REPUBLIC OF KENYA

MINISTRY OF HEALTH

REHABILITATIVE SERVICES AND ASSISTIVE TECHNOLOGY STRATEGY

2022-2026

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Ministry of Health Kenya. Rehabilitative Services and Assistive Technology Strategy Framework, aims to build a progressive and sustainable rehabilitative healthcare sub system that enables individuals with functional limitations and participation restrictions to attain the highest quality of life.

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ACRONYMS

AT Assistive Technology
ASHA American Speech-language-Hearing Association
CBO Community Based Organization
CBR Community Based Rehabilitation
CDH County Director for Health
CEC County Executive Committee Member
CHMT County Health Management Team
COH County Officer for Health
CRH County Referral Hospital
DHIS District Health Information Systems
EARC Education assessment and Resource Centre
ENT Ear Nose and Throat
FBO Faith Based Organization
HMIS Health Medical Information Systems
HR Human Resource
HRH Human Resources for Health
ICF International Classification of Function
KEBS Kenya Bureau of Standards
KEMRI Kenya Medical Research Institute
KEMSA Kenya Medical Supplies Authority
KEPH Kenya Essential Package for Health
KISE Kenya Institute of Special Education
KNBS Kenya National Bureau of Statistics
KNH Kenyatta National Hospital
KRA Kenya Revenue Authority
LMIS Logistic Management Information Systems
M&E Monitoring and Evaluation
MDAs Ministries, Departments and Agencies
MOE Ministry of Education
MOH Ministry of Health
MTRH Moi Teaching and Referral Hospital
NCD Non-communicable Disease
NCPWD National Council for Persons with Disabilities
NGO Non-Governmental organization
NHIF National Hospital Insurance Fund
OPD Out Patient Department
PWDs Persons with Disabilities
RATICC Rehabilitative and Assistive Technology Interagency Coordinating Committee
RTWG Rehabilitation Technical Working Group
SCH Sub County Hospitals
SDG Sustainable Development Goal
SHMT Sub County Health Management Team
SWOT Strength, Weakness, Opportunity and Threat
TWG Technical Working Group
UHC Universal Health Coverage
UNCRPD United Nations Convention on the Rights of the Persons with Disabilities
WHO World Health Organization

DEFINITION OF TERMINOLOGIES

Assistive devices are devices whose primary purpose is to maintain or improve an individual's functioning and independence to facilitate participation and to enhance overall well-being.

Assistive technology is an umbrella term covering the systems and services related to the delivery of assistive products and services.

Audiologists and Speech Therapists are therapists who evaluate, manage and treat physical disorders affecting human hearing, speech communication and swallowing. They prescribe corrective devices or rehabilitative therapies for hearing loss, speech disorders, and related sensory and neural problems. They plan hearing screening programs and provide counseling on hearing safety and communication performance.

Community Based Rehabilitation is a community development strategy that aims at enhancing the lives of persons with disabilities (PWDs) within their community.

Dental officer: Diagnose, treat and prevent diseases, injuries and abnormalities of the teeth, mouth, jaws and associated tissues by applying the principles and procedures of modern dentistry. They use a broad range of specialized diagnostic, surgical and other techniques to promote and restore oral health.

Dermatologist: Is a doctor who specializes in treating skin, hair, nails, mucous membrane diseases and disorders. Disability refers to the interaction between individuals with a health condition, personal and environmental factors which significantly limit their ability to function normally.

ENT Specialist: is a doctor who specializes in diseases that affect the ears, nose and throat as well as head and neck.

General surgeon: Doctor who specializes in surgical procedures for a wide range of common ailments.

Occupational Therapy: Is a client-centered health profession concerned with promoting health and wellbeing through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.

Oncologists: Doctors who specialize in diagnosing and treatment of cancer

Ophthalmologist: a specialist who provide diagnosis, management and treatment services for disorders of the eyes and visual system. They counsel and advise on eye care and safety, and prescribe optical aids or other therapies for visual disturbance.

Orthoses: Branch of medicine that provides splints, braces or special footwear. It supports the body part for the purpose of stabilization, support or movement reminder.

Orthopedic surgeon: A doctor who specialize in prevention, diagnosis and treatment of diseases and injuries of the musculoskeletal system –bones, joints, muscles, ligaments, tendons etc.

Orthopedic Technologists: Health workers, who assess and treat physical and functional limitations resulting from congenital impairments, illness, traumatic injuries etc. They assess, prescribe design, fit, monitor and educate on use and care of an appropriate orthosis/prosthesis or mobility devices that serve individual's functional requirements.

Pediatrician: A doctor focusing on the prevention, diagnosis and treatment of health problems in infants, children and adolescents.

Persons with disabilities: Persons with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others.

Physician: A doctor who usually focuses on non-surgical treatment of patient conditions.

Physiotherapists: Assess, plan and implement rehabilitative programs that improve or restore human motor functions, maximize movement ability, relieve pain syndromes, and treat or prevent physical challenges associated with injuries, diseases and other impairments. They apply a broad range of physical therapies and techniques such as movement, ultrasound, heating, laser and other techniques. They may develop and implement programs for screening and prevention of common physical ailments and disorders.

Prosthesis: An artificial appliance which substitutes the anatomically missing component.

Prosthetist and orthotist: a health care professional who have overall responsibility of prosthetic and orthotic treatment. They prescribe, test and adjust orthotic and prosthetic devices.

Psychiatrist: Focusing on the study and treatment of mental illness and behavioral disorders.

Rehabilitation is a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment.

Rheumatologist: Specialized physician who has expertise in treating arthritis, and other musculoskeletal conditions and autoimmune disorders.

ICF: The international Classification of Functioning, Disability and Health is a classification of health and health related domains. As the functioning of an individual occurs in a context, ICF also includes a list of enviromental factors. ICF is a WHO framework for measuring health and disability at both individual and population levels.

Neurologist: Medical professionals that specialize in diagnosing and treating conditions affecting the nervous system. Introduction

Rehabilitation: Defined as a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment. It is rebuilding or relearning skills that were lost.

Habitation: Refers to a process aimed at helping disabled people attain, keep or improve skills and functioning for daily living. Involves learning and mastering brand-new skills particularly if the person learning those skills is developmentally disabled

FOREWORD

I am delighted to present to you the Rehabilitative Services and Assistive Technology Strategy (2022–2026), which outlines the strategic vision and goals we have identified to help the Ministry of Health realize its full potential and better fulfill its mission to serve the wider Kenyan population.

The process of formulating this Strategic Plan has given us the opportunities to take stock on past successes and failures, to determine our visions and future goals in the light of challenges ahead, and to put forward strategies for our development not only in response to changing needs but also as an active and participating agent to upscale rehabilitative services and increase access to Assistive Technology.

The strategic areas highlighted here attest to our commitment to achieve excellence in provision of rehabilitative services and assistive technology through our core functions of Health policy, Health regulation, National Referral Health facilities, Capacity Building of health work force and offering technical assistance to Counties. This Strategy is an ambitious plan that defines how we will upscale Rehabilitation services and Increase Access to Assistive Technology for the next five years.

This Strategic Plan is a Ministry of Health responsibility and aims to strengthen leadership and governance of rehabilitation, and increase access to rehabilitation services and Assistive Technology to persons who require these services. The Ministry of Health therefore shall spearhead the implementation of this strategy together with stakeholders and partners.
Finally, I thank all the stakeholders who tirelessly put in effort in the development of this strategy.

Sen. Mutahi Kagwe, EGH
Cabinet Secretary for Health

ACKNOWLEGDEMENT

The Ministry of Health would like to thank all the internal and external stakeholders who invaluably contributed to the development of this Rehabilitative Services and Assistive Technology Strategy (2022 - 2026).

I am certain that the full application of this Strategy will contribute to decreasing the economic burden of non - communicable diseases, aging, road traffic accidents and neuro-musculoskeletal disorders on the Kenyan Population, mostly those living with disabilities. The Strategy will also contribute to equitable, affordable and efficient provision of rehabilitative services.

Finally, my sincere gratitude goes to Clinton Health Access Initiative (CHAI) for their continued support, both technically and financially, to ensure that this process has culminated into the Strategy that will help improve the quality of rehabilitation services in Kenya. This work was implemented under the AT 2030 programme, which is funded by UK Aid from the UK government and led by the Global Disability Innovation Hub.

Susan N. Mochache, CBS
Principal Secretary

PREFACE

Today, rehabilitation is considered an integral part of Universal Health Coverage services. Rehabilitative services are essential to ensuring the population improves their quality of life. This is a maiden strategy for rehabilitative services in Kenya. This Rehabilitative Services and Assistive Technology Strategy seeks to increase the accessibility, quality and outcomes of rehabilitation and assistive technology services.

The Strategy borrows heavily from the WHO tools in its development, the process entailed a comprehensive situation analysis whose findings informed the Strategy. The Strategy sheds light on the role of the Ministry of Health, being pivotal in providing rehabilitative services and integrating the same services into the primary, secondary and tertiary services. Another important aspect is the adoption of regulations, practices and rules to enhance the rehabilitation governance as well as increasing access to assistive technology to ensure the provision of high-quality rehabilitative services. Moreover, it focuses on capacity building and training of health professionals, which is one of the core mandates of the Ministry of Health. It is a comprehensive, coherent and beneficial strategic plan that will guide National and County Governments through the process of scaling up rehabilitation and assistive technology services.

The Rehabilitative Services and Assistive Technology Strategic Plan, FY 2022 - 2026, is aligned with the Ministry of Health priorities. The goals and initiatives of this document will provide guidance for the Ministry of Health over the next five years as we develop and implement projects to serve objectives geared towards scaling up rehabilitative services and increasing access to assistive technology. Development of this strategic plan was guided by feedback from internal and external stakeholders. The overall objective of this five-year strategic plan is to scale up rehabilitation services and increase access to assistive technology. Through implementation of this Strategic Plan, the Ministry of Health will move steps closer towards achieving Universal Health Coverage, a key pillar of the Government's Big Four Agenda.

Dr. Patrick Amoth, EBS
Ag. Director General for Health

1 INTRODUCTION

INTRODUCTION

1.1 Background

Rehabilitation is a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment (World Health Organization, 2019). A person with a health condition, including chronic diseases or disorders, injuries or traumas is likely to experience limitations in functioning. Examples of limitations in functioning include difficulties in thinking, seeing, hearing, communicating, moving around, or keeping a job. Rehabilitation enables individuals of all ages to maintain or return to their daily life activities, fulfil meaningful life roles and maximize their well-being.

Rehabilitation is a highly person-centred health strategy that may be delivered either through specialised rehabilitation programmes (commonly for people with complex needs), or integrated into other health programmes and services, for example, primary health care, mental health, vision and hearing programmes (World Health Organization, 2019). Rehabilitation services are offered by rehabilitation specialists across the different disability domains and limitations in functioning. Example of specialists offering rehabilitation services are Physiotherapists, Occupational Therapists, Orthopaedic Technologists, Prosthetists/Orthotists, Psychiatrists, Mental Health Specialists, Ophthalmologists and other Vision Specialists, Speech and Language Therapists, Audiologists and other Specialists. In addition to the rehabilitative services being offered in health facilities, they are also offered in community setting through comprehensive community-based rehabilitation programs. . To complement rehabilitation, habilitation of children is important to ensure acquisition of skills at the right age. Habilitation is designed to establish skills that have not yet been acquired at an age-appropriate level; and need to begin at the earliest possible stage based on multidisciplinary assessment of individual needs and strengths.

Despite the setting in which services are offered, rehabilitation is aimed at maintaining or improving a person's functioning within their unique context and activities of daily living. For example, sensory functions or seeing function can be affected necessitating need for rehabilitation. As such, this Strategy looks at the situation for different disability domains. The disability domains detailed herein are: physical disabilities and progressive chronic conditions, visual, hearing and speech impairment and, mental health disorders, autism spectrum disorders and intellectual disability. These disability domains require different rehabilitative services for the associated health conditions.

In addition, 1 billion people worldwide need assistive technology (AT) to lead productive, inclusive and dignified lives, but only 1 in 10 people globally have access to the AT they need. Access to AT is essential for many people to maintain and improve function, health and well-being, and to participate in education, work and social activities. Among the people who commonly need AT are older people, people with disabilities and people living with chronic conditions. As the world population ages and

the prevalence of noncommunicable diseases increases, the need for AT will continue to rise (WHO, 2018).

1.2 Rationale of the Strategic Plan

This Strategic Plan is geared towards addressing the current scenario of

- Lack of prioritization, funding, policies and plans for rehabilitation at all levels
- Lack of adequate rehabilitation services outside urban areas, and long waiting times
- High out-of-pocket expenses and non-existent or inadequate funding mechanisms
- Inadequate trained rehabilitation professionals, with less than 10 skilled practitioners per one million population in many low- and middle-income settings
- Lack of resources and assistive technologies
- Inadequate opportunities for training rehabilitation professionals
- No available data on disability hence need for more research
- Ineffective and under-utilized referral pathways to rehabilitation
- Lack of early intervention services
- Sectors and different cadres working in silos

1.3 Significance of the Rehabilitative Services

Kenya is committed to making progress towards achieving optimal rehabilitative care for all and streamlining rehabilitative service delivery at all levels of care. This is in line with key frameworks. Under the Bill of Rights (section 54 (1)) in the Constitution of Kenya, a person with any disability is entitled to be treated with dignity, access to public places and information and access material and devices to overcome constraints arising from the person's disability. As such, it is through rehabilitation care that a person who needs such services will be able to enjoy their rights as stipulated in the Constitution. In addition, the Sustainable Development Goal 3 (SDG 3) emphasizes the need for Universal Health Coverage including financial risk protection and access to essential healthcare services.

Rehabilitative service care in Kenya started between 1942 and 1946 in the areas of Occupational Therapy, Physiotherapy and Orthopaedic Technology and henceforth, the Ministry has been offering rehabilitative services. Given rehabilitation is not solely a medical intervention and also encompasses socio-economic aspects key to wholesome rehabilitation care and wellbeing of a person, the Ministry of Health and rehabilitation teams work with other key Government Ministries, Departments and Agencies (MDAs) key in ensuring person's wholesome care. Some of key MDAs to this course are the Ministry of Public Service, Gender, Senior Citizens Affairs and Special Programmes and the National Council for Persons with Disabilities (NCPWD) which was established through Act of Parliament; the Persons with Disabilities Act No. 14 of 2003. MDAs are fundamental in ensuring the social-economic aspect and policies relating to wellbeing of persons who have gone through rehabilitation care and the vulnerable in society are also taken care of too.

At the Ministry of Health, rehabilitative services are critical in both preventive and curative care and the Rehabilitative Services Unit has a mandate to:

1. Develop policy and guidelines
2. Build capacity for practice and create awareness
3. Provide technical assistance to Counties
4. Ensure provision of rehabilitation services
5. Disability mainstreaming
6. Regulate practice
7. Research in rehabilitation services
8. Monitor and evaluate practice
9. Build partnerships and mobilization for resources

With the promulgation of the 2010 Constitution, rehabilitative service delivery among other health functions, was

subsequently devolved to counties and the National Government is essential in the development of policy and guidelines, capacity building, regulation of practice, research, monitoring and evaluation of rehabilitation practice in Kenya. Despite progress made over the years in rehabilitative practice, the country has not had a strategy document on rehabilitation services. Lack of a strategy document has resulted into, among other challenges, lack of clear leadership and governance for rehabilitation services at both National and County levels, limited resource allocation towards rehabilitation services, poor scaling up of services to all levels of care and limited access to assistive devices. Streamlining and scaling up rehabilitation services is in line with the Vision 2030 Social Pillar, the "Big Four" agenda, the SDG 3, and Kenya's commitments globally including the UN Convention on the Rights of Persons with Disabilities (Kenya Vision 2030, 2008).

In addition, the Government of Kenya co-hosted the Global Disability Summit 2018 together with the UK government's Department for International Development and the International Disability Alliance (IDA). The aim of the summit was to galvanise global efforts to address disability inclusion in the poorest countries in the world. Objectives of the summit were to: raise global attention and focus on a neglected area, bring in new voices and approaches to broaden engagement, mobilise new global and national commitments on disability and showcase best practice and evidence from across the world. Kenya being a co-host of the summit that span over 500 commitments on matters disability is not being left behind as different Ministries, Departments and Agencies (MDAs) are working to meet commitments made at the summit. Some of the key commitments are: addressing stigma and discrimination, economic empowerment for persons living with disability and increasing access to assistive technology. These are in line with the Rehabilitation Services Unit's mandate of providing services and building capacity for practice.

Through the commitment and implementations key in scaling up rehabilitative services and strengthening the health system, the Ministry will increase access to essential services in both preventive and curative care at all levels of care. As a result of the implementations, the Ministry will contribute to achieving commitments made at the global scale on matters disability through upholding inclusion and empowerment as a result of offering high quality rehabilitation services.

1.4 Significance of Assistive Technology to all People

Assistive technology is an umbrella term covering the systems and services related to the delivery of assistive products and services (World Health Organization, 2018). Over 1 billion people globally need one or more assistive technology. With an ageing global population and a rise in non-communicable diseases, it is estimated that more than 2 billion people will need at least one assistive device by the year 2030, with older people needing two or more.

Assistive technology is significant to all since it enable users to live healthy, productive, independent, and dignified lives, and to participate in education, the labour market and civic life. Without assistive technology, users are not able to take part in key activities of daily living and as a result, are locked into poverty, thereby increasing the impact of disease and disability on a person, their family, the society and eventually a national burden. All people are candidates for utilizing assistive technology with the dynamic health and socio-economic conditions we live in thus the need to address gaps around policy, products, provision and personnel key in provision of appropriate assistive technology. People who most need assistive technology include: people with disabilities, older people, people with noncommunicable diseases such as diabetes and stroke, people with mental health disorders including dementia and autism and people with gradual functional decline (World Health Organization, 2018).

Despite the estimated increase in need of assistive technology owing to ageing global population and rise in non-communicable diseases, Kenya has huge gap when it comes to access to appropriate assistive technology. As such, many people are not able to participate in activities of daily living. The National Strategy also details plan of action to increase access to appropriate assistive technology in Kenya.

1.5 Development of the Rehabilitative Services and Assistive Technology Strategy 2022-2026

The development of the Rehabilitative Services and Assistive Technology Strategy 2022-2026 was informed by existing

gaps in provision of rehabilitative services by both national and county levels. The process of establishing whether gaps exist commenced through consultative approach between partners and the Ministry of Health. As a starting point, a nation-wide survey was done across all counties in October and November 2019 to establish gaps in rehabilitative service delivery. Subsequently, a team comprising of representative from Ministry of Health together with key stakeholders was brought together to develop a National Strategy to address gaps in rehabilitative services.

After conducting an initial stakeholders' workshop in September 2020, a drafting team with inputs from all members drafted the National Strategy. A follow up stakeholders' workshop was conducted in March 2021 where inputs were incorporated into the National Strategy.

To provide a crucial foundation for addressing the challenges hindering optimal provision of rehabilitative services and strengthen the health system, major strategies in this framework include: increase accessibility of rehabilitative services to

2 SITUATION ANALYSIS

SITUATIONAL ANALYSIS

2.1 Global Situation on Rehabilitative Services

According to the World Health Organization, there is an increasing need for rehabilitation worldwide associated with changing health and demographic trends of increasing prevalence of non-communicable diseases and ageing population. The proportion of individuals aged over 60 is predicted to double by 2050 and there has been an 18% increase in the prevalence of non-communicable diseases in the last 10 years. In addition, 15% of all years lived with disability are caused by health conditions associated with severe levels of disability. Therefore, rehabilitation is a fundamental health intervention and core part of effective health care for all people who need it not necessarily persons with the highlighted health conditions or those with long-term health impairment (World Health Organization, 2019).

There are new demands being placed on the current health system with demographic changes and health trends causing need for rehabilitation to grow rapidly. Health conditions often impact on an individual's functioning and are associated with increased levels of disability. Despite these statistics, the demand for rehabilitation is going largely unmet due to a number of factors which include:

- Lack of prioritization, funding, policies and plans for rehabilitation at a national level.
- Lack of available rehabilitation services outside urban areas, and long waiting times.
- High out-of-pocket expenses and non-existent or inadequate means of funding.
- Lack of trained rehabilitation professionals, with less than 10 skilled practitioners per 1 million population in many low- and middle-income settings.
- Lack of resources, including assistive technology, equipment and consumables.
- The need for more research and data on rehabilitation.
- Ineffective and under-utilized referral pathways to rehabilitation.

2.2 Regional Rehabilitative Services Situation In Africa Continent

Within Africa, rehabilitation need is hugely unmet because services are insufficient and flawed with inadequate commitments and collaborations of stakeholders. In tandem with the global situation with regards to the unmet need for rehabilitation services which the WHO puts at more than 50% in some countries, several studies from Africa, for example, show that between 62.5% and 82.5% of those needing rehabilitation services don't receive them (Mozambique 62.3%; Malawi 76.2%, Zambia 62.5%; and Lesotho 82.5%).

The unmet need for rehabilitative services in Africa is driven by different causes among them, infrastructures and expertise

for rehabilitation are scarce and poorly coordinated. Community-based rehabilitation programs are fragmented and fractured and lack working partnership with rehabilitation services in health care systems. In addition, it is clear that responsive policy frameworks, working service delivery models, and health governance practices are prerequisites for meeting rehabilitation needs of the ever-increasing number of persons with chronic disabling conditions in the continent. However, this is not the case at the moment since the rehabilitation space is hugely fragmented. Concerted global and regional efforts are required for equitable and accessible coordinated continuum of rehabilitation care at various levels of health services and the community in most Sub-Saharan African countries (Geberemichael, et al., 2019).

2.3 Outlook Of Rehabilitative Services In Kenya

Rehabilitation services in Kenya started in early 1940s. It was not until later (1966 for Physiotherapy, 1968 for Occupational Therapy and 1972 for Orthopaedic Technology) that formal training was started by government and rehabilitative services were incorporated within the health care system in the country. Following the incorporation of rehabilitation services in the Ministry of Health service charter, Physiotherapy, Occupational Therapy and Orthopaedic Technology services offered progressively in in level 6, level 5 and several level 4 and some level 3 facilities across the country.. At the National level, rehabilitation services entail the Physiotherapy, Occupational Therapy and Orthopaedic Technology services and Community Based Rehabilitation which are organized under the Rehabilitation Services Unit at the Ministry of Health. In addition, other directorates and divisions within the Ministry are also critical in rehabilitation too. Matters relating to vision impairment, mental health disorders and progressive chronic conditions which lead to disabilities or need of rehabilitation are housed in different divisions or units. Below is the current organogram of the Ministry of Health. Rehabilitative services fall under the Department of National Health Systems Strengthening, Division of National Referral Services.

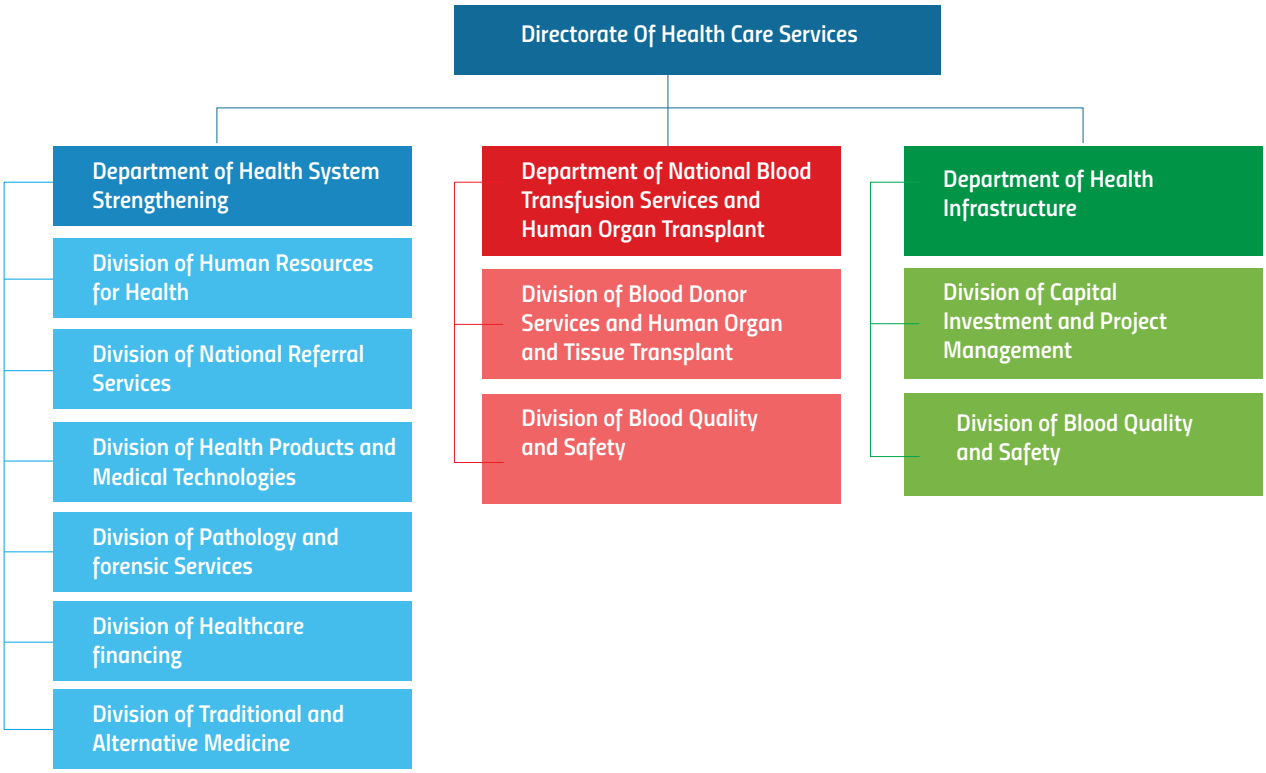


Figure 1: Ministry of Health Directorate of Healthcare Services Organogram

In reference to the above organogram, it will be difficult to cascade and operationalize the rehabilitation policies to the counties. The Unit will be able to address the issues of rehabilitation if it is considered as a division and thus an authority to incur expenditure (AIE).

However, the situation is not the same in counties. Most counties do not have rehabilitation services representation within the

County Health Management teams and as such scaling up rehabilitation services in the county is a challenge. Rehabilitation services in most counties are only available at level 5 and some level 4 facilities. A survey by the MOH Rehabilitative Services team in 2019 found out that the country has less than 1500 rehabilitative officers in all the level 5 and level 4 facilities across the country despite the population of Kenya having increased to 47 million. According to Kenya demographic health survey, the disability prevalence rate in Kenya is estimated at 10% of the population (4.44 million people). 66% of the disabled population lives in the rural areas including remote parts of the Busia and Siaya counties. The age group most affected is ages 0-14 which is at 43.4% (1.92 million people). This is concerning because disability early in life can have a negative impact on school attendance, quality of life and productivity for many years to come.

Effective management of children with disabilities through effective medical intervention will minimize possibility of permanent disability and further ensure the children are integrated in society and are able to realize their full potential through productive opportunities. Additionally, community awareness creation and proven efficacy of the project will enhance secondary disability prevention by ensuring health problems are identified early and services and referrals are provided rapidly The 2019 Population and Housing Census put the population of Kenyans over 55 years of age at over 3.5 million (KNBS, 2019). Despite the country having a youthful population with heavy distribution at below 30 years of age, the aging population needs to be taken care of too because they are more predisposed to needing one or more rehabilitative services. With the existing shortage of rehabilitative staff in most counties and most of the rehabilitative staff based in towns where county and sub county facilities are located, it is an uphill task for the aging population to access rehabilitative services given most of the aging population is located in rural areas where rehabilitative services are not available.

In addition to the aging population who risk not accessing much needed rehabilitative services, the projected growth of non-communicable diseases (NCDs) in Kenya is also a cause of alarm especially when looking at progressive chronic conditions which may result into disabilities and need for rehabilitative services at some point owing to poor prognosis. The Kenya National Strategy for the Prevention and Control of Non-Communicable Diseases project that NCDs will grow by over 20% by the year 2030 and also result into deaths of over 150,000 people annually from the current approximately 100,000 deaths annually (Ministry of Health, 2015). Given NCDs are contributors to disabilities and increase in demand of rehabilitative services, the country needs to plan on scaling up rehabilitative services so as to handle the current demand for rehabilitative services and also be able to deal with future demand arising from disability contributing factors such as NCDs.

To scale up rehabilitative services in Kenya, the country needs to examine the service delivery environment and the supply chain of key commodities and assistive technology, beyond the existing staff shortage in rehabilitation. At the moment, there exist huge gaps in service delivery environment and supply chain. In all counties, rehabilitative staff lack infrastructure and equipment crucial for rendering ideal rehabilitative services. In addition, supply chain is a gap because most facilities do not have budget allocation for rehabilitative services and as such, basic consumable are not available for them to render rehabilitative service and lastly, no facility in Kenya budgets for assistive devices to be issued to users and persons with disabilities for their use outside the facilities. This huge gap needs to be addressed by prioritizing investment in streamlining service delivery and supply chain.

2.4 Swot Analysis On Rehabilitative Services

To understand both the internal and external environment within which rehabilitation services are offered in Kenya, it is significant to map out the Strengths, Weakness, Opportunities and Threats in the rehabilitation services ecosystem. The table below summarizes the SWOT analysis on rehabilitative services.

Table 1: SWOT Analysis on Rehabilitation Services

SWOT ANALYSIS ON REHABILITATION SERVICES				
	Strength	**Weakness**	**Opportunity**	**Threat**
Leadership and organization	Availability of rehabilitation leadership at the national level	Lack of adequate rehabilitation representation at decision and policy making level	Progressive Schemes of Service	Lack of substantive rehabilitative leadership at all levels Poor implemented staffing establishment
Financial	Elaborate budgeting process at national and county level, the Public Finance Management Policy on allocation of finances	Low or totally absent resource allocation to rehabilitative services and assistive technology at national and county level, lack of community-based rehabilitation funding	Lobby for inclusion of rehabilitative services and assistive technology in the NHIF and UHC	Few partners to support rehabilitative services, lack of transparency and accountability
Policy/ guidelines	Availability of: The Constitution; Bill of rights, the disability Act, and the Government ratification of UNCRPD	No rehabilitation strategy and policy, most rehabilitation services unregulated, no guidelines on provision of AT Lack of implementation of existing policy frameworks	Implement existing frameworks, develop policies/ guidelines to anchor rehabilitation service provision	Political interference with implementation
Human resources	Diverse areas of specializations: physiotherapy, occupational therapy ,orthopaedic technology, dentists, ophthalmologists, psychiatrists, orthopedic surgeons	Shortage of staff, professional stagnation, skewed service entry requirements	Progressive schemes of services Training opportunities in medical schools	Poor implementation of schemes of service thus affecting progression, promotion and practice
Service delivery	Availability of services at levels 6, 5 and some of level 4 facilities	Inadequate equipment, inadequate working spaces, lack of integration and collaboration among rehab professionals	Scale rehabilitative services to primary and tertiary facilities, sustainable financing to improve working environment	Poor integration between rehabilitative professional, poor inter sectoral multisectoral coordination
Assistive technology	Availability of few manufacturers/ fabricators of AT within Kenya, KEMSA has working supply chain model for nationwide reach	Limited access to appropriate assistive technology, challenge in distribution of AT, limited training on provision of AT	Incorporate AT into KEMSA supply chain, support counties to increase capacity for provision of AT, implement incentives for manufacturers of AT Forthcoming establishment of Centre of Excellence for AT in Kenya"	Political and unregulated issuance of assistive devices such as wheel chairs, lack of funding for research, innovation and production in rehabilitation

2.5 Situation Analysis per Disability Domains

The International Classification of Functioning, Disability and Health; commonly known as ICF provides a standard language and framework for the description of health and health-related states (WHO, 2018). ICF is a classification of health and health-related domains that help describe change in body function and structure. The classification takes into consideration contextual factors and health conditions in determining one's level of functioning. For example, sensory functions or seeing function can be affected. As such, this Strategy looks at the situation for different disability domains. The disability domains detailed herein are: physical disabilities and progressive chronic conditions, visual, hearing and speech impairment and, mental health disorders, autism spectrum disorders and Intellectual disability. The outlined disability domains require different rehabilitative services for different associated health conditions. Example of possible rehabilitation interventions according to the WHO are:

- Exercises to improve a person's speech, language and communication after a brain injury.
- Modifying an older person's home environment to improve their safety and independence at home and reduce their risk of falls.
- Exercise training and education on healthy living for a person with a heart disease.
- Making, fitting and educating an individual to use prosthesis after a leg amputation.
- Positioning and splinting techniques to assist with skin healing, reduce swelling, and to regain movement after burn surgery.
- Prescribing medicine to reduce muscle stiffness for a child with cerebral palsy.
- Psychological support for a person with depression.
- Training in the use of a white cane, for a person with vision loss.

As highlighted, the possible interventions are unlimited, vary by health conditions associated with each domain, and vary from person to person since rehabilitation is person-centred health strategy that appreciates each person's unique environment and instrumental activities of daily living, not just the underlying health condition. As such, the situation analysis is going to discuss under each domain: key categories of associated health conditions, access to service by Users or PWDs, policy/ guidelines for the domain, service delivery and assistive technology, specifying the assistive devices needed by PWDs under each domain. Below are definitions of disabilities and conditions that each domain discussed in this section entail.

Physical disabilities

Physical disabilities are conditions that affect a person's mobility, physical capacity, coordination, strength, limb length or dexterity. These conditions can be caused by conditions involving among others the neurological,musculoskeletal, global developmental delay, genetic disorders and congenital disorders. Specific types of physical disabilities include; brain or spinal cord injuries, multiple sclerosis, cerebral palsy etc. To manage physical disabilities, affected persons require rehabilitative services and assistive devices to enable them undertake activities of daily living.

Progressive chronic conditions

Progressive chronic conditions are diseases that have a duration that has lasted, or is expected to last at least 6 months, have a pattern of recurrence or deterioration, have a poor prognosis (gets worse with time) and produce consequences or sequelae that impact on the individual's quality of life. Categories of these conditions are: chronic obstructive pulmonary disease (COPD), chronic ischemic heart diseases, cystic fibrosis, rheumatic heart disease, fibromyalgia, severe osteoarthritis, Alzheimer's, Parkinson's, multiple sclerosis, hereditary neuropathy, epilepsy, liver cirrhosis, chronic pancreatic vertigo, psoriasis etc.

It is worth noting that as progressive chronic conditions change over time, they require different types of support specific to the condition and can be manifested as a physical disability at the point of deterioration or otherwise.

Visual Impairment

Visual impairment also known as vision impairment or vision loss occurs when an eye condition affects the visual system and one or more of its functions and causes a decreased ability to see to a degree that causes problems not fixable by usual means, such as glasses, intraocular lenses, contact lenses and surgery. To manage visual impairment, affected persons require visual rehabilitation.

Visual rehabilitation is a continuum of activities from assessment of visual functions through to provision of appropriate assistive

devices and technologies, and social inclusion, all geared towards optimizing visual functioning and a sense of wellbeing. Eye health services aims at providing promotive, preventive and curative services to prevent disability of visual impairment. In the event that all efforts to prevent a person from progressing to disability, fail, then interventions are offered to prevent further deterioration and also enable one to use the remaining vision potential. The eye health team contributes to the provision of/ provide links to an inclusive, supportive environment and facilitate access to rehabilitation, low vision care, including optical and non-optical assistive products to utilise remaining vision optimally, and services for those who are irreversibly visually impaired.

Hearing Impairment

Hearing impairment also known as deafness is usually the result of inner ear or nerve damage. It may be a congenital defect, injury, disease, certain medication, exposure to loud noise or age-related wear and tear. Management of hearing impairment may involve possible surgery or a hearing device. Lip reading skills, written or printed text and sign language may help with communication.

Speech and Language Impairment

This refers to an impaired ability to produce speech sound and may range from mild to severe with disorders such as stuttering, impaired articulation or impaired voice production. Speech disorders could be caused by developmental, genetic, behavioural or psychiatric causes.

Speech disorders affect the vocal cords, muscles, nerves, and other structures within the throat and mouth. Causes may include: vocal cord damage, brain damage, muscle weakness, cleft lip and palate, respiratory weakness, strokes, polyps or nodules on the vocal cords or vocal cord paralysis

Treatment varies and depends on the type of disorder. Mild speech disorders may not require any treatment as some speech disorders may simply go away. In speech therapy, a professional therapist guides a client through exercises that work to strengthen the muscles in the face and throat. Clients learn control of breathing while speaking. Muscle-strengthening exercises and controlled breathing help improve the way words sound.

Some people with speech disorders experience nervousness, embarrassment, low self-esteem and even depression. Speech therapies are helpful in these situations. A therapist discusses ways to cope with the condition and ways to improve the outlook of a client condition. If a client's depression is severe, antidepressant medications can help.

Language impairment is a disorder in one or more of the basic learning processes involved in understanding or in using spoken or written language. Language impairments have effects as inability to use grammatical sentences in conversation by avoiding complex sentences and struggling to produce clear, concise, well organized and grammatically accurate writing and speaking. Treatment depends on the age and needs of the person like helping individuals acquire missing elements of grammar, expand their understanding and use of words, develop social communication skills and also improve on their organizing information.

Mental Health Disorders

Mental disorders comprise a broad range of problems, with different symptoms. However, they are characterized by combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse.

Intellectual Disability

Intellectual disability means significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence) This results in reduced ability to cope independently (impaired social functioning) and begins before adulthood, with a lasting effect on development

Neurodevelopmental disorders

Neurodevelopmental disorders are a group of disorders that affect the development of the nervous system, leading to a slightly different brain function which may affect emotions, learning abilities and memory, more so in children. Examples of neurodevelopmental disorders are: attention deficit hyperactivity disorder (ADHD), autism spectrum disorders (ASD), communication speech and language disorders and specific learning disorders like dyslexia or dyscalculia.

2.5.1 Physical Disabilities Domain Current Situation and Barriers

Access to services by Users/ PWDs:

Access to rehabilitative services by users with physical disabilities is a challenge owing to: lack of services in nearby facilities and where services are available, they are not comprehensive. As a result, users have to travel long distances to reach facilities offering services. Additionally, lack of accessibility infrastructure such as rails, non-slippery walk ways and accessible consultation rooms in facilities, transport system and social amenities not being conducive for user movements, lack of awareness on rehabilitation services available at different facilities, slow implementation of community-based rehabilitation services and rehabilitative services being unaffordable owing to prohibitive costs are the other factors hindering accessibility to facilities and rehabilitative services by persons with disabilities.

Policy/ guidelines for physical disabilities and progressive chronic conditions:

Lack of appropriate policy has resulted in fragmented actions of various stakeholders. There is no implemented policy that informs access to services, financing and service provision for persons with physical disabilities. The country needs policy that informs rehabilitative services and assistive technology.

As a result of policy gaps, there are limited actions channelled to disability issues, data collection and funding because of lack of effective coordination of expected roles of County Governments, Legislative Assemblies, Public Service, Ministries (MOH, Treasury, Education, information and Communication; Transport, Labour & Social Protection, Sports, Interior and Coordination), Judiciary, NGOs, CBOs and FBOs.

Service delivery for physical disabilities and progressive chronic conditions:

Rehabilitative services for persons with physical disabilities are currently available in level 6, level 5 and most of level 4 facilities. However, this is not adequate because most primary level of care facilities (health centres and dispensaries) do not offer any rehabilitative services. This situation results in users travelling long distances in order to access services at referral facilities that do not have sufficient rehabilitative staff critical in providing services.

According to a nationwide assessment on rehabilitative services undertaken by the rehabilitative team at the Ministry of Health in 238 facilities across the country in 2019, there exists massive shortage in: number of facilities offering rehabilitative services, space to offer rehabilitative services and carders critical in providing rehabilitative services. The tables below summarized the outlined shortages:

Table 2: Proportion of Hospitals Offering Physical Disabilities Rehabilitative Services in Kenya

Rehabilitation Services	Number of surveyed facilities offering services	Proportion of surveyed facilities (N=238)	Percentage of county facilities offering service	Percentage of sub county facilities offering service
Physiotherapy	168	71%	100%	63%
Occupational Therapy	142	60%	98%	49%
Orthopaedic Technology	86	36%	40%	22%
Psychosocial therapy	62	26%	82%	24%
Wheelchair assessment and prescription	62	26%	54%	18%
Wheelchair assembly and issuance	26	11%	28%	4%

Table 3: Current Physical Disabilities Rehabilitation Staff and Gaps per the MOH Staffing Norms Guidelines

CADRE	CURRENT STAFF AT CRHS	GAP	CURRENT STAFF AT SCHS	GAP	TOTAL GAP
Physiotherapists	284	566	281	1462	2028
Occupational Therapists	187	413	144	1726	2139
Orthopaedic Technologists	130	170	62	499	699

In addition to the human resource gap, there exist skills and knowledge gap when it comes to offering rehabilitative services. Examples of noted gaps: inadequate number of personnel trained at specialized areas of rehabilitative services and provision of assistive technology such as wheelchairs, prostheses and orthoses, very few rehab personnel have progressed in their line of careers due to lack of funds/ availability of schools for advanced training within the country and lack of personnel specialized in bionic prosthetic systems, musculoskeletal biomechanical specialists and cardio-pulmonary.

Lastly, the working environment in most facilities does not enable efficient provision of rehabilitative services to persons with physical disabilities. This is so because appropriate equipment to offer rehabilitative services is generally unavailable. Example of key equipment lacking in most health facilities are: hoists for transfer, manipulation couch and shockwave therapy machines for physiotherapy; convection ovens, dust extraction equipment, band saws and vacuum forming equipment for orthopaedic workshops. In addition to lack of key equipment, rehabilitative staff in most facilities work in inadequate, out-dated or poorly maintained spaces and rehabilitative cadres is not organized as a department in most facilities.

Assistive technology for physical disabilities and progressive chronic conditions:

Appropriate assistive technologies needed for specific physical disabilities domains are:

- Mobility: - Wheelchair, crutches, walking frames, prostheses, transfer equipment e.g., hoists
- Self-care: Prosthesis, splints, adaptive hand equipment, adaptive cutlery and kitchen, adaptive toiletry, commodes
- Posture: Standing frames, splints, sitting aids and systems, corsets, pressure relieving equipment
- Sunscreen
- Environmental adjustments. For example, ramps and rails for physical access

Despite knowledge of assistive devices required by users, there exists massive gaps in provision and access to assistive devices owing to three broad reasons: financial, policy and supply chain gaps. Financial gaps exist in two folds – users do not access devices due to high prices (and NHIF schemes do not cover all AT) and capacity of local manufacturing having decreased owing to lack of financial incentives to stimulate local production and unavailability of key equipment in most facilities owing to high cost of appropriate equipment. Policy gaps exist because there are no adopted policy/ guidelines to anchor provision of assistive technology. Supply chain gaps exist owing to lack of adequate assistive technology, the leading government supplier the Kenya Medical supplies Authority (KEMSA)not supplying assistive technology and there being no quality testing of mobility assistive devices.

2.5.2 Visual, Hearing and Speech Impairments Current Situation and Barriers

Access to services by Users/ PWDs:

Access to rehabilitative services by users with visual, hearing and speech impairments is a challenge owing to the rehabilitative services they require being offered by very few facilities mostly in urban areas. As such, they have to travel for long distances, sometimes outside their counties to see the specialized services. In addition, there is lack of appropriate accessibility amenities at facilities to cater for these user (e.g., persons with hearing impairment need good posters and direction guides to service points in facilities and persons with visual impairment need audio guide to point of service and non-slippery/ non-bumpy walk ways to facilitate movement in health facilities). Also, accessibility is a challenge because: the transport system and social amenities beyond the facilities are not conducive for user movements, there lack of awareness on rehabilitation services available at different facilities, poverty which makes access cost prohibitive, lack of domesticated community referral system and community services that promote early identification and diagnosis of visual, speech and hearing impairment.

Additional challenges visually impaired users experience is: poor unclear signage at facilities (no braille, sound and sign language interpreters), lack of translated policy/ guidelines in both national / local language and braille, large and legible print for low vision users and translations to motherese language for younger audience. To compound the accessibility problem, delayed care seeking as a result of lack of awareness of cultural practices, especially for children, may aggravate their conditions which would otherwise benefit from early intervention.

Policy/ Guidelines for Visual, Hearing and Speech Impairments:

There exist multiple policies and guidelines within the visual, hearing and speech domains which are not fully implemented in

Kenya. Some of the frameworks are:

- Special Needs Education Policy 2009 –the policy purpose is to provide guidance to the Ministry of Education staff and other stakeholders in the provision of education to learners with special needs. The policy aims at ensuring that learners with special needs fully participate and are treated equally in learning activities at all levels. However, there is a gap in implementation of this policy because despite one of the strategies being MOE engaging other ministries on assessments and rehabilitation procedures, this has not been realized.
- National Guidelines for Identification and Referral of Children with Disability 2010–the guidelines purpose is to guide identification of particular disabilities and special needs of children with disability with the aim of providing them with appropriate interventions, both medical and social interventions. Despite the guideline detailing key interventions for such children, inter sectoral collaboration is currently not working hence identification and referral is a challenge.
- The Persons with Disabilities Act 2003 – the law aims at mainstreaming the disability space in Kenya through establishment of the National Council for Persons with Disabilities (NCPWD), detailing rights and privileges of PWDs and establishing the national development fund for PWDs. The law to date has however not been implemented fully as there are glaring gaps when it comes to PWDs access to health services, access to buildings and mobility and improvement of functioning since provision of appropriate assistive technology is a gap.
- ASHA guidelines for screening for speech and language delay and disorders in children (WHO), which provides methods for screening for speech and language delay in preschool-aged children. ASHA guidelines are internationally recognized yet their uptake and implementation in Kenya is a big gap.

Despite there being multiple local and international policies that can be domesticated and adopted to streamline service delivery within Kenya, implementation of guidelines in the disability domains of visual Impairment, hearing impairment and speech has not been optimized and there is need for dissemination and sensitization.

In addition, there are no guidelines on how to adjust buildings for accessibility, implement measures to prevent discrimination against PWDs and push for securing rehabilitation for PWDs within their own communities – all of which are provided for under PWDs rights as detailed in the Persons with Disabilities Act 2003. Specific to the current coordination challenge at both national and county level, there are no policy/ guideline specifying the involvement of rehabilitation officers in disability mainstreaming.

Service Delivery for Visual, Hearing and Speech Impairments:

Rehabilitative services for visual, hearing and speech impairments are currently available in level 6 and a few level 5 facilities only. Visual services offered are: eye screening, ophthalmology, low vision therapy, cataract surgery, vitreo retinal treatment and optical services. Hearing and speech services offered are: ear screening, audiogram, cochlear implant, hearing aids programming and fitting, speech audiometry and speech therapy. All these are very specialized services and the main point of access to services offered by the Ministry of Health is in level 6 and a few level 5 hospitals only. These services are not available at primary health care level. In addition to the few tertiary facilities offering these services, there are a few non-state actors who offer the services in informal settlements within Nairobi and very few urban settings across the country. This is a challenge as most users who need visual, hearing or speech services are not able to access due to services not being offered at level 4 and primary healthcare facilities. The services should be cascaded to all levels of care and the community.

Healthcare workers involved in visual, hearing and speech rehabilitation are: speech therapists, sign language interpreters, audiologist, visual rehabilitation officers, optometrists, specialists in ophthalmology, paediatricians, occupational therapist, and community health workers.

According to National Human Resources for Health and Standards and the National Eye Health Strategy 2020 – 2025, the shortage across cadres' key in providing visual, hearing and speech rehabilitation services are as follows for hospitals in Kenya. Note: primary level facilities have no staff who provide the specialized rehabilitation services for the domains.

Table 4: Current Visual, Hearing and Speech Disabilities Rehabilitation Staff and Gaps per the MOH Staffing Norms Guidelines

CADRE	CURRENT STAFF AT CRHS	GAP	CURRENT STAFF AT SCHS	GAP	TOTAL GAP
Speech therapists	0	94	0	258	352
Sign language interpreters	0	94	0	258	352
Audiologists	0	84	0	47	131
Audiology technologist	10	141	0	94	235
ENT /Audiology clinical officers	86	400	15	100	500
Optometrists	190				14
Ophthalmologist	145				45

In addition, there is need for specialized training for respective staff (and care givers) involved with visual, hearing and speech rehabilitation to bridge existing gap in: braille training, sign language, orientation and mobility guide for the visually impaired, shortage of speech therapist, sensory paediatric occupational therapists and audiologists.

In order to ensure optimal service delivery, the specialists involved with visual, hearing and speech rehabilitation need to be close to the rehabilitation department at facilities for ease of coordination. The state of the practicing environment is not ideal and the space does not meet the required measurements and organization. It would be ideal for the domains to have a common inception assessment room and intake of patients that has an audio system with a multidisciplinary approach whereby each team members evaluates and does treatment plan to be agreed upon by all staff handling the specific disability domain.

In facilities with the visual, hearing and speech rehabilitation staff, ideal equipment key for assessments are not available. As such, there is need to invest in ophthalmic equipment and audiometry machines at facilities in the country.

Assistive technology for visual, hearing and speech impairments:

Appropriate assistive technologies needed for visual, hearing and speech domains are:

- Eye glasses
- Braille machines
- White cane
- Cochlear implants
- Alternative Augmented Communication platform

Despite knowledge of assistive devices required by users with visual, hearing and speech impairments, the devices are not accessible to most users owing to these reasons: prescription services for appropriate assistive devices are only available at national levels, level 4 &5 facilities (poor distribution of services and the available few assistive devices), assistive devices for these disabilities are generally not available because rehabilitation is not ranked as priority in budgetary planning and allocation both in national and county governments and lastly, the assistive devices are costly thus most people can't afford them.

To compound the problem of limited access to assistive technology, there is no system in place for supply chain on these assistive devices.

2.5.3 Mental Health Disorders, Intellectual Disability and Neurodevelopmental Disorders CurrentSituation and Barriers

Access to services by Users/ PWDs:

Health professionals are required to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care (UNCRPD, 2008).

On the contrary, there exist gaps in the country when it comes to mental health and neurodevelopmental disorders because:

- There is lack of awareness on availability of services in the health facilities
- There is widespread stigma and neglect associated with mental health disorders
- Most people with mental and neurodevelopmental disorders ares not aware that their illnesses fall under these categories

In addition to the highlighted gaps relating to UNCRPD, within facilities there are no clear signage directing users to where mental health departments or neurodevelopmental services are. Mental health is not featured on the service charter of the facilities, there are no uniform triage guidelines for users, therefore users are usually directed to a service outside the area of domain (for example children are admitted to medical wards) and infrastructure is not accommodative for mental health and neurodevelopmental disorders clients (especially wards allocations, space, facility structure and security services).

Policy/ guidelines for mental health disorders, Intellectual disability and neurodevelopmental disorders:

There exist multiple policies and guidelines within mental health in Kenya. Some of the guidelines are:

- Kenya Mental Health Policy 2015-2030. The policy aims to attain highest standard of mental health for all by detailing determinants of mental health and mental disorders, outlining strategies for achieving optimal health status and capacity for each all and detailing national priorities for mental health.
- Global Comprehensive Mental Health Action Plan 2013-2020. The action plan developed by the WHO and adopted by the 66th World Health Assembly. The objectives of the action plan as acted upon by member states are: strengthening effective leadership and governance for mental health, provision of comprehensive, integrated and responsive mental health and social care services in community-based settings, implementing strategies for promotion and prevention in mental health and, strengthening information systems, evidence and research for mental health.
- Draft Kenya Mental Health Strategy 2017-2021. The aim of the strategy is to address mental health issues in relation to leadership and governance, health services, human resources, health financing, infrastructure, health products and technologies, Health Information System and Research, advocacy and partnerships, vulnerable groups and social cultural perspectives.
- Taskforce on Mental Health Report 2020 - the report aims at providing recommendations on possible national interventions that will ensure good mental health and wellbeing for all. The task force report put forth recommendations, which fall into three broad categories: administrative recommendations around drugs supply and emergency care, legislative changes and criminal justice system changes and improved budgetary allocation.
- Mental Health Act 1989, was revised in 2012 and now in Parliament. The revised but yet to be passed framework purpose to provide a law essential in establishing and institutionalizing mental health in Kenya by providing for establishment of Kenya Board for Mental Health, establish mental hospitals, structure for handling voluntary and involuntary patients and judicial powers and offences related to mental health service provision.

Despite existence of the highlighted policy/ guidelines, it is worth noting these policy gaps:

- Lack of inclusion of neurodevelopmental disorders (autism, learning disabilities etc.) in any of the frameworks
- Lack of health policy guidelines for assessment and school placement of children with neurodevelopmental disorders
- Lack of collaboration between Ministry of Education, MOH, social welfare on policy
- Lack of collaboration in policy development and implementation
- Lack of policy on treatment interventions for children

Case in point of collaboration gap: according to the Ministry of Education National Special Needs Education Policy Framework 2009, the MOE shall establish and enhance linkages with the Ministry of Health and other relevant ministries for appropriate assessment, intervention, and referral and follow up of learners with special needs. MOE in collaboration with other stakeholders shall develop and liaise with the Ministry of Health to ensure that learners with special needs and disabilities are provided with regular treatment and medicine to preserve or improve their level of functioning and put in place measures to ensure appropriate modification of learning institutions respond to their needs. The MOE document places the rehabilitation team at a front line in ensuring inclusivity and the smooth process for learners with intellectual, mental and autism spectrum. However, unlike the statement in the document, there are no structures established between MOE and MOH on implementation of the above statement. If there is anything done so far to meet the above needs, it is minimal and may only be seen at the Kenya Institute of special education (KISE). There exists a big collaboration gap too.

Service delivery for mental health disorders, Intellectual disability and neurodevelopmental disorders:
Services are available at level 5, 6 and 26 level 4 public facilities only and specialists in mental health, such as psychiatrists and occupational therapists are very few and available in urban areas where the national and select county facilities are located. Owing to scarcity of mental health specialists, 4 out of 5 (80%) of persons with mental disorders do not have access to mental health services. In addition, majority of facilities offering mental healthcare services lack the necessary space, equipment and the desired environment to meet the needs of persons with mental health disorders, autism spectrum disorders and intellectual disability. The situation is direr for children with autism and intellectual disabilities since there is not a single facility in the country that has a special ward for children with intellectual disabilities, mental health care problems or autism spectrum disorders. This means that for these children, the inpatient services are integrated within the common paediatric departments in the health facilities in the few facilities offering mental health services.

In addition to limited number of facilities offering mental health and neurodevelopmental services, Kenya has only one child psychiatrist, very few development paediatricians and there are no structured services for children with neurodevelopmental disorders in public institutions. Healthcare workers involved in rehabilitation within mental health, autism spectrum disorders and intellectual disability rehabilitation are: occupational therapists, physical therapists, speech therapist, orthopaedic technologist. Support services needed beyond the outlines staff involved in rehabilitation are services of: counsellors, physiatrists, pharmacists, social workers, community workers, nutritionist and teachers.
According to the Ministry of Health, the number and distribution of mental health support services staff within public health facilities in the country is as follows:

Table 5: Current Mental Health Disorders, Autism Spectrum Disorders and Intellectual Disability Rehabilitation Staff and Gaps per the MOH Staffing Norms Guidelines

CADRE	CURRENT STAFF AT CRHS & SCHS	CURRENT STAFF AT NATIONAL FACILITIES	TOTAL GAP
Counsellors	112	22	4588
Psychiatrists	24	31	1512
Social workers	387	117	2864

About organization of rehabilitative services key to mental health, it is worth noting:

- Each service point is a standalone, far from each other. The few services that are housed under one roof at facilities are not extensively equipped or organized to offer quality services under one roof
- The disciplines are not in one central location, the few services under one central place once again are not organized to into teams offer the service appropriately hence poor service delivery.
- Mental health services are only available at National Referral Hospitals and county hospital hence lack of the service at primary healthcare.
- Some facilities have mental health units/ divisions located far away from the main hospital. This makes referral, and transportation of the clients to mental health unit very difficult as some of them are transported in tied in chains, which mostly lead to secondary injuries.

It is a clear indication that the organization of services is not ideal at facilities since mental hospital needs to be mainstreamed within the general health care services. There is also need to establish an organizational structure that links the rehabilitation departments with the Special Units and the Education Assessment and Resource Centres (EARCS) for the purposes of assessment/ screening, school placement, follow up and environmental modification and adjustments in the learning institutions for the learners.

Despite a few public facilities dealing with mental health, only KNH and Mathari National Teaching and Referral Hospital have most aspects of ideal practicing environment though not at optimal level. Most hospitals still missing key aspects for best practise. There are no equipped sensory integration units for screening and treatment of clients with autism and intellectual disabilities established within the Government facilities. Those that exist with private institutions and facilities are too expensive for most clients to afford. This leaves client with no option but to try to access the few mental health services at the MOH government facilities.

Assistive Technology for Mental Health Disorders, Intellectual Disability and Neurodevelopmental Disorders:

Appropriate assistive technologies needed for Mental health disorders and Intellectual disability are:

- A communication board can support a child with speech difficulties to express themselves
- Educational apps for iOS and Android devices
- Digital voice recorders, MP3 players, and playback equipment
- An abacus and manipulatives for learning math concepts
- Curricula for dyslexia, dysgraphia, and dyscalculia
- Task lists
- Picture schedule and calendar
- Picture based instructions Timer
- Manual or automatic reminder
- Smartphone with adapted task lists
- Schedules
- Calendars
- Audio recorder
- Adapted toys and games
- Behaviour Charts
- Vision Boards
- Incentive Charts
- Reminder Devices
- Talk lights

Assistive Technology for Neurodevelopmental Disorders:

- Mobility technology: manual or motorized

- Communication technology: low-tech (boards) or high-tech (apps)
- Typing and writing technology: pencil grips
- Activities of daily living technology

Despite knowledge of assistive devices required by users with mental health disorders, autism spectrum disorders, Intellectual disability and neurodevelopmental disorders, the devices are not accessible to most users owing to these gaps:

- Cost of assistive devices
- Lack of guidelines of assessment and management of autism and learning disability that would lead to establishment of list of tools.
- Lack of equipment and guidelines to assess for AT need
- The rehab professionals are not trained in use of assistive technology
- No budgetary allocation for provision of Assistive Technology
- Some basic equipment is available in KNH but the other centres do not have.
- No awareness on where the services are available
- Assistive technologies for this domain are not readily availability in Kenya
- Standardized tests key in provision are not available in government facilities only available in private facilities with prohibitive assessment costs
- Lack data on people who need AT

To compound the problem of limited access, there are bureaucracies in importation of these specialized assistive devices resulting to the devices becoming very costly to users. In addition, KEMSA has no structures or policies set to procure standardized appropriate AT in the county. AT has been left in the hands of anybody willing to import or produce.

Leadership and Governance Situation Analysis

At the national level, rehabilitative services are established as a unit in the Ministry of Health. Physiotherapy, occupational therapy and orthopaedic technology services exist as sub-units of rehabilitative services. Rehabilitative services unit is placed under the department of Health Systems Strengthening in the Directorate of Healthcare Services.

In the counties, rehabilitation services are not indicated in the Health Management. As such, county decision makers do not discuss matters related to rehabilitative services during County Health Management team meetings. Counties however have different operational structures for rehabilitation services; some counties have appointed one county rehabilitation coordinator while others have three coordinators draws from the three rehabilitative cadres. The county coordinators mostly operating from health facilities and are only called upon when coordination need arises. Job description for those appointed is often not available.

In addition to the outlined gaps in rehabilitative services unit leadership and governance, the visual, speech and hearing domains have a varying/ no representation. At the national level, the visual impairment services unit does not appear as a distinct service area in the Ministry's organogram. The unit is under the Division of National Referral Facilities in the Department of Health Systems Strengthening in the Directorate of Healthcare Services. The hearing impaired and speech impairment services are not represented at National Level. Representation of speech and hearing starts at level 6 facilities with the KNH and MTRH having the services. At the KNH, speech impairment is managed under ENT whereas visual impairment is independent and reports to Director Clinical Services at the facility. ENT is a unit under surgery.

County organograms are not clear on the Visual and Speech domains. At the county facilities, each of the domains are independent departments - even in representation at the Hospital Management Teams.

2.6 Summary of Cross Cutting Barriers Across The Domains

As highlighted, there exist barriers related to access, policy and guidelines, service delivery, assistive technology, financing and leadership and governance across the different disability domains. Few barriers are specific to domains while most are cross-cutting across the different domains. The table below summarizes the crosscutting barriers.

Table 6: Summary of Cross Cutting Barriers across the Domains

SITUATIONAL ANALYSIS FOCUS AREA	BARRIERS
Access to services by Users/ PWDs	1. Lack of awareness of available services 2. Concentration of services at National and County facilities hence services are not easily accessible by most users owing to scarcity and high cost 3. Lack of ideal infrastructure to support PWDs at facilities (accessibility amenities, ideal signages and/or interpreters) 4. Poor community-based rehabilitation (CBR) and referral networks
Policy/ guidelines	1. Policy gaps for service delivery across all domains 2. Lack of implementation of existing policies/ guidelines 3. Poor coordination between MDAs and counties to implement existing policies 4. Lack of guidelines for AT standards and provision
Service delivery	1. Massive shortage of human resources 2. Skills and knowledge gaps for key specializations and AT provision 3. Limited working spaces and lack of specialized equipment at point of services in facilities 4. Lack of integration between rehabilitative cadres and into the healthcare system
Assistive Products	1. High cost of assistive devices to clients 2. Lack of quality check for AP in facilities and country 3. Lack of incentives for local manufacturers and fabricators of AP 4. Lack of a consolidated national supply chain system for assistive technology through KEMSA
Financing	1. Lack of financing of assistive devices; not catered through budgetary allocations at most facilities. 2. Limited financing of rehabilitative services
Leadership and governance	1. Representation and reporting structures for different disability domains not clear at the national and county level 2. Rehabilitative teams operating in silos at country levels and facility management teams 3. Speech and hearing domains do not have representation at the national level

2.7 Justification for the National Strategy for Scaling up Rehabilitative Services and Increase Access to Assistive Technology

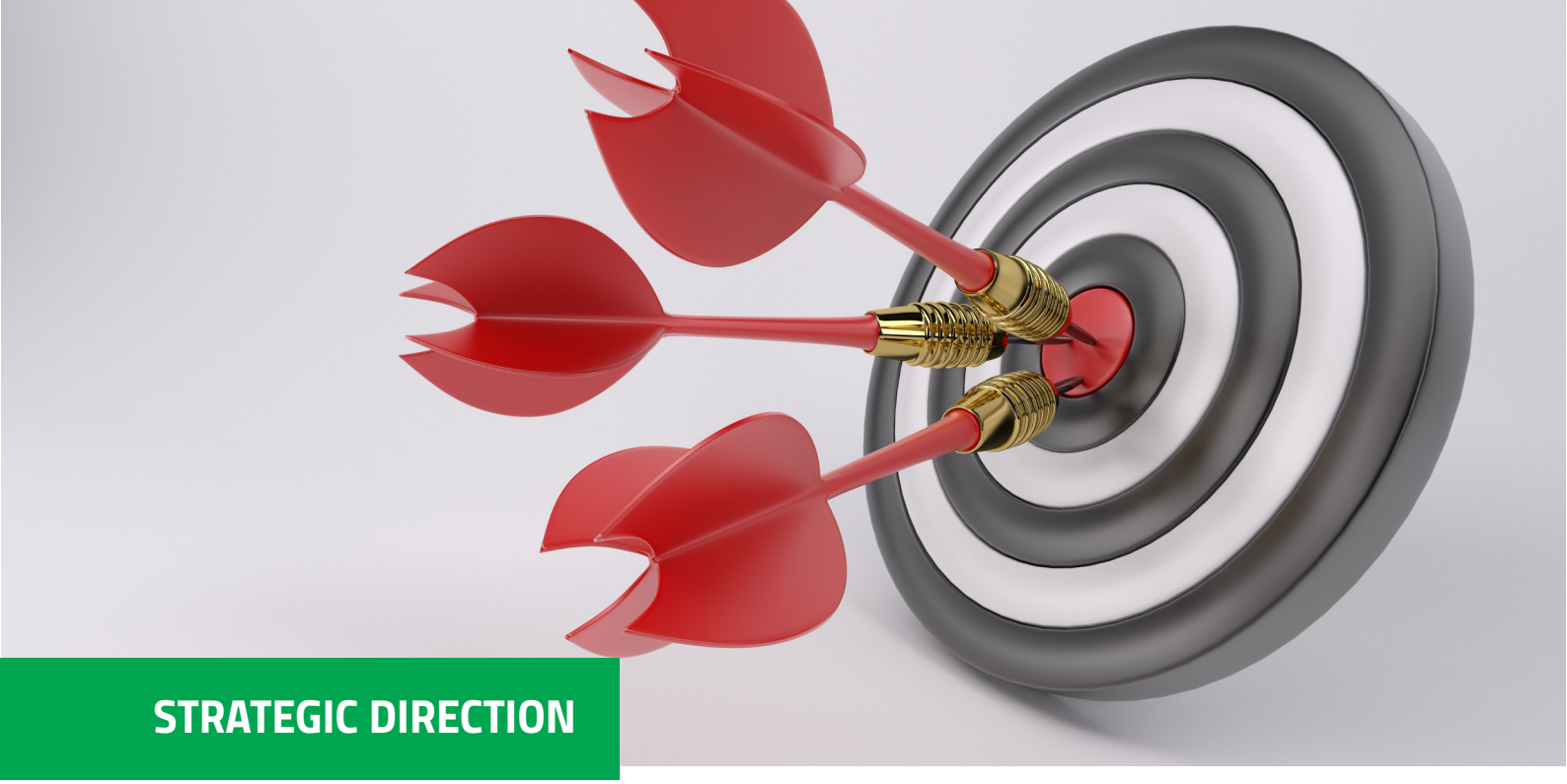
The government of Kenya is committed to enhancing healthcare service delivery for all from both the preventive and curative care perspective at all levels of care. In line with this commitment, which is ring-fenced through the Vision 2030, key policies within public health and implementation of the UHC, the National Strategy for Scaling up Rehabilitative Services and Increase Access to Assistive Technology seeks to contribute to attainment of health for all citizens through attainment of Vision 2030 health aims as stipulated under the Social Pillar. Despite the efforts and commitment by the government to attain health for all citizens, preventive care has lagged behind concerning health system strengthening and resource allocations, in which rehabilitative services play a critical role.

Key gaps within preventive and curative care, which the National Strategy for Scaling up Rehabilitative Services and Increase Access to Assistive Technology will provide clear way forward on, are:

- Limited access to rehabilitative services by majority of the citizens, particularly persons with disabilities
- Lack of policies and guidelines to anchor key aspects of service delivery and access to appropriate assistive technology
- Fragmented service delivery of rehabilitative services and poor integration
- Limited access to appropriate assistive technology
- Lack of comprehensive resource allocation mechanisms for rehabilitative service
- Lack of appropriate leadership and governance structures through which rehabilitation services is able to make decisions

It is through implementation of this National Strategy for Scaling up Rehabilitative Services and Increase Access to Assistive Technology that the identified gaps will be addressed and rehabilitative services will contribute to achieving the country's commitment to attain health for all citizens from both the preventive and curative care perspectives.

3 STRATEGIC DIRECTION



STRATEGIC DIRECTION

Vision:

A healthy, productive and globally competitive nation

Mission:

To build a progressive and sustainable rehabilitative healthcare sub system that enables individuals with functional limitations and participation restrictions to attain the highest quality of life.

Goals:

1. Attaining equitable, affordable, accessible and quality rehabilitative services for all
2. Foster innovation and be at the fore front of evidence-based policy and practice
3. Create competent and responsive rehabilitative human resource

Core Values:

Ethical, professionalism, efficiency, effectiveness, teamwork, integrity and accountability

3.1 Introduction

This Chapter outlines implementations of the Rehabilitative Services and Assistive Technology Strategy by detailing the strategic objectives under each of the six strategic directions. 18 strategic objectives and 68 interventions have also been developed in order to contribute towards achieving the chosen strategic direction. The six strategic directions are:

1. Increase accessibility ofr ehabilitative services to all including PWDs
2. Implement existing policies/ guidelines develop other policy frameworks key in scaling up rehabilitation services
3. Scale up and strengthen rehabilitative service delivery at all levels of care
4. Increase access to appropriate assistive technology
5. Enhance financing for rehabilitative services and assistive technology
6. Secure political and leadership commitment to scale up rehabilitative services and increase access to assistive technology

3.2 Users of Rehabilitative Services

Strategic Direction 1: Increase accessibility of rehabilitative services to all including PWDs

Strategic Objective 1: Increase accessibility of services and facilities by users

Key interventions:

- Scale up community-based rehabilitation (CBR)

- Scale up rehabilitative services to primary care facilities
- Establish a working referral system for accessing rehabilitative services at all levels of care
- Build accessible infrastructure and amenities for different disability domains at all levels of care, within the transport system and public institutions

Strategic Objective 2: Improve user awareness of services and reduce stigma associated with disability

Key interventions:

- Undertake awareness creation campaigns at community level using properly packages information on available rehabilitative services
- To develop and enhance inclusive communication of available services and guidance of users including legible posters and disability specific interpreter
- Disseminate policy and guidelines to users and caregivers
- Reinforce and improve caregiver support through skills development trainings

Strategic Objective 3: Implement universal health coverage insurance for PWDs to reduce out of pocket expenditure

Key interventions:

- Subsidize cost of seeking rehabilitative services at all levels of care
- Subsidize cost of commodities associated with different disabilities to increase access to required commodities
- Subsidize cost of acquiring appropriate assistive devices for use by PWDs

3.3 Policy and Guidelines

Strategic Direction 2: Implement existing policies/ guidelines and develop other policy frameworks key in scaling up rehabilitation services

Strategic Objective 1: Implement existing policies in full and foster collaboration between MDAs key in implementation

Key interventions:

- Implement the Disability Act No 14 of 2003
- Kenya Mental Health Action Plan 2021-2025
- Implement Kenya Mental Health Policy 2015-2030
- Adopt the ASHA guidelines for screening for Speech and Language delay and disorders in children (WHO)

Strategic Objective 2: Develop policies and guidelines for streamlining rehabilitation services

Key interventions:

- Develop policy on rehabilitation services for persons with disabilities outlining integration of services and budgetary allocation from government
- Develop guideline for introduction of rehabilitation module and key best practice training aspects in all medical schools
- Develop policy on assistive technology
- Establish appropriate staffing norms for all disability domains at all levels of care
- Revise existing disability guidelines to include autism and intellectual disability
- Develop guidelines and protocols for secure inpatient structure for different disability domains at facilities

3.4 Service Delivery

Strategic Direction 3: Scale and strengthen rehabilitative service delivery at all levels of care

Strategic Objective 1: Scale up rehabilitative services to all levels of care

Key interventions:

- Define rehabilitative services to be offered at different levels of care across the domains
- Establish rehabilitation services at all levels of care including primary level
- Identify human resource gaps at all levels of care and hire specialized rehabilitation staff across all disability domains

to address shortage

- Develop a multidisciplinary team approach in provision of rehabilitation services
- Develop and implement standards for an ideal rehabilitative service department in facilities
- Establish rehabilitative services as essential services at the Ministry of Health

Strategic Objective 2: Enhance training of personnel and capacity building across disability domains

Key Interventions:

- Build capacity in training institutions to have modules on different disability domains
- Enhance harmonized curricula in training institutions to ensure standardization of rehabilitation services practice
- Enhance capacity of existing rehabilitation staff across all levels of care through training
- Redefine roles and responsibilities of rehabilitation professionals to enable multidisciplinary implementation of trained on aspects

Strategic Objective 3: Enhance rehabilitation services practicing environment to have ideal infrastructure and equipment

Key Interventions:

- Define ideal infrastructure and equipment for optimal service delivery per level of care
- Budget for infrastructure and acquire equipment for facilities in each county

Strategic Objective 4: Strengthen stakeholder collaboration and integration within rehabilitation services

Key interventions:

- Enhance integration within rehabilitation services at national and county levels
- Integrate rehabilitatiive services and medical team at facilities to enhance wholesome care for clients
- Promote inter-ministerial collaboration on rehabilitation services
- Promote collaboration of stakeholders at national and county governments

3.5 Assistive technology

Strategic Direction 4: Increase access to appropriate assistive technology

Strategic Objective 1: Integrate the supply of assistive devices into the KEMSA system

Key Interventions:

- Determine AT need for all disability domains
- Develop a dynamic database of persons who need AT
- Develop capacity to handle all ranges of assistive devices in KEMSA depots
- Purchase and distribute assistive devices through the national supply chain system
- Use hospital inventory management system for AT and create a dynamic catalogue for assistive devices need

Strategic Objective 2: Build capacity of rehabilitation team to provide appropriate assistive technology

Key interventions:

- Train rehabilitation teams on provision of different assistive devices per international best practices and WHO standards
- Liaise with training institutions to incorporate international AT provision standards into curricula
- Establish mentorship plan on AT provision skills at all levels of care

Strategic Objective 3: Build local capacity for production of quality and affordable assistive devices

Key Interventions:

- Build skills critical for local production of assistive devices
- Enhance local manufacturing capacity through incentives, including tax incentives
- Establish seed capital for AT production, research and innovation
- Establish a nation Center of Excellence for AT to enhance continuity of care

Strategic Objective 4: Advocate for introduction of relevant policies and guidelines to anchor quality of assistive technology

Key Interventions:

- Develop standards for appropriate provision of assistive devices for each disability domain
- Create job aids for provision of different assistive devices
- Implement AT quality check and measures through KEBS

Strategic Objective 5: Establish and strengthen collaboration with stakeholders and partners

Key Interventions:

- Mapping of partners involved with production, distribution and provision of AT
- Define roles of partners in the ecosystem for optimal provision of AT
- Establish and strengthen collaboration between stakeholders and partners
- Establish a nation Center of Excellence for AT to enhance continuity of care

3.6 Financing

Strategic Direction 5: Enhance financing for rehabilitation services and assistive technology

Strategic Objective 1: Mobilize and invest adequate resources in rehabilitative services

Key Interventions:

- Advocate for policies and guidelines for sustainable financing of rehabilitative services at national and county level
- Lobby for inclusion of rehabilitative services and assistive devices in budgets at county and facilities

Strategic Objective 2: Expand UHC to include rehabilitative services and assistive technology

Key interventions:

- Expand the NHIF scheme toto include rehabilitative services and assistive devices to be accessed by all
- Advocate for private health insurance schemes to o include provision of rehabilitative services and assistive devices

3.7 Leadership and Organization

Strategic Direction 6: Secure political and leadership commitment to scale rehabilitation services and increase access to assistive technology

Strategic Objective 1: Develop appropriate health governance structures for rehabilitation services at the National and County Government

Key Interventions:

- Launch and disseminate the Rehabilitative Services and Assistive Technology Strategy
- Prioritize rehabilitative services as essential health services
- Advocate for development and legislation of key rehabilitation policies and laws
- Incorporate rehabilitation services into existing governance and management structures at national and county level

Strategic Objective 2: Promote equitable allocation of resources, good governance, accountability

Key Interventions:

- Lobby policy makers at national and county level for inclusion of rehabilitation services and assistive devices in budget planning and allocation
- Promote public accountability at all levels of services delivery to address efficiency, transparency and participation in utilization of resources

4

NEW ARRANGEMENT FOR REHABILITATION SERVICES

NEW ARRANGEMENT FOR REHABILITATION SERVICES

4.1 Introduction

The desired change for this Strategy is to ensure there is scaling up of rehabilitation services and increased access to assistive technology in Kenya. Rehabilitation services play a critical role in both preventive and curative care. To achieve the desired change a total of 4 new arrangements for the Strategy have been identified. The new arrangements have corresponding structures presented in this section.

4.2 A summary of proposed new arrangements

1. Reorganization of rehabilitative services
2. Governance and leadership
3. Financing for rehabilitative services
4. National supply chain for assistive technology

4.3 Reorganization of rehabilitative services

In order to ensure there is optimal service delivery of rehabilitative services, there is need to shift the way services are organized and delivered so as to ensure:

- Increased access to rehabilitative services at all levels of care
- Optimized delivery of rehabilitative services
- Efficient allocation of resources to rehabilitative services (sustainable financing)
- Appropriate implementation of policies and guidelines and,
- Increased access to appropriate assistive technology

There exist huge gaps in the aforementioned aspects because in addition to lack of representation of rehabilitative services at policy and decision-making levels, the focus within healthcare in Kenya has predominantly been curative and skewed towards some services. Despite these services playing a critical part in curative care too, has been a challenge because they are deemed more of preventive care and a non-medical emergency. In the same breadth, counties have not been allocating resources to scale up rehabilitative service delivery beyond a meagre allocation to consumables for some rehabilitative services by a few counties. Also, rehabilitative services are not available in all levels of care; most primary health facilities do not provide rehabilitation services.

Moving forward, it is envisaged that rehabilitative services in Kenya are going to be prioritized at all levels of care so that persons

who need them (persons with disabilities, the aged and other vulnerable people who already have a challenge with movement) do not have to travel beyond 5km of their residences to access these critical services. In addition, it is envisaged that both the national and county governments are going to allocate adequate resources for rehabilitation services to ensure availability and access at all levels of care. Table 7 below shows the key features of rehabilitation service and decision making which need to be adopted to ensure scale of rehabilitative services.

Table 7: Proposed Rehabilitative Services Delivery Transformation

PROPOSED REHABILITATIVE SERVICES DELIVERY TRANSFORMATION			
	Transformation feature	**Current status**	**Recommended arrangement**
1	Leadership	Lack of representation at policy and decision-making	Substantive rehabilitative services representation at policy and decision-making levels
2	Access	Check indentation, seems slightly left compared to below points in	Availability of services at all levels of care with clear and optimized referral network between levels
3	Service delivery	Skills gap, HR shortage and non-optimal infrastructure and equipment	Sustainable investment in revamping infrastructure, acquisition of equipment and building capacity of HR
4	Integration	Rehab cadres operate in silos and also isolated physically in facilities	Integration of rehabilitative cadres at facilities and integration of rehab and medical teams for optimal care
5	Financing	Very limited budgetary allocation to services at national and county level resulting in users paying out of pocket for rehabilitative services and AT	National and county governments to establish a budget line for rehabilitative services and clients to be covered by existing benefit schemes
6	Supply chain	Poor storage spaces and lack of integration with hospital systems	Integration in hospital supply chain systems and plug into the national supply chain for AT

To realize scaling up of rehabilitation services, it is anticipated that counties will implement measures to ensure existing services are made more robust and missing rehabilitation services are established and financed appropriately at all levels of healthcare at the County. Beyond the reactive model of operation, it is envisaged that counties will progressively incorporate rehabilitative services in community healthcare (by implementing Community Based Rehabilitation). This is key since not all people who require rehabilitative services have the ability to access facilities thus active demand generation is important. The national level will be critical in formulation of rehabilitative policies and guidelines.

The proposed rehabilitative services to be offered at the different levels of care are defined below:

Level 6 and 5: Offer more specialized care across all the disability domains, offer mentorship, training and research across all disability domains and, establish a model rehabilitation department with workshops for production/ fabrication and maintenance of AT mobility (see Annex. 1 for an example of a Rehabilitation Department Layout).

Level 4: Offer rehabilitative services across all the disability domains, provide optimized network of integrated UHC in primary care facilities and plan for capacity building

Level 3 & 2: Offer basic rehabilitative services (physiotherapy, occupational therapy, orthopaedic technology services, speech and language services and audiology) and outreach services

Level 1:provide health education, promotion and Community Based Rehabilitation (CBR) services and, develop referral pathways. At level 1, CBR need to entail community sensitization, home visits, development monitoring at 18 and 24 months by the CHWs.

4.3.1 Proposed Kenya's Rehabilitative Services Health System Structure

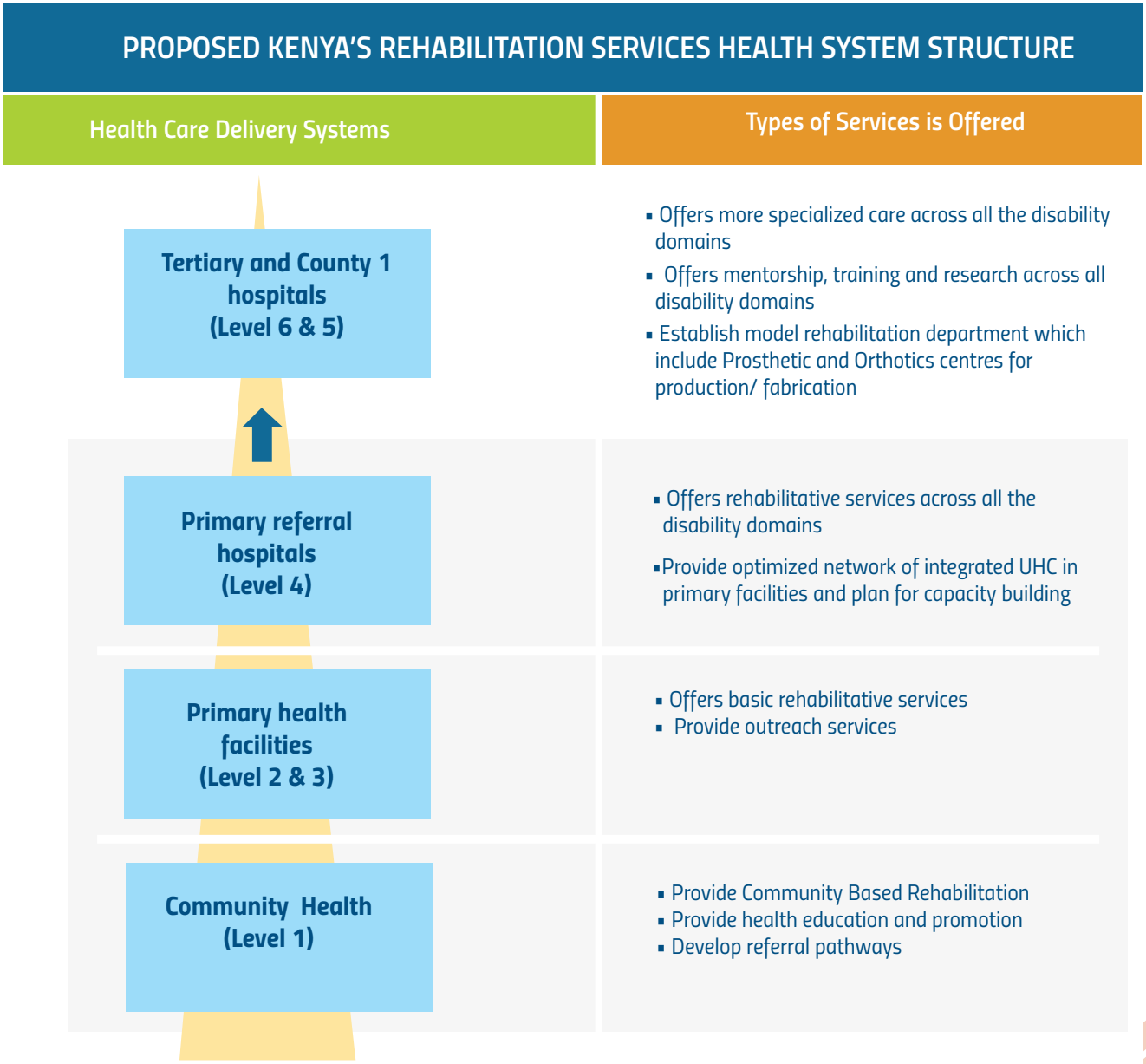


Figure 2: Proposed Rehabilitative Services Health System Structure

4.3.2 Rehabilitation Services Integration needs within Health Facilities

Access to rehabilitation services in Kenya is a challenge partly due to lack of integration in rehabilitative cadres at facilities and integration of rehabilitation services and medical teams. As a result of this disjoint, there are missed opportunities to provide optimal care and clients are condemned to costly search for services. In addition, the lack of integration has resulted in inefficiencies in service delivery and siloed approach to provision of rehabilitative services.

For wholesome care of clients, there is need to ensure there is integration within rehabilitation services and other services at the health facilities. Integration within rehabilitation services at facilities is key to ensuring the client gets the best of available services since most aspects of assessment and services are best offered by multi-cadre approach. In addition, looking at the client/ patient journey when they visit a health facility, it is best to integrate rehabilitation services with other healthcare services at facilities for two benefits; first, the rehabilitative cadres at facilities will be aware of users medical conditions and interventions already made as they seek services in the rehabilitative department hence in a position to offer them the best rehabilitation services (most times, patients seek rehabilitation services after medical intervention) and secondly, the

rehabilitative team will be able to plan their workload better since they will be aware of the work coming to their department from other departments within the health facilities.

In order to ensure integration of rehabilitation services for ease of access, optimal service delivery, capacity building and coordinated resource mobilization, it is envisaged that rehabilitative cadres in health facilities will be organized under one department. The client's first point of call upon referral to rehab will be the rehabilitative department under which rehabilitation services fall. This organization will eradicate confusion when users seek service and enhance reporting and tracking of users and interventions at health facilities. In addition, there is need for rehabilitation services to integrate with other health services at facilities for optimal care of users and patients, right from the OPD. For example, integration and involvement of all cadres is key in ensuring referral back to medics for co-morbidities that come with children with disabilities such as tone management,

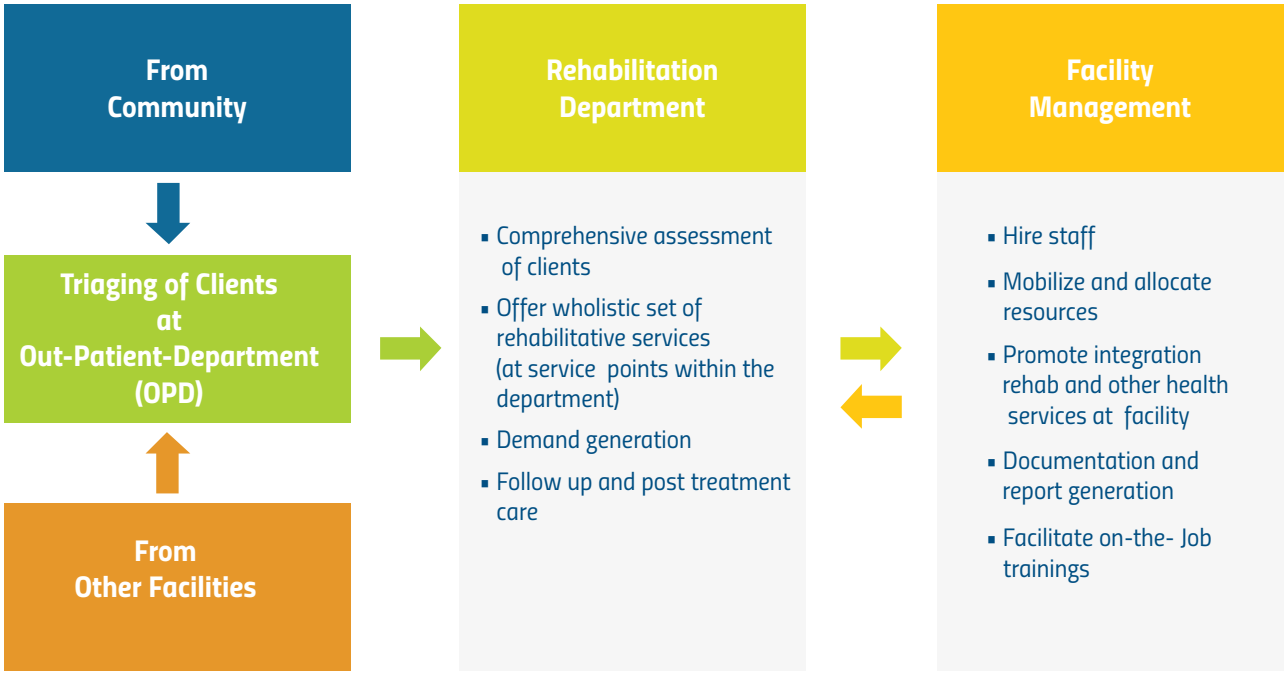


Figure 3: Flow on Referral to Rehabilitation Department for Services

4.4 Governance and Leadership for Rehabilitative Services

As highlighted in Chapter 2, rehabilitation services are represented at the national level as a unit within the Department of National Health Systems Strengthening. Within the counties, there is scarce representation of rehabilitation services at policy and decision-making level; rehabilitation services are not part of the County Health Management Team (CHMT). To move from the current state and enhance service delivery, there is need to shift the way rehabilitation services are governed at both the national and county level. It is anticipated that rehabilitation services representation will be enhanced at both the national and county level to have rehabilitation services recognised and involved in policy and decision-making.

4.4.1 National Rehabilitative Services Structure

At the national level, it is envisaged that rehabilitation services will be organized under a rehabilitation Division with each of the cadres in Rehabilitation standing as Units. The rational for this is that rehabilitation services are wide and span across different disability domains but none of these domains has representation at the policy or decision-making level. As such, it will be paramount to have a Rehabilitation Division, which coordinates all the rehabilitation services in order to ensure that matters on rehabilitation are well represented at the national level. Figure 4 below show the proposed organization of rehabilitation services at the national level.

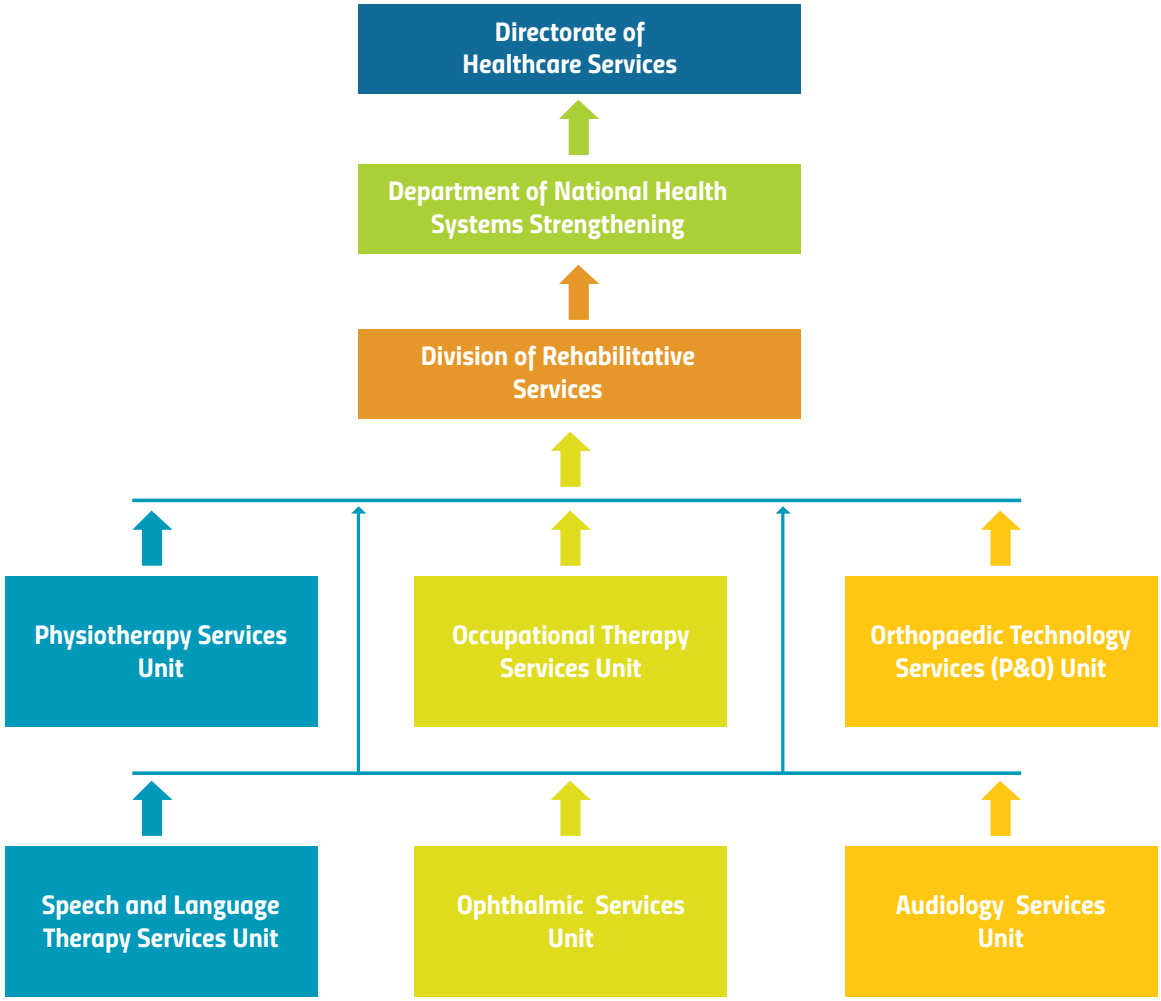


Figure 4: National Rehabilitative Services Structure

The national level Division of Rehabilitatitive Services functions will be to:

- Formulate rehabilitation policies, guidelines, standard and norms
- Plan capacity building for rehabilitation staff at all levels
- Mobilize resources for rehabilitation services and assistive technology
- Coordinate partners, stakeholders and technical working groups
- Secure political and administrative commitment on rehabilitative services
- Oversee implementation of referral system for rehabilitation services including CBR
- Conduct collaborative research and innovation

4.4.2 County Rehabilitative Services Structure

It is envisaged that rehabilitation services will have substantive representation at both the County Health Management Team (CHMT) and the Sub County Health Management Team (SCHMT). Each county will have a County Rehabilitation Coordinator (drawn from one of the rehabilitation services directors at the county level) and Sub County Rehabilitation Coordinator (draws from a facility within Sub County). The County Rehabilitation Coordinator will have substantive membership in the CHMT and with direct reporting to the CDH. The Sub County Rehabilitation Coordinator will have substantive membership in the SCHMT. In addition, it is envisaged that each county will have a Rehabilitation Technical Working Group (RTWG) that will report directly to the County Director for Health (CDH). The RTWG will be in charge of shaping the county rehab agenda and advising the CDH on county process on the implementation of this Strategy. The RTWG will be constituted of the County Rehab Coordinator, Rehabilitation Services Directors, SCMOH, Sub County Rehab Coordinators and key partners within rehabilitative services space in the county. Figure 5 below show the proposed organization of rehabilitative services at the county level.

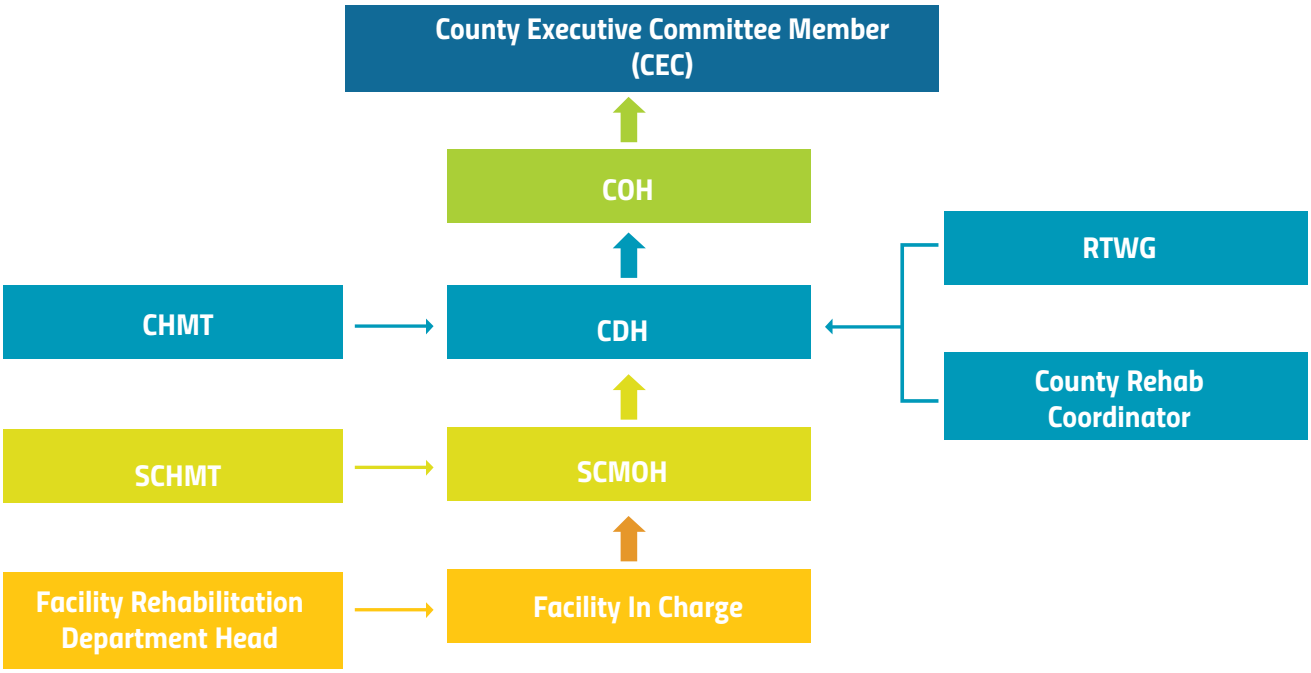


Figure 5: County Rehabilitative Services Structure

Utilizing the proposed county structure, county functions will be:

- Scaling up rehabilitative services to all levels of care
- Resource mobilization
- Allocation of funds to rehabilitative services and assistive technology
- Hiring of rehabilitative staff at all levels of care
- Capacity building of staff according to national advisory and WHO standards
- Infrastructure development – at point of rehabilitative services and facility accessibility by PWD
- Investment in rehabilitation machines and equipment for all rehabilitative services
- Supply chain management for rehab consumables and assistive devices
- Securing political and administrative commitment on rehabilitative reforms
- Partners management and stakeholder's coordination
- Implementation of policies and guidelines and sensitization of target groups

4.4.3 Inter- sectoral Coordination

To realize scaleup of rehabilitative services and access to facilities and services by all, there is need to strengthen collaboration among key stakeholders in health sector and the disability space in the country such as social protection, education, transport, housing etc. Concerted efforts are necessary to achieve the desired change at both national and county level.

The Ministry of Health shall be directly in charge of coordinating and overseeing the implementation of the Strategy at the national level through a Rehabilitative and Assistive Technology Interagency Coordinating Committee (RATICC) and technical working groups. In addition, each county will have Secretariats to coordinate and monitor implementation as envisioned in Figure 5 above. At all the levels, rehabilitative services and assistive technology stakeholders will play crucial roles in implementation of this Strategy through the established structures.

RATICC will have four subcommittees, namely:

- Rehabilitative Services–provide enabling environment for implementation of the National Strategy; this will include resource mobilization to support implementation and influence policies
- Assistive technology – advise on implementation to increase access to assistive technology; this include advise on aspects of services, supply chain, demand generation and production.

- Research and Trainings – organize forums for research, trainings and curriculum reviews; backed by professional associations and learning institutions
- Monitoring and Evaluation – receive progress reports on implementation and organize for dissemination among stakeholders

The four subcommittees will have technical working groups (TWGs), anchored on the different disability domains, to undertake specified tasks. Membership of the TWGs shall be drawn from the health sector and the disability space in the country.

4.4.4 Community Participation and Outreach Services

Communities are significant in decision making about their own health in addition to being the recipients of health services. As such, utilization of health services depends strongly on ownership from the community which mostly comes from community participation on key health care issues. As such, for there to be uptake of rehabilitative services in counties, there is need for an elaborate community participation plan by the county to be realized through outreach services and sensitization of communities. Outreach services will be critical in sharing with the community what rehabilitation services entail as demand for services is actively sort by rehabilitation officers especially during CBR.

In addition to active demand generation through CBR sessions and scheduled outreach services, sensitization forums will also be critical in discussing the available services with communities and sharing about their rights to access services as stipulated by different policies. Sensitization forums would be key in ensuring community participation and getting buy in for utilizing services in light of reforms within the rehabilitative services space.

4.4.5 Health Partnerships

Creation of a robust health partnerships framework is significant in ensuring successful implementation of the Strategy. Public and other stakeholders are crucial to the partnership as both are instrumental in resource mobilization, technical support for implementation, service delivery, policy and guidelines development, provision of assistive technology and driving innovations and efficiencies. Currently, provision of rehabilitative services and assistive technology is by other stakeholders hence crucial to strengthen and sustain health partnerships in scaling up rehabilitative services in the counties. The active partners' involvement framework as detailed below in Table 8 on Stakeholders Roles and Responsibilities.

Table 8: Stakeholders Roles and Responsibilities

STAKEHOLDERS ROLES AND RESPONSIBILITIES	
Stakeholder	**Roles and responsibilities**
Ministry of Health (National Level)	▪ Oversee implementation of the Rehabilitative Services and Assistive Technology Strategy ▪ Capacity building to all levels ▪ Disseminate and operationalize the implementation framework of the Strategy ▪ Coordinate regular review meetings at national and county levels to monitor progress in implementation of the Strategy ▪ Develop policies and guidelines that would ensure scaling up of rehabilitative services and increase access to assistive technology ▪ Resource mobilization ▪ Ensure inclusion of rehabilitative services and provision of assistive technology in the UHC agenda and NHIF financing schemes ▪ Develop and roll out a communication mechanism for the Strategy ▪ Strengthen rehabilitation HRH ▪ Strengthen M&E frameworks key to implementation ▪ Provide technical support to counties ▪ Close collaboration with Division of Neonatal, Child Health and Adolescent Health

STAKEHOLDERS ROLES AND RESPONSIBILITIES

Stakeholder	Roles and responsibilities
County Government Department of Health	▪ Rehabilitation service delivery ▪ Infrastructure development at service points and accessibility amenities for PWDs in facilities ▪ HRH hiring, staffing and capacity building ▪ Regular review meetings to monitor progress in implementation of the Strategy ▪ Advocacy and resource mobilization for rehabilitative services ▪ Supply chain management for rehabilitative consumables and assistive devices ▪ Partners management and stakeholder's coordination ▪ Scaling up rehabilitation services to all levels of care ▪ Implement the communication strategy ▪ Preparation of work plans ▪ Supervision and monitoring implementation
Other Ministries, State Departments and Agencies	Key MDAs include; Ministries –Public Services, Gender, Senior Citizens Affairs and Special Programmes, National Treasury, Labour, Education, Transport & Infrastructure, Housing Urban Development and Public works. Agencies – NCPWD, NHIF, KEMRI, KEBS, KRA, KNBS, KEMSA ▪ Policies for PWDs in respective sectors e.g., policies for children, elderly etc. ▪ Harmonize policies and guidelines ▪ Resource mobilization and inclusion of rehabilitative services and access to assistive technology into existing financing schemes ▪ Joint advocacy and sensitization campaign ▪ Infrastructure and amenities to facilitate mobility of PWD ▪ Database on PWD and assistive devices need ▪ Incentives for local manufacturing of assistive devices ▪ Develop standards and regulations ▪ Supply of commodities and assistive devices ▪ Healthcare financing for rehabilitative services and AT ▪ Budgetary allocation to rehabilitative services and AT
Development Partners	▪ Participate in policy formulation and implementation ▪ Provide technical assistance in scaling up rehabilitative services ▪ Resource mobilization for implementation of the Strategy ▪ Monitoring and evaluation of the Strategy implementation
Implementation Partners and Civil Society Organisation	▪ Support implementation of activities at both national and county levels and across facility levels ▪ Monitoring progress made on implementation ▪ Resource mobilization ▪ Advocacy, communication and sensitization
Training facilities, referral facilities and AT manufacturers	▪ Research and development ▪ Pre-service and in-service training of health care workers to improve service delivery per international standards ▪ Influence policies and standards
NGOs and private organizations	▪ Public private partnerships ▪ Support implementation of the Strategy
Media	▪ Advocacy and communication

4.5 Financing for rehabilitative services in Kenya

4.5.1 Resource gaps

Rehabilitative services are hugely underfunded in Kenya. The current sources of funding for rehabilitative services and assistive technology are:

- Out of pocket payments (OOP)
- Donor funds
- Government budgetary allocation
- NHIF
- Private insurance

Currently, rehabilitation services are largely financed by out-of-pocket payments (OOP) and donor funds. Government financing of rehabilitation services is meagre. According to a comprehensive national assessment done by MOH Rehabilitation Services in all counties in 2019, 55% of hospitals in Kenya do not allocate any resource to rehabilitation services and, only 5% of facilities allocate more than KES. 1 million to Rehabilitative Services. Of note, the entire allocation made by few facilities is for consumables and no hospital in the country explicitly allocated any funds to provision of assistive devices. Figure 6 below summarizes allocations by hospitals across the country, according to the 2019 national assessment.

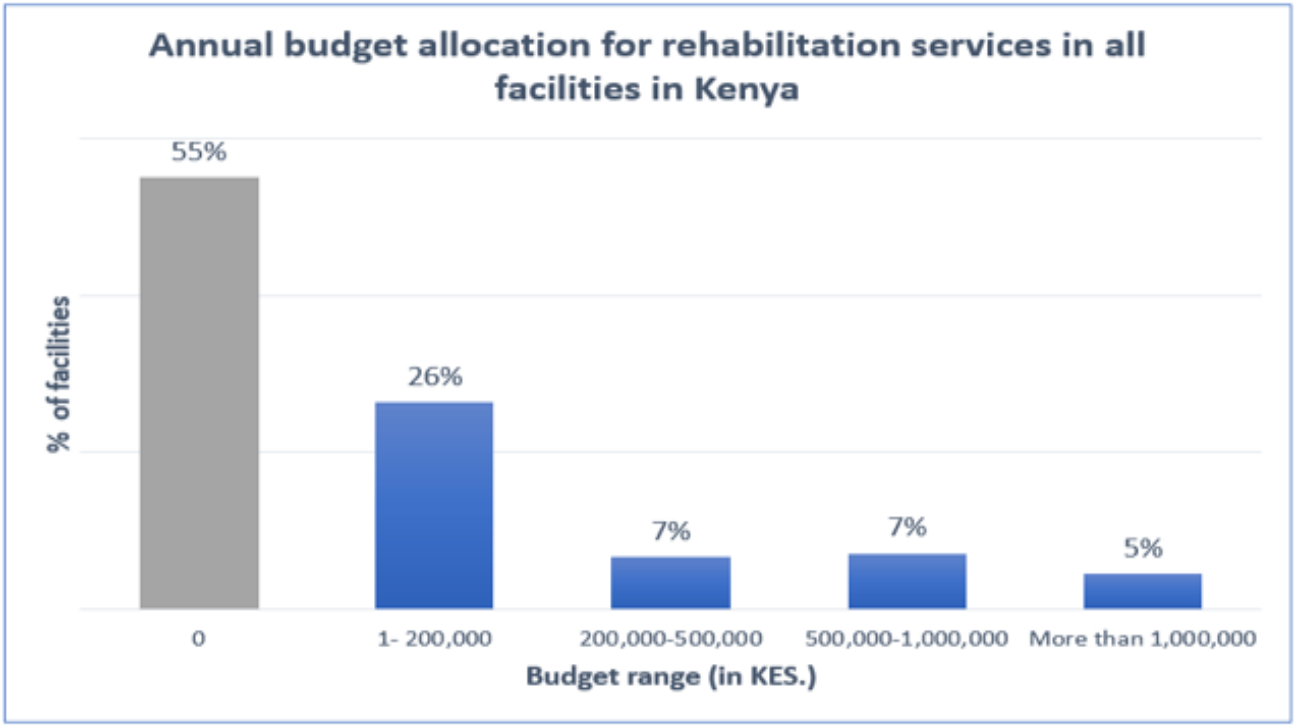


Figure 6: Budget allocation for rehabilitative services by hospitals

At the national level, the situation is not different. Budget allocation to rehabilitation services is very meagre and has been inconsistent and inadequate over the 5 years (see Figure 7 below). In addition to the meagre allocation which is not sufficient in enabling the rehabilitation team to undertake their mandate, the budget line for rehabilitation services only indicates physiotherapy services. Other rehabilitation cadres do not have explicit budget lines in the allocation. Figure 7 below captures the trend in allocation to rehabilitation services at the national level over the last 5 years.

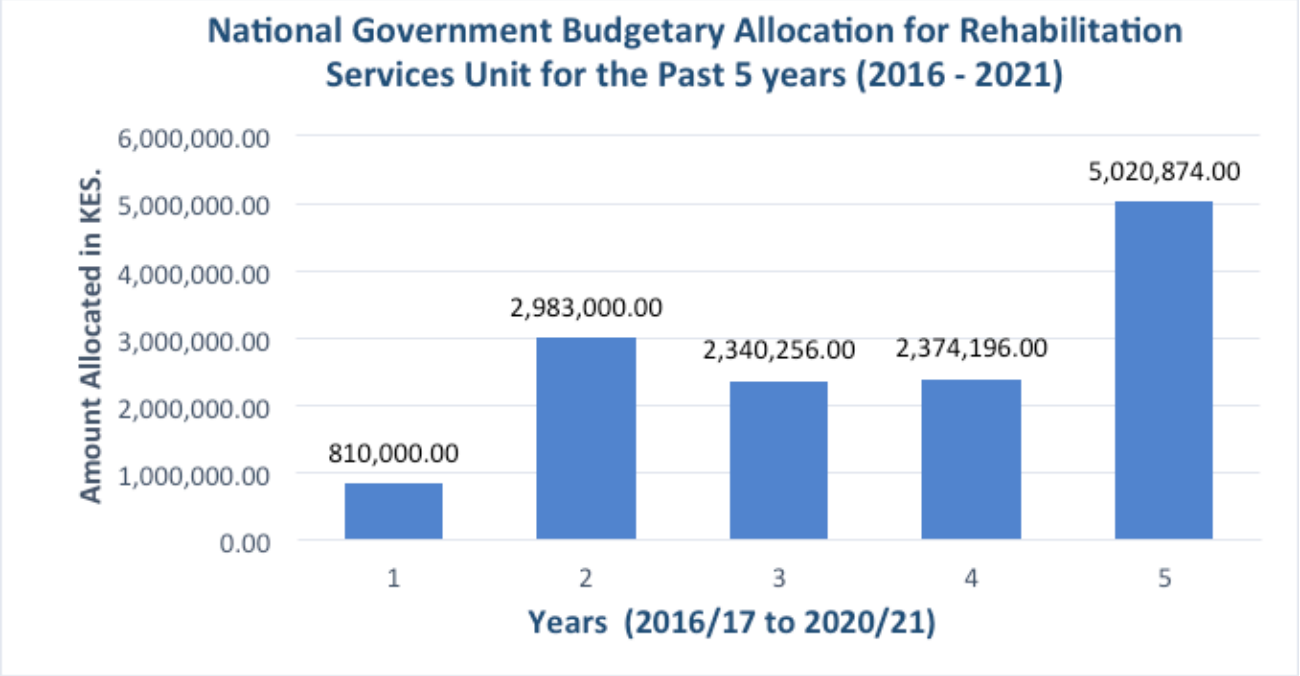


Figure 7: Budgetary allocation to rehabilitative services at national level over the past 5 years

As seen in Figure 7 above, budgetary allocation to rehabilitation services at the national level has been inconsistent and inadequate over the 5 years. There is need to allocate adequate finance to rehabilitation services at the national level too to ensure optimal service provision by the national facilities and adequate support is extended to counties as both national and county levels work together to implement the National Strategy.

4.5.2 Resource mobilization strategies

To appropriately scale up rehabilitative services and increase access to assistive technology in the country, there is need to mobilize financial resources from different sources, with the government spearheading the mobilization efforts and committing resources. Optimal financing of rehabilitative services and assistive technology in Kenya can be made possible through:

i. Lobbying for increased budgetary allocation to rehabilitative services at national and county level
ii. Comprehensive coverage of rehabilitation services and assistive devices by the national hospital insurance fund (NHIF) for all contributors
iii. Support from development partners to finance rehabilitative services and assistive technology
iv. Lobbying private insurance to improve coverage for rehabilitative and assistive devices

4.6 National Supply Chain Model for Assistive Technology

4.6.1 Consolidated Supply Chain Model

It is envisaged that the supply chain for assistive devices will be consolidated given the supply is currently very fragmented. The essence of consolidating the national supply chain for assistive devices is three-fold: to ensure there is better forecasting and quantification of assistive devices need, for the country and users to benefit from the economies of scale which come with bulk ordering of products and lastly, to enhance transparency and visibility on available assistive devices in the country at any point in time.

The proposed supply chain model is centred on utilizing the KEMSA supply infrastructure to ensure that assistive devices across all the disability domains are ordered in bulk from suppliers and delivered to KEMSA regional depots for county collection per the respective counties consolidated orders. As such, counties will have agreement with KEMSA regarding supply of assistive devices. Operation wise, counties will be consolidating orders (assistive devices backlog and demand forecast for a period based on the agreement with KEMSA) from facilities within the counties and relaying the county consolidated order to KEMSA. The supply authority will consolidate orders from multiple counties and purchase the assistive

devices from pre-qualified suppliers. Upon receipt of the assistive devices, KEMSA deliver the product to the regional depots for counties collection. The last mile distribution and handling of assistive devices will be covered for by the counties. As such, Figure 8 below is the proposed model for supply of assistive devices utilizing the KEMSA supply infrastructure and counties being in charge of last mile distribution upon collecting assistive devices from the regional KEMSA depot.

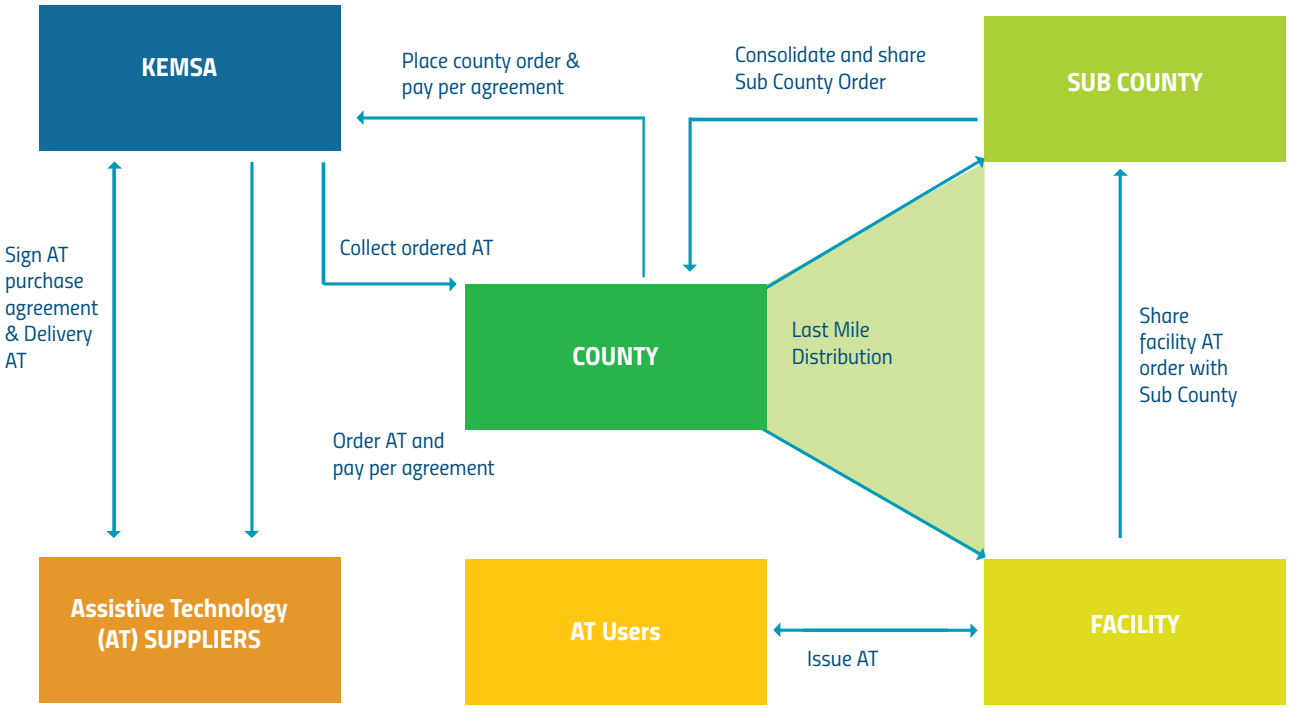


Figure 8: The New Assistive Technology Supply Model

Note: KEMSA would deliver ordered AD to its depot nearest to the county or whichever depot the supply authority agrees upon with the county for seamless subsequent logistics.

4.6.2 Last mile supply of assistive technology

It is envisaged that counties will be responsible for last mile supply of assistive device. KEMSA would supply AT to the regional depot then it would be the county's mandate to collect the AT from regional depots and distribute to the facilities. Counties would need to prepare in advance on how they will handle AT owing to some AT such as wheelchairs being bulky and others such as eye glasses being delicate thus need for extra care when handling. As such, it would be paramount for counties to establish AT hubs in each sub county (ideally in a hospital) which will act as the sub county storage for AT pending collection by facilities in each sub county. In addition, it would be paramount to have designated AT handling staff at the county who would be in charge of handing the distribution at the county and the sub county level so as to ensure last mile distribution is seamless. Lastly, it would be significant for the county to utilize a standard system for tracking AT need, AT stock and reporting by all hospitals in the county. This visibility will be critical in forecasting and quantification of AT and informing referral for AT.

4.6.3 System need for capturing demand and tracking assistive technology

To ensure seamless data flow between KEMSA and counties, there would be need for counties to utilize the existing systems used for medicines when sharing information with KEMSA and other government authorities. Incorporating assistive devices metrices in the existing information management systems will provide good reference for policy and decision makers because AT information will also be aggregated and acted upon in the same frequency metrices on essential medicines in hospitals is acted upon. This will be crucial in enhancing transparency and timely information sharing around AT.

4.6.4 Need for training on handling assistive technology

Both KEMSA officials and the county officials who will be involved in distribution of assistive devices would need training on the ideal handling and storage of different devices. This will be necessary owing to assistive devices not being homogeneous in nature and varying greatly across the different disability domains. Case in point, wheelchairs are very bulky in nature, eyeglasses are delicate in nature and most a time, the devices are transported in parts owing to their nature hence the need to appreciate the parts of different assistive devices and how to handle them.

It would be essential for this training to be conducted prior to commencement of supply through the consolidated national supply infrastructure. In addition, it will be key for the officials involved in the distribution to be given refresher training on AT parts and handling at least bi-annually for all the officials involved to best handle and store assistive devices.

5 IMPLEMENTATION PLAN

IMPLEMENTATION PLAN

5.1 Implementation of the Rehabilitative Services and Assistive Technology Strategy 2022-2026

This Strategy shall be launched and there will be stakeholder forums through which all counties and other stakeholders will be sensitized on the Strategy. All sections of the strategy will be discussed in detail and counties encouraged to adopt and work on the detailed strategies within the specified timelines. Key activities which will take place throughout the implementation of this strategy are:

1. Sensitization of County leadership and staff
2. Advocacy and communication to all stakeholders

5.1.1 Sensitization of County and facilities leadership

A significant aspect of the implementation is ensuring that all counties are onboard with regard to the purpose of the national strategy and expected actions. As such, there will be sensitization forum for county and facilities leadership on what the strategy entails and how counties can implement the strategy to ensure there is scaling up of rehabilitative services and increased access to assistive technology to all levels of care. The main aim of this sensitization will be to ensure institutionalization and sustainability of key implementations made by counties.

5.1.2 Advocacy and Communication to All Stakeholders

Advocacy and communication will be provided to all stakeholders. The advocacy and communication strategy will be developed and will target three key audiences: policy makers at both levels of government, health teams and MDAs and private stakeholders key in rehabilitative services and provision of assistive technology in Kenya. The advocacy and communication strategy aim to increase awareness and lobby for support and prioritization on implementation of the Rehabilitative Services and Assistive Technology Strategy.

5.2 Implementation Matrix

Key (N – National, C – County, B – Both levels)

Intervention	Activities	Responsible Party	YEAR1	YEAR2	YEAR3	YEAR4	YEAR5
Users and Persons with Disabilities: Strategic Direction 1: Increase Accessibility of rehabilitation services to all							
Strategic Objective 1.1: Increase accessibility of services and facilities by users							
Scale up community-based rehabilitation (CBR)	Determine rehab service to provide at community level	B	X				
	Sensitization of communities on available services	C		X	X		
	Provision of CBR with services like screening and referrals	C		X	X	X	X
Scale up rehabilitation services to primary care facilities	Determine rehab services to be offered by dispensaries and health centres	B	X				
	Fund and equip primary facilities to offer the identified rehab services	C		X	X	X	X
	Sensitize community, including PWDs and care givers on available service	C		X	X	X	X
Establish working referral system for accessing rehabilitation services	Map referral network for rehab services at county and national level	B	X				
	Develop documentation and system to be used for referral	N	X	X			
	Train healthcare workers on appropriate referral process/ system	C		X	X		
Build disability friendly infrastructure and amenities at all levels	Map accessibility needs for all disability domains	B	X				
	Budget for and implement infrastructure change at all levels of care to increase accessibility	C	X	X	X	X	X
Strategic Objective 1.2: Improve user awareness of services and reduce stigma associated with disability							
Undertake awareness creation campaigns at community level using properly packaged information	Undertake capacity building needs assessment for each domain – for user, caregiver and community	B	X	X			
	Prepare capacity building materials and schedule capacity building sessions	C		X	X		
	Carry out community sensitization on rehabilitative services and disability	C		X	X	X	X
Introduce legible posters and disability specific interpreters at facilities to enhance communication	Convene stakeholders meeting to come up with posters content for all disabilities and interpreter needs for different levels of care	C		X			
	Print and distribute the posters to all facilities	C		X	X	X	X
	Hire interpreters at facilities	C		X	X		

Intervention	Activities	Responsible Party	YEAR1	YEAR2	YEAR3	YEAR4	YEAR5
Disseminate policy and guidelines to users and caregivers	Sensitize users and care givers on available policies and guidelines	C	X	X			
Reinforce and improve caregiver support through skills development trainings	Determine skills care givers need to support PWDs for each domain	B		X			
	Schedule training sessions to sensitize care givers	C		X	X	X	X
Reduce stigma associated with disability	Determine gaps in embracing of disability by community	B	X				
	Prepare and package communication right format to reach target audience – health talks, electronic and print media	B		X			
	Sensitize the community with goal of reducing stigma	C		X	X	X	X
Strategic Objective 1.3: Implement universal health coverage insurance for PWDs to reduce out of pocket expenditure							
Subsidize cost of seeking rehabilitative services at all levels of care	Rehabilitative services unit to work with health financing team to include rehab services in UHC	B		X	X	X	X
Subsidize cost of acquiring appropriate assistive technology for use by PWDs	Rehabilitative services unit to work with health financing team, NHIF to include assistive technology in UHC	B		X	X	X	X
Policy and Guidelines: Strategic Direction 2: Implement existing policies/ guidelines and develop other policy frameworks key in scaling up rehabilitative services							
Strategic Objective 2.1: Implement existing policies in full and foster collaboration between MDAs key in implementation							
Implement the Kenyan Constitution of 2010, the Persons with Disability Act 2003, the Kenya Mental Health Action Plan 2021-2025, the Kenya Mental Health Policy 2015-2030 and adopt the ASHA guidelines for screening for Speech and Language delay and disorders in children (WHO)	Document aspects of existing frameworks which have not been fully implemented despite commencement	N	X	X	X	X	X
	Hold consultative intersectoral and multi sectoral meeting to discuss implementation of unimplemented framework aspects	N	X	X	X	X	X
	Implement all existing policies and guidelines key to improving the disability space	B	X	X	X	X	X
Strategic Objective 2.2: Develop policies and guidelines for streamlining rehabilitation services							
Develop policy on rehabilitation services for persons with disabilities outlining integration of services and budgetary allocation from government	Determine policy and guidelines gaps related to service delivery, integration and financing of rehab services	B	X	X	X	X	X
	Draft new policies or guidelines key in streamlining and scaling up rehabilitative services	B	X	X	X	X	X
	Disseminate and implement guidelines in all counties	C			X	X	X

Intervention	Activities	Responsible Party	YEAR1	YEAR2	YEAR3	YEAR4	YEAR5
Develop guideline for introduction of rehabilitation module and key best practice training aspects in all medical schools	Work with learning institutions to determine gaps in curricula	N	X	X	X	X	X
	Revise curricula to reflect current global best practices in provision of rehab service	N	X	X	X	X	X
Develop policy on assistive technology	Work with the State Department of Social Protection and other key MDAs to develop an Assistive Technology policy	N	X				
	Disseminate and implement the Assistive Technology policy	N		X	X	X	X
Establish appropriate staffing norms for all disability domains at all levels of care	Determine rehabilitative staffing need at all levels of care	N	X	X			
	Formulate ideal staffing norms for all levels of care	B		X	X		
	Work with intersectoral team to update and disseminate Staffing Norms Guidelines	N		X	X	X	X
Service Delivery: Strategic Direction 3: Scale and strengthen rehabilitation service delivery at all levels of care							
Strategic Objective 3.1: Scale up rehabilitation services to all levels of care							
Define rehabilitation services to be offered at different levels of care across the domains	Undertake capacity assessment for all levels of care to determine rehabilitative services gaps	B	X				
	Develop structure on rehab services to be offered at different levels of care	B	X	X	X		
	Invest in equipment, space and tools key to offering the rehab services	C		X	X	X	X
Establish rehabilitative services at all levels of care including primary level	Establish rehabilitation services at all levels of care including primary level	B	X	X			
Identify human resource gaps at all levels of care and hire specialized rehabilitation staff across all disability domains to address shortage	Undertake comprehensive assessment to determine HR gaps at all levels of care including for CBR	B	X	X			
	Hire specialized rehabilitative staff at all levels of care and in line with MOH Staffing Norms	B		X	X	X	

Intervention	Activities	Responsible Party	YEAR1	YEAR2	YEAR3	YEAR4	YEAR5
Develop standards for an ideal rehabilitation service department in facilities	Determine standards for an ideal human resource mix at rehabilitative departments	N	X				
	Determine standard for ideal workflow and optimal service delivery to users at rehabilitative department	B	X	X			
	Establish rehabilitative departments which constitute all the key cadres in all facilities	C		X	X		
Establish rehabilitation services as essential services at the Ministry of Health	Establish rehabilitative services as essential services at the Ministry of Health	N	X	X			
	Factor in rehabilitative services in key ministerial plans for preventive and curative care	N		X	X	X	X
Strategic Objective 3.2: Enhance training of personnel and capacity building across disability domains							
Build capacity in training institutions to have modules on different disability domains	Information sharing between rehabilitative services and training schools on global good practice around rehabilitative services and assistive technology	B		X	X	X	X
	Hold periodic sensitization forums to share on new global practices around rehabilitative services	B		X	X	X	X
Enhance harmonized curricula in training institutions to ensure standardization of rehabilitative services practice	Hold consultative stakeholders meeting between schools offering rehab education to agree on core items to add to curricula	N		X			
	Revise curricula to include core items agreed upon by stakeholders for standardized knowledge sharing	N		X	X		
Enhance capacity of existing rehabilitation staff across all levels of care through training	Assess skills gap to determine capacity building need at all levels of care	B	X				
	Develop capacity building plan for all levels of care	B	X				
	Train rehabilitative service providers to enhance capacity for better service delivery	C		X	X	X	X
	Employ and induct new rehabilitation professionals into service to address skills and human resource shortage	C		X	X		
Redefine roles and responsibilities of rehabilitation professionals to enable multidisciplinary implementation of trained on aspects	Define roles of rehabilitative staff based on new workflows and department settings	B	X	X			
	Redistribute rehab staff within county facilities based on need and training	C		X	X	X	
	Monitor redefinition of roles and redistribution impact on service delivery	C		X	X	X	X

Intervention	Activities	Responsible Party	YEAR1	YEAR2	YEAR3	YEAR4	YEAR5
Strategic Objective 3.3: Enhance rehabilitation services practicing environment to have ideal infrastructure and equipment							
Define ideal infrastructure and equipment for optimal service delivery per level of care	Define ideal infrastructure and space need per level of care	B	X				
	Define infrastructure needs for adults and children per level of care	N	X				
	Define rehab equipment need per level of care	B	X				
Budget for infrastructure and acquire equipment for facilities in each county	Budget for infrastructure and acquire equipment for facilities in each county	B		X	X	X	X
Strategic Objective 3.4: Strengthen stakeholder collaboration and integration within rehabilitation services							
Enhance integration within rehabilitation services at national and county levels	Enhance integration within rehabilitation services at national and county levels	B	X	X	X	X	
Integrate rehabilitative and curative services at facilities to enhance wholesome care	Integrate rehabilitative and curative services at facilities to enhance wholesome care	C	X	X	X	X	
Promote inter-ministerial collaboration on rehabilitation services	Promote inter-ministerial collaboration on rehabilitation services	N	X	X	X	X	X
Promote collaboration of stakeholders at national and county governments	Sensitize management on importance of stakeholder collaborations within rehabilitative services	B	X				
	Initiate and maintain intersectoral and multisectoral stakeholder engagements	B	X	X			
Assistive Technology: Strategic Direction 4: Increase access to appropriate assistive technology							
Strategic Objective 4.1: Integrate the supply of assistive devices into the KEMSA system							
Determine AT need for all disability domains	Conduct nationwide survey to determine AT need	B	X	X	X		
	Identify stakeholders to validate findings of the survey and develop action plan to address the need	B		X	X	X	
	Address need	B				X	X
Develop a dynamic database of persons who need AT	Develop the key metrices to use in tracking AT need	B	X	X			
	Develop a dynamic database of persons who need AT	N				X	X

Intervention	Activities	Responsible Party	YEAR1	YEAR2	YEAR3	YEAR4	YEAR5
Develop capacity to handle all ranges of assistive devices in KEMSA depots	Hold meetings with KEMSA and discuss inclusion of AT in KEMSA supply chain	B	X				
	Assess regional KEMSA depots for capacity to handle/ distribute assistive devices	B	X	X			
	Counties to firm up AT supply agreements with KEMSA	C		X	X		
Purchase and distribute assistive technology through the national supply chain system	Purchase and distribute assistive technology through the national supply chain system	N		X	X	X	X
	Define last mile supply of assistive technology in counties	C	X	X			
	Implement last mile supply of assistive technology to facilities	C		X	X	X	X
Use hospital inventory management system for AT and create a dynamic catalogue for assistive technology	Develop metrices to be used in tracking AT in facilities	B	X	X			
	Incorporate the metrices in hospital inventory management system for AT	B		X			
	Integrate the inventory system with KHIS for monthly reporting	N		X			
	Create catalogue for assistive technology and share with counties	N		X	X	X	X
Strategic Objective 4.2: Build capacity of rehabilitation team to provide appropriate assistive technology							
Train rehabilitation teams on provision of different assistive devices per international best practices and WHO standards	Collate and update information on ideal AT provision standard per international best practices	N	X				
	Share updated information on international best practices with counties annually	B		X	X	X	X
	Organize for training of county teams at least once annually to upskill to international AT provision standards	C		X	X	X	X
Liaise with training institutions to incorporate international AT provision standards into curricula	Liaise with training institutions to incorporate international AT provision standards into curricula	N		X	X		
Establish mentorship plan on AT provision skills at all levels of care	Keep record of the rehabilitation professionals trained on various aspects of AT provision	B		X	X	X	X
	Schedule for mentorship sessions at facility level	B		X	X	X	
	Monitor progress made with regards to mentorship and skills transfer at facilities	B		X	X	X	X

Intervention	Activities	Responsible Party	YEAR1	YEAR2	YEAR3	YEAR4	YEAR5
Strategic Objective 4.3: Build local capacity for production of quality and affordable assistive devices							
Build skills critical for local production of assistive devices	Identify local manufacturers of assistive technology	N	X				
	Hold periodic meeting with local manufacturers of AT to discuss their needs	N	X	X			
	Organize stakeholders forums to address the needs of local	N		X	X	X	
Enhance local manufacturing capacity through incentives, including tax incentives	Conduct survey to determine current manufacturing capacity of AT in the country	B	X	X			
	Establish incentives to address gaps in meeting AT need in the country e.g. tax incentives	B		X			
	Implement incentives and monitor change in manufacturing capacity	B		X	X	X	X
Establish seed capital for AT production, research and innovation	Lobby for seed capital for AT production, research and innovation	B	X	X	X		
	Establish and monitor uptake and accountability of the seed capital by beneficiaries	B		X	X	X	X
Strategic Objective 4.4: Advocate for development of relevant policies and guidelines to anchor quality of assistive technology							
Develop standards for appropriate provision of assistive devices for each disability domain	Develop standards for appropriate assistive devices	N	X	X			
	Engage stakeholder to refine the standards	B		X			
	Implement standards for appropriate assistive devices	B		X	X	X	X
Create job aids for provision of different assistive devices	Create job aids for provision of different assistive devices	N		X			
	Distribute protocols to all facilities	C		X	X		
Implement AT quality check and measures through KEBS	Implement AT quality check and measures through KEBS	N		X			
Strategic Objective 4.5: Establish and strengthen collaboration with stakeholders and partners							
Mapping partners involved with production, distribution and provision of AT	Mapping partners involved with production, distribution and provision of AT	N	X				
	Share information on partners with intersectoral and multisectoral disability focused institutions	N	X	X			
Define roles of partners in the ecosystem for optimal provision of AT	Define roles of partners in the ecosystem to boost synergy in AT provision	B	X	X			
	Share proposed definition of roles with partners for input	B	X	X			
	Implement and monitor the defined roles	B		X	X		

Intervention	Activities	Responsible Party	YEAR1	YEAR2	YEAR3	YEAR4	YEAR5
Establish and strengthen collaboration between stakeholders and partners	Hold quarterly meeting with stakeholders to share progress made with increasing access to appropriate AT	B		X	X	X	X
	Hold annual meeting to discuss progress and plan for the following year	B		X	X	X	X
Financing: Strategic Direction 5: Enhance financing for rehabilitative services and assistive technology							
Strategic Objective 5.1: Mobilize and invest adequate resources in rehabilitative services							
Advocate for policies and guidelines for sustainable financing of rehabilitative services at national and county level	Hold meetings to determine structure and guidelines for financing rehabilitative services	B	X				
	Develop county legislative mechanisms for budgeting for and financing rehabilitative services	C		X			
Lobby for inclusion of rehabilitative services and assistive devices in budgets at county and facilities	Lobby for inclusion of rehabilitative services and assistive devices in budgets at county and facilities	B	X	X			
	Lobby for adequate resource allocation to rehabilitative services and assistive devices in facilities	B		X			
Strategic Objective 5.2: Expand UHC to include rehabilitative services and assistive technology							
Expand the NHIF scheme to include assistive technology to be accessed by all	Conduct meetings with NHIF to develop service package for rehabilitative services and assistive devices	B	X				
	Implement service package for rehabilitative services and assistive technology	B		X	X	X	X
Advocate for private health insurance schemes to provision of rehabilitative services and assistive technology	Conduct meetings with private health insurance providers to lobby for inclusion of rehabilitative services and AT provision in their essential package	N	X	X			X
Leadership and Organization: Strategic Direction 6: Secure political and leadership commitment to scale up rehabilitative services and increase access to assistive technology							
Leadership and organization: Strategic Direction 6: Secure political and leadership commitment to scale up rehabilitative services and increase access to assistive technology							
Launch and disseminate the Rehabilitative Services and Assistive Technology Strategy	Hold one prelaunch meeting to discuss the strategy and action points of both levels of government	B	X				
	Hold a national launch with key stakeholders invited	N	X				
	Hold dissemination meeting for national stakeholders	N	X				
	Hold dissemination meetings for counties	B	X				

Intervention	Activities	Responsible Party	YEAR1	YEAR2	YEAR3	YEAR4	YEAR5
Prioritize rehabilitative services as essential health services	Hold sensitization meetings for national policy makers to prioritize rehabilitation services as essential health services	N	X	X	X	X	X
	Hold sensitization meetings for county policy makers to prioritize rehabilitation services as essential health services	B	X	X	X	X	
Advocate for development and legislation of key rehabilitation policies and laws	Hold bi-annual meetings to discuss gaps in legislation and policies	N		X			
	Hold meetings with legislatures and policy makers to discuss need for enabling frameworks	N		X			
	Disseminate policies and guidelines to all stakeholders	N	X	X	X	X	X
Incorporate rehabilitation services into existing governance and management structures at national and county level	Establish health care governance structure which incorporates rehabilitative services at national decision/ policy making	N	X	X			
	Establish health care governance structure which incorporates rehabilitation services at county decision/ policy making	C	X	X			
Strategic Objective 6.2: Promote equitable allocation of resources, good governance and accountability							
Lobby policy makers at national and county level for inclusion of rehabilitation services and assistive technology in budget planning and allocation	Hold meeting with policy makers at national level to lobby for inclusion of rehabilitation services and assistive devices in budget planning and allocation	N	X				
	Hold meeting with policy makers at county level to lobby for inclusion of rehabilitation services and assistive devices in budget planning and allocation	B	X	X			
Promote public accountability at all levels of services delivery to address efficiency, transparency and participation in utilization of resources	Sensitive service providers and policy makers on Public Finance Management Policy	N	X	X			

6

MONITORING AND EVALUATION FRAMEWORK

MONITORING AND EVALUATION FRAMEWORK

6.1 Rationale for Monitoring and Evaluation

To ensure there is a basis for guiding key aspects of decision making, implementation, information sharing and unified approach for planning elements across the different disability domains, there is need to have a comprehensive M&E framework. The M&E framework section encompassed data architecture, data collection and management, indicator matrix, data analysis and information sharing.

6.2 Data Architecture for Disability Domains

To ensure there is comparability and coordinated data generation, aggregation and information sharing, there is need to have a common data architecture which outlines key implementation indicators and how they will be measured during routine Monitoring and Evaluation. This will ensure efficient information management and consumption by decision makers and stakeholders. The Rehabilitative Unit together with multisectoral stakeholders have identified indicators for monitoring and evaluating the implementation of the Rehabilitative Services and Assistive Technology Strategy 2022-2026 which will be used to monitor rehabilitative services and access to assistive technology.

During implementation the outlined indicators will be measured using existing health systems for reporting and information sharing, with required integrations in some highlighted areas to facilitate seamless flow of data. The mapped indicators will measure interventions, activities, outputs and outcomes of the different strategic focus areas across the different disability domains.

Table 9: M&E Implementation Indicators

SUMMARY OF IMPLEMENTATION INDICATORS

INPUT	OUTPUT	OUTCOME
Finance, leadership and governance 1. Total expenditure on rehabilitative services (as a % of health expenditure) 2. County government expenditure on rehabilitative service (as a % of county health expenditure) 3. Total expenditure on assistive devices (as a % of the rehabilitative budget at national and county level) 4. Expenditure on assistive devices (as a % of the NCPWD budget) 5. Counties with rehabilitative services and assistive devices incorporated in UHC plans 6. Utilization rate for allocation to rehabilitation services and assistive devices in NHIF benefit packages (%) 7. Availability of reports to track rehabilitation financial expenditure at facilities 8. Availability of annual workplan for rehabilitative services and implementation of the Strategy 9. Establishment of rehabilitative services as essential services in counties 10. Rehabilitation representation on a permanent basis in County Health Management Team 11. Availability of rehabilitation focal person at County and Sub County levels 12. Number of intersectoral and multi sectoral progress meetings	**Service delivery** 1. Rehabilitation health worker and distribution per cadre 2. Proportion of facilities offering comprehensive rehabilitation services 3. Proportion of facilities with ideal infrastructure (% of facilities in county) 4. Proportion of facilities with ideal equipment to offer service per cadre (% of facilities in county) 5. Availability of assistive devices in facilities' storage 6. Proportion of rehabilitation HRH who take part in capacity building sessions 7. Integration of rehabilitation service (% of facilities with integrated services)	**Access to rehabilitative services** 1. Proportion of facilities with accessibility amenities 2. Availability of key posters to guide users at facilities 3. Access to rehabilitation services within 5km of one's place of living 4. Access to essential commodities and medicines per domain 5. Number of sensitization sessions attended (rehabilitation clients) 6. Number of sensitization sessions attended (care givers)
Policy/ guidelines 1. Implementation of existing frameworks 2. Developed frameworks for different domains 3. Dissemination of policies/ guidelines to healthcare workers 4. Stakeholder sessions to disseminate policy/ guidelines to community	**Service and assistive technology quality** 1. Availability of standard job aids for rehabilitation at points of service 2. Standardization of documentation and referral system 3. Curricula review by medical schools to include rehabilitation and assistive devices (% of schools) 4. Product standard and quality for all assistive devices (by KEBS) 5. Uptake of CBR per CBR guidelines per WHO (% of facilities)	**Access to assistive technology** 1. Number of people screened for AT need 2. Proportion of AT need met (provision as % of AT need) 3. Local production capacity (Ability to meet need) 4. Proportion of AD supplied through KEMSA system 5. Proportion of HRH trained on provision of AT (as a % of rehabilitation HRH) 6. Availability of dynamic catalogue for assistive devices (% of counties) 7. Annual stakeholders progress meeting

SUMMARY OF IMPLEMENTATION INDICATORS (CONTINUED)		
INPUT	**OUTPUT**	**OUTCOME**
Health information and reporting 1. Availability of reporting tools 2. Inclusion of rehabilitative services and AD in Hospital Information Management system 3. Timely reporting in DHIS2 4. Systems and data review at county level 5. Implement dynamic national database on PWD and AT need		**Risk factors** 1. Users with secondary conditions 2. Extreme disability users with helpers 3. Lack of access to service due to stigma 4. Out-of-pocket payment for rehabilitative services 5. Accuracy and completeness of reports (%) 6. Medical errors and provision of inappropriate AT

6.3 Data Collection and Management

Data relating to rehabilitative services and assistive technology shall be collected through the existing data collection systems. The Health Management Information System (HMIS) which is utilized in collecting service data in counties will be utilized and information relayed to the HMIS web portal. Key indicators as outlines will also be relayed through DHIS2 for subsequent disaggregation and decision making.

Logistics data relating to assistive technology supply chain will be captured in multiple systems. The Logistics Management Information System (LMIS) will be utilized at facility/ county level to capture ordering, supply and utilization data. The information collected in LMIS will need to be automatically submitted to KEMSA for quantifications and supply action and as such, integration of LMIS and other KEMSA reporting systems will be fundamental to allow for system queries and caching of essential data for seamless supply of assistive devices and generation of reports.

Table 10: Scaling up Rehabilitation Services and Increase Access to AT Indicator Matrix

SCALING UP REHABILITATION SERVICES AND INCREASE ACCESS TO AT INDICATOR MATRIX										
Outcome Indicators										
KRA	INDICATOR	BASE-LINE	2021/22	2022/23	2023/24	2024/25	2025/26	Data Source	Reporting Frequency	Responsibility (Both mean – County & National)
Access to rehabilitation services	Proportion of facilities with accessibility amenities	-	-	25	50	75	100	-	-	Both
	Availability of key posters to guide users at facilities	-	100	100	100	100	100	-	-	County
	Proportion of people accessing rehabilitative services within 5km of one's place of living	-	-	25	50	75	100	-	-	Both
	Proportion of people accessing essential commodities and medicines per disability domain	-	-	50	100	100	100	-	-	Both
	Number of sensitization sessions attended (rehab clients)	-	4	4	4	4	4	-	-	County
	Number of sensitization sessions attended (care givers)	-	4	4	4	4	4	-	-	County
Access to assistive technology	Number of mass screening clinics done to identify AT need	-	4	4	4	4	4	-	-	County
	Proportion of AT need met (provision as % of AT need)	-	20	40	60	80	100	-	-	Both
	Local production capacity to meet demand	-	20	40	60	80	100	-	-	Both AT manufacturers
	Proportion of AT supplied through KEMSA system	-	20	40	60	80	100	-	-	Both
	Proportion of HRH trained on provision of AT (as a % of rehab HRH)	-	20	40	60	80	100	-	-	Both
	Availability of dynamic catalogue for assistive devices (% of counties)	-	-	-	100	100	100	-	-	National
	Annual stakeholders progress meeting	-	-	-	1	1	1	-	-	Both

SCALING UP REHABILITATION SERVICES AND INCREASE ACCESS TO AT INDICATOR MATRIX (CONTINUED)

Outcome Indicators

KRA	INDICATOR	BASE-LINE	2021/22	2022/23	2023/24	2024/25	2025/26	Data Source	Reporting Frequency	Responsibility (Both mean – County & National)
Risk factors	Accuracy and completeness of reports (%)	-	100	100	100	100	100	-	-	County
Service delivery	Availability of Rehabilitation health worker per cadre at facility	-	-	50	75	100	100	-	-	National
	Proportion of facilities offering comprehensive rehabilitative services	-	20	40	60	80	100	-	-	Both
	Proportion of facilities with ideal infrastructure (% of facilities in county)	-	-	30	50	80	100	-	-	Both
	Proportion of facilities with ideal equipment to offer service per cadre (% of facilities in county)	-	-	30	50	80	100	-	-	Both
	Proportion of available assistive devices in facilities' storage	-	-	-	50	-	100	-	-	Both
	Proportion of rehabilitative HRH who take part in capacity building sessions	-	-	30	60	80	100	-	-	Both
	Integration of rehabilitation service (% of facilities with integrated services)	-	-	-	70	-	100	-	-	Both
Service and assistive technology quality	Proportion of available standard operating procedures at points of service	-	-	-	60	-	100	-	-	National
	Standardized referral system in all health facilities	-	-	50	100	100	100	-	-	Both
	Curricula review by medical schools to include rehabilitation and assistive devices (% of schools)	-	-	-	80	-	100	-	-	National
	Product standards for all assistive devices (% of products with standards	-	100	100	100	100	100	-	-	National KEBS
	Uptake of CBR guidelines as per WHO (% of facilities)	-	20	40	60	80	100	-	-	Both

SCALING UP REHABILITATION SERVICES AND INCREASE ACCESS TO AT INDICATOR MATRIX (CONTINUED)

Outcome Indicators

KRA	INDICATOR	BASE-LINE	2021/22	2022/23	2023/24	2024/25	2025/26	Data Source	Reporting Frequency	Responsibility (Both mean – County & National)
Financing, leadership and governance	Total expenditure on rehabilitative services (as a % of health expenditure)	-	-	-	-	-	-	NHA	-	National
	County government expenditure on rehabilitative service (as a % of county health expenditure)	-	-	-	-	-	-	NHA	-	County
Financing	Total expenditure on assistive devices (as a % of the rehabilitative budget at national and county level)	-	-	-	30	-	50	-	-	Both
	Expenditure on assistive devices (as a % of the NCPWD budget)	-	-	-	-	-	-	NCPWD	-	National NCPWD
	Counties with rehabilitation services and assistive technology incorporated in UHC and county plans	-	-	-	47	47	47	-	-	County
	Utilization rate of allocation to rehab services and assistive technology in NHIF benefit packages (%)	-	-	-	60	-	100	-	-	National NHIF
Leadership and governance	Number of reports to track rehab financial expenditure at facilities	-	-	-	48	48	48	-	-	Both
	Number of annual workplans for rehabilitative services in line with implementation of the Strategy	-	-	48	48	48	48	-	-	Both
	Number of established rehabilitative services as essential services in all levels of care	-	-	48	48	48	48	-	-	County
	Number of counties with rehabilitation represented in County Health Management Teams	-	-	47	47	47	47	-	-	County
	Proportion of representation of rehabilitation services at Sub County levels	-	-	100	100	100	100	-	-	County
	Number of intersectoral and multi sectoral progress meetings	-	2	4	4	4	4	-	-	Both

SCALING UP REHABILITATION SERVICES AND INCREASE ACCESS TO AT INDICATOR MATRIX (CONTINUED)										
Outcome Indicators										
KRA	INDICATOR	BASE-LINE	2021/22	2022/23	2023/24	2024/25	2025/26	Data Source	Reporting Frequency	Responsibility (Both mean – County & National)
Policy/ guidelines	Number of frameworks developed for different domains	-	-	-	-	-	-	-	-	Both
	Number of policies/ guidelines disseminated to healthcare workers	-	-	-	-	-	-	-	-	National
	Number of stakeholder sessions held to disseminate policy/ guidelines to community	-	-	47	47	47	47	-	-	County
Health information and reporting	Number of counties using the reporting tools	-	-	47	47	47	47	-	-	County
	Inclusion of rehab services and AT in Hospital Information Management system	-	-	-	50	75	100	-	-	Both
	Timely reporting in DHIS2	-	-	47	47	47	47	-	-	County
	Systems and data review at county level	-	-	47	47	47	47	-	-	County
	Number of counties implementing the dynamic national database on PWD and AT need	-	-	47	47	47	47	-	-	Both

6.4 Data Analysis and Review

Information on the detailed indicators will be analysed according to the Rehabilitative Services and AT Strategy M&E Framework. For optimal analysis for information consumption by different decision makers, analysis will be done in the following lines;

1. Overall national analysis to outline achievements
2. Analysis by county to outline achievements
3. Disaggregation of findings by:
   - Strategic direction
   - Strategic objective
   - By Kenya Essential Package for Health (KEPH) level

The analysis report will be validated by stakeholders to obtain stakeholders insight on the analysis, obtain consensus on findings and strengthen ownership and commitment from decision makers and all stakeholders to monitoring and evaluation.

6.5 Enhanced Information Sharing

Upon obtaining consensus on findings from stakeholders, data will be packaged and disseminated to stakeholders in formats ideal for their consumption and reference. This dissemination will be key in informing process, financing and policy decisions. For the 5 years the strategy is implemented, there will be need to publish annual report aggregating data from the M&E and key information from other interventions in rehabilitative services.

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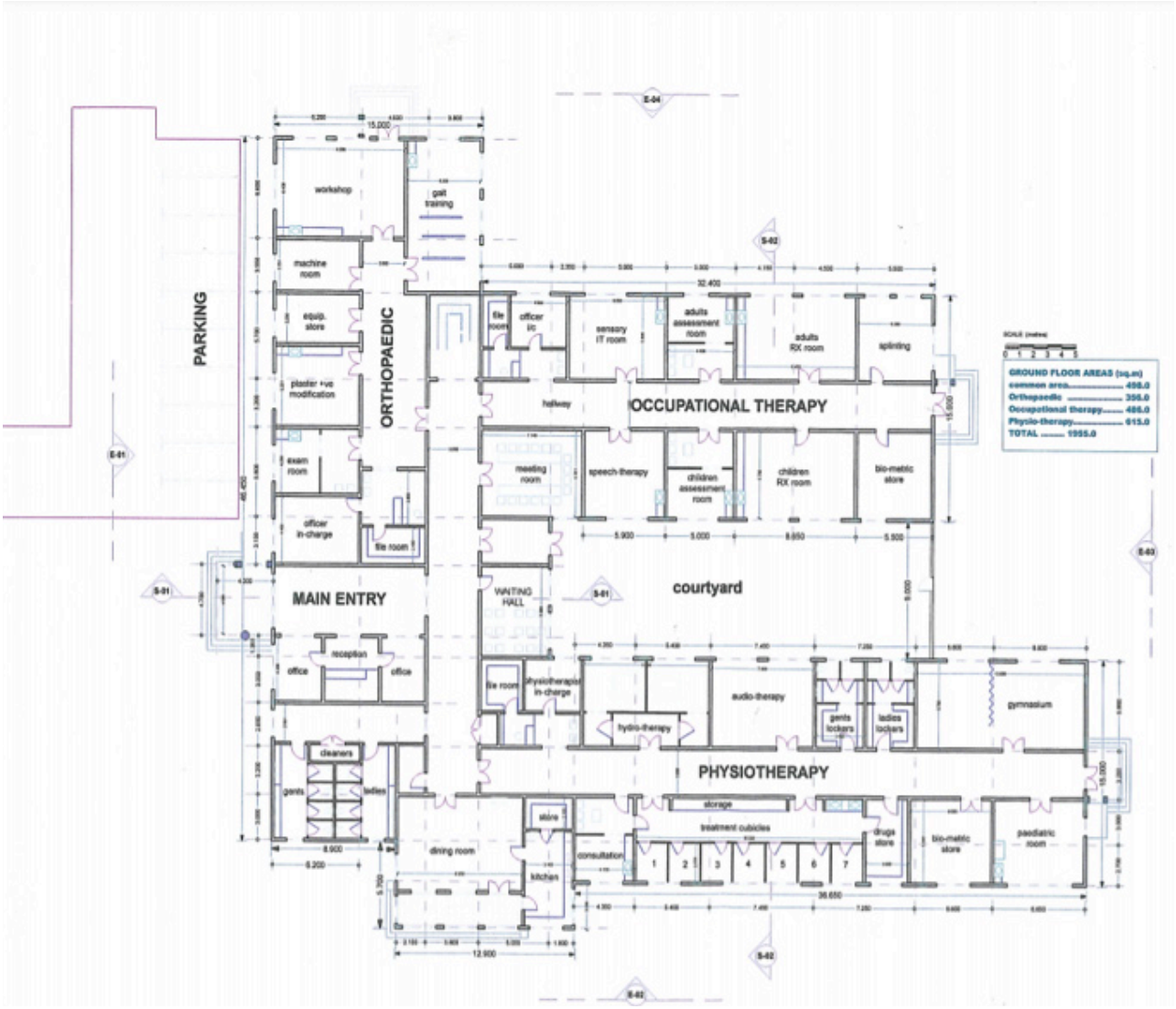
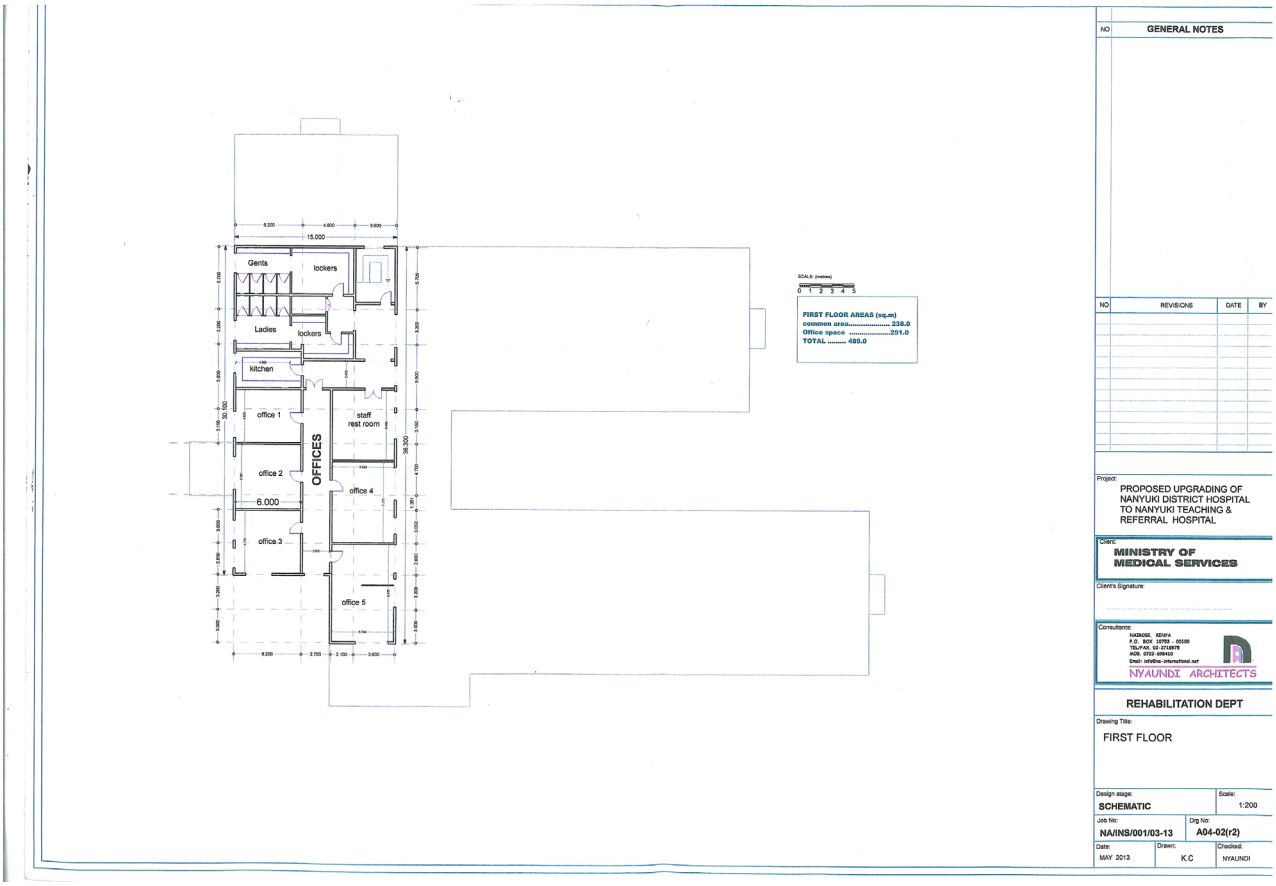
8 ANNEXES

Annex 1: Example of Rehabilitation Department Layout (for Physiotherapy, Orthopaedic Technology and Occupational Therapy Services)



Annex 2: Example of Rehabilitation Department Layout (for Physiotherapy, Orthopaedic Technology and Occupational Therapy Services)



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REHABILITATIVE SERVICES AND ASSISTIVE TECHNOLOGY STRATEGY

2022-2026

This policy is intended as a guide for the health sector for management of Rehabilitative Services in Kenya towards the provision of quality health care