Christian Health Association of Kenya

Strategic Plan 2011-2016

Revised in August 2013

Promoting access to quality health care in the devolved health system in Kenya

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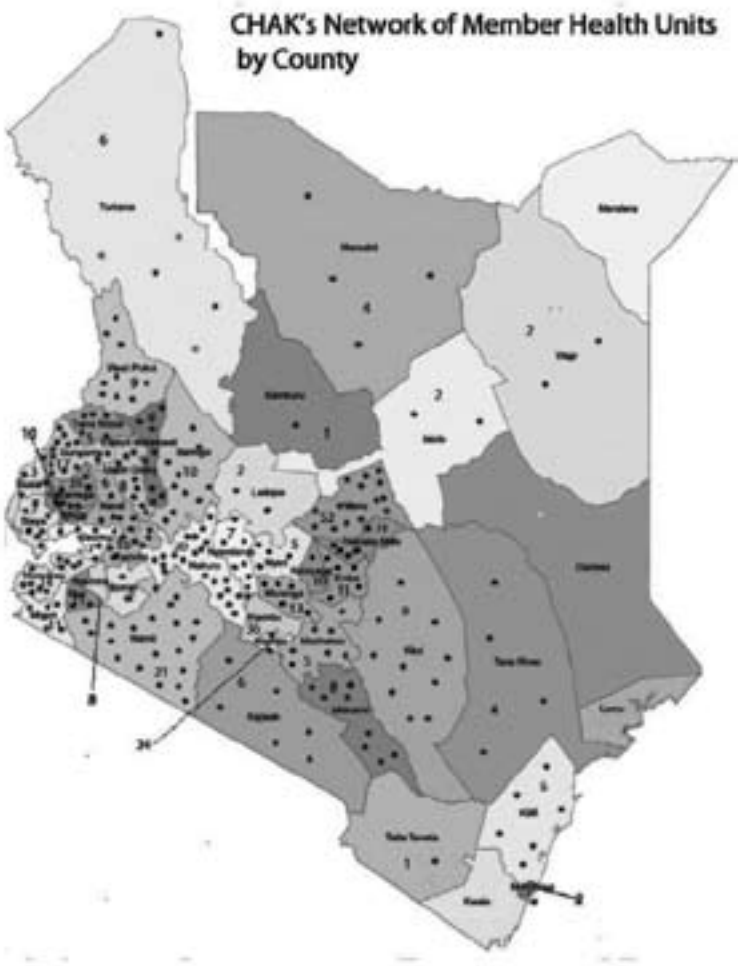
through advocacy, capacity building, health systems strengthening, networking and innovative health programs

Christian Health Association of Kenya
P.O. Box 30690, GPO 00100, Nairobi, Kenya
Editing, design & layout: Anne Mbugua
Printed by

National network of membership

CHAK is a national network of Protestant Churches' health institutions and programmes from all over 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"

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"*

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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 mid-term external evaluation of the Strategic Plan 2011 - 2016 and the development of this Revised Strategic Plan 2011 - 2016.

We thank all CHAK Member Health Units (MHUs) 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 2011 – 2016 MHUs evaluation workshop held in Nairobi in July 2010. Their input has been very valuable in informing the environmental analysis and refocusing the priorities in this revised strategic plan.

CHAK Secretariat staff have worked tirelessly to facilitate the mid-term review of the strategic plan and the development process of this revised strategic plan.

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 revised strategic plan.

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

The ministries responsible for health have steered the health sector through critical reforms since the promulgation of the new Constitution which include definition of devolution in the health sector, development of the Health Sector Policy 2012 – 2030 and development of the Proposed Health Law. Following the General Elections of March 4, 2013 and establishment of the Jubilee Government, the Ministry of Medical Services and the Ministry of Public Health and Sanitation were merged into one Ministry of Health. We thank the Ministry of Health for its leadership of the health sector and for recognition, involvement and support to CHAK in the new policy developments. This has increased our knowledge of the emerging developments in the health sector and created impetus for the development of this revised strategic plan.

We cannot forget to thank our dependable development partner Bread for the World-Protestant Development Service who provided the needed resources for the evaluation process. We thank Bread for the World-Protestant Development Service for its long-term partnership with CHAK which has contributed tremendously to the organization's development and programmes. We also sincerely thank our other partners - Global Fund, CDC, USAID, GIZ, Packard Foundation, OSI Foundation, CRS, Capacity Kenya, DANIDA/Novo Nordisk for supporting the implementation of specific components of the Strategic Plan.

It is our prayer and hope that we shall continue to partner in the implementation of this revised strategic plan over the remaining period 2014 - 2016.

May God bless you all.

Dr Samuel Mwenda
General Secretary

Foreword

Implementation of the CHAK Strategic Plan 2005-2010 came to an end in December 2010. During this plan period, CHAK made major strides in organizational 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 breath 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 for information sharing and peer learning and also provided visibility and opportunities for advocacy in the international arena.

The external evaluation of CHAK Strategic Plan 2005-2010 conducted by CORAT Africa identified organizational strengths and environmental opportunities which we need to build on. It however also pointed out our internal capacity gaps and external threats. Staff motivation and retention and sustainability were identified as the 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 implementation of the new Constitution promulgated on August 27, 2013, and following the first General Elections under the new constitutional dispensation held on March 4, 2013. The country's political structure has been devolved into a national government and 47 county governments. In the health sector, the national government's role has been limited to health policy, regulation, capacity building of the counties and national referral hospitals while the county governments are responsible for primary health care and county referral health services. Counties have also been mandated to do planning, resource mobilization, supervision and coordination of the health sector stakeholders. In this strategic plan, CHAK has introduced a strategic focus area that will deal with our strategy for engagement with the county health system.

CHAK will restructure the Regional Coordinating Committees (RCCs) to create County Engagement Structures (CES) to coordinate members' engagement with the county government health system. We shall build on the existing MoU partnership framework between the Faith Based Health Services and Ministry of Health to establish strong and effective partnerships at county level.

The revised CHAK Strategic Plan 2011–2016 whose theme is ***"Promoting access to quality health care in the devolved county health system in Kenya"*** 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 ***"Efficient and high quality health care that is accessible, equitable, affordable and sustainable to the glory of God".***

The mission statement that guides secretariat programmes towards the realization of this 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 in the utilization of the available scarce resources, CHAK has adopted a strategy of integration. The strategic plan priority areas have been grouped in nine strategic directions namely, health service delivery, health systems strengthening, governance and accountability, partnership, research, advocacy and communication, health care financing and sustainability, Human Resources for Health (HRH), grant management, quality management in health care and engagement in the devolved county health system.

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. A health quality management system has been included to introduce total quality management for continuous service improvement.

During the implementation of this plan, CHAK will scale up use of modern technology to enhance efficiency in the management of MHUs. The integrated CHAK Hospital Management software will be rolled out for installation and use in MHUs to enhance their resource management and report generation to support 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 partners to join hands with us and to support our efforts towards 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 will create major 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 Strategic Plan theme is "promoting access to quality health care in the devolved county health system" and it has the vision which states ""Efficient and high quality health care that is accessible, equitable, affordable and sustainable to the glory of God"

The six year plan has its core activities organized in nine strategic directions as follows:
1. Health service delivery
2. Health systems strengthening
3. Governance and accountability
4. Research, advocacy, partnerships and communication
5. Health care financing and sustainability
6. Human Resources for Health (HRH)
7. Grant management
8. Total quality management and patient safety
9. Engagement with devolved county government health system

Strategic direction 1: Health service delivery
Strategic priorities
1. Health policy
a. Participate in health policy development and facilitate dissemination of policies, protocols and guidelines to member health units.
b. Promote human rights based programs to mainstream gender issues for PLHWAs and people with disabilities in health programs.

2. Primary Health Care
a. Support implementation of community strategy
b. Facilitate capacity building and implementation of robust MNCH & RH Programs.
c. Promote environmental health and sanitation programs.

3. Communicable Diseases
a. HIV&AIDS prevention, treatment, care and support programmes
b. Promote TB and Malaria control and management programs
c. Facilitate disaster preparedness and Emergency Response

4. Non Communicable diseases
a. Promote screening and management of NCDs
b. Facilitate capacity building in eye care, disability and mental health programs

5. Essential drugs and Commodities: To promote access, use and management of essential drugs and commodities.

6. Coordination of capacity building: Internship training for health care workers, training of Family Medicine doctors, training of health workers training and continuous professional development

7. Technical support to MHUs: Ensure adherence to quality assurance guided by Norms and Standards and regulatory guidelines in the health sector

Strategic Direction 2: Health Systems Strengthening
Strategic priorities
1. Enhanced participation of MHUs in health sector joint planning and monitoring (National and County Health Management Team Sector forums)
2. Establishing specifications and functional medical equipment and consumables for the health sector in Kenya through collaboration with KEBS/GOK

3. Mobilization of resources in response to relevant specific areas of felt needs by MHUs
4. Effective response to requests from MHUs for technical support.
5. Health Care Technical Services available and affordable for all church health units and other clients through the Medical Equipment Programme (HCTS)
6. Capacity building on governance and management for MHUs
7. Enhanced support to MHUs by empowered Regional Co-ordinating Committees that are further devolved to county engagement structures in line with the Kenya Constitution
8. To strengthen the role of Regional Co-coordinating Committees to actively participate in County engagement structures
9. Support MHUs to utilize the available modern technology for information sharing
10. Support MHUs to acquire updated Standard Operating Procedures
11. Disseminate governance and management policy and procedures manuals to MHUs for quality assurance and standard improvement

Strategic direction 3: Governance and accountability
Strategic priorities
1. Support to CHAK governance structures (AGM, EXCO, Trustees, RCCs and Management Team)
2. CHAK financial management and reporting
3. CHAK Internal and external audit
4. CHAK Donor compliance and reporting
5. CHAK Legal/statutory compliance
6. Support MHUs in the implementation of financial management policies
7. Secretariat administration, procurement and logistics support
8. CHAK Assets maintenance and management

Strategic Direction 4: Research, Advocacy, Partnerships 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. Publications, documentation and resource centre for information storage and dissemination
4. Strengthen partnership strategies for engagement with various health sector stakeholders
5. Conduct advocacy for articulation of CHAK issues at the national and county levels

Strategic Direction 5: Strengthening Human Resources for Health
Strategic priorities
1. Strengthening the HRH management practices across the network
2. HRM professional capacity building
3. Improving linkages and integration with HRH training institutions for continuous professional development (CPD)
4. Support to CHAK medical training institutions in capacity building and collaboration with various regulatory bodies.
5. Improving HRH motivation and retention
6. Enhancing HRH performance and productivity
7. Addressing human resource information system gaps within the network
8. Coordination of the annual national internship programs in MHUs e.g. doctors' internship

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 equipment and software
3. Support MHUs to mobilize communities for enrolment with NHIF and other insurances
4. Support MHUs to be accredited to NHIF
5. Innovative income generating activities
6. Capacity building in proposal writing for fundraising
7. Support CHAK guest house in the review of business strategy and ensure periodic performance monitoring through the Guest House Management Committee
8. Lobby for share of equipment and secondment of staff as proposed by national government

Strategic direction 7: Grant management
Strategic priorities
1. HSSF fund disbursement to MHUs and reporting/accountability

2. CHAP project implementation and site management
3. CHAK Business Development Unit for fundraising and networking with development partners at national and county level
4. APHIA PLUS Kamili project implementation.
5. Global Fund sub recipient role.
6. Technical assistance/capacity building in financial management for MHUs and CHAK Secretariat

Strategic Direction 8: Total Quality Management and Patient Safe Care
Strategic priorities
1. Develop and implement Total Quality Management systems within CHAK network on the KQMH framework
2. Educate and supervise staff in Total Quality Management systems including Kenya Quality System for Health (KQMH)
3. Institutionalize quality management in health in the network
4. Establish Centers of Excellence in Total Quality Management for Health in the CHAK network
5. Establish a functioning peer learning structure within the network

Strategic direction 9: CHAK engagement in the devolved county health system
1. Development of a framework for partnership and engagement between CHAK, the MHUs and the county health systems
2. Mobilization of resources for effective county partnerships and engagements

Detailed activities and M&E indicators have been presented in a logframe. The implementation management structure has been drawn under four departments and a supportive unit with HR, M&E, ICT and HMIS.

1 Context

New Constitution and political reforms

Kenya has experienced a rebirth following the adoption of a new Constitution which received majority endorsement at a national referendum held on August 4, 2010, and was subsequently promulgated on August 27, 2010. The constitution implementation took full effect following the March 4, 2013, General Election which ushered in a national government and 47 county governments. The new Constitution is expected to create a framework for major political and institutional reforms in Government which should enhance human rights, security, public service and accountability.

One major reform is the creation of county governments under the leadership of elected governors and county assemblies. The county government has the executive headed by the Governor and Deputy Governor, and 10 county executives heading various departments. The county public service board is responsible for the recruitment and management of all county staff including health care workers. The county assembly is responsible for policy development and oversight of the executive. The constitution provides for the devolution of public funding with atleast 15 per cent of the national budget being allocated to the counties and an equalization fund being created for counties that have lagged behind in economic development.

Health has been provided as a right for every Kenyan and no person should be denied emergency medical treatment. The counties are responsible for the provision of primary health care, community health services and county referral health services through various health facilities up to the district level hospitals. The national government has been assigned the responsibilities of health policy, regulation, capacity building of counties and running of the national referral hospitals. It is expected that several laws will be legislated to operationalize this new constitution including legislation related to health.

The County Health Services are headed by the County Health Executive who reports to the County Assembly and is appointed by the Governor. Health technical services are headed by the County Chief Health Officer who is supported by the County Health Management Team with the overall mandate of coordinating all county health services. The county governments have been given the constitutional mandate of health services delivery from community level to county referral services. To create the legal and institutional framework for facilitating discharge of this mandate, the MOH has developed the Health Law which will be enacted once it is passed by Parliament.

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 the new health policy development, particularly in areas touching on the devolved health sector coordination structure, health care financing at the county level, access to HRH and medical commodities support 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 a major impact on the country's economic performance. Following peaceful elections and transition of leadership from retired President Mwai Kibaki to President Uhuru Kenyatta, the country has demonstrated increasing investor activity and the economic growth is expected to be steady. The country however continues to experience high poverty levels with 46 per cent of the population living below one dollar a day (poverty line).

Kenya Vision 20/30

The Government of Kenya has launched Vision 20/30, a long-term economic development plan that aims to achieve 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 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.

Kenya Health Policy 2014 - 2030

Kenya has completed the development of a new Health Policy Framework that will guide the health sector during the period 2014 – 2030. The Kenya Health Policy (KHP) has the goal of 'attaining the highest possible health standards in a manner responsive to the population needs'.

The policy aims to achieve this goal through supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans. It targets to attain a level and distribution of health at a level commensurate with that of a middle income country, through attainment of specific health impact targets. The policy directions in the Kenya Health Policy are structured around six service delivery outcomes, and seven system investment orientations. The Policy shall be achieved through five year strategic plans with the first one covering the period 2014-2018.

This strategic plan provides the health sector medium term focus, objectives and priorities to enable it move towards attainment of the Kenya Health Policy directions. The health sector refers to all the health and related sector actions needed to attain the health goals in Kenya. It is not restricted to the actions of the Health Ministry, but includes all actions in other related sectors that have an impact on health. It will guide both county and national governments on the operational priorities they need to focus on in health.

This strategic plan follows on the 2nd National Health Sector Strategic Plan (NHSSP II), who's overall goal was to reduce inequalities in health care services and reverse the downward trend in health-related outcome indicators. Recommendations from implementation of the five strategic objectives of the NHSSP II have guided prioritization of interventions for implementation during this strategic plan.

The health sector strategic focus in Kenya is guided by the overall Vision 2030 that aims to transform Kenya into a globally competitive and prosperous country with a high quality of life by 2030 through transforming the country from a third world country into an industrialized, middle income country. Its actions are grounded in the principles of the 2010 constitution, specifically aiming to attain the right to health, and to decentralize health services management through a devolved system of governance. This strategic focus has been defined in the Kenya Health Policy, which has elaborated the long term policy directions the country intends to achieve in pursuit of the imperatives of the Vision 2030, and the 2010 Constitution.

Kenya Health Policy directions

The health sector has elaborated its Kenya Health Policy (KHP) to guide attainment of the long term health goals sought by the country, outlined in the Vision 2030 and the 2010 constitution.

The policy framework has, as an overarching goal, 'attaining the highest possible health standards in a manner responsive to the population needs'. The policy will aim to achieve this goal through supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans.

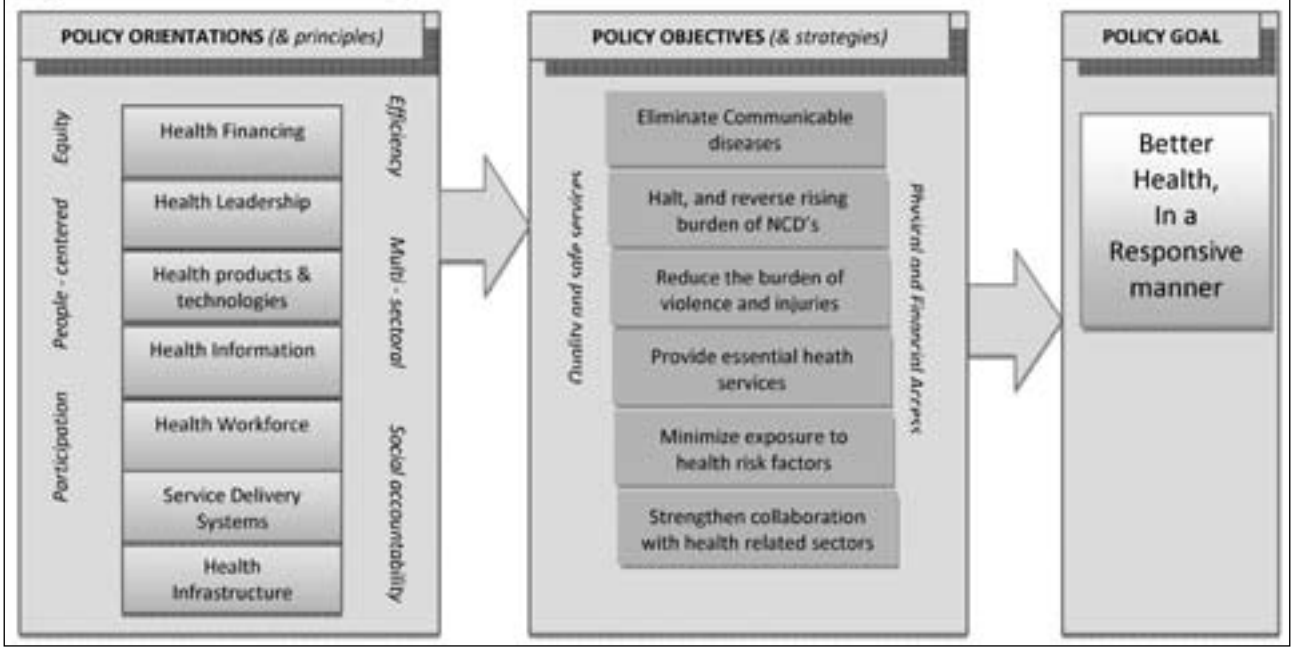
The target of the policy is to attain a level and distribution of health commensurate with that of a middle income country. It focuses on attaining two critical obligations of the health sector - a rights based approach and ensuring health contributes to the country's development.

Six policy objectives, therefore, are defined, which address the current situation, each with specific strategies for focus to enable attainment of the policy objective.

1. Eliminate communicable conditions: This it aims to achieve by forcing down the burden of communicable diseases, till they are not amajor public health concern.
2. Halt, and reverse the rising burden of non communicable conditions: This it aims to achieve by ensuring clear strategies for implementation to address all the identified non communicable conditions in the country.
3. Reduce the burden of violence and injuries: This it aims to achieve by directly putting in place strategies that address each of the causes of injuries and violence at the time.
4. Provide essential health care: These shall be medical services that are affordable, equitable, accessible and responsive to client needs.
5. Minimize exposure to health risk factors: This it aims to achieve by strengthening health promoting interventions, which address risk factors to health, plus facilitating use of products and services that lead to healthy behavior in the population.
6. Strengthen collaboration with health related sectors: This it aims to achieve by adopting a 'Health in all Policies' approach, which ensures the Health Sector interacts with and influences design implementation and monitoring processes in all health related sector actions.

Policy Directions to guide the attainment of this policy intent are defined in terms of six policy objectives (relating to health and related services), and seven policy orientations (relating to investments needed). These are interlinked as shown in the figure below.

Figure 1: Framework for Policy directions



The policy framework outlines the need for medium-term (five-year) strategic plans that will elaborate, in a comprehensive manner, the medium term strategic and investment focus the sector will apply every five years, as it moves towards attaining the overall policy directions. The five-year plans are aligned to the Government Medium Term Plan to ensure they are well integrated into the overall Government agenda (Kenya Vision 2030).

The Kenya Health Policy key targets include the following:

Target	Baseline status (2010)	Policy target (2030)	% change
Life expectancy at birth (years)	60	72	16% improvement
Annual deaths (per 1,000 persons)	10.6	5.4	50% reduction
Years lived with disability	12	8	25% improvement

The Kenya Health Policy is guided by both the Constitution, and the Country's Vision 2030 by focusing on implementing a human rights based approach and maximizing health contribution to overall country development.

Kenya Health Sector Strategic Plan (KHSSP) 2014-2018 - Strategic direction

Kenya has articulated a strategic plan to guide the first five years of the health policy implementation. This strategic plan has, as its vision, having a globally competitive, healthy and productive nation.

The plan has, as its goal, 'accelerating attainment of health impact goals' as defined in the Health Policy. The mission of this strategic plan is "To deliberately build progressive, responsive and sustainable technologically-driven, evidence-based and client-centred health system for accelerated attainment of highest standard of health to all Kenyans". This the sector aims to attain through focusing on implementation of a broad base of health and related services that will impact on health of persons in Kenya. It places main emphasis on implementing interventions, and prioritizing investments relating to maternal and newborn health, as it is the major impact area for which progress was not attained in the previous strategic plan. It is designed to provide information on:

a) The scope of health and related services the sector intends to focus on ensuring are provided for persons in Kenya – outlined in the Kenya Essential Package for Health, KEPH
b) The investments required to provide the above-mentioned services – outlined across the seven investment areas

for health
c) How the sector will monitor and guide attainment of the above

Kenya Essential Package for Health (KEPH)

The Kenya Essential Package for Health in this strategic plan, therefore, defines health services and interventions to be provided for each policy objective, by level of care and cohort (where applicable).

The tiers in the KEPH are the levels of care as defined in the Kenya Health Policy.

1. Community level: The foundation of the service delivery system, with both demand creation (health promotion services), and specified supply services that are most effectively delivered at the community. In the essential package, not only the interventions provided through the Community Health Strategy as defined in NHSSP II but all non facility based health and related services are classified as community services.
2. Primary care level: The first physical level of the health system, comprising all dispensaries, health centres, maternity/nursing homes in the country. This is the first care level, where most clients' health needs should be addressed
3. County level: The first level hospitals, whose services complement the primary care level to allow for a more comprehensive package close to clients
4. National level: The tertiary level hospitals, whose services are highly specialized and complete the set of care available to persons in Kenya.

The KEPH interventions by cohorts are defined only for those specific to a given cohort, not for all KEPH interventions. The cross cutting interventions are not aligned to any cohort. Specific KEPH cohorts are:

1. Pregnancy and the newborn (up to 28 days): The health services specific to this age-cohort across all the policy objectives
2. Childhood (29 days – 59 months): The health services specific to the early childhood period
3. Children and Youth (5 – 19 years): The time of life between childhood and maturity
4. Adulthood (20 – 59 years): The economically productive period of life
5. Elderly (60 years and above): The post–economically productive period of life

Health care financing

The Government of Kenya has adopted Sessional Paper No.7 on Universal Health Coverage which seeks to introduce national social health insurance coverage by transforming NHIF. The NHIF has started out-patient medical cover for all public servants and uniformed forces. A similar scheme is expected for teachers and these present opportunities to obtain health care financing by MHUs. 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. The NHIF has introduced new premiums to ensure adequate coverage of both in-patients and out-patients. This development creates an opportunity for CHAK member health facilities to get accredited as service providers.

Health care financing 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.

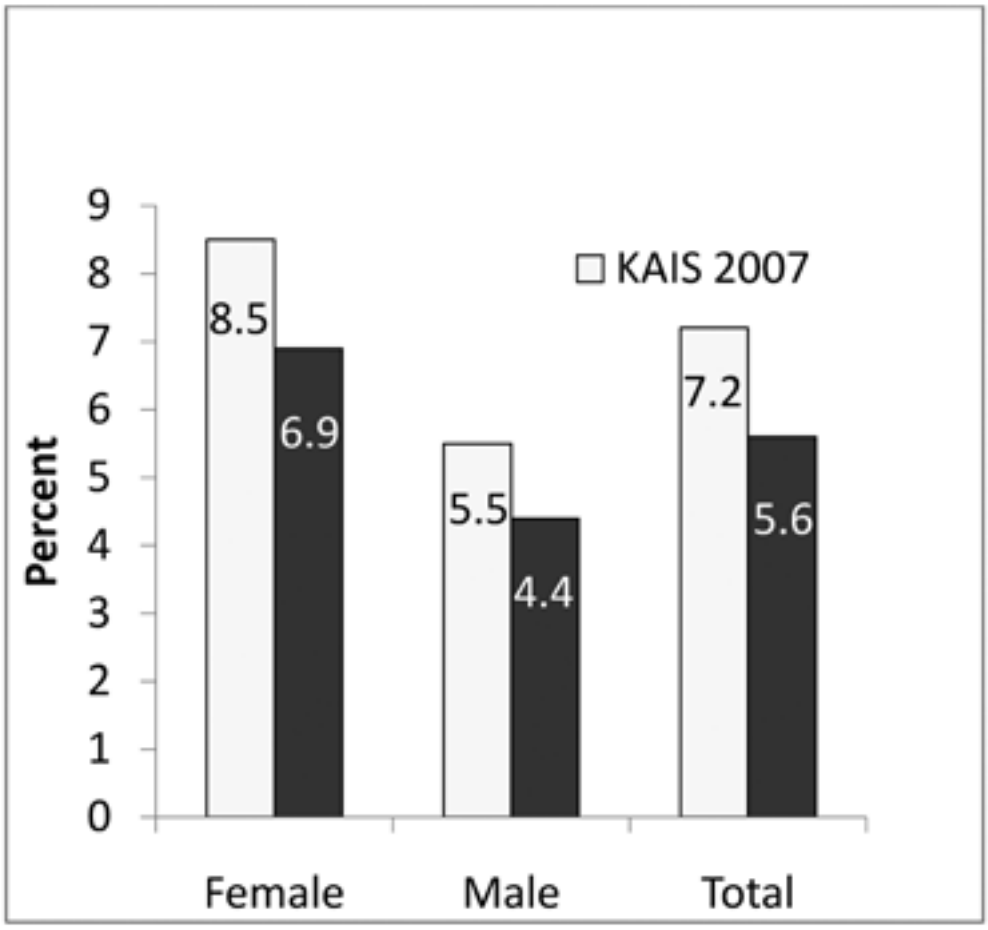
HIV&AIDS impact

The HIV epidemic in Kenya peaked in the late 1990s with an overall prevalence of 14 per cent in adults. This declined over the next decade, with the national HIV prevalence reaching 7.2 per cent in 2008 and further declined to 5.6 per cent in 2012 per cent in the age group 15-64.

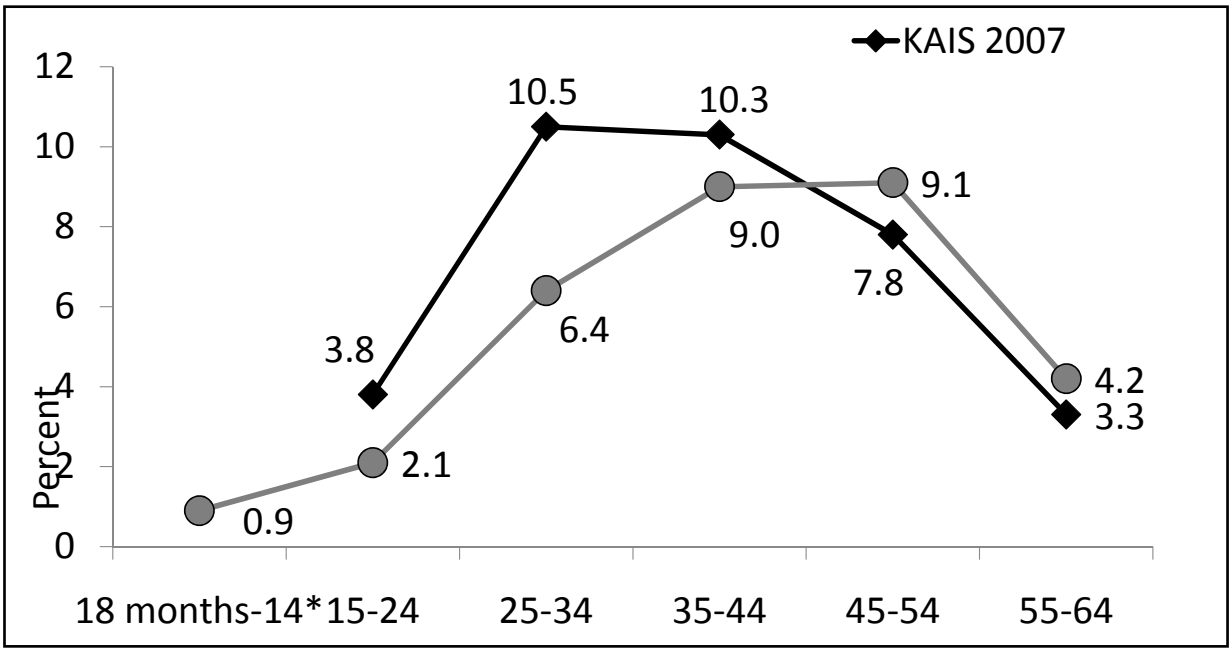
KAIS results on HIV status

The 2012 KAIS indicates that HIV prevalence has declined from 7.2 in 2007 to 5.6 in the 2012 for Kenyans aged 15-64. More women are infected with HIV (6.6 per cent) compared to men (4.4 per cent). Prevalence among children age 18 months to 14 years was 0.9 per cent. HIV. HIV prevalence among adult varied by region with the highest prevalence in Nyanza and lowest in North Eastern region. Most other regions showed a decrease in prevalence with the highest decline in Coast, Nairobi and Rift Valley regions. Out of the women who delivered between 2007 – 2012 and attended antenatal clinics, 92 per cent received HIV testing and of those positive, 90 per cent received ART .

HIV prevalence by sex



HIV prevalence by age



Source: KAIS Preliminary Report 2012, NASCOP

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 MOH's National AIDS and STI Control Program (NASCOP) provides technical leadership in producing technical guidelines in prevention, care and treatment which include CT, PITC, eMTCT, ART (adult and paediatric), Voluntary Male Medical Circumcision (VMMC) and Home Based Care (HBC).

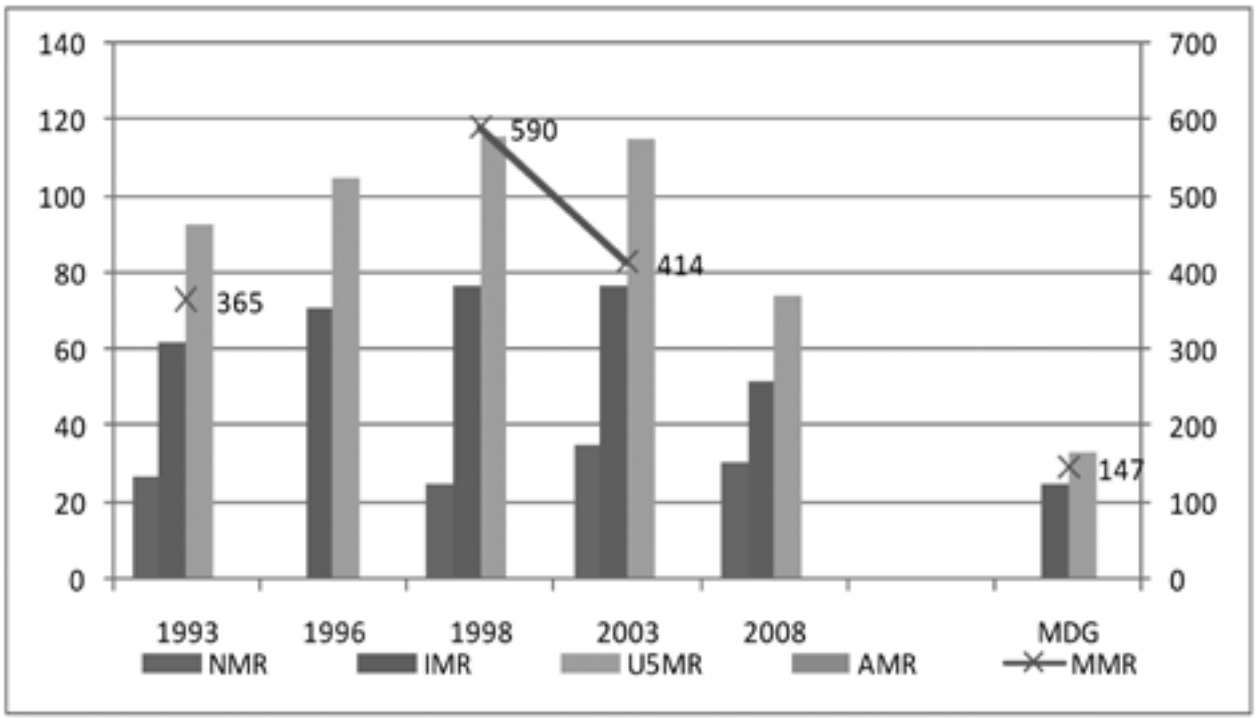
A national framework known as the Kenya National AIDS Strategic Plan III (KNASP) is developed through partner engagement to guide the national response. In addition, a Monitoring and Evaluation (M&E) framework is developed to define national targets in the response and guide performance monitoring. These strategy documents follow the UNAIDS recommended "Three ones" – one National Strategy, one Coordinating Agency and one M&E Framework.

Health situation analysis

The health sector recently undertook several detailed studies that aimed (i) to provide evidence on what had been done and with what result over the period of the previous Kenya Health Policy 1994-2010 and (ii) to identify the direction and priorities for the next health policy, the Kenya Health Sector Strategic and Investment Plan (KHSSP, July 2013 - June 2017). In addition, an end term review of the NHSSP II 2005 – 2012 provided valuable inputs to the process.

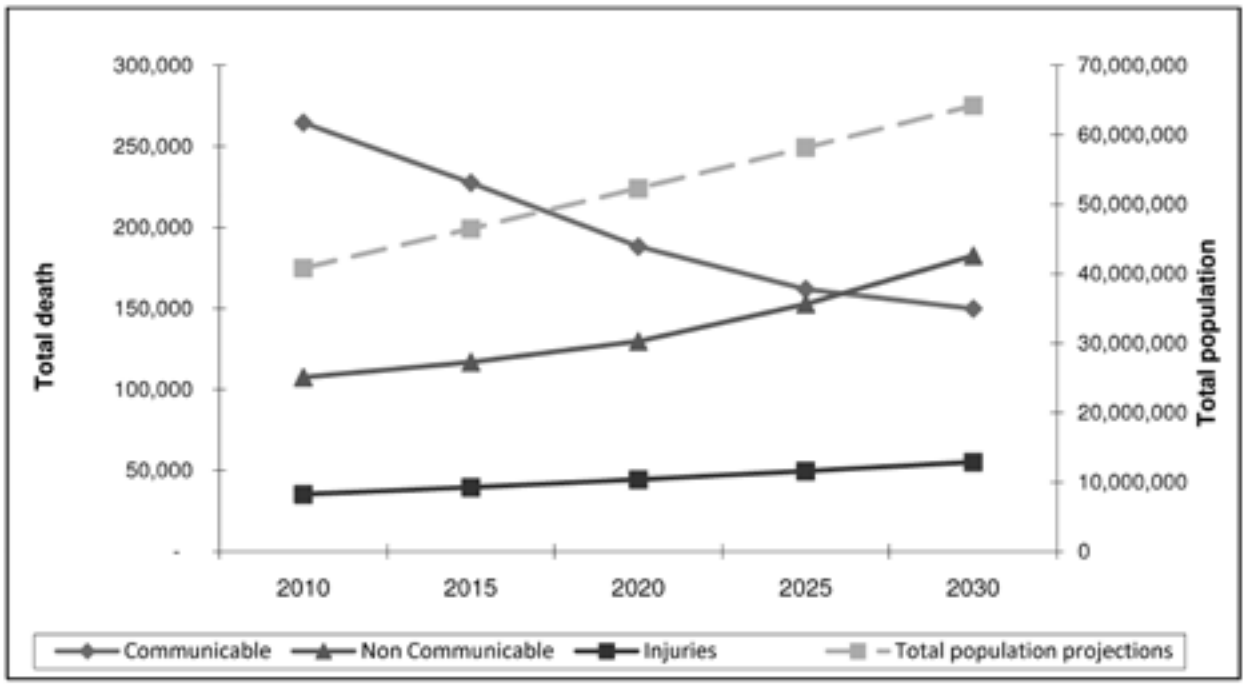
By the end of the NHSSP II, the sector was beginning to see improvements in some health impact targets, in particular adult mortality, Infant mortality and child mortality (see below). Evidence of improvements in neonatal and maternal mortality was not yet seen. Geographical and gender differences in age specific cohorts persists all through the policy period.

Trends in health impact indicators during the period of the policy review



All three disease domains (communicable diseases, non communicable conditions, and violence/injuries) contribute to the high disease burden in the country. Current trends suggest non communicable conditions will continue to increase over time, if not checked at present.

Projections of disease burden 2011 - 2030



In the coming years, it is estimated that HIV&AIDS will still be the leading cause of death accounting for about 30 per cent of all deaths. Infectious diseases including HIV&AIDS, lower respiratory tract infections, TB, diarrhoeal diseases and malaria account for over 50 per cent of all deaths in Kenya. HIV&AIDS together with other infectious diseases such as malaria, lower respiratory infections and TB also account for almost half of all DALYs in Kenya.

Overall, malaria has accounted for the highest proportion of mortality, consistently over 12 per cent throughout this period. Lower respiratory tract infections and HIV/AIDS are the next two leading causes of in-patient mortality and this trend has remained largely unchanged during the reporting period.

Looking at specific outcomes, there appears to be stagnation of maternal and neonatal health impact. At the output level, such as ante natal coverage (down from 95 per cent to 92 per cent) and skilled birth attendance (down from 45 per cent to 42 per cent) show a similar pattern. Child health on the other hand shows improvement, though ill-health among children remains high (e.g. children reporting diarrhea are still around 49 per cent, up from 41 per cent in 1993).

The malaria burden remained high, but there are indications that effective interventions such as ITN, IPT and IRS have shown improvements in the targeted areas. The malaria epidemiological map in the country has significantly improved.

Non Communicable Diseases (NCDs) represent a significant (and increasing) burden of ill health and death in the country, the most important being cardiovascular disease, cancers, respiratory and digestive diseases, diabetes and psychiatric conditions. Together they represent 50-70 per cent of all hospital admissions during the policy period and up to half of all inpatient mortality. There is no evidence of reductions in these trends.

Injuries and violence also feature among the top 10 causes of morbidity and mortality in the country, increasing incrementally over the years (especially in young and unemployed people).

Changes in donor environment

The traditional ecumenical development partners from Europe who have been long-term partners of CHAK have been restructuring their operations. Stringent requirements with emphasis on impact, accountability and mutual partnership are emphasised.

Global financing initiatives present major 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 Paris Declaration on AID Effectiveness have

provided guidance on donor harmonization that should support country developed strategic plans and assist to strength country systems. The Sector Wide Approach Strategy (SWAPs) has created a policy framework for improving coordination and collaboration in planning, implementation, financing and monitoring.

During NHSSP II, a Code of Conduct (CoC) for SWAps was 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. It is expected that following the development of a new health policy and national health sector strategic plan, a new SWAps partnership framework will be negotiated to guide the new partnership arrangements.

Accessing donor funding opportunities has become very competitive among local and international civil society organizations. It also calls for strict accountability on programmatic results and funds utilization. In order to attain all the competencies for an effective bid, organizations tend to get into consortia or partnerships. CHAK has embraced partnerships in proposal development and projects implementation with positive results.

Technological advancement

Kenya is experiencing rapid developments in information technology. The arrival of fibre-optic cable and expanded coverage to the various counties and expansion of mobile technology including money transfer services has opened up great opportunities in telecommunication.

Mobile phones 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 high speed Internet access through fibre, VSAT or wimax which has greatly enhanced communication. CHAK Secretariat has installed fibre-optic internet connectivity which has higher speeds at lower costs. Telemedicine will become more accessible following these developments.

CHAK has developed a Hospital Management Software (CHMS Software) built on an open source system (CARE2X). The CHMS software will be installed in MHUs to enhance efficiency in resource management and generate timely reports to support decision making.

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

A Memorandum of Understating (MoU) was signed between Government and Faith Based Health Service providers in Kenya to provide a structured framework for enhancing partnership and collaboration. The MoU was signed by the Ministry of Medical Services (MoMS) and Ministry of Public Health & 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 service providers. 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 the Government and Development Partners. The support would 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.

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 FBO Secretariats. Human resource support through secondment of health workers from Government would be better structured, coordinated and managed. The MOH-FBOs-TWG would coordinate and provide oversight to the implementation of the MoU.

2 Background information and overview

Organizational 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. CHAK has thus transformed its mandate to a technical support organization for member Church health facilities with core mandate in advocacy, lobbying, representation, health systems strengthening, programmes development, resource mobilization and capacity building.

CHAK organizational development and programmes are guided by six-year strategic plans. The MHUs, EXCO and Secretariat staff participate in the 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. The MHUs' core function remains health service delivery.

CHAK has attained steady organizational development by embracing a culture of continuous learning and partnerships. CHAK utilizes lessons pointed out by evaluation reports to strengthen its systems. Each strategic plan undergoes a mid-term external review and an end term external 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 organizational 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 in Kenya which picked important lessons on public-private partnership. These were utilized in the development of an MoU between the Government and faith based health services providers which was approved in 2009. In 2007, CHAK was mandated to establish the Secretariat for the Africa Christian Health Associations Platform (ACHAP), which was eventually legally registered in Kenya in May 2012. 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 secretariat and has evolved to become a leader among Africa Christian Health Associations, a role which has opened up key 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. In addition, CHAK has attained good capacity in project proposal development and grants management. During the first phase of the current strategic plan, CHAK received project funds from CDC, Bread for the World/EED, GDC, Global Fund, USAID and Packard Foundation among other donors. CHAK Secretariat is housed at the new office block located on Musa Gitua Road, off Waiyaki Way, in Nairobi. The premises also include the CHAK Guest House & Conference Centre (www.chakguesthouse.org). These provide infrastructure for the Secretariat, conference facilities for meetings and income generation opportunities.

CHAK membership

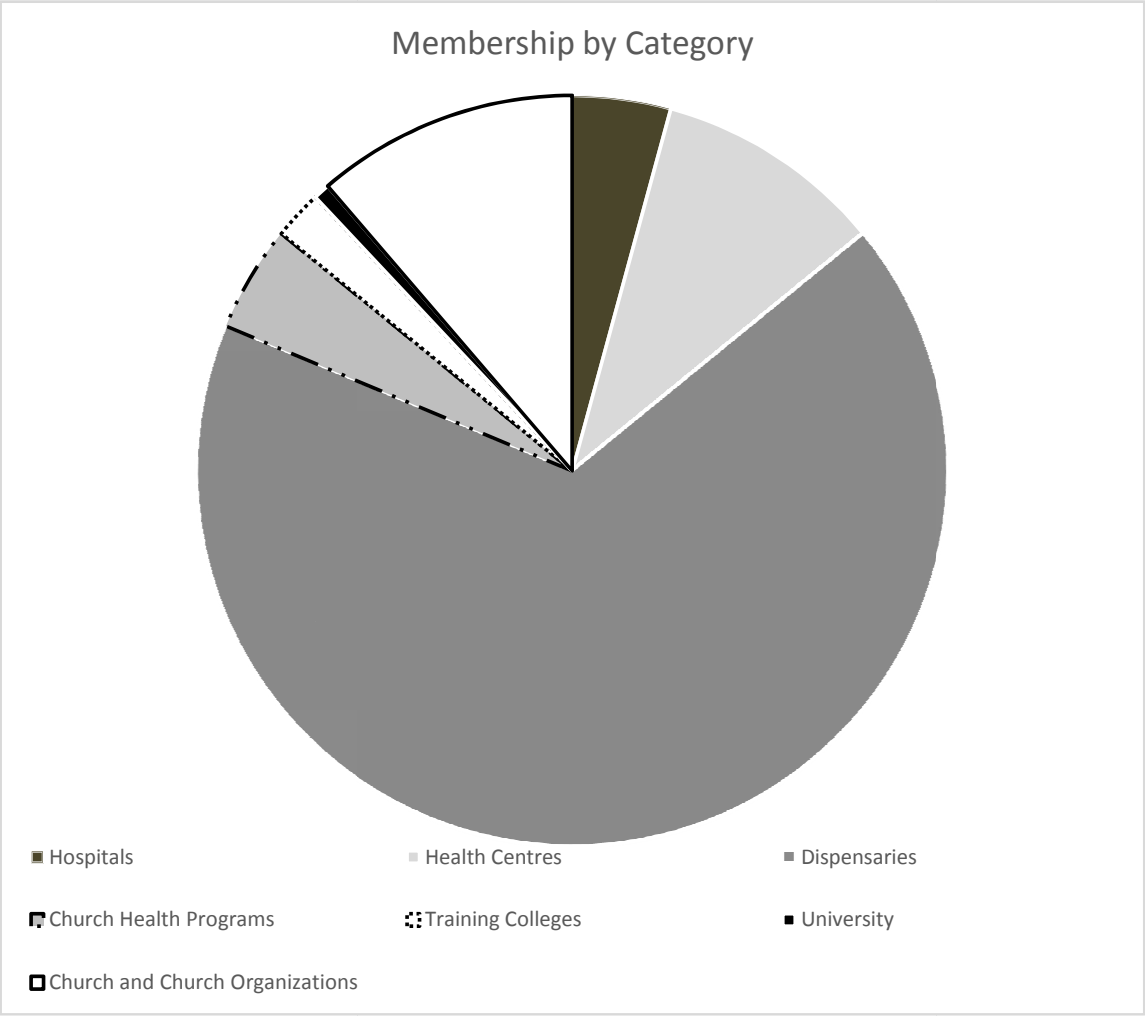
CHAK has a large membership that is growing steadily. The CHAK Constitution provides that "Any Christian church or church sponsored or related non-profit making organisation or community group with the objective of promoting health and health service within the Republic of Kenya shall be eligible for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

The total membership as at December 31, 2012, was 563, comprising 23 hospitals, 53 health centres, 381 dispensaries, 63 churches/church organizations, 26 community-based health care programs and 12 Medical Training

The CHAK membership is grouped into four regions covering the whole country. Each region has several counties. These regions are:

- Eastern/North Eastern region
- Nairobi/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.



CHAK membership by category

Category	Number
Hospitals	24
Health Centres	56
Dispensaries	381
Church Health Programmes	26
Training Colleges	12
Universities	4
Churches and Church Organizations	64
Total	**567**
Church affiliations	50

3 Mission, vision, values and purpose

Identity
CHAK is a national network of Protestant churches' health institutions and programmes from all over Kenya.

Vision
Efficient and high quality health care that is accessible, equitable, affordable and sustainable to the glory of God

Mission
To facilitate member health units in their provision of quality healthcare services through advocacy, health systems 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 promote access to quality health care by facilitating member health institutions to deliver accessible, comprehensive, quality health services to Kenyans in accordance with Christian values, professional ethics and national health sector policies. CHAK also engages communities to empower them to seek and access quality health care.

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 review workshops attended by members and other key stakeholders. The Secretariat technical staff and EXCO also gave their input in the environmental analysis using both the SWOT and PESTEL tools.

Functional area: Health service delivery

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• National network coordinating health services delivery with regional representation in 87 per cent of the counties • Major stakeholder in heath sector delivery contributing above 20 per cent of health services in the country • Specialized and quality health services e.g. eye care, heart surgery, rehabilitative • Holistic approach to health care meeting also emotional and spiritual needs • Capacity for emergency response to outbreak of diseases/national disasters foundation exists • Availability of HRH • Broad range of services in communicable and non-communicable diseases • Existing outreach services and CBHC programmes with strong linkages • Availability of IEC materials and guidelines from MOH • Trained volunteer CHWs/religious leaders • Selected commodities provided by the government (nets, vaccines, anti–TB drugs and anti -malaria drugs, IEC materials) • Available funding for health programs • MEDS	• In adequate skilled staff • Inadequate medical supplies and equipment • Poor documentation of service delivery statistics • Poor staff retention at MHUs • Weak leadership and governance systems at MHUs • Poor/weak fund raising /resource mobilization strategy • Weak strategies for sustainability and efficiency • Weak communication strategy	• Opportunities for secondment of specialized/skilled personnel from the Government • Networking with national referral centres and higher institutions of learning • Emergency Response to outbreak of diseases/national disasters potential exists • Devolution opens opportunity for advocacy at county level • Opportunities to expand range of services in non-communicable diseases, RH, FP and mental health • Restructuring of KEMSA leading to efficiency in drugs' distribution • Restructuring of the supply systems of commodities - Roll out of the pull system • Health days – World AIDS Day, Malaria day and TB day • Capacity to develop proposals addressing health promotion, prevention and management at secretariat • Availability of KEMSA supplies and drugs in FBO facilities	• Recruitment of health workers from CHAK facilities to other health facilities • High costs of services delivery • High poverty levels in most counties • Shortage of specialized personnel in the job market • Poor infrastructure e.g. roads, electricity, ICT • Competition from public and private health services • Experienced, skilled expatriates and volunteer professionals • Competition for limited donor funding by many players • Diminishing role of national level advocacy • Emerging epidemics and natural disasters • Competition for limited donor and Government resources

Functional area: Health systems

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• Existing heath systems structures • HMIS reporting tools • Functional equipment and infrastructure • Existing financial systems in place • Operating within the national/county health sector plans • Representation in government policy agencies-NHIF Board, CCM, NCK, ICCs, KEBS, RPB • MHUs accredited to NHIF • Availability of highly specialized services in our facilities • Some of our facilities are national referral hospitals • Medical training institutions/universities • Internship programs • Family medicine (IFAMED) • Existing medical maintenance equipment unit at the Secretariat	• Inadequate information sharing with stakeholders • Inadequate health systems structures at the lower level facilities • Inadequate participation in health sector planning in some regions • Insufficient documentation and reporting on service delivery for advocacy • Inadequate sharing of best practices • Slow acceptance of best practice medical equipment maintenance practices • Inadequate resources to deliver medical equipment services effectively • Lack of budget to support clearance and distribution of new donated equipment	• Roll out of NHIF outpatient cover • Sector Wide Approach (SWAP) • Specific donor interest in HSS funding. • Roll out of HSS Fund • Devolved health care system • Use of existing MoU at county level • Expression of interest to support new medical equipment to CHAK MHUs (DAK Rotary International, Brother and Brothers for Africa)	• Inadequate funding especially to small health facilities • Competition for space and representation by CSO networks • Free government health services especially maternity and OPD services • Devolved system of government

Functional area: Governance and accountability

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• Clear Governance structures in place • Clearly stated mission and vision • Governance guidelines and capacity building for MHU boards. • Independent internal and external auditors transparently appointed • Procurement and finance policy in place • Strategic plan developed • Audited finance report shared with members during the AGM	• Weak governance structures in some MHUS • Low coverage in some areas • Slow flow of information on devolved government system • Inadequate governance policies	• RCCs which reach out to all facilities in their regions • Strong MHUs that can mentor small MHUs	• Increased donor reporting demands and regulations • Improved Government structures and employment terms.

Functional area: Human Resources for Health

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• Member training institutions for HRH (16 schools of nursing and five universities are CHAK members). • Access for CPD through seminars and other short term CMEs • Internship training for Doctors • Skilled and committed workforce in the secretariat and the members facilities • HR policy framework in the secretariat and in the member facilities in place • HRM in the secretariat is institutionalized and a continuous supportive supervision mechanism for the member facilities in place • Christian values and spiritual support • Peer learning cycle in place for sharing best practices in HR management within the network	• Non-competitive terms and conditions of service • Perceived job insecurity compared to the public sector • Limited avenues for career progression • Minimal capacity of training institutions in terms of numbers, diversity in training courses. • Slow adoption of HR policies and intervention • Staff Shortages • Lack of adequate workforce data • Staff turnover due to lack of retention policies	• Secondment of staff by GoK • MOU for advocacy to access more HR support from GoK • Training opportunities by other players • Potential regional and local HR technical assistance and financial support • Support from committed partners' to fill in existing HR gaps • Newly enacted HRM act in Kenya (2012)	• Competitive HR packages by other players- CDF, GoK & other players • Migration of health workers • Uncertain secondment of staff by the county government • County priorities may affect budget allocation for health workers • Industrial labour unrest

Functional area: Health care financing and sustainability

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• MHUs registered with NHIF • CHAK representation in NHIF Board • CHAK is a member of other health financing institutions e.g. Afya Yetu initiative, KCBHCFA	• Some members not accredited to NHIF • Over reliance on user fees • High debt burden	• Existing relationship with KEMSA on supply of free medical kits • Good relationship with MoH on secondment of staff	• Set standards for accreditation • Low per capita income

Functional area: ICT/Technology

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• Development and on-going implementation of CHAK hospital management software at MHUs and secretariat level • ICT infrastructure in place in some MHUs • ICT technical capacity at secretariat level for oversight exists • Improvement of service delivery at MHUs level due to good ICT infrastructure • Existing capacity on M&E • Improved fibre optic cable connectivity in all counties • High Mobile phone network penetration countrywide • Increased use of smart phones	• Insufficient funds to support ICT development and maintenance in MHUs • Insufficient ICT infrastructure and skills at MHUs • Resistance to technological change • Limited HR personnel to support huge network at Secretariat	• Expansion of fibre optic cable network • Improved/increased diagnostic equipment • Changes in technology • Existence of OMRS • Telemedicine for efficiency and sharing of resources	• Increase in counterfeit equipment in the market • Limitation in resources to keep up with changes in technology • Fibre optic vandalism • Removal of VAT Exemption on medical equipment and zero rating of tax on computers

Functional area: Community strategy and linkages

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• 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 • Well established church groups and organizations through which we can drive health program • Ownership of community programs started by the church • Church leaders are the opinion leaders in the community • Church has the capacity to mobilize funds from the community to support community health programs.	• Reliance on volunteers to serve as CHWs • Insufficient feedback mechanisms between MHUs and the community • Inadequate mechanisms for motivation and involvement of CHWs • Inappropriate management of clients by CHWs • High moral standards and values demand by the church on the communities	• Existence of a national community health strategy • The community offers an entry and justification for programs.	• Provision of non- uniform incentives to CHWs by private practitioners and NGOs, • Influence of alternative medicine • Competition for organized community Organizations from different agencies (NGOs) • Competition from county governments for community program donor funding. • Higher attrition rate of CHWs

Functional area: Institutional development and management

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• Accountable and functional governance structures • Sound governance and management policies and guidelines in place • Nationwide spread of membership • Skilled/qualified human resource • 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 pieces of land • Church Health Services Coordinating Committee commissioned by Bishops for advocacy purposes • CHAK is represented in the NHIF Board • CHAK is represented in various TWGs • Proactive and responsive to developments in the health sector. • CHAK has the capacity and spirit to organize forums • WHO prequalification of MEDS quality control laboratory	• Inadequate capacity in implementing governance, finance and management policies and guidelines • Insufficient staffing numbers at all levels • Sustainability challenges • High staff turnover • Inadequate accountable and functional governance structures • Weak MHU management committees. • Criteria used to compose facility management committees are faulty. • Facility management committees do not embrace best practices • Absence of effective supervisory support at various levels. • Management practice exercised by the MHUs does not embrace best practice standards.	• 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 • Potential programs have a leadership and management capacity building component. • Potential funding through HSSF. • County government offers an opportunity for strengthening institutional systems of MHUs. • Big number of MHUs spread across the counties	• CDF health facilities • Improved terms and conditions of service in the Government. • Shifting focus by donors • Free health care services from the Government facilities • County government introduces competition through putting up model facilities next to existing FBO health facilities

Functional area: Church support and relations

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• Goodwill from both local and international Churches • Support from key church leaders in advocacy • Holistic nature of our services	• Weak church support in the management of the MHUs	• Expansion of networks with other church networks • Church involvement in county activities	• Competition for resources from international church networks

Functional area: Devolution of services to the county

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• Existing MHUs in 44 counties • Existing rapport & relationships with the county health leadership and the technocrats • CHAK MHUs are part of devolved county health systems • Specialised capacity within some MHUs • Significant contribution to total health care delivery in some counties. • Running community programs that we can leverage on. We still do have established county government - CHAK relationships to support program activities in counties, • Existing CHAK regional structure	• Inability to retain staff • Low management capacity in some MHUs	• Support from the county government to the MHUs • County and problem specific community programs are feasible.	• Lack of certainty on secondment of staff • Failure by the county leadership to recognise MHUs • Hostility by county government to the church • Political attitude of creating own facilities for selfish ends. • Differing strategies and approaches to community programs amongst counties.

Functional area: Advocacy

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• Existing communication and advocacy strategies • Existing referral and specialized facilities in some counties • Access to information on devolution • Successful past experience in advocacy • Joint advocacy structures with other FBOs(CHSCC, FBHSCC) • Senior church leaders to support advocacy	• Lean structures at Secretariat to meet county advocacy demands • Lack of communication and advocacy strategies specific to the counties • Inadequate resources for county level advocacy • Low mainstream media engagement	• Church institutions working with county officials in their management boards and functions • Some of our people have been elected in the county government system, we can use them as linkages and entry points for engagements in the devolved government structures • New methodologies for advocacy strategies i.e. social media	• Competing interests among the FBOs • Uncertain operating environment and policies in some counties • Competing political interests

Functional area: Partnership, networking and coordination

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• Existing partnership and networking with the following bodies: national Government (MOH), International NGOs, bilateral partners such as USAID, CDC, multilateral partners such as UNFPA and UNICEF, communities, MEDS, ACHAP, churches and church institutions • MoU with National Government • 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(CHSCC) • Membership to HENNET and KENAAM • Regional Coordinating Committees (RCCs)/County Coordinating Committees that aid networking and coordination within the CHAK network • Strategic position and recognition as a secretariat for Protestant Church health facilities in Kenya • Guest House services	• Uncoordinated communication of activities to MHUs • Gaps in management and governance in MHUs • Inadequacy of funds leads to MHUs being unable to meet their part of partnership bargains • Networking among the MHUs is not as much as expected • Lack of a defined basic package for MHUs • Lack of CHAK offices at county level	• MOU with National and County Governments to provide a forum for advocacy and collaboration • National and county/sub county Health Stakeholders Forums to provide platforms for advocacy partnership and networking • The EAC common market is an opportunity for expansion of networks and information sharing • Trust capital/goodwill with donors • Sector Wide Approach (SWAPs) • Devolved system that is closer to and recognises the MHUs	• Uncertainty with the new political and policy players • Uncertainty of impact of new constitution on health service delivery • Loss of identity of MHUs by county governments due to continual institutional support • Emergence of other Health Care Networks and NGOs claiming FBO space • Donor dependency

Functional area: Total quality management and patient safe care

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• KQMH as a national quality framework is in place • The members recognize quality services as a standard (becomes a priority) • Adherence to national service standards • KENEF as a national accreditation board	• So far no specialised staff in quality management in the facilities • No national training curriculum in quality management in health (only training curriculum for KQMH) • Lack of a long term transition plan • Weak management and leadership structure in member facilities	• Commitment of the donor to support expertise • Constitution has quality as a standard • Building a peer learning structure in quality management for the MHU's • National health policy and quality indicators in place • Quality demands from the regulatory authority • Demand from the professional boards to get certified • NHIF uses KQHH to accredit facilities for refunding	• Sustainability of CHAK support • Declining health out comes • Clients are more and better informed/have access to health information (media/internet) • More and more competition among health facilities

Functional area: Grant management

Existing Strengths	Existing Weaknesses	Opportunities	Threats
• Strong governance and leadership in place • Strong grant management systems, policies and practice. • Experienced, skilled and professional staff • Experience in management of donor funds • Compliance with statutory requirements • Positive report on grant evaluations • Internal and external audits	• No business team for grant writing proposal • Grant management roles not fully operationalized. • Inadequate training opportunities and development. • Under staffing • Poor representation of CHAK MHUs in certain counties	• Strong Networks • Partnership with the Government • Donor strategies-eg. PEPFAR 5 year Strategy –Sustainability moving grant from international to local organizations • Specific donors looking to fund Health systems strengthening	• Reduced Donor funding and many players. • Tight compliance requirements from donors • Competition in the devolved government structure • Donor defined areas of for funding

5 Implementation approach

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

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

CHAK will engage in strategic partnerships in joint proposal development, resource mobilization and project implementation to ensure successful project design and effective implementation. Collaboration with both national and county governments will be nurtured for referral, to ensure compliance with health sector policies and for routine service data reporting.

In response to the wishes of its members, CHAK Secretariat has maintained a facilitative approach that incorporates elements of accompaniment and implementation especially for innovative projects/programmes 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.

In order to diversify sources of funding and technical support, CHAK will scale up efforts in resource mobilization through partnerships and proposal development while ensuring efficient and effective implementation of funded projects to the satisfaction of donor partners, communities served and other stakeholders.

The strategies to be engaged include:
- Participation in health sector coordination structures for joint planning and performance monitoring/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 and scale up 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 and KCM. Additionally, CHAK has a leadership role in the functioning of the MOH-FBHS-TWG by serving as its secretariat and also the Faith Based Health Services Coordinating Committee (FBHSCC) and Church Health Services Coordinating Committee (CHSCC). CHAK will continue to take advantage of these structures to proactively articulate issues from MHUs.

CHAK will restructure to facilitate engagement with the county government health system. County engagement structures will be established to coordinate MHUs advocacy and engagement in planning and service delivery collaboration at county level. A county engagement strategy will be developed and implemented to facilitate an effective county engagement process.

The CHAK Secretariat will seek to maintain a human resource compliment that is lean, competent, 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 technical 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. It is from here that CHAK shall draw technical support for capacity building and mentorship.

CHAK will give priority to the health sector coordination structures and opportunities and build the 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, analysis, information dissemination and use. This will create an evidence base for advocacy as well as for process and impact assessment.

6 Mid-term review of CHAK Strategic Plan 2011-2016

The major changes in the political, social, economic and health policy environment brought about by the implementation of Constitution of Kenya 2010 necessitated a mid-term review of CHAK Strategic Plan 2011-2016. The review which was conducted CORAT Africa, involved desk review of various reports and documents and interviews with key stakeholders. CHAK MHUs were engaged in the review process through a national workshop held in Nairobi. The review report has made some observations, conclusions and recommendations as summarised in the following paragraphs.

CHAK has so far performed very well and is on course to meeting its targets. The Association is also consistently meeting its obligations to funding partners. The funded activities have therefore been well executed. The Association's funding base and diversity as well as asset base have also grown tremendously over the last three years. The staffing base has expanded with programme and field staff increasing manifold. In other words, CHAK has remained on a growth trajectory over the last three years.

However, the evaluation identified a number of issues that CHAK needs to address in the second phase of the strategic plan programming and implementation. First, most of the funded programmes target large health facilities leaving out majority of the small health facilities. CHAK being a member focused Association needs to explore an inclusive approach to its programming especially in negotiating for funding. The Secretariat has nevertheless tried to mitigate this challenge by advocating for HSSF grants and government support mainly targeting the small facilities i.e. dispensaries and health centres.

Second, despite the growth in staff, the human resource management function at the secretariat is still weak with only one staff dedicated to human resource functions. More challenging is balancing between short term project staff and long term core staff in terms of remuneration. This will require a clear salaries and remuneration policy that is deemed to promote fairness and transparency in management of staff matters including salary and benefits. This policy should also inform grant negotiations with donors to ensure consistency and sustainability.

Third, the CHAK structure has been focused on MHUs at the sub national level with the RCCs designed for coordination and advocacy at the regional or former provincial levels. However, with the devolved system of Government which has seen substantial health service delivery powers vested in the county governments, CHAK's presence needs to be felt in all the counties especially where it is represented by MHUs. This presents a critical challenge with financial and structural implications that require both practical and strategic approaches. It also has direct implications on CHAK's structure. CHAK therefore needs to develop a clear plan and strategy for transition into the county health system.

Fourth, CHAK is getting into the business and investment realm but without a clear business development,

investment and risk management strategy. This is critical for the organization as it seeks to diversify its revenue base from the dominant donor funding towards sustainability

Fifth, previous CHAK strategic plans have not been costed. As a result, CHAK has not been able to develop clear resource mobilization strategies for its planned activities. For this reason, some activities remain unimplemented. CHAK has however, been developing a three year programme mainly funded by EED. The evaluators recommended that CHAK develops a financial plan to accompany the Strategic Plan, a good business practice.

Recommendations

- There is need for CHAK to review its strategic positioning and approach in the context of the national and county health structures. This should include re-evaluation of the functions of RCCs and CCCs.
- There is need for CHAK to review its business approach in order to position itself as a mission driven social enterprise supporting and catalyzing the social service agenda in the country through MHUs and the disadvantaged communities. CHAK needs to develop a business strategy for the technical services (HCTS, architectural services) in order to enhance their sustainability.
- There is need for CHAK to establish a business development unit to spearhead project proposal development, grant making, consultancy and other revenue development ventures.
- There is need for CHAK to establish a member health facility support Fund (endowment fund) and allocate resources every year. CHAK can also leverage on private corporate social responsibility opportunities, through public-private-partnerships to support the fund.
- There is need for CHAK to develop a clear salaries and remuneration policy for short term and core staff to ensure fairness and transparency in the management of staff remuneration matters including salary increments, benefits, among others. This policy should inform CHAK grant negotiations with donors to ensure consistency and sustainability.
- There is need for CHAK to review its programme development approach in the context of the Devolved Health system
- In future, CHAK strategic plan should be costed and accompanied by a resource mobilization plan.

7 Strategic directions

1. Health service delivery
2. Health systems strengthening
3. Governance and accountability
4. Research, advocacy, partnerships and communication
5. Health care financing and sustainability
6. Human Resources for Health (HRH)
7. Grant management
8. Total quality management and patient safety
9. Engagement with devolved county government health system

Strategic Direction 1: Health Service Delivery
Strategic priorities

1. Health policy

a. Participate in health policy development and facilitate dissemination of policies, protocols and guidelines to member health units.
b. Promote human rights based programmes to mainstream gender issues, PLHWAs, and people with disabilities e.t.c in health programs.

2. Primary Health Care

a. Support implementation of the community strategy
b. Facilitate capacity building and implementation of robust MNCH & RH programmes
c. Promote environmental health and sanitation programmes

3. Communicable diseases

a. Scale up HIV& AIDS prevention, treatment, care and support programmes
b. Promote TB and Malaria control and management programmes
c. Facilitate disaster preparedness and emergency response initiatives

4. Non communicable diseases (NCDs)

a. Promote screening and management of NCDs such as diabetes, hypertension and cancers
b. Facilitate capacity building in eye care, disability and mental health programmes through specialized programmes in MHUs

5. Essential drugs and commodities: To promote access, use and management of essential drugs and commodities through collaboration with MEDS

6. Coordination of capacity building: Internship training for Doctors and other health care workers, training in Family Medicine specialization, collaboration with regulatory bodies for health professionals and continuous professional development

7. Technical support to MHUs: Ensure adherence to quality assurance guided by norms and standards and regulatory guidelines in the health sector through dissemination of policies and guidelines and technical assistance

Strategic Direction 2: Health Systems Strengthening
Strategic priorities

1. Enhanced participation of MHUs in health sector joint planning and monitoring (national and county health management structures and forums)
2. Contribute to the development of specifications and functional medical equipment and consumables for the health sector in Kenya (HCTS & RPB, KEBS/GOK)
3. Mobilization of resources in response to relevant specific areas of felt need by MHUs through development of programmes, project proposals and partnerships
4. Ensure effective response to requests from MHUs for technical support
5. Health Care Technical Services (HCTS) made available and affordable for all church health units and other clients through the CHAK Medical Equipment Programme

6. Capacity building on governance and management for MHUs
7. To strengthen the role of Regional Co-coordinating Committees to actively participate in county engagement structures
8. Support MHUs to utilize the available modern technology for information sharing and learning
9. Support MHUs to acquire updated Standard Operating Procedures for various diagnostic equipment
10. Disseminate governance and management policies and procedures manuals to MHUs for quality assurance and standards improvement

Strategic direction 3: Governance and accountability
Strategic priorities
1. Support to CHAK governance structures including AGM, Trustees, EXCO and Finance Committee
2. CHAK financial management and reporting to members and governance structures
3. CHAK internal and external audit
4. Ensure compliance with donor funding and reporting requirements
5. Ensure legal and statutory compliance
6. Support MHUs in the implementation of financial management policies
7. Secretariat administration, procurement and logistics support
8. CHAK Assets maintenance and management

Strategic Direction 4: Research, advocacy, partnership and communication
Strategic priorities
1. Conduct operational research to inform programmes improvement and document best practices and lessons learnt
2. M&E for projects and programmes
3. Produce publications and documentation and maintain the CHAK Resource Centre for information storage and dissemination
4. Strengthen partnership engagement strategies with the various health sector stakeholders
5. Conduct advocacy for articulation of CHAK issues at the national and county levels

Strategic Direction 5: Strengthening Human Resources for Health
Strategic Priorities
1. Strengthening HRH management practices across the CHAK network
2. HRM professional capacity building
3. Improving linkages and integration with HRH training institutions for continuous professional development
4. Support to CHAK medical training institutions in capacity building and collaboration with various regulatory bodies.
5. Improving HRH motivation and retention
6. Enhancing HRH performance and productivity
7. Addressing human resource information system gaps within the network
8. Coordination of the annual national internship programmes in MHUs for doctors and other cadres

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 equipment and software
3. Support MHUs to mobilize communities for enrolment with NHIF and other insurances
4. Support MHUs' accreditation with NHIF
5. Innovative income generating activities
6. Capacity building in proposal writing for fundraising
7. CHAK Guest House business strategy review and performance monitoring
8. Lobby for support from MOH and county governments with equipment, health commodities, funding and staff secondment

Strategic direction 7: Grant management
Strategic priorities
1. MHUs' HSSF fund disbursement and reporting
2. CHAK HIV&AIDS project (CHAP) management and site management
3. CHAK Business unit for resource mobilization and networking with donors at national and county government levels
4. APHIA PLUS Kamili project transition and implementation
5. Effective performance in Global Fund sub recipient role for awarded grants

6. CHAK and MHUs technical assistance and capacity building in financial management

Strategic Direction 8: Total Quality Management and Patient Safe Care
Strategic priorities
1. Develop and implement Total Quality Management systems within the network on the KQMH framework
2. Educate and supervise staff in Total Quality Management systems including Kenya Quality Model for Health (KQMH)
3. Institutionalize quality management in health services within the network
4. Establish Centers of Excellence in Total Quality Management for Health within the CHAK network
5. Establish a functioning peer learning structure within the member network

Strategic direction 9: CHAK engagement in the devolved county health system
1. Development of a framework for partnership and engagement between MHUs and the county health systems (CHAK country engagement strategy)
2. Mobilization of resources for effective county partnerships and engagements
3. Facilitating MHUs advocacy at county level

8 Monitoring & Evaluation and research

CHAK has a well-developed Monitoring and Evaluation department which guides the process of monitoring, evaluation and research at the Secretariat. The department has technical officers who are responsible for guiding the development of the integrated Secretariat work plan which is used in guiding the program/project staff in developing individual and quarterly work plans.

Under the leadership of the General Secretary, there will be technical review meetings that will be held quarterly and annually to review performance of projects and programmes. The review will inform progress made by various interventions implemented by the Secretariat.

The monitoring and evaluation department and the technical programme team will on quarterly, bi-annual and annual basis compile narrative reports which will be shared with partners and key stakeholders highlighting the progress made during the programme implementation and key challenges that were faced. The Secretariat will conduct end-of-year review and findings will be used to inform review of strategies and approaches for the following year. The information gathered from end of year review will be used in coming up with the Association's Annual Report.

The plan proposes the use of a "dashboard" approach to measure progress towards goals. This means that rather than assessing each target individually, achievements will be reviewed in the aggregate considering movement on all or most of the indicators together.

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 MHUs and other stakeholders.

The M&E unit will support use of MOH-HMIS data collection and Rreporting tools in CHAK MHUs by training M&E/HMIS contact persons in data collection and reporting. An M&E work plan will be developed to assist the facilities in implementing MOH-HMIS system, 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.

Frequency	Target	Focus	Level of Monitoring
Monthly	Monthly Activity Report	Identify activities whose implementation is delaying delivery of outputs, and plan to address challenges	Activity level
Quarterly	Quarterly Progress Report	Identify outputs whose achievement during the year is threatened, and plan to address challenges affecting them	Output level
Annual	Annual progress Report	Identify progress, issues and challenges affecting implementation of outputs, and make recommendations of priorities for coming year	Output level
Mid-Term	Mid-Term Review	Identify progress, issues and challenges affecting implementation of outcomes towards supporting the achievement of the overall goal, and make recommendations for the remaining half of the strategic plan	Outcome level
End-Term	End-Term Review	Identify progress, issues and challenges that affected achievement of the overall goal, and make recommendations for the next strategic plan focus to enable it to support achievement of overall sector policy	Goal level

Medical records management

CHAK continues to receive data from MHUs to support analysis and advocacy. However, two key challenges are experienced: delayed reports and lack of a comprehensive database. The MHUs have been sending their reports through courier or the post office leading to late delivery. The M&E and HMIS units are in the process of piloting Electronic Medical Records (EMR) in some sites and the lessons learnt will inform scale-up. To ensure timely reporting, CHAK is working to develop a database that will be web based. This will facilitate timeliness in reporting. However, MHUs without Internet access would continue to send their reports via courier and postal services.

The M&E team will on monthly and quarterly basis analyse the collected data to enable the programme staff to monitor their performance and make strategy reviews and technical support.

Mid-term and end-term evaluations will be done as per programme and project specifications and also as per the Secretariat schedule. The strategic plan will also be subjected to end-term evaluation and the evaluation reports reviewed by EXCO and presented to the AGM and partners.

9 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 all the assets of the Association.

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

CHAK Guest House and Conference Centre Management Committee oversees the management of the Guest House and Conference Centre and submits it's 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 capacity building and networking activities.

Regional Coordinating Committees (RCCs) and County Engagement Structures

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.

The chairpersons of the four regions are also members of EXCO together with CHAK's national officials, namely, the chairman, vice-chairman, treasurer and vice-treasurer. The General Secretary serves as the secretary and represents the Secretariat.

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

Following the creation of 47 county governments with scope of mandate that includes health services provision, planning, supervision and decision making in resource allocation, CHAK proposes to establish County Engagement Structures (CES) to support RCCs in mobilization, coordination and advocacy for MHUs engagement at county level. The county engagement structures shall be defined in a County Engagement Strategy to be articulated by CHAK. These will take into consideration the strength of membership presence at the county including Medical Training Colleges.

Secretariat

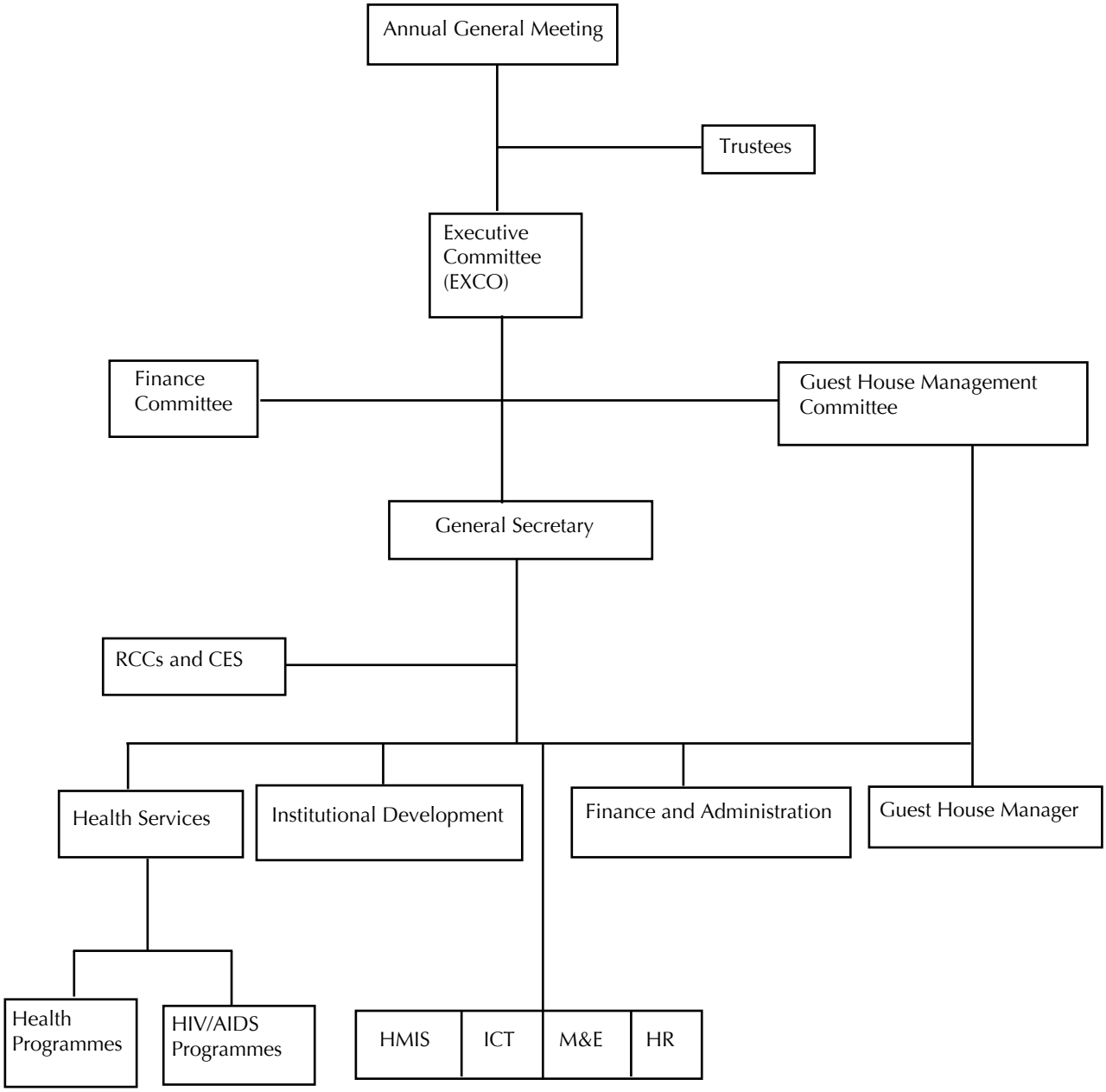
The implementation of the Strategic Plan is facilitated by the Secretariat management and technical staff under the leadership of the General Secretary. The Secretariat has been restructured into three departments:

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

These are provided with support by HMIS, M&E, ICT and HR units under the office of the General Secretary. These are responsible for the functions of IT, HMIS, HR, Communication, Publications and M&E. These have staff with adequate competencies to support these functions. A job evaluation has been conducted which has provided appropriate job descriptions, a salary structure and a performance based managed system for all essential staff. It has also provided a structure to accommodate staff expansion according to various projects.

Each department is led by a Head of Department (HOD) responsible for staff supervision and provision of leadership towards achievement of set targets. It is also recognized that CHAK Secretariat cannot afford to maintain in its establishment all professional competencies required hence engaging short-term external consultancy services for defined assignments would assist fill gaps or serve specific needs. However, there exists space and 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 implementation of relevant health projects.

The organizational structure for CHAK is as below:



10 Implementation log frame

i. HEALTH SERVICES

a. HIV&AIDS

Objective 1.1.1: Promote HIV prevention through provision of HTC, EMTCT, PwP, PEP and VMMC by 2016

Outcome 1.1.1: Reduction of HIV-related morbidity and mortality by 50% in Kenya through provision of comprehensive high quality services at member health units.

Impact 1.1.1: Reduced HIV incidence by 50% in Kenya by 2016

No.	Activities	Indicators	Data Source	Freq. of reporting
a)	Facilitate universal access to HIV Counselling & Testing	Increased HTC coverage in all MHUs by 50%	HTC Register	Quarterly
b)	Training of HCW and CHW on HTC	500 HCWs and 500 CHW trained each year on HIV C&T	Training reports	Quarterly
c)	Facilitate provision of buffer HIV Test kits	80% of all MHUs offering HIV C&T services have no stock out every month of each year	Delivery notes	Quarterly
d)	Support MHUs to conduct community sensitisation and mobilization	75% of all MHUs supported during the reporting period	Facility reports	Quarterly
e)	Provide PwP services at member health units	90% of HIV infected patients in all MHUs received the minimum package PwP services	PwP Reports	Quarterly
f)	Provide EMTCT services in member health units.	90% of all MHUs provided EMTCT services	HEI Cohort Analysis tool	Quarterly
g)	To promote HIV prevention through targeted behaviour change among MARPs in MHUs	Increased number of CHAK MHUs who provide HIV prevention to MARPs by 20% by 2016	Facility report	Quarterly
i)	Provision of voluntary medical male circumcision services in CHAK MHUs.	Increased number of CHAK MHUs who provide male circumcision services by 20% by 2016	Facility reports	Quarterly
j)	Provide PEP services in all member health units	100% of all MHUs provided post-exposure prophylaxis (PEP)	ART register	Quarterly

Objective 1.1.2 To facilitate treatment, care & support for 40,000 PLWHAs through CHAK MHUs by 2016

Outcome 1.1.2 Provision of high quality comprehensive HIV care and treatment services to 40,000 clients at member health units by 2016

No	Activities	Indicators	Data source	Freq.of reporting
a)	Training of health workers in the management of HIV&AIDS	150 HCW trained on HIV care and Treatment every year.	CHAK reports	Quarterly
b)	Scale-up HIV Care & treatment at MHUs	No. of new sites offering HIV care & treatment increased by 50% up to 2016	CHAK reports	Quarterly
d)	Facilitate enrolment and retention of HIV patients	Retention rates in all MHUs offering HIV C&T services maintained at 80% during the entire reporting period.	EMR reports	Quarterly
f)	Integrate TB/HIV services	80% of all MHUs with integrated TB/HIV services	TA reports	Quarterly
g)	Provide nutritional support to all medically eligible clients	Out of all MHUs offering nutrition services, atleast 40% supported clients with nutritional services.	Facility reports	Quarterly

h)	Facilitate Community Based HIV care services	90% of all MHUs offering HIV&AIDS services have community based care and treatment services.	Facility reports	Quarterly

1.2: Malaria

Objective 1.2: To reduce the level of malarial infection by 40% by 2016

Outcome1.2: Morbidity and mortality from Malaria reduced by 40% in MHUs by 2016

No	Activities	Indicators	Data source	Freq. of Reports
a)	Capacity building of HCW and CHWs on Malaria management	Increased number of health workers and CHWs trained on malaria by 50% annually	Training reports	Quarterly
b)	Support community mobilisation activities	Atleast 50% of all MHUs supported in community mobilization meetings annually	Reports	Monthly
c)	Promote malaria preventive interventions through ensuring access to ITNs in MHUs	100% of All MHUs have access to ITNs throughout every year.	Reports	Quarterly

1.3 Tuberculosis

Objective1.3: To improve diagnosis and management of TB by treating 90% of registered TB patients and increasing case detection to 80% by 2016

Output 1.3: Contribute to TB burden reduction by 50% by 2016

No	Activities	Indicators	Data source	Freq. of Reports
a)	Increase case finding & detection, and treatment.	90% of all MHUs conducted TB cases finding and treatment.	TB registers MHU reports	Quarterly
e)	Ensuring MHUs conduct defaulter and contact tracing	100% of all MHUs offering TB services conduct defaulters and contact tracing.	TB registers MHU reports	Monthly
g)	Renovation and provision of start-up equipment of MHUs requiring systems strengthening for TB diagnosis	50% of all MHUs which required renovation and equipment are renovated and equipped by 2016.	Report	Annual

1.4 Disaster preparedness and emergency response

Objective1.4: To build capacity of CHAK in Disaster and Emergency preparedness and response by 2016.

Outcome1.4: CHAK respond effectively to disasters and emergencies by 2016

No	Activities	Indicators	Data source	Freq. of Reports
a)	Increase value of CHAK emergency drugs kitty by 100%	All MHUs have increased of drug kitty value	Finance reports	Quarterly
b)	Train CHAK secretariat staff in disaster and emergency response management	100% of CHAK staff trained on emergency detection and response by 2016	CHAK reports	Six monthly

1.5 Reproductive Health/Family Planning

Objective: To support 90% of MHUs to increase scale up family planning services

Outcome: Improved access to reproductive health and uptake of family planning services in the MHUs by the end of 2016

No	Activities	Indicators	Data source	Freq. of reporting
a)	Conduct community mobilization and education to create awareness and demand for RH/FP	At least 50% of all MHU supported in community mobilization meetings annually	Activity Report	Quarterly
b)	Improve the knowledge and skills of the HCW and CHWs to provided RH/ FP service	Increased the number of health workers and CHWs trained on RH/FP by 50% annually	Training reports Attendance list	Quarterly

c)	Strengthen the linkages and logistic flow of RH/ FP commodities, Equipment, IEC materials, data collection and reporting tools from MOH to the MHUs.	80% of all MHUs have access to RH/ FP commodities, Equipment, data collection and reporting tools from MOH throughout every year.	Activity Reports	Quarterly
d)	Support integration of RH/FP in MCH, HIV/AIDS, STI and other services outlets.	80% of all MHUs with integrated RH/FP in MCH, HIV/AIDS, STI and other services outlets.	Activity Report	Quarterly
e)	Support the MHUs to undertake community based RH/ FP services and linkages including religious leaders and community opinion leader.	90% of all MHUs undertaking community based RH/FP services and linkages.	Activity Report	Quarterly
f)	Build capacity of the MHUs to offer supportive supervision and mentorship to CHWs to improve quality of RH/FP services.	Increased number of supportive training by 50% to CHWs to improve quality of RH/FP services annually	Activity Report	Quarterly
g)	Support the MHUs to develop and implement adolescent/Youth friendly RH/FP and HIV prevention and treatment services	Increased number of CHAK MHUs who provide adolescent/Youth friendly RH/FP and HIV prevention and treatment services by 20% by 2016	Activity report	Quarterly

1.6 Maternal, Neonatal and Child health

Objective1.6 To assist 90% MHUs to implement maternal and child health programs at the community and facility level in order to reduce maternal, infant and child mortality rates by 2016

Output 1.6 Support 90% MHUs to offer focused antenatal care (FANC) to pregnant mothers seeking antenatal services at the MHUs

No	Activities	Indicators	Data source	Freq. of reporting
a)	Support the all MHUs implement focused antenatal care to contribute to reduced maternal and neonatal mortality.	Increased No of MHUs implementing FANC by 80% by 2015	Statistic Reports MOH Registers	Quarterly
b)	Integrate HCT, PMTCT and TB screening at the MNCH and Community level	80% of all MHUs with integrated HCT, PMTCT and TB screening at the MNCH and Community level	Activity Report	Monthly Quarterly
c)	Increase the proportion of ANC mothers attending 4 visits by supporting 20 MHUs MCH clinics to put in place defaulter tracing mechanism.	20 Facilities supported with Defaulter tracing Mechanism by 2015	Statistic Reports MOH Registers	Monthly Quarterly
d)	Increase the proportion of MHUs offering skilled delivery.	Increased No of MHUs offering skilled deliveries by 80% annually	Statistic Reports MOH Registers	Monthly Quarterly
e)	Build the capacity of the MHU staff to offer emergency Obstetric care	Increased No of MHUs offering emergency obstetric care by 50% annually	Statistic Reports	Monthly Quarterly
i)	Support the MHUs to put in place infection prevention and control systems.	Increased No of MHUs with Infection Prevention and control strategies by 100% by 2016	Activity Report	Quarterly
j)	Promote the use of mother child booklet at child welfare clinic (CWC) at all MHUs to	Increased rate of utilization of mother child booklet at CWC at all MHUs to monitor growth,	Activity Report	Monthly

	monitor growth, immunization and nutrition status.	immunization and nutrition status by 100% by 2016		

1.7 Community Strategy

Objective 1.7: To improve the health outcomes of the community by supporting 47 community based and focused health interventions in the MHUs' BY 2016.

Outcome 1.7: improved health outcomes through Community based health programs

No	Activities	Indicators	Data source	Freq. of Reports
a)	Support MHUs in implementation of the Community Strategy	Increased No of MHUs implementing the community strategy to 80% by 2016	Reports	Quarterly
b)	Strengthen MHUs community health outreaches through community and church participation. .	90% of all MHUs conducted outreaches in their communities.	Event reports	Quarterly

1.8 Non Communicable Diseases

1.8.1. Eye care services in CHAK MHUs

Objective 1.8: To prevent eye infections, injuries and effective management of secondary causes of blindness in 90% MHUs by 2016.

Outcome 1.8: Reduced eye infections and injuries**.**

No	Activities	Indicators	Data source	Freq. of Reports
a)	Support MHUs to implement and strengthen the prevention and management of eye infection at both facilities and community level.	Increased No of MHUs implementing prevention and management of eye infection at both facilities and community level 80% by 2016	Facility statistical reports	Monthly Quarterly
b)	Facilitate capacity building for HCW and CHWs in eye care.	Increased the number of health workers and CHWs trained on eye care by 30% annually	Training reports	Quarterly

1.8.2. Diabetes mellitus

Outcome 1.8. 2: Reduced morbidity and mortality caused by diabetes.

Objective 1.8.2: To reduce the morbidity and mortality caused by Diabetes by 25% at 50% of MHUs by 2016.

No	Activities	Indicators	Data source	Freq. of Reports
a)	Support 100 MHUs to put in place community based diabetes surveillance and early diagnosis and lifestyle change program to promote prevention and early treatment of diabetes;	100 MHUs supported by 2016	Activity Reports	Quarterly
b)	Assist MHU access to affordable quality diabetes control medicines.	100% of all tier 3 & 4 MHUs accessing subsidized diabetes control medicines	Activity Reports	Quarterly
c)	Support MHUs put in place effective diabetes management protocols in place.	100 MHUs with Diabetes management protocols and SOPs ,	Activity Reports	Quarterly
d)	Support MHUs to initiate Community based Psychosocial support groups (PSSG) for diabetic patients	50 functional diabetes PSSG	Activity Reports	

e)	Support Lab services in MHUs to improve diagnosis and control of diabetes.	1000 DM clients attending PSSG meetings	Reports	Quarterly

1.9. Hypertension

Objective 1.9: To scale up management of hypertension in 40 MHUs by 2016

Outcome 1.9: Reduced morbidity and mortality caused by hypertension

No	Activities	Indicators	Data source	Freq. of Reports
a)	Promote health education training on prevention of hypertension in the community through community mobilization-nutrition, physical activities	Increased the number of health workers and CHWs and HCW trained on hypertension at the community and facility level by 50% annually	Activity reports	Monthly
b)	Strengthen linkages between the community and health facilities	100% MHUs linked with communities by 2016.	Activity reports	Monthly
c)	Strengthen and establish psychosocial support groups	50 psychosocial support groups established by 2016.	Activity reports	Monthly
d)	Support MHUs to ensure availability of drugs	80% of all MHUs offering hypertension services have no stock of hypertension medicines each year	MOH Drug registers	Monthly

1.10 Mental Health

Objective 1.10: to prevent and Manage mental health illnesses in all MHUs by 2016.

Outcome 1.10: Reduced burden of mental Health illnesses.

No	Activities	Indicators	Data source	Freq. of Reports
a)	Conduct community sensitisation on causes , management and prevention of Mental health illnesses and reduce stigma	Increased No of MHUs conducting community sensitisation on causes, management and prevention of Mental health illnesses by 80% by 2016.	Activity reports	Quarterly
b)	Promote linkages, integration and networking with partner and stakeholders dealing with mental health management and prevention. e.g. NACADA	100% of all MHUs offering mental health services linked to the different partners and stakeholders dealing with mental health illness.	Activity reports	Quarterly

1.11 Care and support for disability services

Objective 1.11: To support 50 MHUs to improve access to disability care and rehabilitation services

Outcome 1.11: Improved access to care and support for people with disability in 50 MHUs.

No	Activities	Indicators	Data source	Freq. of reporting
a)	Support MHUs to conduct community sensitization and identification of disabilities and to identify the type of care needed.	Increased No of MHUs conducting community sensitisation on causes, management and prevention of disability by 80% by 2016.	Reports	Quarterly
b)	Support capacity building for staff in the MHUs in disability care.	Increase number of trained staff in disability care by 50% by 2016.	Reports	Quarterly
c)	Strengthen MHU Referral services to specialized centres	Increase number of clients referred for specialized care by 50% by 2016	Reports	Quarterly

ii HEALTH SYSTEMS STRENGTHENING

2.1 Medical equipment maintenance

Objective 2.1.1: To contribute to the collective effort to establish Standards & Specifications for Medical equipment and consumables in the health sector in Kenya.

Outcome 2.1.1 Equipment and consumables employed in the health sector are in accordance with the applicable Kenyan Standard

No	Activities	Indicators	Data source	Freq. of reporting
a)	To participate in monthly Technical Committee (TC) workgroup and research meetings at KEBS	36 meetings by 2016	Workgroup Minutes	monthly
b)	To participate in 6 monthly stakeholders forum for reviewing and adopting the output given by the TC standards workgroups.	6 meetings by 2016	Stakeholders' Minutes	Bi-annually
c)	To participate in the presentation of the final drafts of the standards to the board of KEBS.	3 meetings by 2016	Kenya Standard (KS) Drafts	annually
d)	To participate in quarterly regulatory meetings for medical equipment standards and specifications.	12 meetings by 2016	Minutes	quarterly

Objective 2.1.2: To provide Medical equipment maintenance & repair services, procurement and installation of medical equipment, and training of users of new equipment

Outcome 2.1.2 High standards attained in clinical diagnosis and therapy

No	Activities	Indicators	Data source	Freq. of reporting
a)	To respond to un-scheduled emergency invitations to provide technical repair services, following breakdowns annually.	270 facilities served by 2016	Records	Quarterly
b)	To provide technical advice to 50 church health facilities procuring new medical equipment or sourcing donations annually.	150 facilities served by 2016	Records	Quarterly
c)	To inspect donated equipment, service, install and commission for use in 5 church health facilities annually.	15 facilities served by 2016	Records	Quarterly
d)	To inspect, install and commission newly acquired medical equipment for 5 church health facilities annually.	15 facilities served by 2016	Records	Quarterly
f)	To carry out Quality assurance in radiology equipment in accordance to the RPB Kenya mandate in 30 MHUs annually.	90 QA Assessment conducted by 2016	records	quarterly

2.2. Support Governance and Management for MHUs

Objective 2.2.1: To facilitate health facilities boards/committees build their governance capacity and to give them exposure to others who rate highly with respect to best practices.

Outcome 2.2.1: MHUs functioning effectively

No	Activities	Indicators	Data source	Freq. of reporting
a)	To participate in board meetings for 10 MHUs	30 MHUs supported by 2016	Minutes	Quarterly
b)	To organize learning exchange visits between boards for 15 MHUs	9 MHUs supported by 2016	Report	Quarterly
c)	To facilitate induction for new boards for 12 MHUs	6 MHUs inducted by 2016	Report	Quarterly
d)	To facilitate customization of generic governance policy guidelines for 60 MHUs	15 MHUs supported by 2016	Report	Quarterly
e)	To hold an experience sharing conference on best practices in governance for 120 MHUs	60 MHUs participating by 2016	report	Annual
f)	To review and support streamlining of governance systems and structures in 10 hospitals	25 MHUs supported by 2016	report	Six monthly

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

Outcome: 2.2.2: Stakeholders are satisfied with the performance of the MHUs

No	Activities	Indicators	Data source	Freq. of reporting
a)	To organize learning exchange visits between management teams for 12 MHUs	6 MHUs supported by 2016	Reports	Annually
b)	To hold management workshops for 150 MHUs	75 MHUs participating by 2016	Reports	Annually
c)	To facilitate 12 MHUs in developing Strategic Plans.	6 MHUs supported by 2016	Reports	Annually
d)	To facilitate 30 MHUs in carrying out a management audit of the institution.	30 MHUs supported by 2016	reports	Annually
e)	To streamline governance and management practice of 20 dispensaries and Health Centres annually on the basis of the determined facility needs	60 MHUs supported by 2016	reports	Six monthly
f)	To hold an experience sharing conference on best practices in management for 75 MHUs	75 MHUs participating by 2016	Reports	Annual

2.3 Support to MHUs by empowered Regional Coordinating Committees and county engagement structures

Objective 2.3.1: To support and coordinate the RCC efforts in addressing the needs, concerns and interests of MHUs at the County level

Outcome: 2.3.1: MHUs are integrated in the County health systems and are adequately supported from the County

No	Activities	Indicators	Data source	Freq. of reporting
a)	To hold 3 regular meetings quarterly for receiving needs/concerns from MHUs, receiving information/reports from secretariat and learning & experience sharing.	36 meetings held by 2016	Records	Quarterly
b)	To hold annual planning and budgeting meeting for the regions	12 meetings held by 2016	Records	Annually
c)	To organise and hold introductory meetings with the County health systems	34 of meetings by 2016	Records	Annual
d)	To advocate for the MHUs needs and concerns with the County administration and other relevant stakeholders	60 advocacy events by 2016	Records	Quarterly
e)	To vet CHAK membership applicants and recommend to EXCO for approval	30 applicants vetted by 2016	Records	Quarterly
f)	To implement approved activities and report	360 MHUs participating by 2016	Records	Quarterly

2.4 Technical support facilitated for MHUs

2.4.1 Architectural services

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

Outcome: 2.4.1: Suitable and supportive work and living space environment in MHUs

No	Activities	Indicators	Data source	Freq. of reporting
a)	To develop preliminary designs for discussion with the client for 20 MHUs based on expressed need	9 MHUs supported by 2016	Records	Monthly
b)	To develop final designs and produce architectural drawings for 20 MHUs	20 MHUs supported by 2016	Records	Monthly
c)	To prepare general and technical specifications for the project in 20 MHUs	20 MHUs supported by 2016	Records	Monthly
d)	To submit 4 sets of the architectural drawings to the local authorities for approval	9 approved projects by 2016	Records	Monthly
e)	To assist the 20 MHUs on the process of environmental impact assessment (EIA) & the application of the NEMA certificate of no objection to the project.	20 MHUs received NEMA certificate by 2016	Records	Annually
f)	To assist the MHUs to access relevant engineering services for the approved architectural design	12 MHUs supported by 2016	Records	Records
g)	To facilitate the costing/BQs preparation for the project	6 MHUs supported by 2016	Records	Quarterly
h)	To assist the MHUs in the process of tender action	6 Contracts signed by 2016	Records	Quarterly
i)	To provide supervisory support during construction up to completion	6 Projects supported by 2016	Records	Monthly

j)	To make final inspection of completed works, list defects to be made good and handover to the MHUs	6 completed projects by 2016	Records	Quarterly

2.4.2 Project Formulation and proposal writing

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

Outcome: 2.4.2: MHUs are successfully mobilizing resources from both local and external sources towards their felt needs

No	Activities	Indicators	Data source	Freq. of reporting
a)	To identify 120 MHUs to participate in the workshop on project formulation and proposal writing	60 MHUs participating by 2016	Records	Quarterly
b)	Train 2 staffs each from the 120 MHUs identified in proposal development	720 individuals trained in proposal development by 2016	Training reports	Quarterly
c)	To provide post training support through follow up and review of project proposals developed by participants after the workshop for 6 MHUs	6 proposals reviewed by 2016	Records	Quarterly

2.5 Participation of MHUs in Health sector joint planning and monitoring (National & County Health Management Team ector Forums)

Objective 2.5.1: To facilitate the participation of MHUs in the joint Health Sector Planning & Monitoring at the County and National levels in accordance with the Kenya health framework 2013-2018

Outcome: 2.5.1: MHUs are integrated in the County health systems and are adequately supported from the County and National Governments (Level 4 MHUs)

No	Activities	Indicators	Data source	Freq. of reporting
a)	To sensitize 70% MHUs on the importance and potential benefits of participating in district/county level AOPs and DHSFs	70% of MHUs supported annually	Records	Annually
b)	To support 70% of MHUs in the process of planning and monitoring the implementation of their funded AOPs in partnership with RCCs	70% of MHUs are supported annually	Records	Quarterly
c)	To facilitate RCCs to advocate for resource allocation to MHUs involvement AOPs at district/county level	12 advocacy meetings by 2016	Records	Quarterly

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 MHUs felt needs and Secretariat health systems strengthening needs.

Outcome 2.6.1: CHAK successfully mobilizing resources from both local and external sources towards MHUs felt needs

No	Activities	Indicators	Data source	Freq. of reporting
a)	To formulate 30 projects and write proposals in selected areas of focus for funding- HSS, Health services and HIV&AIDS response	15 proposals written and successfully funded by 2016	Reports	Quarterly

2.7: Information Technology

Objective 2.7.1: Strengthening financial and data management through computerized system (CHAK Hospital Management Software (CHMS)

Outcome 2.7.1: Finance and data management system developed, implemented and sustained in MHUs

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Rollout of CHMS software in member health units	10 facilities with HMIS software installed annually		Quarterly

b)	Train users in the MHU facilities in the use of CHMS system	Increased number of staff trained in the CHMS software by 30% annually	Implementation reports	Quarterly

Objective 2.7.2: Develop clinical HMIS system for Level 5 health facilities and implement it in at least 5 member hospitals by 2016

Outcome 2.7.2: Improved clinical data management in CHAK MHUs

No	Activities	Indicators	Data source	Freq. of reports.
a)	Develop, pilot and launch OpenMRS system with both clinical and business management components	Clinical OpenMRS developed by 2014	OpenMRS system	Yearly
b)	Implement the OpenMRS system in 5 hospitals	5 hospitals have OpenMRS system by 2016	Report	Yearly
c)	Provide maintenance support for the system	5 health facilities supported	Report	Yearly

Objective 2.7.3: To develop and maintain CHAK membership database

Outcome: To have real time CHAK membership directory

No	Activities	Indicator	Data Source	Freq. of reporting
a)	Develop and pilot membership directory	Membership directory developed by 2014	Functional database	Yearly
b)	Implement the membership directory	Real time membership directory in use by CHAK network by 2014	CHAK IT network	Yearly
c)	Support and maintain membership directory	No of down times of the database	Reported downtimes report	Yearly

3.0 Governance and Accountability

Objective 3.1 To facilitate the structured meetings of CHAK

Outcome 3.1: Functional and accountable governance and management structures

Impact 3.1: CHAK governance structure embracing good corporate governance

No	Activities	Indicators	Data Source	Frequency
a)	Hold Secretariat staff meetings weekly for Devotion and Communication	150 staff secretariat meetings held by 2016	Attendance list, Weekly memo	weekly
b)	Hold technical planning and monitoring meetings quarterly	12 technical planning meetings held by 2016	Reports	Quarterly
c)	Hold Management Team (MT) meetings monthly	36 management meetings held by 2016	Minutes	Monthly
d)	Hold CHAK Tender Committee meeting annually	3 Tender Committee meetings held by 2016	Reports	Annually
e)	Hold CHAK Finance and EXCO meetings quarterly	12 CHAK Finance and EXCO meetings held by 2016	Minutes	Quarterly
f)	Participate in MEDS Board meetings and other meetings quarterly	12 MEDs board meetings held by 2016	Minutes	Quarterly
g)	Hold CHAK Trustees meeting annually	3 CHAK Trustees meetings held by 2016	Minutes	Annually
h)	Participate in MEDS Trustees meetings annually	3 MEDS trustees meetings held by 2016	Minutes	Annually
i)	Hold CHAK Annual General Meeting (AGM) and Annual Health Conference in April each year	3 AGM/AHC meetings held by 2016	Minutes/ Report	Annually
j)	CHAK staff annual planning retreat	3 meetings held by 2016	Report	Annually

k)	CHAK Guest House and Conference Centre Management Committee meetings quarterly	12 meetings held by 2016	Minutes	Quarterly
l)	Hold CHAK Procurement and Supplies meeting quarterly	12 procurement and supplies meetings held by 2016	Minutes	Quarterly

4.0 Research, Partnership Advocacy and Communication

4.1 Monitoring and Evaluation

Objective 4.1.1: To continuously monitor and evaluate CHAK programmes and projects

Outcome indicator 4.1.1: Functional monitoring and evaluation systems in place in CHAK secretariat and 100% of all MHUs by 2016

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Develop and maintain reporting systems at secretariat and MHU level.	Reporting system established and maintained at secretariat and 90% of all MHUs by 2016.	Activity report CHAK database	Monthly Quarterly Annually End term
b)	Collect, process and disseminate service statistics	100% of reports received analysed and disseminated to secretariat, MHU's, MOH and other partners by 2016	MoH/NASCOP HMIS tools. Service statistics reports	Monthly Quarterly Annually End term
c)	Establishing an electronic medical records (EMR) system at secretariat and MHU's levels	Electronic medical system established and maintained at secretariat and 40% MHUs by 2016.	Activity reports Service statistics	Annually

Objective 4.1.2: To provide evidence based information through operational and other research activities

Outcome 4.1.2: Carry out operational research and other health related research activities

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Establish an operational research system	3 operational research conducted by 2016	Abstracts, Published success stories Research publications	Six monthly

4.2 Communication, Documentation and Publication

Objective 4.2.1: To document, and disseminate CHAK reports and publications, paying special attention to detailing impact of CHAK's work

Outcome 4.2.1: Well and appropriately informed CHAK network by 2016 by producing at least 3 CHAK Times issues annually, one annual report, one AHC report and at least 36 documentations annually.

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Documenting CHAK events and activities	CHAK activity reports prepared and disseminated to 90% of all CHAK network, partners, and stakeholders	CHAK reports and publications, website and social media.	Weekly Monthly Quarterly Annually End term

Objective 4.2.2: To produce promotional/informational communication materials for CHAK and its projects

Outcome indicator 4.2.2: IEC materials for CHAK Secretariat and MHUs disseminated

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Plan, Design, Produce and Disseminate IEC materials	3000 copies of Health related IEC materials produced and disseminated to CHAK, MHUs and partners on specified reporting periods every year.	IEC materials	Quarterly, Annually, End term

4.3 Africa Christian Health Associations Platform (ACHAP)

Outcome 4.3: Improve operations of Christian Health Association (CHA's)

Objective 4.3.1: To create a networking forum for all Africa Christian Health Associations,

No	Activities	Indicators	Data source	Freq. Of reports
a)	Document ACHAP activities	12 bulletins produced and uploaded on ACHAP website	Bulletin, Website, Social media	Quarterly Annually
b)	Establish Partnerships and linkages among CHA's and partners	Increased number of linkages and partnerships by 25 % annually	Reports MoU's	Annually
c)	ACHAP provides technical support to CHA's	4 technical support provided to CHA's annually	Activity reports	Quarterly
d)	Establish operational research strategy in ACHAP for CHAs	3 operational research activities conducted by 2016.	Activity report Minutes of meeting	Annually

Objective 4.3.2: To facilitate joint advocacy for the CHAs in Africa

No	Activities	Indicators	Data source	Freq. Of reports
a)	To identify strategic in-country and global events for CHAs advocacy.	60 CHAs advocacy events identified by end of 2016	Reports	Annually

4.4 Advocacy

Objective 4.4: To advocate for CHAK member health units for recognition, involvement in policy development, planning and resource allocation

Outcome 4.4: CHAK MHUs needs and concerns articulated to national and county governments and other relevant stakeholders

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Develop substantive advocacy strategy supported by research & documentation	Substantive advocacy strategy developed by 2015	Advocacy strategy report	Annually
b)	Participate in county, national, regional and international networks and fora for advocacy eg ACHAP, MOH, FBHSCC,CHSCC, CHSHF, CCIH, WCC, WHO, & UN Agencies	45 forums attended by 2016	Activity report	Annually
c)	Provide secretariat support to MOH-FBHS-TWG and participate in it's meetings and activities	Support provided to MOH-FBHS-TWG	Minutes	Six monthly
d)	Participate in relevant policy making bodies Board meetings.	12 Board meetings attended on a quarterly basis.	Minutes	Six monthly

4.5 Partnership and Networking

Objective 4.5: To strengthen partnerships and networking in the CHAK network by 2016

Outcome 4.5: New partnerships and enhanced recognition for CHAK by 2016

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Engage in strategic partnerships with likeminded organizations for technical support, capacity building, resource mobilization and joint project design and implementation	12 partnerships established by 2016	Proposals, MoU, Reports	Annually
b)	Ensure representation in strategic partnership and networking organizations and fora	Increased number of organizations to which CHAK is a subscribed member by 30% by 2016	Membership certificates. Subscription record	Annually

5.0 Human Resources for Health

Objective 5.1: To strengthen human resource management practices in CHAK member units

Outcome Indicator 5.1: Professional HRM practices applied at member health facilities

No	Activities	Indicators	Data source	Freq. of reporting
a)	Work with CHAK Secretariat team and other partners to evaluate impact of HRM policy implementation at CHAK member health units (MHUs)	Human resource management gaps identified in 90% of all MHU's by 2016	Evaluation report	Every three years
b)	Mentorship and professional support provided to MHU HR officers, managers and HR point persons	Individual development plans for MHU HR staff in 50% of the CHAK health facilities	Monthly HR report	Monthly
c)	Provide HR job aids and tools for day to day HR management	HR management technical tools disseminated to 90% of CHAK health facilities by 2016	HR Database	On-going

Objective 5.2 To Ensure HRM professionals in CHAK MHUs are in alignment with new HRM professional regulations.

Outcome Indicator: 5.2: Availability of skilled human resource managers and officers at CHAK MHUs

No	Activities	Indicators	Data source	Freq. of reporting
a)	Support HR officers, managers and other HR point person at MHUs to comply with new HRM professional Act 2012	80%MHU staff registered with IHRM by 2016	Records	On-going
b)	Support MHUs recruitment and selection processes for HR professional positions both on request and on initiation by CHAK secretariat	HR professions in place at MHUs	Recruitment & Selection Reports	On-going
c)	Identify and disseminate HRM professional training opportunities with the MHUs in the CHAK network	50 HR professionals from CHAK MHUs participating in HR professional training programs annually	HR database	On-going

Objective 5.3: To strengthen linkages and integration of CHAK health training institutions at the national and county level.

Outcome Indicator 5.3: Improved quality of training and management of CHAK training institutions

No	Activities	Indicators	Data source	Freq of reporting
a)	Represent CHAK and CHAK MHUs in key national and county health training planning and partnership forums	4 meetings attended annually	Meeting reports	On-going

Objective 5.4: To build capacity of CHAK medical training institutions in collaboration with various regulatory bodies.

Outcome Indicators: 5.4: Increased number of health workers graduating from CHAK training institutions

No	Activities	Indicators	Data source	Freq of reporting
a)	Ensure representation and adherence to regulation by CHAK and CHAK MHUs with professional regulatory bodies and councils eg MOUs by training institutions and the hospitals	100% of CHAK member health training institutions adhering to health worker professional training regulations	Meeting reports and MOU documents	On-going

b)	Work with CHAK technical staff, MOH, Regulatory Bodies and key development partners to ensure CHAK participation in health training curriculum development, review and dissemination.	Health training curricular developed, reviewed and disseminated to CHAK training institutions	Revised curricular	On-going
c)	In collaboration with relevant development partners, provide technical assistance and support to CHAK training institutions' faculty to improve class room teaching and mentorship skills	Regular feedback and progress reports from 15 selected faculty members at CHAK training institutions	Progress reports	On-going

Objective 5.5: To support CHAK MHUs to enhance and address human resource motivation and retention

Outcome Indicator 5.5: Motivated health workforce in CHAK health institutions

No	Activities	Indicators	Data source	Freq
a)	Support and coordinate health worker job satisfaction surveys at CHAK hospitals and health centres	100% MHUs carrying out annual health worker job satisfaction surveys annually	Job satisfaction survey reports	Annually
b)	Establish the annual staff turnover rate for CHAK hospitals and health centres	Staff turnover rate (i.e. the no. of health workers who left employment in the last year as a percentage of those at the beginning of the year)	HR annual report	Annually
c)	Provide technical assistance and relevant tools to address emerging gaps from job satisfaction and client surveys	Technical resources and tools availed to 50% of CHAK MHUs to address motivation and retention	HR resource database	On-going

Objective 5.6: To enhance human resource performance and productivity in CHAK

Outcome Indicator 5.6: Quality health service delivery

No	Activities	Indicators	Data source	Freq
a)	Provide technical support in the development of relevant performance management tools	Performance management tools in use in 15 selected CHAK health facilities	HR reports	On-going
b)	Support CHAK MHUs to identify and address productivity gaps	Productivity analysis tools in use in 15 selected CHAK facilities	HR reports	On-going
c)	Work with CHAK secretariat staff to implement an effective performance management system	Key performance Indicators met by 80% of CHAK secretariat Staff	Performance reviews	annually
d)	Support CHAK management team to enhance staff productivity and to address emergent gaps	Effective organizational systems and processes in place to support CHAK Secretariat staff performance and productivity	Audit reports, Performance appraisal feedback and staff meetings	On-going

Objective 5.7: To establish a robust human resource information system to enhance a culture of data driven decision-making across the network

Outcome Indicator: 5.7: Health workforce data utilized for planning and decision making at both Secretariat and MHU level

No	Activities	Indicators	Data source	Freq
a)	Work with CHAK secretariat staff and development partners to support human resource information systems (HRIS) implementation in MHUs	15 MHUs implementing HRIS annually	HR reports	Bi-annually
b)	Participate in national human resource for health strategic planning and other engagements	HRIS data used in decision-making and planning at CHAK secretariat, national and county levels	HRIS (system)	On-going

Objective 5.8: To work with relevant partners and institutions to establish and support an effective pre-service internship program

Outcome Indicator 5.8: Skilled health professionals graduating from CHAK training institutions to offer quality health services

a)	Coordination of a medical internship program in collaboration with CHAK health training institutions	16 medical /professional interns at CHAK training facilities by 2016	Internship distribution report per cadre	On-going
b)	Support CHAK training health institutions to ensure compliance and regulatory matters eg DIT/NITA regulations, the labour laws and professional council requirements	100% CHAK training institutions complying with internship regulations by 2016	CHAK HRD report	On-going

6.0 Health Care Financing

6.1Financial Management and Reporting

Objective 6.1.1; Review and implement financial management systems

Outcome 6.1.1: CHAK equipped with sound financial management systems

Impact: Efficient, reliable and accurate financial management systems

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Conduct bi-annual briefings to staff on the revised Finance and Procurement Policy manual	6 briefing meetings held by 2016	Report	Bi- annually
b)	Review of finance policy documents and recommend changes to EXCO for adoption	4 policy documents revised by 2016	Annual review reports	Annually
c)	Conduct an annual upgrade and training of CHAK Payroll and Accounting Software	15 staff trained by 2016	Annual License	Annually

Objective 6.1.2: To provide timely financial services for the secretariat

Outcome 6.1.2: CHAK secretariat operating with efficient financial support services

Impact: Efficient, reliable and accurate financial management systems

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Prepare master budget for the strategic plan 2013-2016	1 approved master budget annually	budget reports	After 3 years
b)	Prepare budgets specific to projects as per funding agreements	10 approved project budgets annually	Approved project budget	On-going
c)	Prepare, monthly quarterly, semi-annual and annual financial management accounts reports	10 financial Management accounts prepared annually	Reports	On-going
d)	Prepare quarterly cash flow forecast for Secretariat and projects	4 Cash flow statements annually	Reports	Quarterly
e)	Update, verify and review Asset Register semi-annually	2 reviews annually	Asset registers.	Semi-Annual

Objective 6.1.4: To provide routine auditing services to CHAK Secretariat and other donor funded projects

Outcome 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.
a)	Coordinate external financial audit for CHAK, Guest House and Projects by end of the specified accounting period	At least 2 External Audit Reports annually	Audit Report	Annually
b)	Support internal audit exercise on a continuous basis	1 Internal audit per year through an external Audit Firm	Audit Report	On-going

Objective 6.1.5: To support implementation of the generic Financial Management Guidelines in 30 MHUs

Outcome 6.1.5: MHUs financial management capacity enhanced for efficiency and accountability

Impact: MHUS with reliable efficient financial management systems

No	Activities	Indicators	Data source	Freq. Of reports.
a	To conduct capacity assessment of the financial management systems of 10 MHUs every year	10 MHU's assessed annually	Report	Annually
b	Hold annual workshop targeting 30 MHUs from lower level facilities and train them on financial management (planning, budgeting, internal controls and auditing)	30 staff trained on financial management annually	Report	Annually
c	To make supervisory and mentorship visits to 6 MHUs for Technical support in the implementation of the Financial Management Manual	6 supervisory visits annually	Report	Annually
d	Support the 6 selected MHUs in their preparation of annual budgets, production of management reports and external audit reports annually	6 MHU's supported annually	Report	Annually

6.2 Health Care Financing and Sustainability

Objective 6.2.1: MHUs supported to be able to cost health services

Outcome 6.2.1: Sustainable Health care financing in CHAK MHUs

Impact: Financial stability in CHAK MHUs

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Conduct a study on costing of health services for evidence based pricing in CHAK MHUs	1 document developed by 2016	Report	Annual
b)	Using the report generated, support MHUs to revise their pricing of services and negotiate on better rebates with NHIF	20 MHUs supported annually	Reports	On- going

Objective 6.2.2: MHUs supported to register with NHIF and enrol community members

Outcome 6.2.2: MHUs accredited to provide NHIF services and number of NHIF enrolled community members

No	Activities	Indicators	Data source	Freq. Of reports.
a	Disseminate information on NHIF recruitment, accreditation and enrolment	At least 40 MHUs reached annually	mailing/attendance list	On-going
b	Participate in assessment of MHUs for reaccreditation for NHIF inpatient and/or outpatient services	20 MHUs accredited annually	NHIF list	On-going
c	Hold meetings for MHUs and NHIF to advocate for improvement of rebates	At least 10% change in rebates to MHUs	NHIF report	On-going
d	Participate in NHIF board as per the NHIF Act	4 NHIF board meetings attended annually	Minutes	Quarterly

Objective 6.2.3: To support MHUs in identifying alternative sources of income

No	Activities	Indicators	Data source	Freq. Of reports.
a)	To empower MHUs to generate income by Disseminating Information for identifying alternative sources of income	At least 10 MHUs are trained on alternative sources of income	IGA reports	On-going

Objective 6.2.4: Support CHAK Guest House & Conference Centre in developing a new Business Strategy

Outcome 6.2.4: Excellent conference centre hosting trainings and meetings

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Develop a Business Strategic Plan & for CHAK Guest House & Conference Centre and ensure its implementation	Business Strategic Plan and annual Business Plans with performance targets	Strategic plan	Once
b)	Monitor performance on business strategy implementation	4 reviews annually – quarterly Guest House Management Committee meeting minutes	Reports	Quarterly

7.0 Grant Management

Objective 7.0: Strengthen CHAK Secretariat capacity to effectively manage grants

Outcome7.0: Grants are sourced, received, disbursed and accounted for on a timely basis

Impact: Efficient, reliable and accurate grant management systems

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Train staff on grant management systems	6 staff trained annually	Report	On-going
b)	Establish a grant management system at CHAK to receive, disburse and account for grants	Increase the number of grants managed by 10% annually	Report	On-going
c)	Ensure compliance with Grant Management Policy and donor requirements	Sustained donor funding	Reports	On-going

8.0 Total Quality Management and Patient Safe Care

8.1 Develop and implement Total Quality management systems within the network on the KQMH framework

Objective 8.1: Establish a Total Quality Management System on the KQMH framework and applicable ISO Standards within a two year timeframe

Outcome8.1: At least 60% CHAK member hospitals have developed and implemented a total quality management system on the KQMH framework, including their health centers and dispensaries by 2016

Impact 8.1: High Quality Care in over 60% hospitals and their health units is provided within their catchment area

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Establish a quality focal person within the hospitals during the first year of the implementation process	100% of designated persons who work more than 75% as quality management officer and have a job description accordingly.	HR files	yearly
b)	Establish a policy for a Total quality management system in the hospital during the first year of the implementation process which is agreed by the Hospital management committee The basic principles of TQM are conducted (patient exit surveys, suggestion boxes for customers and employees, employee feedback	100% with signed policy documents on TQM system by the hospital management boards	Policy, Survey reports, Feedback reports	Yearly
c)	Quality Improvement Teams (QIT) and Work Improvement Teams (WIT) for each department in place to work with the PDCA/PDSA Cycle during the first	80% of all trained QITs and WITs work with the PDCA Cycle 9 months after the implementation process	Minutes and reports e.g.	yearly

	6 months of the implementation process.		reports	
d)	Formulate their key processes in the hospital and hospital departments during the first year of the implementation process. A review system is in place	100% out of the 60% of member hospitals which have their key processes defined and documented	TQM Folders	yearly
e)	The departments are organized after the 5s, as detailed in KQMH	100% of the trained hospitals which have a 5s culture implemented	Internal audits reports	6 months
f)	Internal are done every 6 months and external audits once a year.	90% of trained hospitals which have carried out internal and external assessment according to the Policy documents.	Internal and external audits reports	6 and 12 months
g)	Actions out of audits are documented in an action plan and carried out under PDCA-Cycle	A continuous quality improvement system is implemented	PDCA plans	yearly

8.2 Educate and supervise staff in quality management systems including KQMH

Outcome 8.2:100% of all QITs and WITs are trained in Total quality management and KQMH and 80% work as Trainer of Trainers after 18 months.

Objective 8.2: Establish a Total Quality Management System on the KQMH framework and applicable ISO Standards within a two year timeframe

Impact 8.2: Sustaining the total quality management system

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Development of a module course with a step wise approach on the basis of the KQMH curriculum and others scientific based sources	Curriculum of the module course including presentations and other needed material is available after 3 months.	Curriculum and associated papers	End of 2013
b)	Rolling out of the training in interested hospitals which runs for at least 12 months.	At least 60% interested hospitals are trained.	Reports	After each module by facilitator
c)	Coaching of the quality focal person	100% of all quality focal persons are competent in Total quality management and their work	Quality Assessment	End of 24 months coaching

8.3 Institutionalize quality management in health in the network

Objective 8.3: Each year the MHU's include at least two objectives on TQM in the annual operational plan and allocate a budget.

Outcome 8.3: At least 60% of the member hospital facilities have TQM objectives in their annual operational plan supported by a budget

Impact 8.3: Sustaining the MHU's high quality health care

No	Activities	Indicators	Data source	Freq. Of reports.
a)	Sensitization and advocacy work for Total Quality Management through secretariat	6 CHAK secretariat involvement in sensitization of TQM annually	Workshops and Publications	yearly
b)	1. Development of the objectives out of the results of the audits and M&E by the hospital management committee and selected members of the QIT, including	100% of all trained hospitals have TQM objectives in their AOPs.	AOP	Yearly

	and selected members of the QIT, including quality focal person. 2.Quality focal person is in the budget planning			
c)	The hospital or special departments of the hospital are certified through an independent body (e.g. ISO)	20% of all trained hospitals/hospital departments which are certified/or in the process to be certified	Certificate	Yearly/ Every second year

8.4 Establish Centers of Excellence in Total Quality Management for Health (Hospital level) in the network

Objective 8.4: Identify leading member hospitals in TQM within their own structure as well as a resource for training, evidence based knowledge, research and science within the network and on a national and county level by 2016

Outcome 8.4: A minimum of 2 member institutions become centers of excellence

Impact 8.4: Maintaining high quality of health care by being a leading organization in TQM

No	Activities	Indicators	Data source	Freq. Of reports.
a)	1.Health facility implemented the first three strategic points 2. A staff member is allocated to coordinate TQM	Centers of Excellence have all (100%) allocated a person who is doing research, information distribution and training on TQM for at least 25% of their working time	HR file	yearly
b)	1.Develop criteria and conduct an assessment of willing TQM implementing hospitals 2.Sensitization on the role of a Center of Excellency	Criteria and Assessment to show success in TQM is developed and applied in order to be selected as Center of Excellence	Criteria and assessment	2014

1.5 Establishing of a functioning peer learning structure within the network

Objectives 8.5: Dispensaries and health centres are trained and supported to maintain TQM in the network by 2016

Outcome 8.5: A peer learning system is established with the MHU's affiliated to the 14 hospitals by 2016

Impact 8.5: Maintaining TQM in tier 2 health facilities

No	Activities	Indicators	Data source	Freq. Of reports.
a)	The quality management focal person ensures that the all facility employees have a training in TQM	80% trained in TQM in tier 2 affiliated health facility.	Reports	Yearly
b)	The quality focal person is holding quarterly mentorship sessions with the affiliated health facilities	12 mentorship session per year, including attendance and content of the session per trained hospital	Minutes	Yearly
c)	An audit on TQM is done every 6 months in the health facility.	2 audits per year are conducted in every affiliated tier 2 health facility	Audit report	yearly

8.6 Sustaining the TQM and Patient Safe Care project

Objectives 8.6: Maintaining and sustaining TQM for the network over the time of the duration of the seconded expertise and beyond

Outcome 8.6: The project is passed on to a counterpart at least 6 months prior to the expertise exit (so far Feb. 2015)

Impact 8.6: Sustaining TQM approach in the network

No	Activities	Indicators	Data source	Freq. Of reports.
a)	A counterpart is mentored in the objectives of the project	The counterpart knows the objectives of the project. The counterpart has no concerns in taking over the project	Orientation checklist	After 3 and 6 months
b)	The counterpart is introduced to the necessary contact and KQMH/TQM network	At least 90% contacts introduced	Contact checklist	After 3 and 6 months
c)	The network is informed about the change	At least 90% of the network members are informed about the change	Media –Email, Mobile, Print media	4 month

9.0 Devolution

Objective 9.1: To develop a framework for partnership and engagement between MHUs and the county health systems

Outcome 9.1 Effective partnership and engagement between MHUs and the county health systems

No	Activities	Indicators	Data source	Freq. of reports
a)	To participate in County Health Policy development activities/process	Participated in atleast 80% County Health Policy development meetings in every year.	Meeting minutes Reports	Quarterly
b)	To participate in various relevant County Forums	Participated in atleast 80% County fora every year.	Reports	Quarterly
d)	To organise for county introductory meetings	41 Introductory meetings held annually	Reports Meeting minutes	Quarterly

Objective 9.2: To mobilize and channel resources for effective county engagement

Outcome 9.2: MHUs integrated in the County health system and are adequately supported with required resources for service delivery

No	Activities	Indicators	Data source	Freq. of reports
	Project formulation and proposal writing To market written proposals	At least 2 proposals are written and funded annually	Reports Reports	Quarterly Quarterly
	Networking with partners including County health officers	Increased number of devolution network to 30 % annually	Meeting minutes Attendance registers	Quarterly

Revised Strategic Plan 2011-2016

P.O. Box 30690, 00100, GPO, Nairobi, Kenya,
Tel: (+254) 722 203 617 / 733 334 419 / 0718 180 967
secretariat@chak.or.ke
www.chak.or.ke