure the RCCs to facilitate effective engagement at the county level.

CHAK governance structure has served it well during the strategic plan period. Despite the flat management structure and lean technical staff establishment, CHAK has achieved over 80 per cent in many of the strategic objectives. However, demands on the General Secretary and managers have at times been overwhelming.

The evaluation recommends that CHAK reviews its organisational structure and establishment in line with the scope of work in the strategic plan. A performance-based management system would ensure optimal use of technical staff time and skills and entrenchment of a result-oriented work culture.

Human resource motivation and retention was identified by MHUs as a crisis facing health facilities due to the better terms and conditions of service offered by MOH. The evaluation recommends that CHAK dedicates greater attention to HR retention strategies and improvement of HR management and work climate. The medical training institutions within the CHAK network should be supported to increase their production capacity.

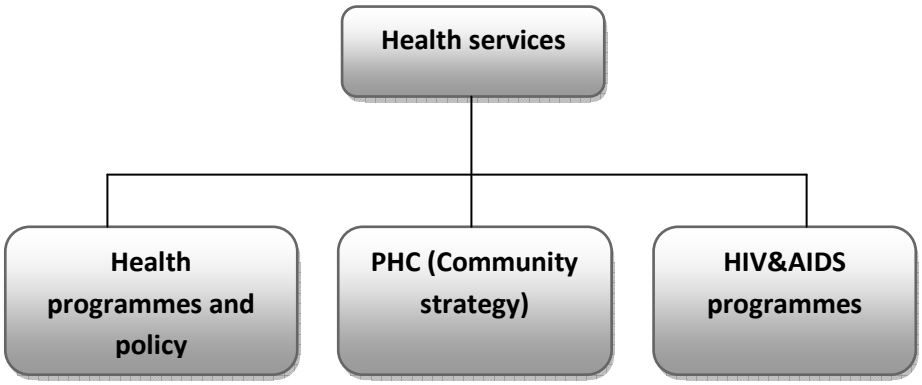
Research activities should be stepped up to generate knowledge and strategies for enhancing performance and quality of services. CHAK should build on its communication strategy and avenues to store and disseminate policies, information and best practices to MHUs and stakeholders.

5 Strategic direction

The seven strategic areas of focus are as follows:

1. Health service delivery
2. Health systems strengthening
3. Governance and accountability
4. Research, advocacy and communication
5. Health care financing and sustainability
6. Human Resources for Health (HRH)
7. Grant management

Strategic direction 1: Health service delivery



Strategic priorities

1. **HIV&AIDS programs:** To promote HIV and AIDS prevention, treatment, care and support and mitigation of stigma by promoting the rights of PLWHA
2. **Health Programs:** To facilitate capacity building in health programmes targeting malaria, TB, reproductive health, child health, eye care and disability rehabilitation services among others
3. **Health policy:** To participate in health policy development and facilitate dissemination of policies, protocols and guidelines to member health units
4. **Essential drugs access and rational drug use:** To promote access, use and management of essential drugs
5. **Coordination of Capacity building:** Internship training for doctors, family medicine, nurse training and continuous professional development
6. **Technical support to MHUs** to ensure that they adhere to quality assurance guided by norms and standards and regulatory guidelines in the health sector
7. Facilitate **disaster preparedness and emergency response** in MHUs
8. **Primary Health Care** through implementation of the community strategy

Strategic direction 2: Health Systems Strengthening

Strategic priorities

1. Enhanced participation of MHUs in health sector joint planning and monitoring (AOPs and District Health Sector Forums)
2. Establishing specifications for medical equipment and consumables for the health sector in Kenya (HCTS and KEBS/GOK)
3. Mobilization of resources in response to relevant specific areas of felt needs by MHUs (projects)
4. Responding to requests from MHUs for technical support in architectural services, project formulation and proposal writing (Technical assistance)
5. Health Care Technical Services available for all church health units (HCTS)
6. Governance and management support for MHUs
7. Enhanced support to MHUs by empowered RCCs (devolved to CCCs in line with the new Constitution)

Strategic direction 3: Governance and accountability

Strategic priorities

1. Support to CHAK governance structures
2. Financial management and reporting
3. Internal and external audit
4. Donor compliance and reporting
5. Legal/statutory compliance
6. Support MHUs in the implementation of financial management policies
7. Secretariat administration, procurement and logistics support
8. Assets maintenance and management

Strategic direction 4: Research, advocacy and communication

Strategic priorities

1. Conduct operational research to inform programmes improvement and document best practices and lessons
2. M&E for projects and programmes
3. HMIS for health service, systems data and resource management
4. ICT to enhance information retrieval, processing, dissemination and storage
5. Publications and Resource Centre for information storage and dissemination

Strategic direction 5: Human resources for health

Strategic priorities

1. Implementation of the HRM Policy Manual
2. HRM capacity building
3. Support to HRH training institutions
4. HRH motivation and retention strategies
5. Performance based management systems
6. Work climate improvement initiatives

Strategic direction 6: Health care financing and sustainability

Strategic priorities

1. Costing study of health services for evidence-based service pricing
2. Efficiency in resource management through HMIS software
3. NHIF- inpatient and outpatient insurance medical cover including support to health facilities in compliance and mobilization of communities for NHIF enrolment
4. Innovative income generating activities
5. Capacity building in proposal writing for fundraising
6. Support CHAK Guest House and Conference Centre in the development of a business strategy

Strategic direction 7: Grant management

Strategic priorities

1. HSSF fund disbursement and reporting
2. AIDS Relief transition project and site management
3. Global Fund sub recipient role
4. Technical assistance/capacity building in financial management
5. Other projects financial and project management

6 Justification for the strategic priorities

Strategic direction 1: Health services

1) HIV&AIDS

Since the first HIV/AIDS case was diagnosed in 1984, the epidemic has spread rapidly. The Kenya AIDS Indicator Survey (KAIS) of 2007 estimated the HIV prevalence rate among adults aged 15-49 years to be about 7.4 per cent up from to 6.7 per cent in 2003 according to the Kenya Demographic Health Survey (KDHS). Women are disproportionately infected at 8.7 per cent compared to men at 5.6 per cent. In total, 1.4 million Kenyans are currently living with the HIV virus. Nearly one out of 10 pregnant women in Kenya are HIV positive (9.6 per cent according to KAIS 2007) compared to 7.3 per cent in the KDHS of 2003. About 83 per cent of Kenyans do not know their HIV status according to KAIS study of 2007.

CHAK and other partners are in a position to contribute to the Kenya National AIDS Strategic Plan (KNASP) III vision of *'An HIV–free society in Kenya.'* Under the KNASP III the following four impacts are envisioned to be achieved by 2013:

1. The number of new infections reduced by at least 50 per cent
2. AIDS–related mortality reduced by 25 per cent
3. A reduction in HIV-related morbidity
4. Reduced socio-economic impact of HIV at household and community levels

CHAK will endeavour to contribute to the reduction of the national HIV prevalence rate through its MHUs by scaling up prevention, care and treatment to additional sites. Mitigation and reduction of stigma by promoting the rights of PLWHAs with the ultimate goal of reaching more patients especially in hard to reach areas will also be undertaken.

1.1 Prevention of new HIV infections

CHAK will use the following interventions to contribute to the realization of this result:

- HIV counseling and testing
- Expanding prevention of mother to child transmission of HIV in CHAK MHUs
- Promoting behaviour change
- Post-Exposure Prophylaxis (PEP)
- Promoting Prevention with Positive (PWP) strategy
- Voluntary medically assisted male circumcision

1.2 To scale up care and treatment from 28 to 40 CHAK MHUs

PEPFAR has supported comprehensive HIV/AIDS treatment and care programmes in nine CHAK hospitals through the AIDSRelief project of the CRS Consortium currently under transition to local partners, CHAK, KEC and MEDS. Through resources from Global Fund Round 2, CHAK scaled up comprehensive HIV care and treatment to an additional 18 sites during the last strategic plan period. The Walter-Reed project is supporting two CHAK hospitals to run comprehensive HIV/AIDS treatment and care programmes.

With assistance from these partners, CHAK MHUs have established and equipped Comprehensive Care Clinics to provide quality HIV/AIDS treatment and care services. Some sites have evolved into centres of excellence in HIV/AIDS treatment and are being used to train and mentor health workers.

About 90 per cent of Kenya's funding for HIV/AIDS interventions comes from donors. CHAK will therefore pursue partnership opportunities and develop proposals for resource mobilization to support, sustain and expand HIV/AIDS treatment and care services.

Currently there are about 368,000 adults, 45,000 children and 103,000 pregnant women living with HIV in need of care and treatment according to Kenya National AIDS Strategic Plan III (KNASP III). Church health facilities affiliated to CHAK and KEC through PEPFAR funding have 61,572 patients on care while 42,222 are on HAART as at June 30, 2010.

CHAK plans to scale up HIV/AIDS treatment and care in 40 member health units through donor support in this strategic plan period.

Capacity building for health care workers in HIV care and treatment will ensure an empowered and results-oriented workforce. Capacity building will be done through sponsored short courses, continuous medical education and mentorship sessions, all organized by CHAK.

1.3 Mitigation and stigma reduction by promoting the rights of PLWHAs

The KNASP III recognizes human rights as an essential part of improving the quality of life for those infected and affected by HIV/AIDS. It recognizes that HIV is a human rights issue and hits hardest where human rights are least protected.

Gender equity and promotion of human rights among PLWHIV will be a key focus in the implementation of this strategic plan. CHAK established a partnership with Open Society Institute in 2007 which has supported the integration of human rights in HIV/AIDS treatment and care programmes in 15 health facilities. This initiative has built the capacity of health care workers, community opinion leaders and PLWHAs on human and legal rights as enshrined in the HIV Prevention and Control Act 2006 as well as other related pieces of legislation and international human rights instruments.

In a bid to improve the quality of life of PLWHAs, CHAK has facilitated economic empowerment through capacity building and financial support to implement innovative IGAs. This initiative has also facilitated the provision of free legal services to PLWHAs whose rights have been violated in the project implementation areas through pro bono lawyers. There is need to scale up this initiative to more health facilities and diversify activities to reach out to PLWHAs who continuously face HIV related human rights violations.

2) Health policy

CHAK shall participate in the structures of the health sector that develop, review or monitor implementation of health policies, treatment protocols and guidelines. These include various Interagency Coordinating Committees (ICCs) and Technical Working Groups. This shall ensure that we proactively contribute to policy development. CHAK will facilitate dissemination of new or revised policy documents and guidelines and support member health facilities in their interpretation and application. The CHAK AHC/AGM will be specifically used to disseminate any available new policy documents and health sector resource materials.

3. Malaria

The Government of Kenya recognizes Malaria as a health and socio-economic burden and, as articulated in the National Health Sector Strategic Plan II (NHSSP II 2005-2010) and the Ministry of Public Health and Sanitation 2008-2012 Strategic Plan, considers malaria control a priority investment necessary for the realization of Kenya Vision 2030 and MDGs. Malaria is responsible for 30 per cent of outpatient consultation, 19 per cent of admissions and 3-5 per cent of inpatient deaths in Kenya. About 70 per cent of Kenya's population lives in malaria endemic areas.

CHAK will contribute to the achievement of the MDG on fighting malaria and other diseases through building capacity on case management and co-ordination of malaria control. Capacity building on the new malaria treatment guidelines produced by the Government will be conducted for health workers in CHAK MHUs. This will strengthen the quality of diagnosis, ensure timely, effective treatment or appropriate referral.

CHAK will continue advocating for free anti-malarial drugs supply to the FBOs by the Government through MEDS. CHAK will seek to continue with this partnership and build additional collaborations with the USG Presidential Malaria Initiative and Global Fund to access more resources for improving diagnostic capacity in its MHUs.

CHAK will also continue with community mobilization for distribution of ITNs for pregnant women and children under five years of age. The M&E component will be conducted using MOH tools and reports submitted on a

monthly basis to the Division of Malaria Control. This will also track utilization of the free anti-malarial drugs for accountability purposes. CHAK Secretariat will monitor and ensure continuous access to the free ACT/AL drugs in all existing and new MHUs.

CHAK will continue its participation and involvement in the various Malaria technical working groups and the Malaria Inter Agency Coordinating Committee (ICC). Membership to the Kenya Network of NGOs against Malaria (KENAAM) will also be continued.

4) Tuberculosis

The HIV/AIDS pandemic has brought with it an escalating number of tuberculosis cases, compounding human resource and infrastructure challenges in CHAK Member Health Units. To combat emerging and existing challenges such as the Multi-Drug Resistant TB strain, CHAK MHUs must have adequate human resource capacity.

Adequate human resource will facilitate achievement of targets set by the national TB programme including raising the TB case detection rate from the current 47 per cent to 55 per cent by 2010 and 60 per cent by 2015 as per the MDGs. Empowerment of community health workers to establish contact with patients, trace defaulters and link them to treatment centres will be given priority.

Training of health care workers to improve TB management will be a key strategy for CHAK. Equipping MHUs with basic diagnostic equipment and supplies will be equally important and will ensure quality, efficiency and effectiveness in TB diagnosis.

Most FBO health facilities receive free TB drugs from the National TB Programme and give them to patients at no cost. The Government also provides updated TB treatment guidelines. All service providers submit M&E reports for TB activities to the National TB programme. CHAK acknowledges the reliable support received from the Government in addressing the TB menace and will continue to engage in positive partnership with the National TB Programme for technical support, commodities and M&E materials.

During this phase of the strategic plan, CHAK will scale up efforts to integrate HIV/AIDS counselling and treatment services with TB diagnostic and management services due to the huge burden of TB in HIV/AIDS patients. We shall also seek to mobilize resources to increase diagnostic centres within the CHAK network and ensure that TB prevention and treatment services are integrated into the HIV/AIDS training programmes.

5) Reproductive health

CHAK shall endeavour to contribute to the Millennium Development Goals to reduce infant mortality and improve maternal health. Maternal mortality is a major public health issue in Kenya. The Kenya Demographic Health Survey (KDHS 2003) placed the MMR at 414 per 100,000 live births but this dropped slightly to 410 in the KDHS of 2008. The KDHS 2003 also found that the number of women attending antenatal care at least once during pregnancy dropped from 92 per cent in 1998 to 88 per cent in 2003. About 81 per cent of all women who deliver do not return for postnatal services. The proportion of women attended to by a skilled birth attendant dropped from 44 per cent to 41 per cent during the same period. According to KDHS 2008, delivery by a skilled birth attendant stands at 44 per cent while delivery at a health facility is at 17-43 per cent.

CHAK targets to address the major causes of maternal mortality in Kenya by providing quality reproductive health services in line with the National Reproductive Health Policy Framework of October 2007 and the National RH strategy 2009-2015 whose aim is to promote access to quality efficient and effective RH services at all KEPH levels.

CHAK as a leading FBO providing reproductive health services nationwide is faced with shortage of skilled health workers to provide the full range of services including:

- Safe motherhood: maternal and neonatal health
- Family planning
- Adolescent/youth sexual RH
- Gender, sexual and reproductive health rights
- Other RH components like HIV/AIDS and reproductive tract infections
- Infertility, cancers of the reproductive organs and reproductive health services for the elderly

Although the acceptance rate for family planning in Kenya is low (25 per cent) there are indications that demand is rising where services are client friendly. The current CPR is estimated to be 39-47 per cent. CHAK shall work

with other players in health care delivery to reduce the Maternal Mortality Ratio by 75 per cent by 2015 as per the MDGs and aggressively engage in a demand creation strategy for family planning.

CHAK is currently participating in a pilot project on the Output Based Approach (OBA) strategy in Kisumu, Kiambu and Kitui districts in addition to two slums in Nairobi. This project aims to promote access to quality reproductive health care, including Gender Violence Prevention and Recovery Services (GVRS) to poor women. It is supported by the German Government through KFW and is implemented by the National Coordinating Agency for Population and Development (NCAPD).

CHAK health facilities accredited to provide these services to OBA clients have recorded over 100 per cent increase in the utilization of ANC and delivery services. CHAK will continue to support the RH-OBA program by participating in its advisory board and facilitating member health units' accreditation as providers of this essential service. CHAK will also address issues arising during the project's implementation. It is our hope that before the end of the five-year pilot, this initiative will be approved for nationwide scale up.

Adolescent-friendly services are available in only a few areas while immunization coverage is low. Approximately 52 per cent of infants complete vaccination regimes. It is apparent that the reproductive health status of Kenyans, particularly in safe motherhood and child survival, has deteriorated in recent years. Maternal deaths could be averted if mothers had access to skilled attendants at birth and essential obstetric care.

To reverse these trends, CHAK shall work closely with MOH through joint planning, co-ordination and synergy with other programmes (HIV/AIDS, malaria, KEPI). This will enhance the implementation of the Community Health Strategy through the CBHC programme with focus on sustained skills transfer to well defined target groups (mid-wives, nurses and skilled birth attendants). CHAK will step up resource mobilization for reproductive health programs and dedicate more resources to maternal and child health programs in line with the national strategy.

6) Child health programmes

The child mortality rate is currently 74 per 1000; infant mortality rate is 52 per 1000 while neonatal mortality rate is 31 per 1000. The national strategy aims to reduce these indicators by 50 per cent every ten years.

Achievement of this target may be hampered by lack of adequate skills among health professionals to manage childhood illness effectively according to IMCI guidelines. There is also lack of awareness in communities on the importance of detecting childhood illnesses and seeking care at appropriate times.

CHAK MHUs shall participate in the scale-up of child health services as guided by plans and policy guidelines from the Department of Child Health at MOH. These will include promotion of breastfeeding, immunization, BCC, use of ITNs, use of simple treatments for diarrhoea e.g. ORS, early diagnosis of HIV&AIDS in children and effective treatment of major killers of children such as pneumonia, diarrhea, malaria and malnutrition.

CHAK Secretariat will ensure that the policy environment for promoting child health and systems to support service delivery are strengthened. The secretariat will also organize and facilitate capacity building for heath workers in MHUs on IMCI, including HIV/AIDS counselling and treatment. The FBO fraternity supports the Child and Mother Health and Nutrition Weeks (CMHWKs) initiative of the MOH which has also been embraced by some development partners.

It is expected that CHAK MHUs shall contribute towards increasing the number of children under one year who are fully immunized from the current 57 per cent to the MDG target of 100 per cent by 2015. Contribution in all districts will be reflected in targets set in the annual District Health Plans.

7) Primary Health Care/Community Health Strategy

The NHSSP II recognizes that in order to achieve rapid and significant gains in reversing the declining trends in the health indicators of Kenyans, there is need to target disease prevention and lifestyles that promote health at the individual, household and community levels. Subsequently, the community has been identified as the first level of health intervention. The Ministry of Public Health and Sanitation has been implementing the community strategy over the last five years.

CHAK will make concerted efforts to facilitate the implementation of the community strategy in its MHUs through the Community Based Health Care approach. CHAK's network brings on board the additional value of having

close linkages with churches and long-term experience in partnering with communities through outreaches. These outreaches are targeted at providing preventive and promotive health services. CHAK will also strengthen community systems by building the capacity of community health workers, providing them with reporting tools and establishing referral linkages with the health facilities. Best practices in the community strategy within the CHAK network will be documented and disseminated for lesson learning.

8) Support scale up of eye care and disability rehabilitation services within the CHAK network
CHAK member health institutions play a significant role in providing eye care services that range from community education on blindness prevention to diagnostic evaluation, treatment, surgery and rehabilitation services. These services are offered within the health facilities and in outreach programmes with the support of Christian Blind Mission (CBM), among other partners.

Through this strategy, CHAK member health units have evolved as leading providers of cataract surgery services in Kenya responsible for over 50 per cent of all surgeries conducted. Among them, four MHUs have developed into centres of excellence in Kenya for ophthalmic services and eye care training.

These are PCEA Kikuyu Hospital, Friends Church Sabatia Eye Hospital, Lighthouse for Christ and Tenwek Hospital. Other CHAK health facilities providing comprehensive eye care services include Arsim Dispensary in Samburu and AIC Health Ministries through a network of its health facilities including AIC Kapsowar and AIC Litein Hospitals.

The Government has not given much attention to eye care services in its plans and budgetary allocations despite high incidence of preventable blindness in children and adults.

Equally, disability identification, sensitization and rehabilitation services have not been given attention in the National Health Sector Strategic Plan II 2005 – 2010. CHAK member hospitals, AIC Cure International Hospital at Kijabe and PCEA Kikuyu Orthopaedic Rehabilitation Unit, offer specialized surgical services in orthopedic rehabilitation. In addition, Tenwek hospital and Meru North Disability Programme offer surgery and community rehabilitation services respectively.

During the period of this plan, CHAK will establish a strategic partnership with CBM and its partners in advocating for inclusion of eye care and disability rehabilitation services in Annual Operational Plans and Budgets of MOH. Joint advocacy efforts will be directed to MOH through the Division of Ophthalmic services. Our advocacy strategy would target to achieve greater recognition of disability and eye care issues, resource allocation, policy development, training and services scale up.

CHAK will partner with CBM and other stakeholders in these services to mobilize planning for eye care and disability services at the district level for inclusion in District Health Plans (DHPs) and subsequently, AOPs. Through this partnership, the capacity of CHAK in planning will be enhanced to cope with this new responsibility.

Three CHAK Hospitals specialized in eye care services, Kikuyu, Sabatia and Lighthouse for Christ, have developed high quality training capacity. CHAK Secretariat will partner with CBM to support access to these training resources for health workers in other CHAK health facilities. Relevant courses aimed at building skills in ophthalmology will be implemented for clinical officers, nurses and technicians. Where necessary, collaboration will be established with Kenya Medical Training College (KMTC) Ophthalmology Department, which is already providing ophthalmology training for clinical officers and nurses at post basic diploma level.

By tapping the specialized eye care resources existing in the mentioned CHAK hospitals, the CHAK/CBM partnership will support the establishment and scale up of ophthalmic prevention and treatment services in other CHAK health facilities across the country. All the service providers will have a referral linkage with the specialized centres for patient referral and technical support. In the implementation of this scale up strategy, collaboration with MOH through the SWAps spirit will be emphasized at all levels.

Close collaboration will be established with the Association of People with Disabilities in Kenya (APDK) and relevant Government Ministries in advocating for disability rehabilitation services.

9) Coordination of capacity building
One of the key roles of CHAK is to coordinate capacity building for its Member Health Units. A Doctors' Internship Programme is coordinated by CHAK in collaboration with the University of Nairobi Medical School and Moi University Medical School. In this programme, CHAK advocates with the Government to ensure that over thirty

medical officer interns are deployed annually to work in MHUs during their one-year internship period. Five CHAK member hospitals, PCEA Tumu Tumu, AIC Kijabe, PCEA Kikuyu, Tenwek and PCEA Chogoria hospitals receive doctor interns.

CHAK also coordinates training of nurses in ten schools of nursing and four CHAK-affiliated universities. Continuous professional development through seminars, conferences and continuous medical education sessions are also coordinated by CHAK.

Additionally, CHAK hosts the Institute of Family Medicine and coordinates training of Family Medicine practitioners in collaboration with Moi University School of Medicine. There may also be collaboration with University of Nairobi School of medicine to expand training of Family Medicine practitioners. CHAK also mobilizes resources for capacity building for MHUs and the Secretariat.

10) Disaster preparedness and emergency response

Disasters and out break of diseases such as cholera, highland malaria, floods and inter-tribal clashes, often affect the catchment populations of CHAK member health units. This stretches the MHUs' capacity in terms of human resources, drugs and medical supplies, among others.

CHAK allocates a budget annually to respond to emergency situations in its Member Health Units (MHUs). CHAK also proactively prepares its members to be ready for disasters and responds to requests for support in times of emergencies and disasters. This is done in conjunction with the Department of Disease Surveillance and Emergency Preparedness and Response at the Ministry of Public Health and Sanitation.

11) Promoting access to Essential Drugs

CHAK advocated through the MOH-Faith Based Health Services TWG for Government supply of rural health facility drug kits to level one and two MHUs. Currently, over 300 dispensaries are receiving the rural drugs kits as a result of this advocacy effort. CHAK will enhance advocacy efforts for more MHUs to benefit from the rural drugs kits.

The Secretariat is also charged with coordinating the distribution of the kits and monitoring their use. This has involved disseminating guidelines on rational use of essential drugs and raising awareness in MHUs on the availability of the essential kits.

The MHUs are also encouraged to buy drugs from MEDs, a drugs supply agency owned by CHAK and KEC, for quality assurance. CHAK coordinates capacity building by MEDS for MHUs on pharmaceutical supplies and management.

Strategic direction 2: Health systems strengthening

1) **Enhanced participation of MHUs in health sector joint planning and monitoring (AOPs) and District Health Stakeholder Forums)**

The health sector in Kenya is moving towards decentralization. The country has adopted a bottom-up annual planning culture starting at the district level. This may undergo some reforms following the creation of County Governments by the new Constitution.

In the 2005-2010 CHAK Strategic Plan, effort was made to create awareness among CHAK MHUs on the need to participate in District Health Stakeholders Forums and formulation of District Health Plans. There has been significant improvement in the number of MHUs participating in these activities. However, participation is still inadequate.

Additionally, there have been new developments at the national level including signing of the MOU between FBOs and MOH/GOK. The MOU provides for close partnership and sharing of resources at the local level. Following this development, it has become increasingly important for MHUs to participate in regional level health sector planning and monitoring of service delivery activities.

CHAK will use the RCCs to track members' involvement in planning at the district/county level and advocate as necessary for allocation of resources and ensure representation in the AOP joint planning and review committees at the national level. This process which is now entrenched in the SWAPs arrangement is expected to facilitate allocation of resources from district envelopes and donor partners to support service delivery towards achieving set health indicators.

2) Mobilization of resources in response to relevant specific areas of felt needs by MHUs

In the 2005-2010 Strategic Plan period, activities targeting institution development depended on CHAK core funding. However, some specific MHU needs could not be met with the limited core funds. For instance, some church health facilities required medical equipment maintenance services which they could not afford.

In this new plan, CHAK hopes to solicit funding to meet such needs whenever they arise. This will create synergy with activities funded from the core budget to ensure achievement of set targets.

3) Responding to requests from MHUs for technical support in architectural services and building the capacity of staff in project formulation and proposal writing (Technical Assistance)

Architectural services support covers a scope of technical services comprising site visits/site analysis, client brief analysis, inception design, scheme design, detailed design and working drawings, general and technical specifications, supervision of construction works to completion and costing of works.

The 2005-2010 CHAK strategic plan targeted to provide architectural support to nine MHUs. This target was exceeded by 100 per cent, proof that there has been increased interest among MHUs in this support area. Architectural services are quite costly in the open market, thus this service provides some financial relief for CHAK MHUs.

In this new plan, CHAK hopes to increase the coverage of architectural services to all MHUs that request this service.

Additionally, the MHUs continue to express the need for technical support in formulating projects and writing proposals. The external environment provides various opportunities from which the MHUs could tap. These include CDF, LATF, HIV/AIDS–NACC support funds and other NGOs interested in community based projects.

CHAK will continue to offer rapid trainings in project formulation and proposal writing to health workers in our MHUs. With the passing of the new Constitution which is expected to devolve public resources to the county level, we envisage proposal writing skills to be even more urgently needed by MHUs.

4) Health Care Technical Services available for all church health units (HCTS)

CHAK Health Care Technical Services (HCTS) programme has been in existence for over ten years providing technical support in planning for new medical equipment, procurement, installation, repair and maintenance. It provides affordable services to all church health facilities in Kenya.

A Board made up of representatives of church health facilities provides governance oversight for HCTS services. HCTS provides specialized maintenance services for anaesthetic and radiology equipment and general maintenance services for other equipment. During the Strategic Plan 2005-2010, the HCTS programme built its capacity to introduce the specialized services. It also underwent restructuring to consolidate its operations from four regional workshops to one centrally located workshop hosted by CHAK Secretariat in Nairobi.

Inability of some church health facilities to pay for services rendered has left the HCTS heavily indebted. In some cases, church health facilities are unable to pay for services due to high poverty levels in their catchments. HCTS will develop creative credit control strategies to reduce debt levels.

Support to MHUs in procurement, installation, repair and maintenance of medical equipment will be on-going. However, there will be need for donor support to cater for capacity building, quality assurance and M&E.

5) Establishing specifications for medical equipment and consumables for the health sector in Kenya (HCTS and KEBS/GOK)

In 2009, CHAK HCTS technicians were invited to participate in quarterly meetings of the Kenya Bureau of Standards Medical Equipment and Consumables Chapter. CHAK HCTS has been recognized by KEBS as a key player in equipment maintenance, hence the invitation to participate in development of standards in medical equipment and consumables.

These standards will eventually set benchmarks for medical equipment and consumables to be used in the health sector in Kenya. Meetings to develop the standards will be held monthly and quarterly over the next three years. The CHAK HCTS technicians will play an active role in supporting this process. It is anticipated that once the standards are enacted, the volumes of sub-standard medical equipment entering the country will be reduced.

6) Governance and management support for MHUs

Recent evaluations have revealed that governance and management practices in CHAK MHUs are still wanting. In the implementation of strategic plan 2005-2010, effort was put towards building the capacity of management and governance bodies as well as developing generic governance and management guidelines.

In some facilities, significant improvement has been noted while others are yet to begin implementation. Facilities with better governance, management and ICT setups have managed to adopt the generic governance and management guidelines while those without have found it a challenge. One area that has been hailed for its effectiveness is information and experience sharing exchange visits between facilities.

Participation of Secretariat staff in governing boards of member hospitals to offer technical advice where invited has also been acknowledged.

In the period 2011-2016 the focus shall be to assist the MHUs adopt the generic guidelines, continue with the information and experience sharing exchange visits, hold capacity building workshops for boards and managements and continue participating in the governing boards of hospitals.

7) Enhanced support to MHUs by empowered RCCs and CCCs in line with the new Kenya Constitution

CHAK RCCs are now fully established and functional with clearly defined roles and responsibilities. The chairman of each RCC is elected at the CHAK AGM as the regional representative to the CHAK EXCO (Board). The RCCs hold regular meetings providing a forum for communication between MHUs and the national level. They also provide a forum for sharing information and resources within the regions.

Despite operating with limited resources, the RCCs have been able to organize regional advocacy meetings with the MOH in the provinces to address various concerns especially human resource challenges. Currently, the RCCs provide guidance to the Secretariat on the areas of focus in capacity building activities supported by CHAK. It is clear that the RCCs have the potential to increase the overall CHAK coverage if empowered with skills and resources.

During this plan's implementation, CHAK will empower RCCs to continue with regional advocacy efforts, continue providing a forum for sharing information and resources in the regions and assist in giving guidance to new projects on specific aspects of the regional contexts.

The RCCs will be assisted to devolve to several County Coordinating Committees (CCCs) within their regions, as provided for in the new Constitution. The necessary support to help position them strategically with respect to resources towards health at the county level will be provided. The CCCs will facilitate MHUs engagement with the County Government structures on matters of health policy, planning, resource allocation and service delivery.

Strategic direction 3: Governance and accountability

1) Support to CHAK governance structures

CHAK Secretariat governance structures functioned well in the 2005-2010 Strategic Plan implementation period. The AGM was held annually, quarterly EXCO and Finance Committee meetings organised while Trustees were often called upon to lead advocacy efforts. Management Team meetings were held monthly while staff devotion and communication meetings were held weekly.

During the life of this strategic plan, CHAK Secretariat will uphold and enhance its internal management systems and continue to facilitate its governance structures to ensure sustained efficiency and accountability in line with the principles of good corporate governance.

2) Financial management and reporting

The Finance and Administration Department prepares financial reports which are routinely presented to management, Finance and EXCO committees and shared with donors. The annual operational budget for the CHAK core and projects are prepared at the beginning of every year and shared with EXCO for approval.

End of year external audits are carried out and reports disseminated at the AGM. Specific project reports are also routinely prepared in accordance with the donor requirements and agreements.

The increased need for accurate and timely reporting due to donor compliance requirements saw CHAK install the PASTEL accounting software. An annual upgrade of the software is envisaged. Implementation of secretariat

finance and procurement policy documents revised and approved in the previous strategic plan period will also take priority.

3) Internal and external audit

In compliance to statutory and donor requirements, an external audit is conducted every year. The end term evaluation and other assessments have recommended a need to set up an internal audit function at the secretariat. CHAK will pursue efforts to put in place this function during this new strategic plan period.

4) Donor compliance and reporting

As donor support to CHAK has increased, so have compliance and reporting requirements. The already existing grants compliance function will be strengthened to cope with increased demand for monitoring and reporting.

5) Support implementation of financial policies to MHUs

The Situational Analysis Study conducted in 2006 identified weak financial management systems as a key challenge for most CHAK MHUs. To address this, CHAK developed and disseminated a generic financial management and procurement policy to all MHUs during the last strategic plan. As we move into the new strategic plan, we intend to support MHUs in the adoption and implementation of the policy.

6) CHAK secretariat administration, procurement and logistic support

The Finance and Administration Department will facilitate administrative procedures and procurement services for CHAK secretariat and projects.

7) Asset maintenance

The secretariat will review old assets and budget for replacements. To improve asset maintenance systems, the secretariat plans to upgrade and retrain staff on the asset module available in the PASTEL software.

Strategic direction 4: Health care financing and sustainability

1) Costing of health services

A costing study of mission health services conducted in the last strategic planning period concluded that most MHUs lacked a system for determining fees to be charged for different services, thus costs incurred were rarely recovered from patient fees.

CHAK will support similar costing studies, build capacity of MHUs to determine service pricing and advocate for optimal NHIF rebates.

2) Efficiency in resource management through HMIS software

Most MHUs lack a hospital management software to capture both statistical and financial data. In the last strategic plan period, CHAK developed a comprehensive hospital management software, CHAK HMIS Software, built on the open source CARE 2X, which was piloted in four MHUs. Rollout of the software will be done in the life of this strategic plan and will involve procurement of equipment, software installation, user training and system maintenance as well as ongoing technical support to the MHUs.

3) NHIF inpatient and outpatient cover

High poverty levels within MHU catchments have led to soaring debt burdens for many CHAK facilities. Studies indicate that the NHIF contributes over 10 per cent of CHAK MHUs' income. This is expected to rise following gazzetement of increased NHIF contributions and broadening of the cover to include outpatient services.

To maximise on the new opportunity, discussions focusing on ways of enhancing collaboration between CHAK MHUs and the NHIF will be held. CHAK will support NHIF initiatives in recruitment and accreditation of MHUs and advocate for optimal rebates. Through the community strategy, CHAK will also support enrolment of populations in MHU catchments in the NHIF. The Secretariat will support MHUs in NHIF compliance.

4) Capacity building in proposal writing for funding

Both CHAK and MHUs rely to a large extent on donors to fund their operations. A lot of this funding comes

through projects and programs. There is need to sustain support for ongoing activities and develop new proposals to address other areas of need. CHAK will work closely with MHUs to identify areas of need. The secretariat will develop project proposals and facilitate MHUs to develop their own proposals. CHAK will also collect, compile and disseminate information regarding potential donors.

5) Support the guesthouse in development of a business strategy

Construction, equipping and staffing of the CHAK Guest House and Conference Centre has been completed and a management structure established. The guest house has recorded substantial progress since it started operations in 2009. However, there is need to strengthen its operation systems. In this strategic plan period, the secretariat will support the guest house to develop a business strategy and implement governance and financial policies.

Strategic direction 5: Grant/project management

1) HSSF funds disbursement and reporting

The Government through Treasury has set up a system of transferring funds directly to health facilities referred to as the Health Sector Services Fund (HSSF).

Following intense advocacy efforts, FBO health facilities will be included in the HSSF after gazzetement by the Government. The recent MOU signed between the GOK and FBOs recognizes the role of FBO secretariats as receiving funds and channeling them to their affiliated health facilities.

CHAK will establish a grants management system for receiving funds from HSSF and channeling the funds to Member Health Units. This role will also involve monitoring, accountability and reporting. The MHUs will be trained in financial management and accountability with regard to the HSSF.

2) AIDSRelief transition project and site management

The Kenya AIDSRelief project which supports HIV treatment in church health facilities with funding from PEPFAR is undergoing transition to local partners comprising of CHAK, KEC, MEDs and UoN. Under this consortium, CHAK and KEC will take on the role of prime recipient in one of the two regions with the responsibility of project management, grant disbursement and management of implementing sites.

CHAK will strengthen its capacity in grant/project management to ensure efficient management of donor resources for scaling up and sustaining high quality HIV prevention and treatment services to communities served.

3) Global Fund sub-sub recipient role

In the last strategic plan period, CHAK received funds from Global Fund to support programmes in HIV/AIDS, malaria and TB. These funds were channeled to selected implementing MHUs which were required to provide reports and account for funds used. An external audit conducted noted weak response to accounting and reporting which resulted in implementation delays.

CHAK will strengthen the grant management system through capacity building, joint planning and budgeting, monitoring and evaluation and information sharing. These are designed to improve efficiency in reporting.

4) Technical assistance/capacity building in financial management

Provision of technical support to MHUs to enhance service quality in the face of increasing competition in the health sector is essential. Technical support will be provided through updates, facility-based mentorship and supportive supervision. CHAK will collaborate with MOH and other potential partners in providing technical assistance to MHUs.

The Secretariat will continue to respond to adhoc requests for technical support and make available the expertise of its staff in providing assistance to MHUs. Additionally, CHAK will encourage networking and exchange of skills and resources among its members.

Strategic direction 6: Research, advocacy and communication

1) Information technology

The IT section continues to offer support services to CHAK departments, management and governance structures. This, however, needs to be enhanced through upgrading and maintenance of the IT system, computerization of MHUs and keeping the Association updated with technological advancements.

Mobile telephony will be a key driver in information sharing and Internet on handsets used to share data and information between the Secretariat and membership.

Embracing Short Message Service (SMS) will enable CHAK to reach more Member Health Units, especially those located in remote and marginalized areas without Internet services, faster and cost effectively. Information sharing within the CHAK membership will be largely dependent on this infrastructure as postal services continue to be unreliable and courier services expensive.

The rollout of fiber optic infrastructure in the country has heralded low internet costs. The secretariat will supplement the current VSAT internet with this technology, enabling remote support for MHUs using the CHAK HMIS software.

2) Health Management Information Systems (HMIS)

Installation and use of CHAK Health Management Information Systems software to address the long standing computerization needs expressed by member health units will give the CHAK network a competitive edge and optimize efficiency in resource management.

CHAK will continue to improve the hospital management software that has already been developed. Installation and support of the software as well as user training will be undertaken in both hospitals and lower level health facilities.

A superior clinical system with a medical dictionary and administrative functions will be developed for Level 5 health facilities (referral and teaching hospitals).

A Technical Working Group with membership from CHAK Secretariat MHUs and partners will oversee development and rollout of the HMIS software and support in monitoring and evaluation.

3) Networking and partnership

CHAK's network of diverse member units brings on board linkages with different Protestant Church denominations, their affiliate programs and the communities they serve. These networks have human resources with varied skills, expertise and experience from which the Secretariat and other member health units can draw.

CHAK as an ecumenical national umbrella body of different denominations facilitates networking through Regional Coordinating Committees, Annual Health Conferences and Annual General Meetings, inter-facility visits as well as documentation in the network newsletter, CHAK Times. Important policy documents and benchmarks in development are also accessible on the CHAK Website (www.chak.or.ke).

CHAK partners with the Government as the secretariat of the Faith Based Health Services- Ministry of Health-Technical Working Group (MOH-FBHS-TWG) which among other things helps in delivering equitable health care to under-resourced areas by advocating for financial and human resource allocation.

It also partners with the Government in various programme initiatives such as combating TB and malaria, HIV/AIDS management, immunization for children, training of Health workers and reproductive health among others.

CHAK will continue to collaborate with other stakeholders in health for advocacy, resource mobilization and health service delivery.

4) Africa Christian Health Associations Platform (ACHAP)

CHAK hosts the Africa Christian Health Associations Platform (ACHAP) secretariat which was conceived during the meeting of CHAs in Bagamoyo, Tanzania, in January 2007. The platform facilitates networking, communica-

tion and sharing of information and experiences among Africa CHAs and their partners. ACHAP also provides a platform for joint advocacy for CHAs in Africa and is supported by development partners.

CHAK has provided support to ACHAP in resource mobilization and logistics management in hosting regional conferences including an Africa FBOs meeting with Global Fund and Biennial CHAs Conference. To enhance communication, ACHAP has a bi-lingual English and French website (www.africachap.org) which contains reports, CHA bulletins and policy documents.

At the ACHAP Biennial Conference and General Assembly held in Accra, Ghana in February 2011, a Constitution for governance and institutional strengthening of ACHAP was discussed. The decision to pursue legal registration of ACHAP was made. During this strategic plan period, CHAK will support the process of legal registration and institutional capacity building of ACHAP with funding and technical support from development partners. The platform will provide technical assistance in HRH management and retention strategies for CHAs in Africa. ACHAP will develop a communication strategy to enhance communication efficiency in order to satisfy the expectations of members and partners.

Documentation and dissemination of best practices will be maintained to facilitate peer learning. CHAK will build on the global recognition of ACHAP to pursue advocacy opportunities for CHAs in Africa.

5) Research

CHAK will continually monitor indicator targets against achievements throughout the lifetime of this strategic plan. It will assess activities, accomplishments and challenges at half year intervals and share these among stakeholders in form of reports.

Disparities or under-achievements in any area will be examined to determine the challenges and future activities re-focused accordingly. Routine data will be collected from the MHUs using MOH tools. The M&E staff will input and analyze the data received and share findings with Secretariat staff as well as members.

The M&E unit will support use of MOH HMIS tools in CHAK MHUs by training point persons in data collection and reporting. M&E plans will be developed to assist the facilities in implementing MOH HMIS, ensure availability of data collection and reporting tools, accurate compilation of client data, quick and efficient health facility reporting, and accurate data entry in client registers.

CHAK health facility interventions will then be evaluated at the third and the sixth year to determine the impact of the programme. This will provide CHAK with a unique opportunity to document the effect of its interventions. As a result, CHAK will publicize and expand those interventions which are found to be most effective and modify those which are not. Specific Operations Research questions may be developed and research done in the study areas.

Health related research will be carried out in CHAK health facilities, data analyzed and findings documented.

6) Communication and documentation

CHAK has a well established communication strategy that enables information sharing and networking between the Secretariat, members and partners, ensuring that they have access to a constant stream of health sector information.

To strengthen its communication and documentation role, the Secretariat has procured and installed ICT facilities including the registration of own domain, development, constant revision and updating of its website (www.chak.or.ke). Key CHAK documents, reports and the network newsletter, CHAK Times, have been made available on the website and in the CHAK resource centre for easy access by member health units and partners.

The Association's newsletter, CHAK Times, is a useful tool that facilitates communication and dissemination of information to member health units and other stakeholders and aids in networking.

The CHAK Annual Health Conference and Annual General Meeting remains a key forum for networking and sharing information on issues relating to the health sector. Reports of this and other major CHAK forums are compiled and widely disseminated in both printed and electronic form to provide a reference point for members wishing to access such information.

Documentation of operational researches and dissemination of findings helps build an evidence base to support

advocacy while IEC materials are play a key role in marketing the organisation.

It is anticipated that with the introduction of county governments which will oversee state health care provision at the local level, reliable and timely information will be critical for the CHAK membership. CHAK will therefore continue with its publication and documentation function to ensure sharing of policy developments that have an impact on the Association's operations as well as advocacy efforts.

Under its ICT unit, CHAK will continue to maintain an address book of members and partners to ease dissemination of documents while internal communication will be facilitated through a weekly activities report or memo.

The Website will continue to play a critical role in CHAK's communication strategy, disseminating information through electronic formats of CHAK publications and news items focusing on developments relevant to the Association and partners. Existing links to MHUs and partners' websites will be maintained and new ones added while interactivity will be enhanced. It is anticipated that this will be complemented by wide dissemination of most CHAK documents in electronic format for wider reach.

The resource centre will continue to provide the Secretariat and MHUs with access to information in both electronic and printed form. Clients using the resource centre will be able to access the virtual library that is the Internet with a cyber café located at the CHAK offices easing this role.

7) Advocacy

CHAK is mandated by member health facilities and churches to coordinate and lead advocacy with Government and other stakeholders within Kenya, regionally and internationally. During the period of the Strategic Plan 2005-2010, CHAK attained significant milestones in advocacy through proactive engagement and lobbying with Government, development partners and NGO networks. The advocacy strategy led to recognition and inclusion of faith based health service providers in the national health arena.

CHAK is the secretariat for the MOH-FBHS-TWG which steered the process of development of the MoU between Government and CHAK, KEC and SUPKEM. The TWG is mandated to oversee implementation of the MoU and coordinate FBO partners' involvement.

CHAK was mandated to establish the Africa CHAs Platform Secretariat in 2007. This secretariat has provided a strategic platform for advocacy and lobbying at the regional and international level. ACHAP has joined other international health networks and is facilitating joint advocacy for CHAs from Africa at international fora. This platform will be strengthened to further enhance its visibility and coordinate joint advocacy for Africa CHAs.

The Church Health Services Coordinating Committee (CHSCC) has been established to facilitate joint advocacy with KEC and MEDS in Kenya. The membership of CHSCC represents 40 per cent of health service delivery in Kenya, with 23 medical training institutions. CHAK will contribute to the leadership and advocacy strategy of CHSCC to solidify the voice of the Church and its leading position in Kenya's health sector.

CHAK will participate in various policy, planning and coordination structures of the health sector and use this position to proactively advocate for the interests of MHUs. These include the Health Sector Coordination Committee (HSCC), various Interagency Coordinating Committees (ICC), CCM for the Global Fund, Nursing Council of Kenya, NHIF Board, Reproductive Health OBA Advisory Committee and NACC KNASP III Monitoring Task team among others. CHAK will also engage in partnerships with like minded organisations to enhance its advocacy efforts.

Strategic direction 7: Human resource management

Human Resources have been recognized as most crucial in health service delivery worldwide. CHAK secretariat and MHUs recognize the importance of this key health systems component. Recent health sector studies, policies, strategies and plans, especially the National Human Resources for Health Strategic plan (2009 – 2012), acknowledge that HRH constraints are hampering health sector planning and service delivery in Kenya.

CHAK through support from the Capacity Project of USAID engaged in intensive strategies within the last strategic plan (2005-2010) to counter HRH challenges affecting MHUs. Among the strategies were development and dissemination of generic HR management policy guidelines for MHUs and conducting a comprehensive salary survey for selected benchmark positions of health workers in hospitals.

However, despite the progress made in addressing HR challenges, economic reforms by Government through introduction of the Economic Stimulus Program (ESP) led to a mass exodus of Nurses from Church health facilities. With the terms and conditions of service in the Government expected to continue improving, CHAK will within this strategic plan 2011-2016 embark on development and adoption of retention and motivation strategies that will cut a niche for the FBO health sector towards becoming an employer of choice. Some of the envisioned strategies include:

- Working with the Member Health Units to adopt the generic HRM policy guidelines and customize them to meet their needs
- Supporting MHUs to adopt and internalize the FBO salary survey report and develop competitive salary structures with the guidance of the report recommendations
- At the national level, CHAK will work with the other sector players including MOH and development partners through representation in the various health sector Technical Working Groups and HRH Interagency Coordinating Committees.
- Holding consultative meetings, workshops and trainings with MHUs to identify, document and disseminate best retention and motivation strategies and practices in HRM
- On production, advocate to maximize the potential of our 10 Medical Training Colleges and four Church universities to train higher numbers of health workers to increase supply of health workers into the health workforce
- Supporting the development and implementation of the Sector Wide Human Resource Information System (HRIS)

7 Institutional framework

CHAK governance and management structure

The CHAK governance structure is defined by its Constitution. CHAK's supreme authority, the AGM, is composed of all registered members and meets annually in April. CHAK has a Board of Trustees composed of seven senior church leaders from member churches who are mandated by the Constitution to hold in trust the assets of the Association.

The Executive Committee (EXCO) is the executing arm of the AGM with the mandate to formulate policies and monitor program implementation as well as accountability on behalf of the AGM. EXCO members are elected by the AGM to serve a term of two years which are renewable to a maximum of six years. A standing Finance Committee reviews budgets and financial reports before presentation to EXCO. Other advisory committees are appointed by EXCO on adhoc basis to address specific terms of reference.

The CHAK Guest House and Conference Centre Management Committee oversees the management of the Guest House and Conference Centre and submits the performance reports to EXCO. The Guest House is managed by a professional team experienced in hotel management as a separate entity from the Secretariat. It provides meeting facilities for CHAK governance, capacity building and networking activities.

Regional Coordinating Committees (RCCs) and County Coordinating Committees

The RCCs coordinate the Association's activities in its four regions - Eastern/North Eastern, Central/Nairobi/South East & Coast, Western/North Rift and Nyanza/South Rift. The chairmen of the RCCs represent their regions in EXCO. The four geographical regions also facilitate planning, regional advocacy, communication and allocation of resources.

Representatives of the four regions sit in the EXCO together with CHAK's national officials, namely, the chairman, vice-chairman, treasurer and vice-treasurer.

The RCCs will coordinate networking and participation in health sector planning at regional level in addition to providing a communication link between the Secretariat and MHUs. They will also facilitate identification of advocacy issues and give feedback to the Secretariat. Further, RCCs will assist the secretariat in the monitoring health services projects within their regions.

Following the adoption of a New Constitution in Kenya which has created 47 county governments as political units of decision making and resource allocation, CHAK proposes to establish County Coordinating Committees (CCCs) to support RCCs in coordination and advocacy for MHUs engagement at county level. They will also encourage members to participate in District Health Stakeholders Forum (DHSF) to ensure inclusion in planning and monitoring at the district level.

Secretariat

The implementation of the Strategic Plan will be facilitated by the Secretariat under the leadership of the General Secretary. The Secretariat will be restructured into three departments:

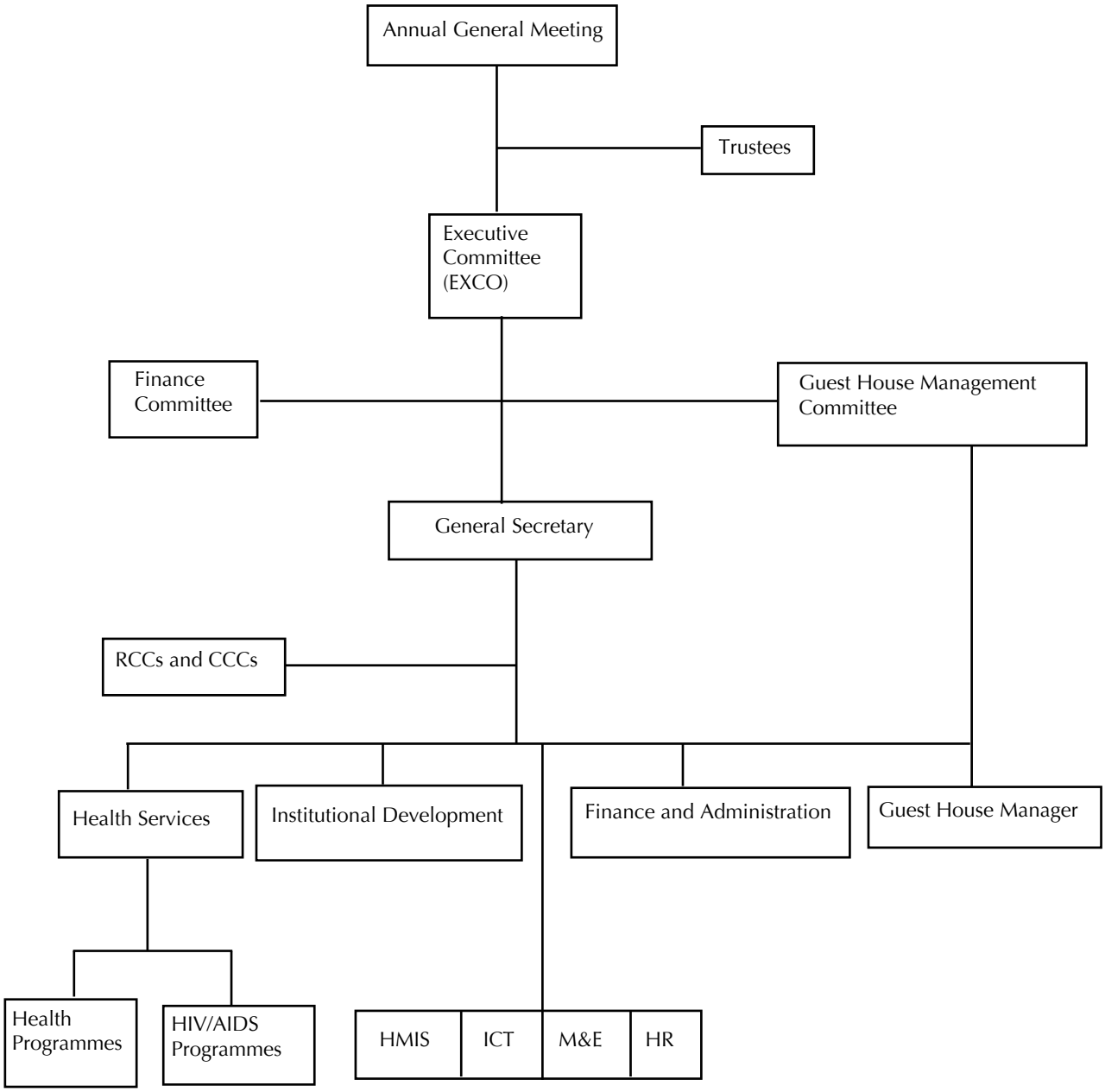
- Health Services
- Institutional & Organisational Development
- Financial Management and Administration

These are all supported by an ICT, HMIS/M&E and HR units under the office of the General Secretary responsible for the functions of IT, HMIS, HR, communication, publications and M&E. These will have staff with competencies in each of these areas.

A manager will head each of the departments and supervise technical and support staff. It is also recognized that CHAK Secretariat cannot afford to maintain in its establishment all professionals required. Engaging short-term external consultancy services for defined assignments will fill gaps or specific needs arising. However, there will

be flexibility to expand CHAK's human resource capacity to cope with new project demands provided the necessary resources are available. CHAK may also draw technical assistance from partners and can join partnerships for relevant joint health projects implementation.

The organizational structure for CHAK will be as below:



8 Monitoring & Evaluation and research

CHAK will develop a Monitoring and Evaluation plan to guide the process of monitoring, evaluation and research at the secretariat. Technical officers will operationalise this plan by preparing quarterly individual and departmental work plans for implementation.

Quarterly, technical review meetings shall be convened under the leadership of the General Secretary to review the accomplishments and challenges in relation to the set targets. Disparities or under-achievements in any area will be examined to determine challenges and future activities re-focused accordingly.

Half-year narrative reports shall then be compiled for sharing with stakeholders and partners. An annual review will be conducted at the end of the year by all staff to provide information for the Association's annual report. The annual report will be submitted for review and adoption by the AGM and thereafter shared with donor partners and other stakeholders.

Data collection and management

The HMIS/M&E officer will develop data collection tools inbuilt in mobile handsets for electronic relaying of reports by MHUs to the Secretariat. This will improve timeliness and reduce costs currently incurred when sending the reports via the post office. However, some MHUs may continue to send data by post due to unavailability of GSM networks in their areas of operation and inadequate infrastructure.

The M&E team will input and analyze data from all collection systems and provide monthly statistics to enable project staff monitor their performance and make requisite changes where necessary.

Mid-term external evaluation will be conducted at the end of 2013 and an external end-term evaluation of the Strategic Plan 2011-2016 will be conducted at the end of 2016. The reports will be discussed by EXCO and presented to AGM and donor partners. The evaluations and the routine data collection processes shall enable the secretariat identify potential operational research questions which shall be used to inform and sensitize the MHUs accordingly.

CHAK shall endeavour to collaborate with MOH and other likeminded partners to carry out health related research activities.

Data quality assurance

The M&E unit will support MHUs by training point persons in data collection and reporting as per the MOH HMIS system. The M&E plans will be developed to assist facilities in implementing MOH HMIS, ensure availability of data collection and reporting tools, accurate compilation of client data, quick and efficient health facility reporting, and accurate data entry in client registers.

Occasional data quality audits shall be conducted at selected MHUs to verify the validity, integrity, reliability and completeness of data collected at the sites.

9 Implementation log frame

1.0 HUMAN RESOURCE MANAGEMENT SUPPORT TO CHAK MEMBER HEALTH UNITS

Objective 1.1: To strengthen recruitment and deployment practices at CHAK MHUs
Output 1.1: Ensure health workers are equitably distributed in CHAK MHUs

No	Activities	Indicators	Data source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To coordinate with the Ministry of health and development partners in the secondment of health workers to MHUs				X	X	X	X	X	X
b)	To empower facilities to plan their staffing needs	No. of MHUs empowered to plan their staffing needs	Records	Quarterly	100	100	100	100	100	100
c)	To provide technical assistance to MHUs in recruitment and selection processes	No. of MHUs provided with TA in recruitment and selection processes	Records	Quarterly	100	100	100	100	100	100

Objective 1.2: To improve the work climate, environment and terms of service of member health units
Output 1.2: Enhance the work setting for health workers at CHAK MHUs to make it more conducive and rewarding

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To provide technical assistance in integration of salary and benefits structures using recommendations from the salary survey done in mission health facilities	No. of MHUs provided with TA on integration of salary and benefits structure	Records	Quarterly	25	50	50	100	100	100
b)	To facilitate the adoption of evidence-based work climate improvement (WCI) interventions in selected CHAK sites	No. of MHUs	Records	Quarterly	10	20	20	30	30	30
c)	To support selected MHUs to develop health worker retention strategies	No. of MHUs	Records	Quarterly	10	20	20	30	30	30
d)	To monitor health worker attrition rates and advise facility managers	No. of MHUs	Records	Quarterly	100	100	150	150	200	200
e)	To support CHAK MHUs to embrace health worker safety and health standards	No. of MHUs	Records	Quarterly	100	100	150	150	200	200

Objective 1.3: To enhance management, leadership and supervisory skills at CHAK facilities
Output 1.3: Improved institutional and health worker performance at CHAK MHUs

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To support the MHUs to institutionalize performance management systems	No. of MHUs supported to institutionalize performance management systems	Records	Quarterly	20	50	100	100	200	200
b)	To support MHUs to enhance recognition and reward schemes	No. of MHUs supported	Records	Quarterly	20	50	100	100	200	200
c)	To provide management, leadership and supervisory skills training across the CHAK network	No. of staff	Records	Quarterly	80	80	80	80	80	80
d)	To support implementation of performance agreements	No. of MHUs	Records	Quarterly	X	X	X	X	X	X

Objective 1.4: To enhance capacity and output of the CHAK training institutions and support in-service training program across the CHAK network
Output: 1.4: Improved human resource development systems at CHAK facilities

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To develop and up-date a training and staff development inventory for CHAK MHUs	Skills inventory	Records	Quarterly	X	X	X	X	X	X
b)	To coordinate community health worker training	No. of CHWs	Records	Quarterly	X	X	X	X	X	X
c)	To support curriculum design and reviews at CHAK training institutions	No. of institutions	Records	Quarterly	X	X	X	X	X	X
d)	To maintain strong networks and collaborations with professional bodies and councils	No. of institutions	Records	Quarterly	X	X	X	X	X	X
e)	To support internship programmes	No. of MHUs	Records	Quarterly	X	X	X	X	X	X

Objective 1.5: To enhance the management of human resource for health, HRIS and planning practices at CHAK facilities
Output 1.5: Strengthened human resources for health planning and management at CHAK member health units

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To support the development and integration of human resource for health plans	No. supported	Records	Quarterly	X	X	X	X	X	X
b)	To coordinate the CHAK MHUs human resources information system(HRIS)	No. supported	Records	Quarterly	X	X	X	X	X	X
c)	To support adoption and implementation of the CHAK HRM policy	No. of MHUs	Records	Quarterly	X	X	X	X	X	X

d)	To provide regular HRM skills development training	No. trained	Records	Quarterly	X	X	X	X	X	X
e)	To provide technical assistance in HRM to member health units	No. of MHUs	Records	Quarterly	X	X	X	X	X	X

Objective 1.6: To ensure MHUs HRH issues are addressed at the national policy level
Output 1.6: CHAK secretariat represented at Key HRH forums both at national and regional levels

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To attend health sector HRH meetings and forums	No of meetings	Minutes	Quarterly	X	X	X	X	X	X
b)	To monitor and Evaluate CHAK HRH initiatives	No. Evaluated	Reports	Quarterly	X	X	X	X	X	X
c)	To report regularly to partners, the Secretariat, MOH and other stakeholders on HRH issues	No. of reports	Records	Quarterly	X	X	X	X	X	X
d)	To partner and collaborate with HRH partners	No. of partners	Records	Quarterly	X	X	X	X	X	X
e)	To fund raise and write proposals to support HRH initiatives	No. of proposals	Records	Quarterly	X	X	X	X	X	X
f)	To develop change management plans to support on-going and anticipated changes affecting both MHUs and secretariat	No. of Plans	Records	Quarterly	X	X	X	X	X	X

Objective 1.7: To enhance sound human resource management practices at the CHAK secretariat
Output 1.7: A highly motivated skilled and performing team at the secretariat

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To manage the staff development and skills building programmes for secretariat staff	Skills inventory	Records	Quarterly	X	X	X	X	X	X
b)	To undertake a comprehensive job evaluation of secretariat positions	Job evaluation report	Records	Quarterly	X	X	X	X	X	X
c)	To align pay structure to job evaluation recommendations and reward systems		Records	Quarterly	X	X	X	X	X	X
d)	To enhance a high performing work culture at the secretariat		Records	Quarterly	X	X	X	X	X	X
e)	To review human resource management and staff development policies		Records	Quarterly	X	X	X	X	X	X

f)	To support implementation and commitment to existing HR policies and processes		Records	Quarterly	X	X	X	X	X	X

2.0 HEALTH SYSTEMS STRENGTHENING

2.1 MEDICAL EQUIPMENT MAINTENANCE

Objective 2.1.1: To develop standards and specifications for medical equipment and consumables for the health sector in partnership with KEBS/GOK.

Output 2.1.1: Medical equipment and consumables standards and specifications manual

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To participate in monthly workgroup meetings at the KEBS	No. of mtgs.	Minutes		12	12	12			
b)	To participate in 6 monthly stakeholders forums for reviewing and adopting the output given by the standards workgroup.	No. of mtgs.	Minutes		2	2	2			
c)	To participate in the presentation of the final draft of the standards to the board of KEBS.	No. of mtgs.	Minutes				1			
d)	To participate in quarterly regulatory meetings for medical equipment standards and specifications.	No. of mtgs.	Minutes		4	4	4	4	4	4

Objective 2.1.2: To provide medical equipment maintenance and repair services to church health facilities

Output 2.1.2: Medical Equipment in church health facilities in good condition

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To develop an annual business plan to guide the operations of medical equipment maintenance services to church health facilities		Records	Annually	X	X	X	X	X	X
b)	To prepare a schedule for planned preventive maintenance visits to church health facilities		Records	Quarterly	X	X	X	X	X	X
c)	To respond to un-scheduled emergency invitations to provide technical repairs following breakdowns (5400 invitations)	No. of emergency invitations	Records	Quarterly	90	90	90	90	90	90
d)	To provide technical advice to 150 church health facilities procuring new equipment/donations	No. of facilities served	Records	Quarterly	25	25	25	25	25	25
e)	To inspect donated equipment, repair/service, install and commission for use for 15 church health facilities	No. of facilities served	Records	Quarterly	15	15	15	15	15	15
f)	To inspect, install and commission newly acquired medical equipment for 5 church health facilities	No. of facilities served	Records	Quarterly	5	5	5	5	5	5

Objective 2.1.3: To acquire agency for medical equipment in the areas of laboratory, laundry, x-ray and oxygen generating plants
Output 2.1.3: Standardized medical equipment in church health facilities

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To identify a potential supplier/manufacturer of the targeted medical equipment		Reports/ minutes	Annually	X	X	X	X	X	X
b)	To establish a partnership with the identified supplier/manufacturer		Records	Annually	X	X	X	X	X	X
c)	To solicit for guarantor support for HCTS in the partnership with supplier/manufacturer		Records	Annually	X	X	X	X	X	X
d)	To market the products under the agency to 50 church health facilities		Records	Annually	10	15	10	5	5	5
e)	To make orders and follow-up on shipments	No. of Orders made	Records	Annually	X	X	X	X	X	X
f)	To clear with freight agent, receive supplies and set up show room	No. of items received	Records	Annually	X	X	X	X	X	X
g)	To supply, install and commission received orders and train staff on usage	No. of LPOs served	Records	Annually	X	X	X	X	X	X

Objective 2.1.4: To procure and sell basic medical equipment to church health facilities
Output 2.1.4: Frequently used basic medical equipment readily available to church health facilities

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To identify the basic medical equipment to be stocked	No. of equipment	Records	Monthly	X	X	X	X	X	X
b)	To procure the identified items	No. of items identified	Records	Monthly	X	X	X	X	X	X
c)	To sensitize and market the products to 100 potential customers.	No. of potential customers reached	Records	Monthly	20	20	20	20	10	10
d)	To equipment as ordered	No. of orders	Records	Monthly	X	X	X	X	X	X

Objective 2.1.5: To train HCTS staff and MHU technicians on specific models of identified machines and new technology
Output 2.1.5: Competent technicians with up to date skills in medical engineering

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To carry out a skills audit and inventory for HCTS and MHU technicians		Records	Quarterly	X	X	X	X	X	X
b)	To identify training needs in MHUs' and HCTS		Records	Quarterly	X	X	X	X	X	X

c)	To conduct the identified trainings for 150 MHU technicians	No. of technicians trained	Records	Quarterly	25	25	25	25	25	25
d)	To support three HCTS technicians to attend the identified trainings	No. of technicians supported	Records	Quarterly	3	3	3	3	3	3

2.2 GOVERNANCE AND MANAGEMENT SUPPORT FOR MHUS
Objective 2.2.1: To facilitate health facilities boards/committees to build their governance capacity and to give them exposure to others who rate highly with respect to best practices
Output 2.2.1: Functional and accountable health facility boards/committees

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To participate in board meetings for 10 MHUs	No. of MHUs supported	Minutes	Quarterly	10	10	10	10	10	10
b)	To organize learning exchange visits between boards for 12 MHUs	No. of MHUs supported	Report	Quarterly	2	2	2	2	2	2
c)	To facilitate induction for new boards for 12 MHUs	No. of MHUs inducted	Report	Quarterly	2	2	2	2	2	2
d)	To facilitate customization of generic governance policy guidelines for 60 MHUs	No. of MHUs supported	Report	Quarterly	20	20	10	5	5	-
e)	To hold an experience sharing conference on best practices in governance for 120 MHUs	No. of MHUs participating	report	Annual	20	20	20	20	20	20

Objective 2.2.2: To facilitate the hospital management teams in enhancing their management capacity
Output 2.2.2: Efficient and competitive operations at the health facilities

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To organize learning exchange visits between management teams for 12 MHUs	No. of MHUs supported	Reports	Annually	2	2	2	2	2	2
b)	To hold management workshops for 150 MHUs	No. of MHUs participating	Reports	Annually	25	25	25	25	25	25
c)	To facilitate 12 MHUs in developing Strategic Plans	No. of MHUs supported	Reports	Annually	2	2	2	2	2	2
d)	To facilitate 6 MHUs in carrying out a management audit of the institution	No. of MHUs supported	reports	Annually	1	1	1	1	1	1
e)	To hold an experience sharing conference on best practices in management for 120 MHUs	No. of MHUs participating	report	Annual	20	20	20	20	20	20

2.3 ENHANCED SUPPORT TO MHUS BY EMPOWERED RCCS (FURTHER DEVOLVED TO CCCS IN LINE WITH THE NEW CONSTITUTION)

Objective 2.3.1: To support and coordinate RCC efforts in addressing the needs/concerns/interests of MHUs in the regions

Output 2.3.1: Effective RCCs in addressing MHUs needs, concerns and interests at regional/county levels

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To hold 3 regular meetings for receiving needs/concerns from MHUs, receiving information/reports from secretariat and learning and experience sharing	No. of meetings held	Records	Quarterly	12	12	12	12	12	12
b)	To hold annual planning and budgeting meetings for the regions/counties	No. of meetings held	Records	Annually	4	4	4	4	4	4
c)	To advocate for the MHUs needs/concerns with the relevant institutions and authorities		Records	Quarterly	X	X	X	X	X	X
d)	To vet CHAK membership applicants and recommend to EXCO for approval	No. of applicants vetted	Records	Quarterly	10	10	10	10	10	10
e)	To implement approved activities and report on them	No. of MHUs participating	Records	Quarterly	120	120	120	120	120	120

2.4 RESPONDING TO REQUESTS FROM MHUS FOR TECHNICAL SUPPORT IN ARCHITECTURAL SERVICES AND IN BUILDING THE CAPACITY OF THEIR STAFF IN PROJECT FORMULATION AND PROPOSAL WRITING

Objective 2.4.1: To assist in architectural design and supervision of construction of buildings in MHUs

Output 2.4.1: Buildings in MHUs are well planned, structurally sound and properly finished

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To develop preliminary designs for discussion with the client for 20 MHUs	No. of MHUs supported	Records	Monthly	4	4	4	3	3	3
b)	To develop final designs and produce architectural drawings for 20 MHUs	No. of MHUs supported	Records	Monthly	4	4	4	3	3	3
c)	To prepare general and technical specifications for the project in 20 MHUs	No. of MHUs supported	Records	Monthly	4	4	4	3	3	3
d)	To submit 4 sets of the architectural drawings to the local authorities for approval	No. of approved projects	Records	Monthly	4	4	4	3	3	3
e)	To assist 20 MHUs in the process of environmental impact assessment (EIA) and application for the NEMA certificate of no objection to the project	No. of MHUs received NEMA certificate	Records	Annually	4	4	4	3	3	3
f)	To facilitate costing/BQs preparation for the project	No. of MHUs supported	Records	Quarterly	2	2	2	2	2	2
g)	To assist the MHUs in the process of tender action	No. of contracts signed	Records	Quarterly	2	2	2	2	2	2

h)	To provide supervisory support during construction up to completion	No. of Projects supported	Records	Monthly	2	2	2	2	2	2
i)	To make final inspection of completed works, list defects to be made good and handover to the MHUs	No. of completed projects	Records	Quarterly	2	2	2	2	2	2

Objective 2.4.2: To assist the MHUs in building the capacity of their personnel in project formulation and proposal writing
Output 2.4.2: MHUs have enhanced capacity in project formulation and proposal writing

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To identify the best suited individuals from 120 MHUs to participate in the workshop	No. of MHUs participating	Records	Quarterly	20	20	20	20	20	20
b)	Train 2 staff each from the 120 MHUs identified in proposal development	No of individuals trained in proposal development	Training reports	Quarterly	240	240	240	240	240	240
c)	To prepare the training package for the workshop		Records	Quarterly	X	X	X	X	X	X
d)	To provide post training support through follow up and review of project proposals developed by participants after the workshop for 6 MHUs	No. of proposals reviewed	Records	Quarterly	2	2	2	2	2	2

2.5: ENHANCED PARTICIPATION OF MHUS IN HEALTH SECTOR JOINT PLANNING AND MONITORING (AOPS AND DISTRICT HEALTH SECTOR FORUMS)
Objective 2.5.1: To facilitate the participation of MHUs in the joint Health Sector Planning and Monitoring at the national, regional and county levels as per the NHSSP and AOPs
.**Output 2.5.1:** Allocation of resources to MHUs at the district/county levels in implementation and monitoring DHPs

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To sensitize 70 per cent MHUs on the importance and potential benefits of participating in district/county level AOPs and DHSFs	No. of MHUs supported	Records	Annually	70%	70%	70%	70%	70%	70%
b)	To sensitize the MOH at the district/county levels on the need to invite/communicate to the MHUs the schedule of AOPs and DHSFs		Records	Quarterly	X	X	X	X	X	X
c)	To support 70 per cent of MHUs in the process of planning and monitoring the implementation of their funded AOPs in partnership with RCCs	Percentage of MHUs participating	Records	Quarterly	70%	70%	70%	70%	70%	70%
d)	To participate in AOPs at the national level by secretariat		Records	Annually	X	X	X	X	X	X

f)	To facilitate RCCs to advocate for resource allocation to MHUs and involvement in AOPs at district/county level	No. of advocacy meetings	Records	Quarterly	4	4	4	4	4	4

2. 6: MOBILIZATION OF RESOURCES IN RESPONSE TO RELEVANT SPECIFIC AREAS OF FELT NEEDS BY MHUS (PROJECTS)
Objective 2.6.1: To formulate projects and develop proposals in areas that address MHU/Secretariat felt needs.
Output 2. 6.1: Resources mobilized to address MHU priority needs

No	Activities	Indicators	Data source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To review emerging MHU priority needs and select those to focus on	No. of priority areas selected	Reports	Quarterly	X	X	X	X	X	X
b)	To formulate 30 projects and write proposals in selected areas of focus for funding	No. of proposals written and successfully funded	Reports	Quarterly	5	5	5	5	5	5

3.0 HIV/AIDS

Objective 3.1: To promote HIV/AIDS prevention through provision of HIV counselling and testing (C&T)

No	Activities	Indicators	Data Source	Freq. of reports	2011	2012	2013	2014	2015	2016
a)	Facilitate access to counselling and testing services through VCT	No of clients counselled and tested through VCT	MOH reporting tool COBPAR	Quarterly	10,000	10,000	12,000	12,000	10,000	10,000
b)	Facilitate access to HIV C&T through home testing	No of clients counselled and tested through home testing who have received results	MOH reporting tool COBPAR	Quarterly	15,000	15,000	18,000	18,000	15,000	15,000
c)	Facilitate access to HIV C&T through PITC	No of clients counselled and tested through PITC and have received results	MOH reporting tool	Quarterly	4,000	4,000	6,000	6,000	6,000	4,000
d)	Training of HCW in counselling	No of HCW trained in HIV counselling and testing	Training reports	Quarterly	60	60	60	60	60	60
e)	Training of CHW in counselling and testing	No of CHW trained in HIV counselling and testing	Training reports	Quarterly	10	10	10	10	10	-
d)	Facilitate provision of back up HIV Test kits	No of test kits distributed	Delivery notes	Quarterly	40	40	40	40	40	40
e)	Support community sensitisation and mobilisation in implementing MHUs	No of people reached	Facility reports	Quarterly	40,000	48,000	48,000	48,000	48,000	48,000
		No of meetings held	Facility reports		2,000	2,000	2,000	2,000	2,000	2,000
f)	Participate in HIV counselling and testing national technical and stake holders meetings	No of meetings attended	Reports	Quarterly	4	4	4	4		4

Objective 3.2: To scale up the provision of high quality PMTCT services from 160 - 280 sites										
No	**Activity**	**Indicator**	**Data source**	**Freq. of reports**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
a)	Scale-up PMTCT services in 120 sites	No of new PMTCT sites	CHAK reports	Quarterly	20	20	20	20	20	20
b)	Sites' needs assessment	No of sites assessed	Assessment report	Annually	25	25	25	25	25	25
c)	Conduct orientation workshop for site managers/in-charges	No of managers/in-charges attended	Workshop report	Annually	40	40	40	40	40	40
d)	Provision of PMTCT start-up equipment	No of equipment provided	Delivery report	Annually	20	20	20	20	20	20
e)	Train HCWs on PMTCT	No of HCW trained on PMTCT	Training reports	Quarterly	60	60	60	60	60	60
f)	Facilitate provision of PMTCT counselling and testing	No. of ante-natal mothers reached	MOH reporting tool	Quarterly	4,800	7,200	7,200	7,200	7,200	7,200
g)	Facilitate quarterly support supervision to all implementing PMTCT sites by CHAK/DASCOs	No. of sites visited	Support supervision reports	Quarterly	80	80	80	80	80	80
h)	Support community mobilization in the PMTCT implementing sites	No of sites supported	Community mobilisation report	Quarterly	20	40	60	80	100	120
i)	Facilitate provision of ARV prophylaxis to HIV-positive mothers	Percentage of HIV ANC positive mothers receiving ARV prophylaxis	MOH Reporting tool	Monthly Quarterly	70%	70%	70%	70%	70%	80%
j)	Facilitate provision of ARV prophylaxis to HIV exposed infants	Percentage of exposed infants received ARV prophylaxis	MOH reporting tool	Monthly Quarterly	50%	60%	60%	60%	60%	60%
k)	Provision of PMTCT supplies	No of PMTCT supplies provided	Delivery Report	Quarterly	20	20	20	20	20	20
l)	Provision of back-up HIV test kits	No of HIV test kits supplied	Delivery Report	Quarterly	20	20	20	20	20	20
m)	Facilitate PCR testing among HIV exposed children	Percentage of exposed infants tested	Report	Monthly Quarterly	50%	60%	70%	80%	80%	80%
n)	Facilitate formation of PMTCT support groups in MHUs	No. of support groups formed	Group-Report Minutes	Quarterly	20	20	20	20	20	20
o)	Facilitate PMTCT outreaches	No of PMTCT outreaches conducted	PMTCT outreach report	Quarterly	20	20	20	20	20	20
p)	Participate in PMCT and ARVs national Technical Working Group meetings	No. of meetings attended	Reports	Quarterly	4	4	4	4	4	4
q)	Facilitate mentorship on PMCT in MHUs	No. of sites mentored	Report	Quarterly	10	10	10	10	10	10
r)	Produce a PMCT newsletter annually for the service providers	No of PMTCT newsletters produced	Newsletter	Annually	1	1	1	1	1	1

s)	Hold a national PMCT experience workshop annually	No. of national workshops held	Workshop report	Annually	1	1	1	1	1	1

Objective 3.3: To promote HIV prevention through targeted behavior change among MARPs

No	Activities	Indicators	Data source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Facilitate HIV counselling and testing among the youth	No of youths counselled and tested and have received HIV results	COBPAR	Quarterly	1200	1200	1200	1200	1200	1000
b)	Facilitate HIV C&T among the CSWs, homosexuals, truck drivers, IDUs, fishmongers	No of MARPS counselled and tested and have received HIV results	COBPAR	Quarterly	600	600	600	600	600	600
c)	Facilitate HIV C&T among discordant couples	No of discordant couples C&T and have received HIV results	MOH reporting tool COBPAR	Quarterly	600	600	600	600	600	600
d)	Promote behaviour change among MARPS	No of MARPS reached with behaviour change messages	Facility reports	Quarterly	600	600	600	600	600	600
e)	Train HCWs on BCC strategy	No of HCWs trained on BCC strategy	Training reports	Quarterly	30	30	30	30	30	30
f)	Facilitate MHUs to work with schools on behaviour change Train HCW using PWP curriculum	No of MARPS reached with behaviour - change messages	Facility reports	Quarterly	10	10	10	10	10	10
		No of HCW trained using PWP curriculum	CHAK reports	Annually	20	20	20	20	20	20
g)	Train PLWHAs using PWP curriculum	No. of PLWHAs trained using PWP curriculum	CHAK reports	Annually	20	20	20	20	20	20
h)	Facilitate advocacy events	No. of HIV advocacy events held	Facility Reports	Annually	30	30	30	30	30	30

Objective 3.4: To reduce HIV infection prevention through safe male circumcision in 10 MHUs

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Training staff on safe circumcision	No. of staff trained on safe MC	Training reports	Annually	20	20	20	20	20	20
b)	Facilitate 10 MHUs to provide safe male medical circumcision in non circumcising communities	No. of clients circumcised	MOH reports/ CHAK reports	Quarterly	300	600	600	600	300	300

c)	Facilitate MHUs to organize male circumcision (MC) holiday camps	No. of youths circumcised in the holiday camps	CHAK reports	Quarterly	3000	3000	3000	3000	3000	3000
d)	Provide sites with supplies and equipment to carry out safe MC	No. of kits provided to carry out safe MC	CHAK reports	Quarterly	1500	1500	1500	1500	1500	1500
Objective 3.5: To facilitate treatment, care and support for 1,400 PLWHAs through CHAK MHUs										
No	**Activities**	**Indicators**	**Data source**	**Freq. Of reports.**	**Year 2011**	**Year 2012**	**Year 2013**	**Year 2014**	**Year 2015**	**Year 2016**
a)	Scale-up HIV Care and treatment to12 MHUs	No. of new sites offering HIV care and treatment	CHAK reports	Annually	2	2	2	2	2	1
b)	Facilitate refurbishment of CCCs in 12 MHUs	No. of new CCCs refurbished	CHAK reports	Annually	2	2	2	2	2	1
c)	Provide basic ART supplies and equipment	No. of facilities supported with basic ART equipment and supplies	CHAK reports	Quarterly /Annually	2	2	2	2	2	1
d)	Provision of CD4 machines to five sites	No. of sites supported with CD4 machines	Placement reports	Annually	-	2	2	1	-	-
e)	Facilitate HIV care provision initiation for adults	No. clients on HIV care	MOH reports	Quarterly	360	600	840	1,080	1,320	1,440
		No. clients ART on treatment	MOH reports	Quarterly	180	300	420	540	660	720
f)	Facilitate HIV care provision initiation for children	No. of Children on HIV care	MOH reports	Quarterly	36	60	84	108	132	144
		No. of children on ART treatment	MOH reports	Quarterly	18	30	42	54	66	72
g)	Provide nutritional support to all medically qualified clients	No. of clients supported with nutritional support	Facility reports	Quarterly	40	70	90	120	140	150
h)	Facilitate community HIV care through home visits	No. of clients visited at home	Facility reports	Quarterly	360	600	840	1,080	1,320	1,440
i)	Facilitate formation of support groups in MHUs	No. of support groups formed in MHUs	Facility reports	Quarterly	2	2	2	2	2	*1*
j)	Facilitate exchange visits for HCWs for benchmarking	No. of HCW who have participated in exchange visits	Facility reports	Bi-annually	10	15	20	25	20	15
k)	Hold national experience sharing workshop	No. of national experience workshops held	Workshop report	Annually	1	1	1	1	1	1

Objective 3.6: Train health workers in HIV/AIDS care

No	Activities	Indicators	Data source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Train health workers on paediatric HIV/AIDS management	No. of HCW trained on paediatric HIV care	Training reports	Annually	30	30	30	30	30	-
b)	Train health workers on adult HIV/AIDS management	No. of HCW trained on adult HIV/AIDS management	Training reports	Annually	30	30	30	30	30	
c)	Train health workers on IMAI HIV/AIDS management	No. of HCW trained on IMAI	Training reports	Annually	20	20	20	20	20	20
d)	Facilitate CPD updates in HIV/AIDS	No of HCW participating in CPDs	Workshop reports	Annually	40	40	40	40	40	40
e)	Participate in national stakeholders meetings	No. of meetings attended	Minutes	Quarterly /Monthly	12	12	12	12	12	12

Objective 3.7: Promote HIV/TB integration

No	Activities	Indicators	Data source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Train HCW on TB/HIV integration	No. of HCW trained on TB/HIV integration	Training reports	Annually	30	30	30	30	30	30
b)	Facilitate HIV testing among TB clients	No. of TB Clients tested for HIV	MOH reports	Quarterly	180	300	420	540	660	720
c)	Facilitate TB/ HIV care integration in MHUs	No. of new sites offering integrated HIV/TB care	MOH reports	Quarterly	2	2	2	2	2	1
d)	Provide technical assistance through quarterly site supervision visits	No. of sites offered TA support	CHAK reports	Quarterly	30	30	30	30	30	30

Objective 3.7: Promoting access to legal rights and justice for PLWHAs in 35 MHUs

No	Activities	Indicators	Data source	Freq. of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Scale up integration of human rights in HIV/AIDS treatment and care to 20 MHUs	No of new sites initiated	CHAK reports	Quarterly	5	5	4	4	2	-
b)	Conduct needs assessment	No of sites assessed	Assessment report	Quarterly	8	8	6	6	4	-
c)	Orientation of site management on human rights strategy in HIV/AIDS prevention and treatment	No of management staff orientated	Orientation report	Annually	5	5	4	4	2	-
d)	Train health workers on the human rights strategy for PLWHAs	No of HCW trained	Training reports	Annually	125	125	100	100	50	-

No	Activities	Indicators	Data Source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
e)	Train 600 PLWHAs as TOTs on the human rights strategy	No of PLWHA trained	Training reports	Annually	150	150	120	120	60	-
f)	Conduct refresher training for HCW on human rights	No of HCW updated	Training reports	Quarterly	525	525	500	500	450	200
g)	Conduct refresher training for PLWHA on human rights	No of PLWHA updated	Training reports	Quarterly	550	550	520	520	460	200
h)	Hold regional public debates on the HIV/AIDS Act	No. of debates held	Reports	Quarterly	3	3	3	-	-	-
i)	Train community opinion leaders on ADR and human rights	No of opinion leaders trained	Training reports	Quarterly	420	150	120	120	60	-
j)	Facilitate formation of watchdog groups to monitor human rights violations in 35 sites	No of watchdog groups formed	Groups Reports	Quarterly	15	5	5	4	4	2
k)	Facilitate provision of legal services by pro bono lawyers through legal clinics	No of clinics held	Reports	Quarterly	60	60	57	57	51	105
l)	Support test cases identified in the project sites	No of cases supported	Case files	Quarterly Annually	20	20	25	20	20	15
m)	Capacity building on economic empowerment of PLWHAs	No of PLWHAs trained	Training reports	Annually	32	20	20	20	20	-
n)	Support economic empowerment for PLWHAs through income generating activities to ensure access to basic needs	No of groups supported	Group reports/accountability documents	Quarterly Annually	8	5	4	4	2	-
o)	Facilitate peer learning exchange visits	No of visits done	Reports	Annually	4	2	2	2	3	3
p)	Development of IEC materials	IEC materials developed	IEC Materials	Annually	1	1	1	1	1	1
q)	Documentation of the project	No of documentaries produced	Documentaries	Annually	2	2	2	2	2	2
r)	Participate in review of legislation and policies related to health	No of review meetings attended	Reports/ Minutes	Quarterly Annually	1	1	1	1	1	1
s)	Hold regional forums on review of legislation related to health	No of review forums held	Reports	Quarterly	3	3	3	-	-	-
t)	Networking and collaboration	No of institutions networking with	Reports	Quarterly	4	4	4	4	4	4

4.0 HEALTH SYSTEMS STRENGTHENING

4.1: HEALTH POLICY
Objective 4.1.1: Participate in health policy planning and review
Output 4.1.1: Increased contribution to health policy development

No	Activities	Indicators	Data Source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Participate in Inter agency Coordinating Committees and TWGs (RH,TB,HIV/AIDS, Malaria and child health)	No. of ICC and TWG meetings attended	Minutes and Reports	Quarterly	4	4	4	4	4	4
b)	Support MHUs in the implementation of new/revised policy documents and guidelines	No of sites supported	Reports	Ongoing	X	X	X	X	X	X

4.2: CAPACITY BUILDING
Objective 4.2.1: Coordinate and support internship program in MHUs
Output 4.2.1: Improve the quality of health care services in MHUS

No	Activities	Indicators	Data Source	Freq. of reports	2011	2012	2013	2014	2015	2016
a)	Support internship planning meetings	No of planning meetings supported	Minutes/Reports	Annually	1	1	1	1	1	1
b)	Support information sharing meetings in the two medical schools (University of Nairobi and Moi University)	No. of meetings supported	Minutes/ Reports	Annually	2	2	2	2	2	2
c)	Support interviews for medical officer interns in the two medical schools	No of interns interviewed	Interview reports	Annually	100	100	100	100	100	100

4.3: QUALITY ASSURANCE
Objective 4.3.1: Promote continuous quality improvements of services in MHUs
Output 4.3.1: Improve quality control measures in MHUS

No	Activities	Indicators	Data Source	Freq. of reports	2011	2012	2013	2014	2015	2016
a)	Adopt national quality assessment tools for: • HIV testing • Counselling skills • Quality of service • Blood safety • Infection prevention	No of tools adopted	Assessment tools	Ongoing	X	X	X	X	X	X
b)	Disseminate and distribute national protocols to MHUs and supervise their use	No of protocols distributed	Reports	Ongoing	X	X	X	X	X	X

4.4: RATIONAL DRUG USE AND ESSENTIAL DRUGS CONCEPT MANAGEMENT
Objective 4.4.1: Promote access, use and management of essential drugs
Output 4.4.1: Increased ordering and use of essential drugs from MEDS and KEMSA by MHUs

No	Activities	Indicators	Data source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Encourage MHUs to procure drugs and medical supplies from MEDS	Percentage of MHUs procuring from MEDs	Reports from MEDS	Quarterly	50%	60%	70%	80%	90%	100%
b)	Facilitate MHUs to participate in MEDS education days	No. of MHUs attending MEDS days	Attendance registers	Annually	50	100	150	200	250	300
c)	Ensure essential drugs list and guidelines are used in MHUs	Percentage of MHUs using guidelines	Supervision reports	Quarterly	30%	40%	50%	60%	70%	80%
d)	Advocate for MHUs to access KEMSA kits	No. of dispensaries (level 2) receiving rural health facility kits	KEMSA reports	Quarterly	100	150	200	250	300	350

4.5: REPRODUCTIVE HEALTH
Objective 4. 5.1: To facilitate the delivery of quality reproductive health programs in MHUs
Output 4.5.1: Improved delivery of reproductive health services within MHUs

No	Activities	Indicators	Data Source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Provide updates on reproductive health issues to MHUs	No. of RH updates conducted	Training reports	Half yearly	4	4	4	4	4	4
b)	Conduct facilitative support supervision for RH activities in MHUs	No. of facilities visited	Support supervision reports	Quarterly	120	120	120	120	120	120
c)	Provide RH trainings to improve health workers' skills	No of staff trained	Training report	Quarterly	120	120	120	120	120	120
d)	Advocate with NCAPD for inclusion of more MHUs in the output based approach (OBA) strategy in reproductive health delivery	No of MHUs with established OBA strategy	MHUs report on the OBA project	Quarterly	5	10	15	20	25	30
e)	Adolescent RH promotion	No of MHUs with youth friendly RH services	MHUs report	Quarterly	15	20	25	30	35	40
f)	Integrate PMCT services in RH	No. of MHUs with integrated services	HMIS	Quarterly	30	40	50	60	70	80
g)	Promote delivery by a skilled attendant	Percentage of deliveries conducted by skilled health attendants in MHUs	Maternity Register	Quarterly	43%	45%	47%	49%	51%	53%

h)	Participate in the RH TWGs and RH Advisory Board	No of TWG meetings and advisory Boards	Minutes	Quarterly	4	4	4	4	4	4
i)	Distribute RH Guidelines to MHUs	No of MHUs using current guidelines	Supervision reports	Quarterly	80	100	120	140	160	180

4.6: MALARIA
Objective 4.6.1: To reduce the level of malarial infection by 40 per cent by 2016
Output 4.6.1: Morbidity and mortality from malaria reduced

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Capacity building on Malaria updates	No. of health workers updated on malaria	Update reports	Quarterly	240	240	240	240	240	240
b)	Train health workers in malaria case management	No. of health workers trained	Training reports	Quarterly	120	120	120	120	120	120
c)	Support community mobilisation activities	No. of mobilization meetings held in the community	Reports	Monthly	100	110	120	130	140	150
d)	Malaria preventive interventions through promoting access to ITNs in MHUs	No. of ITNs distributed	Reports	Quarterly	5000	5000	5000	5000	5000	5000
e)	Facilitative support supervision for MHUs on M & E	No. of sites visited	Supervision reports	Quarterly	120	120	120	120	120	120

4.7: CHILD HEALTH
Objective 4.7. 1: To promote child survival
Output 4.7.1: Reduce childhood morbidity and mortality

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Support MHUs to increase immunization coverage	Percentage of children fully immunized	HMIS	Quarterly	70%	75%	80%	85%	90%	95%
b)	Case management of childhood diseases, impairment and disabilities	No of sites using IMCI strategy	Supervision reports	Quarterly	35	45	55	65	75	85
c)	Conduct Trainings in child health	No of staff trained	Training report	Biannual	120	120	120	120	120	120

4.8: TUBERCULOSIS

Objective 4. 8.1: To improve diagnosis and management of TB

Output4.8.1: Contribute to TB burden reduction

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Increase case finding and detection	Percentage of TB cases detected	TB registers MHU reports	Quarterly	47%	49%	51%	53%	55%	57%
b)	Support TB treatment and adherence counselling	Percentage of patients completing TB therapy	MOH reporting tools	Quarterly	55%	60%	65%	70%	75%	80%
c)	Promote TB/ HIV integration	No. of facilities with integrated TB/HIV services	MHUs and supervision reports	Quarterly	50	60	70	80	90	100
d)	Training on TB/HIV integration	No of staff trained on TB/HIV integration	Training reports	Quarterly	120	120	120	120	120	120
e)	Conduct defaulter tracing	Percentage of defaulters traced	HMIS	Monthly	30%	40%	50%	60%	70%	80%
f)	Renovation and provision of start-up equipment in MHUs	No. of MHUs renovated and equipped	Report	Annual	5	10	10	10	10	10

4.9: COMMUNITY STRATEGY

Output 4.9.1: Community access to quality health care through improved community participation

Objective 4.9.1: To improve the health status of communities served by CHAK MHUS through health promoting interventions at level one

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Support MHUs in implementation of the Community Strategy	No of MHUs implementing the community strategy	Reports	Quarterly	10	20	30	40	50	60
b)	Facilitate training of community health workers from the MHUs on the Community Strategy	No. of community health workers trained	Training reports	Half Yearly	100	200	300	400	500	600
c)	Strengthen health facility-community linkages through community outreach activities and involvement of churches	No. of outreach events held	Event reports	Quarterly	10	20	30	40	50	*60*

4.10: SCALE UP EYE CARE SERVICES IN CHAK MHUS

Objective 4.10.1: To support scale up of eye care services within the CHAK network through advocacy, capacity building, networking and strategic partnership

No	Activities	Indicators	Data source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To support advocacy on eye care needs with government and other stakeholders	No. of advocacy meetings held	Reports and minutes	Quarterly	4	4	4	4	4	*4*

b)	Facilitate skills building training in eye care for health workers	No. of health workers trained	Training reports	Half Yearly	40	40	40	40	40	40
c)	To support scale up of Eye care services	No. of new MHUs offering eye care services	Reports	Annual	5	7	9	11	13	15
d)	Participate in planning and monitoring meetings on eye care services	No. of meetings held	Reports/ minutes	Quarterly	4	4	4	4	4	4

5.0: RESEARCH, ADVOCACY AND COMMUNICATION

5.1: MONITORING AND EVALUATION AND RESEARCH

Objective 5.1.1: To regularly monitor and evaluate CHAK programmes and projects
Output 5.1.1: Ensure Monitoring and Evaluation systems are in place

No	Activity	Indicators	Data Source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Develop and maintain secretariat training database	No of training databases developed	Database reports	Quarterly	1	X	X	X	X	X
b)	Develop and maintain secretariat service statistics database	No of service statistics databases developed	Database reports	Quarterly	1	X	X	X	X	X
c)	Mobilize MHUs to send monthly reports to secretariat	Percentage of MHUs reporting on monthly basis to the secretariat	Monthly Reports received	Monthly	30%	50%	60%	60%	60%	60%
d)	Collect, process and disseminate service statistics				X	X	X	X	X	X
e)	Conduct M&E technical assistance (supportive supervision) visits to MHUs	No of supporting supervision visits conducted	Supervision visit reports	Quarterly	4	4	4	4	4	4
f)	Train facility based data point persons on NASCOP/HMIS data collection tools-session of 30 paxs per training	No of facility based data point persons trained on NASCOP/HMIS data collection tools	Training reports	Quarterly	120	120	120	120	120	120
g)	Sensitize MHUs to use MOH reporting tools	Percentage of MHUs using MOH tools for data capture and reporting	Reports submitted	Monthly	30%	50%	60%	60%	60%	60%
h)	Distribute electronic copies of HMIS reporting tools to MHUs for printing				X	X	X	X	X	X
i)	Distribute HMIS registers				X	X	X	X	X	X
j)	Conduct data quality audits at selected sites	No of data quality audits conducted	DQA reports	Quarterly	4	4	4	4	4	4
k)	Hold quarterly technical review meetings at the secretariat	No. of technical review meetings held	Minutes	Quarterly	4	4	4	4	4	4
l)	Support projects at the secretariat on M&E				X	X	X	X	X	X

m)	Mid and end term reviews		Evaluation reports	After three years			X			X

Objective 5.1.2: To provide evidence based information through operational and other research activities
Output 5.1.2: Carry out operational research and other health related research activities

No	Activities	Indicators	Data source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Operation research questions formulated	No of operation researches conducted	OR publication	Last two years					X	X
b)	Other research conducted	Research activities carried out	Research publications	Every two years			2			2

5.2: COMMUNICATION, DOCUMENTATION AND PUBLICATION
Objective 5.2.1: To document, publish and disseminate research reports as well as reports of CHAK's major events and activities, paying special attention to detailing the impact of CHAK's work
Output 5.2.1: Reports of major CHAK events and activities

No	Activity	Indicators	Data Source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Document proceedings of six CHAK Annual Health Conferences	No. of Annual Health Conferences documented	AHC report	Annually	1	1	1	1	1	1
b)	Publish six CHAK Annual Health Conference reports	No. of AHC reports published	AHC report	Annually	1	1	1	1	1	1
c)	Disseminate 6,000 copies of CHAK Annual Health Conference Reports to members and partners	No. of AHC reports disseminated	Distribution report		1000	1000	1000	1000	1000	1000
d)	Compile and publish six Association's Annual Reports	No. of Annual Reports compiled and published	Annual report	Annually	1	1	1	1	1	1
e)	Disseminate 6,000 Associations Annual Reports to members and partners	No. of Annual Reports disseminated	Distribution report	Annually	1000	1000	1000	1000	1000	1000
f)	Compile and publish reports on other major CHAK events		Reports		X	X	X	X	X	X
g)	Compile, publish and disseminate research findings		Reports		X	X	X	X	X	X
h)	Compile and circulate 300 CHAK Secretariat Weekly Memos	No. Of weekly memos compiled and circulated	Weekly memo	Weekly	50	50	50	50	50	50

Objective 5.2.2: To produce 18 issues of CHAK Times newsletter
Output 5.2.2: Three issues of CHAK Times published and distributed to members and partners every year

No	Activity	Indicators	Data Source	Freq. of Reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Compile and publish 18 issues of CHAK Times newsletter (electronic and print copies)	No. of CHAK Times issues compiled and published	CHAK Times newsletter	Quarterly	3	3	3	3	3	3

b)	Hold 18 *CHAK Times* editorial committee meetings	No. of CHAK Times editorial committee meetings held	Minutes	Every four months	3	3	3	3	3	3
c)	Distribute 18,000 copies of *CHAK Times* to CHAK members and partners	No. of copies distributed	Distribution report	Every four months	3,000	3,000	3,000	3,000	3,000	3,000

Objective 5.2.3: To produce promotional/informational communication materials for CHAK and its projects
Output 5.2.3: IEC materials for CHAK Secretariat and MHUs

No	Activities	Indicators	Data source	Freq. Of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Update and print CHAK brochure twice every year	No. of brochures	Brochure	Half yearly	3000	3000	3000	3000	3000	3000
b)	Print and distribute 6000 CHAK calendars	No. of calendars distributed	Distribution report	Annually	1,000	1,000	1,000	1,000	1,000	1,000
c)	Design and produce promotional materials for CHAK	No. of promotional materials			X	X	X	X	X	X
d)	Design and produce IEC materials for projects	No of IEC materials			X	X	X	X	X	X

Objective 5.2.4: To maintain and update CHAK website
Output 5.2.4: Updated CHAK website

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Maintain CHAK website and update content regularly	No. of updates			X	X	X	X	X	X
b)	Post 18 members' profile on the CHAK website	No. of profiles	Report of profiles posted	Every four months	3	3	3	3	3	3
c)	Post regularly the profile and activities of RCCs on the Website	No. of articles			X	X	X	X	X	X
d)	Create and maintain interactive page on CHAK website				X	X	X	X	X	X

Objective 5.2.5: To maintain a Resource Centre
Output 5.2.5: Resource Centre providing information access and reference materials

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Update catalogue of resource centre materials quarterly	No. of updates	Report	Quarterly	4	4	4	4	4	4
b)	Maintain the Resource Center				X	X	X	X	X	X
c)	Create, operationalize and maintain library software				1	X	X	X	X	X

5.3: INFORMATION TECHNOLOGY
Objective 5.3.1: To maintain a well equipped Information Communication and Technology (ICT) unit at the Secretariat
Output 5.3.1: Strengthening secretariats systems through Information Technology

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Maintain e-mail/Internet and LAN services				X	X	X	X	X	X
b)	Provide user support for staff at the Secretariat				X	X	X	X	X	X

c)	Provide technical assistance to management when procuring ICT equipment/accessories and software				X	X	X	X	X	X
d)	Continuously upgrade the computer equipment at the Secretariat in line with technology changes				X	X	X	X	X	X
e)	Maintain a directory of CHAK members				X	X	X	X	X	X
f)	Maintain and upgrade the Secretariat server				X	X	X	X	X	X
g)	Maintain internet services				X	X	X	X	X	X
h)	Create, maintain and upgrade off-shore backup system for the Secretariat				1	X	X	X	X	X
i)	Install and maintain fibre optic internet at the Secretariat				1	X	X	X	X	X
j)	Create shared drives on the server	No. of drives created			1	X	X	X	X	

Objective 5.3.2: To enhance data transfer between the Secretariat and MHUs through mobile telephony
Output 5.3.2: Established mobile telephony data transfer

No	Activities	Indicators	Data source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Maintain SMS system				X	X	X	X	X	X
b)	Create and maintain data base for use with mobile telephony	No. of databases created	Reports from data base		1	X	X	X	X	X
c)	Develop data collection tools for mobile transmission	No. of tools developed			1	-	-	-	-	-
d)	Support users on the use of electronic tools				X	X	X	X	X	X

Objective 5.3.3: Strengthening financial and data management through computerized system (Health Management Information Systems)
Output 5.3.3: Implement and maintain HMIS software for level 2,3 and 4 facilities

No	Activities	Indicators	Data source	Freq. of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Conduct needs assessment in 60 health facilities	No. of facilities assessed	Assessment reports	Quarterly	10	10	10	10	10	10
b)	Install software in 40 health facilities	No. of facilities where software is installed		Quarterly	5	5	10	10	5	5
c)	Train users in 60 facilities in the use of HMIS system	No. of facilities with users trained	Implementation reports	Quarterly	10	10	10	10	10	10
d)	Support software remotely	No. of facilities added to remote support site			X	X	X	X	X	X
e)	Support software at facility level	No. of facilities supported			X	X	X	X	X	X

Output 5.3.4: Develop and maintain clinical HMIS system for Level 5 health facilities

No	Activities	Indicators	Data source	Freq. Of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Hold TWG meetings quarterly	No. of meetings held	Minutes	Quarterly	4	4	4	4	4	4
b)	Create HMIS modules				1	-	-	-	-	-
c)	Integrate the modules				1	-	-	-	-	-
d)	Pilot the system				-	1	-	-	-	-
e)	Create remote site for HMIS support	No. of facilities added to remote support site			-	1	-	-	-	-
f)	Hold software launch workshop	No. of participants	Workshop report		-	1	-	-	-	-
g)	Install and support HMIS software in 5 health facilities	No. of facilities using the new software	Reports		-	1	2	2	-	-
h)	Train facility users in the new system	No. of facilities with users trained			-	1	2	2	-	-
i)	Support and maintain the software	No. of facilities supported			-	-	X	X	X	X

5.4: ACHAP CAPACITY BUILDING FOR ADVOCACY AND HEALTH SYSTEMS STRENGTHENING FOR FBOs IN AFRICA
Objective 5.4.1: To build the institutional capacity of ACHAP through adoption and implementation of a new constitution and legal registration to enhance organizational identity and governance effectiveness

No	Activities	Indicator	Data Source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	To facilitate ACHAP constitution development, adoption and implementation	Constitution	Reports		X	X	X	X	X	X
b)	To facilitate legal registration of ACHAP for organizational identity and enhanced governance effectiveness	Registration certificate	Reports		X	X				
c)	To facilitate development and implementation of a communication strategy for ACHAP	Communication strategy	Reports		X	X	X	X	X	X
d)	To develop and facilitate implementation of biennial ACHAP strategy and work plan	Biennial Strategy and work plan	Reports		X	X	X	X	X	X
e)	To support Health Systems Strengthening for CHAs through partnerships and technical working groups and sharing of best practices	Reports	Reports		X	X	X	X	X	X

5.5: ADVOCACY, LOBBYING AND REPRESENTATION

Objective 5.5.1: To represent, lobby and advocate for CHAK member health units for recognition, involvement in policy development, planning and resource allocation

Output 5.5.1: CHAK MHUs rights and concerns articulated and given attention by Government of Kenya and other relevant stakeholders

No	Activities	Indicators	Data source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Solicit and receive issues for advocacy	Issues recorded	Report	Quarterly	X	X	X	X	X	X
b)	Develop substantive agenda for advocacy supported by research and documentation	Agenda	Report	Half yearly	X	X	X	X	X	X
c)	Present/share with relevant authorities and give feedback to MHUs		Report	Half yearly	X	X	X	X	X	X
d)	Where necessary engage church leaders in high level advocacy	Leaders involved	Report	Annually	X	X	X	X	X	X
e)	Participate in the Church Health Services Coordinating Committee (CHSCC) meetings monthly	No. of meetings	Report	Quarterly	12	12	12	12	12	12
f)	Participate in regional and international networks and fora for international advocacy e.g. ACHAP, CCIH, WCC, WHO, MMI & UN Agencies	No of meetings attended	Report	Annually	X	X	X	X	X	X
g)	Participate in MOH planning, policy review and development meetings to proactively articulate MHUs' interests and concerns	Policy	Report	Half yearly	X	X	X	X	X	X
h)	Participate in SWAps Health Sector Coordinating Committee	No. of Meetings	Minutes	Quarterly	4	4	4	4	4	4
i)	Participate in the various Inter Agency Coordinating Committees (ICCs) - RH,TB,HIV/AIDS, Malaria,HR,Child Health	No. of Meetings	Minutes	Quarterly	24	24	24	24	24	24
j)	Participate in the Kenya CCM for Global Fund	No. of Meetings	Minutes	Half yearly	4	4	4	4	4	4
k)	Participate in the NGO coordinating meetings in HENNET, KENAAM, KCBHFA and PPP Committee	No. of Meetings	Minutes	Half yearly	16	16	16	16	16	16
l)	Provide secretariat support to MOH-FBHS-TWG and participate in its meetings and activities	No. of Meetings	Minutes	Halt yearly	4	4	4	4	4	4
m)	Participate in the SWAps Joint Planning and Review Meetings as provided for in the health sector annual planning cycle	No. of Meetings	Minutes	Annually	2	2	2	2	2	2
n)	Participate in the RH-OBA Advisory Board	No. of Meetings	Minutes	Annually	3	3	3	3	3	3
o)	Advocate for and mobilise MHUs participation in the District Health Stakeholders Forum (DHSF) in all Districts and County level meetings	No. of Meetings	Minutes	Half yearly	X	X	X	X	X	X

p)	Participate in NCK Board, NHIF Board and other relevant policy making bodies	No. of meetings	Minutes	Half yearly	8	8	8	8	8	8
q)	Assist MHUs and church leaders to pursue advocacy at regional level	Advocacy issues addressed	Report	Annually	X	X	X	X	X	X
r)	Hold annual meetings with Church Leaders/CHAK Trustees to review the advocacy agenda and plan for the year ahead	No. of meetings	Report	Annually	1	1	1	1	1	1

5.6: PARTNERSHIP

Objective 5.6.1: To strengthen partnerships for health

Output 5.6.1: CHAK capacity, programmes and visibility enhance through partnerships

No	Activities	Indicators	Data source	Freq. of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Publish and disseminate copies of the MoU between GOK and FBHS on health services	No. of MoU copies published and disseminated	Report	Half yearly	2,000	1,000				
b)	Support meetings of the MOH-FBHS-TWG	No. of meetings	Minutes	Half yearly	4	4	4	4	4	4
c)	Annual implementation Work plan for the MoU developed and used by MOH-FBHS-TWG	Implementation plan	Report	Half yearly	X	X	X	X	X	X
d)	Engage in strategic partnerships with likeminded organizations for technical support, capacity building, resource mobilization and joint project design and implementation	No. of partnerships	Reports	Quarterly	X	X	X	X	X	X
e)	Participate in the Church Health Services Coordinating Committee (CHSCC) meetings monthly	No. of meetings	Report	Quarterly	12	12	12	12	12	12
f)	Host Africa Christian Health Association's Platform (ACHAP) Secretariat and support its activities	Functional ACHAP Secretariat	Report	Annually	X	X	X	X	X	X
g)	Maintain membership in various strategic partnership organizations e.g EPN, CCIH, HENNET, KENAAM, FKE, ACHAP	Up-to-date membership	Membership records	Annually	X	X	X	X	X	X
h)	Support implementation of MoU with University of Nairobi Medical School for technical resource sharing, telemedicine, research, capacity building and joint health projects design and implementation	No. of partnership initiatives	Reports	Annually	X	X	X	X	X	X

6.0: Finance and Administration

6.1: GOVERNANCE AND ACCOUNTABILITY

Output 6.1.1: Functional and accountable governance and management structures

Objective 6.1.1: To facilitate the structured meetings of CHAK

No	Activities	Indicators	Data source	Freq. of reports	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Hold secretariat staff meetings weekly for devotions and communication	No. of staff secretariat meetings held	Attendance list/ Weekly memo	Weekly	50	50	50	50	50	50
b)	Hold technical planning and monitoring meetings quarterly	No. of technical planning meetings held	Reports	Quarterly	4	4	4	4	4	4
c)	Hold Management Team (MT) meetings monthly	No. of management meetings held	Minutes	Monthly	12	12	12	12	12	12
d)	Hold CHAK Tender committee meetings annually	No. of tender committee meetings held	Reports	Annually	1	1	1	1	1	1
e)	Hold CHAK Finance Committee and EXCO meetings quarterly	No. of CHAK Finance and EXCO meetings held	Minutes	Quarterly	4	4	4	4	4	4
f)	Participate in MEDS Board meetings and other meetings quarterly	No. of MEDs board meetings held	Minutes	Quarterly	4	4	4	4	4	4
g)	Hold CHAK Trustees meeting annually	No. of CHAK Trustees meetings held	Minutes	Annually	1	1	1	1	1	1
h)	Participate in MEDS Trustees meetings annually	No. of MEDS trustees meetings held	Minutes	Annually	1	1	1	1	1	1
i)	Hold CHAK Annual General Meeting (AGM) and Annual Health Conference in April each year	No. of AGM/AHC meetings held	Minutes/ Report	Annually	1	1	1	1	1	1
j)	CHAK staff annual planning retreat	No. of meetings held	Report	Annually	1	1	1	1	1	1
k)	CHAK Guest House and Conference management committee meetings quarterly	No. of meetings held	Minutes	Quarterly	4	4	4	4	4	4
l)	Hold CHAK procurement and supplies meeting monthly	No. of procurement and supplies meetings held	Minutes	Monthly	12	12	12	12	12	12

6.1.2: FINANCIAL MANAGEMENT AND REPORTING

Objective 6.1.2: Review and implementation of financial management systems

Output 6.1.2: CHAK equipped with sound financial management systems

No	Activities	Indicators	Data source	Freq. of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Conduct bi-annual briefings to staff on the revised finance and procurement manual	No. of briefing meetings held	Report	Bi-annually	2	2	2	2	2	2

b)	Review the finance and procurement manual and recommend changes to EXCO for adoption		Revised manual	Annually	X	X	X	X	X	X
c)	Support implementation in CHAK and project operations			On-going	X	X	X	X	X	X
d)	Conduct an annual update of payroll and accounting software		Updated software	Annually	X	X	X	X	X	x
e)	Re train on accounting, asset and multi currency software modules	No. of staff trained	Report	Annual	1					

Output 6.1.3: CHAK secretariat operating with efficient financial support services
Objective 6.1.3: To provide timely financial services for the secretariat

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Prepare master budget for the strategic plan 2011-2014		Approved master budget	After 3 years	1			1		
b)	Prepare annual budget based on annual operation plan		Approved annual budget	Annually	1	1	1	1	1	1
c)	Monitor and control the budget on a continuous basis		Performance reports	On-going	X	X	X	X	X	X
d)	Prepare budgets specific to projects as per funding agreements	No. of approved project budgets	Approved project budget	On-going	X	X	X	X	X	X
e)	Prepare quarterly management accounts report and present to MT, Finance Committee and EXCO	Management accounts prepared	Reports	Quarterly	4	4	4	4	4	4
f)	Prepare management accounts specific to projects in accordance to donor requirements	Project accounts prepared	Reports	On-going	X	X	X	X	X	X
g)	Prepare quarterly cash flows forecast for Secretariat and other projects	No. of Cash flow statements	Reports	Quarterly	4	4	4	4	4	4

Objective 6.1.4: To provide routine auditing services to CHAK Secretariat and donors
Output 6.1.4: Timely financial audit reports generated in accordance with the requirements of CHAK and donors

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Prepare annual consolidated accounts for CHAK and its projects	No. of Consolidated statement	Reports	Annually	1	1	1	1	1	1
b)	Coordinate external financial audit for CHAK, Guest House and Projects by end of the accounting period	No. of External Audit Reports	Audit Report	Annually	1	1	1	1	1	1
c)	Contract internal audit services on annual basis	No. of Internal audit reports	Audit Report	Annually	1	1	1	1	1	1
d)	Support internal audit on continuous basis		Audit Report	On-going	X	X	X	X	X	X

e)	Receive recommendations made by external and internal audit and support improvement on weaknesses identified		Audit report	On-going	X	X	X	X	X	X
Objective 6.1.5: To provide administrative and procurement services for the Secretariat **Output 6.1.5:** CHAK secretariat operating with efficient administration, procurement and logistic support										
No	**Activities**	**Indicators**	**Data source**	**Freq. Of reports.**	**Year 2011**	**Year 2012**	**Year 2013**	**Year 2014**	**Year 2015**	**Year 2016**
a)	Update payroll with remuneration changes monthly		Payroll Report	Monthly	x	x	X	X	X	X
b)	Process monthly payrolls and timely submission of statutory deductions		Payroll Report	Monthly	X	X	X	X	X	x
c)	Coordinate employees medical cover and insurance schemes		Medical Policy	Annually	X	X	X	X	X	X
d)	Process gratuity payments at the end of the contract for respective personnel	No. of staff whose contract ended	Gratuity paid to staff	On-going	X	X	X	X	X	X
e)	Coordinate transport arrangements for Secretariat and project needs as per requests	No. of request supported	Requests approved	On-going	X	X	X	X	X	X
f)	Coordinate vehicle maintenance and insurances	No. of vehicles insured	Cover policy	On-going	X	X	X	X	X	X
g)	Support procurement of goods and services as per need	No. of LPOs issued	Requisitio n forms	On-going	X	X	X	X	X	X
h)	Timely processing of payments for bills and supplies to service providers	No. of payments vouchers processed	Approved Payment Vouchers	On-going	X	X	X	X	X	X
Objective 6.1.6: To equip the Secretariat with vehicles, furniture, fittings and office equipment **Output 6.1.6:** A well equipped secretariat										
No	**Activities**	**Indicators**	**Data source**	**Freq. Of reports.**	**Year 2011**	**Year 2012**	**Year 2013**	**Year 2014**	**Year 2015**	**Year 2016**
a)	Review condition of all CHAK assets yearly	Updated Fixed assets register	Report	Annually	1	1	1	1	1	1
b)	List items that require repairs/disposal	No. of assets listed	Report	Annually	X	X	X	X	X	X
c)	Prepare a budget for replacement	Budget prepared	Report	Annually	X	X	X	X	X	X
d)	Procure the approved items for use	No. of new assets bought	Report	On-going	X	X	X	X	X	X
e)	Ensure items are adequately insured and secured	No. of assets insured	Cover policy	On-going	X	X	X	X	X	x
f)	Maintain and update fixed assets register	Updated Fixed assets register	Report	Annually	1	1	1	1	1	1
g)	Update CHAK Core and projects inventory annually	Updated inventory record	Report	Annually	1	1	1	1	1	1
Objective 6.1.7: To support implementation of the generic Financial Management Guidelines in 30 MHUs **Output 6.1.7:** MHUs financial management capacity enhanced for efficiency and accountability										
No	**Activities**	**Indicators**	**Data source**	**Freq. Of reports.**	**Year 2011**	**Year 2012**	**Year 2013**	**Year 2014**	**Year 2015**	**Year 2016**
a)	To conduct a needs assessment in 10 MHUs every year	No. of MHUs' assessed	Report	Annually	10	10	10	10	10	10

b)	To support at least 5 MHUs to implement the generic financial guidelines every year	No of MHUs supported	Report	Annually	5	5	5	5	5	5
c)	To make supervisory visits to 6 MHUs for technical support in the implementation of the Financial Management Manual	No of supervisory visits	Report	Annually	6	6	6	6	6	6
d)	Support the 6 selected MHUs in their preparation of annual budgets, production of management reports and external audit reports annually	No of MHUs supported	Report	Annually	6	6	6	6	6	6
Objective 6.1.8: Facilitate capacity building in financial management **Output 6.1.8:** MHUs operating with efficient financial management systems										
No	**Activities**	**Indicators**	**Data source**	**Freq. Of reports.**	**Year 2011**	**Year 2012**	**Year 2013**	**Year 2014**	**Year 2015**	**Year 2016**
a)	Hold annual workshop targeting 30 MHUs from lower level facilities and train them on financial management (planning, budgeting, internal controls and auditing)	No of staff trained in financial management	Report	Annually	30	30	30	30	30	30
b)	Follow- up visits to provide technical assistance in the implementation of workshop results	No of visits to MHUs	Report	Annually	X	X	X	X	X	X
6.2: HEALTH CARE FINANCING AND SUSTAINABILITY **Objective 6.2.1:** MHUs supported to be able to cost health services **Output 6.2.1:** Strengthen MHUs capacity to carry out costing of health services										
No	**Activities**	**Indicators**	**Data source**	**Freq. Of reports**	**Year 2011**	**Year 2012**	**Year 2013**	**Year 2014**	**Year 2015**	**Year 2016**
a)	Develop tools for collection of data for costing of health services in year 1		Report	Annual	1					
b)	Train 20 MHU staff on collecting data using the study tools developed in year 1	No. of staff trained on data collection	Report	Annual	20					
c)	Facilitate collection of data using the study tools from the selected MHUs		Report	Annual	1					
d)	Compile and disseminate the report to MHUs		Report	Annual	1					
e)	Using the report generated, support MHUs to revise their pricing of services and negotiation of better rebates with NHIF year 2 through 6	%age of MHUs supported and NHIF accredited	Reports/ NHIF accreditation list	On- going	X	X	X	X	X	X
Objective 6.2.2: To facilitate 12 MHUs to implement the hospital management software **Output 6.2.2:** Efficiency in resource management through HMIS software										
No	**Activities**	**Indicators**	**Data source**	**Freq. Of reports.**	**Year 2011**	**Year 2012**	**Year 2013**	**Year 2014**	**Year 2015**	**Year 2016**
a)	Support installation of the software in the 12 selected facilities	No. of MHUs with the software installed	Report	Annual	12					

b)	Train users in 12 selected MHUs	No. of users trained	Report	Annual	X					
c)	Procure required equipment	No. of equipment procured	Asset register	Annual	X					
d)	Support MHUs in report production	No. of MHUs supported	Report	Annual	X	X	X	X	X	X
e)	Continuously maintain the software			On-Going	X	X	X	X	X	X

Objective 6.2. 3: MHUs supported to register with NHIF and enrol community members
Output 6.2.3: NHIF inpatient and outpatient insurance cover

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Disseminate information on NHIF recruitment, accreditation and enrolment	No. of MHUs reached	NHIF list	On-going	X	X	X	X	X	X
b)	Participate in assessment of MHUs for reaccreditation for NHIF inpatient or outpatient cover	No. of MHUs reached	NHIF list	On-going	X	X	X	X	X	X
c)	Hold meetings with NHIF to advocate for improvements of rebates to our MHUs	%age change in rebates	NHIF report	On-going	X	X	X	X	X	X
d)	Participate in NHIF board as per the NHIF Act	No. of NHIF board meetings held	Minutes	Quarterly	4	4	4	4	4	4

Objective 6.2.4: Support CHAK Guesthouse and Conference Centre in developing a business strategy
Output 6.2.4: An excellent centre hosting trainings and meetings

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Develop operational policies and guidelines	No. of policies developed	Policy document	On-going	X	X	X	X	X	X
b)	Support implementation of policies and guidelines		Reports	On-going	X	X	X	X	X	X
c)	Develop a business strategic plan and ensure its implementation		Strategic plan	After 5 years	X				X	
d)	Participate in quarterly management committees meetings to plan and monitor performance	No. of management meetings held	Minutes	Quarterly	4	4	4	4	4	4

6.3: GRANT/PROJECT MANAGEMENT
Objective 6.3.1: Strengthen 450 MHUs' capacity to effectively account for HSSF funds
Output 6.3.1: A structured plan for HSSF fund

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Train and disseminate guidelines for Financial management for HSSF as provided by GOK	No. of staffs from MHUs trained	Report	On-going	X	X	X	X	X	X
b)	Establish a grant management system at CHAK to receive, disburse and account for HSSF fund	No. of MHUs receiving HSSF	Reports	On-going	X	X	X	X	X	X

c)	Support meetings and workshops for HSSF at regional and national level	No. of meetings held	Minutes	On-going	X	X	X	X	X	X

Objective 6.3.2: Strengthen secretariat and MHUs capacity to efficiently use and account for AIDSRelief project funds
Output 6.3.2: AIDSRelief project transition process supported

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Participate in AIDSRelief transition meetings	No. meetings attended	Minutes	On-going	X	X	X	X	X	X
b)	Strengthen grant management system at CHAK to receive, disburse and account for AIDSRelief Funds	No. of MHUs receiving AIDSRelief Funds	Reports	On-going	X	X	X	X	X	X
c)	Participate in project proposal development for AIDSRelief project transition and serve the role of prime	Successful project efficiently managing and reporting performance and funds accountability	Reports	On-going	X	X	X	X	X	

Objective 6.3.3: Strengthen secretariat and MHU's capacity to efficiently account for resources from Global Fund and other project donors
Output 6.3.3: Global Fund sub-recipient role and prime role for other projects

No	Activities	Indicators	Data source	Freq. Of reports.	Year 2011	Year 2012	Year 2013	Year 2014	Year 2015	Year 2016
a)	Participate in all Global Fund meetings including KCM and ICCs	No. of meetings attended	Minutes	On-going	X	X	X	X	X	X
b)	Respond to calls for proposals	No. of proposals funded	Agreement	On-going	X	X	X	X	X	X
c)	Train CHAK staff and MHUs in reporting and compliance	No. of staff trained	Report	On-going	X	X	X	X	X	X
d)	Support internal and external audits for Global Fund	No. of audits	Audit Reports	On-going	X	X	X	X	X	X
e)	Receive, disburse and account for Global Fund monies	No. of MHUs receiving Global Fund monies	Reports	On-going	X	X	X	X	X	X
f)	To prepare project proposals, receive funding, disburse funds and account for funds use and performance results	No. of MHUs receiving and efficiently using donor funds	Financial and programmatic reports	On-going	X	X	X	X	X	X

Strategic Plan 2011 - 2016

P.O Box, 30690, 00100 GPO, Nairobi, Kenya
Tel: (254-20) 4441920, 4445160, 4441845; Fax: (254-20) 4440306; Email: secretariat@chak.or.ke; Website: www.chak.or.ke