

## KENYA 3-YEAR CATALYTIC CONCEPT NOTE

<b>Project Details:</b>	3-Year Catalytic Concept Note requesting ATscale to support the Government of Kenya to implement the Rehabilitation Services and Assistive Technology Strategy (2022-2026)
<b>Country:</b>	Kenya
<b>Chair of Country Secretariat</b>	Ministry of Health
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<b>Contact Person:</b>	The Principal Secretary, Ministry of Health
<b>Proposed Date of Project Implementation</b>	1 <sup>st</sup> October 2022 – 30th September 2025
<b>Total Budget</b>	\$7.5Million over 3 years

### I. Background

According to the World Health Organization (WHO), more than 2 billion people globally will need at least 1 assistive product by 2030 while only 1 in 10 out of people in need of assistive technology have access<sup>1</sup>. In Kenya, it is estimated that 606,700<sup>2</sup> children below 5 years and 1,104,000<sup>3</sup> of people above 5 years are living with disabilities. The major causes of disability as established during the 2019 national census are: physical (42%), visual (36%), cognitive (23%) while 17% are hearing related. The need for Assistive Technology (AT) amongst the 1.7m Kenyans living with disability is therefore huge yet with very limited access. For example, 25% of people living with physical disability need a wheelchair in Kenya, yet less than 5% have access<sup>4</sup>. Without AT, many children are denied the opportunity to get an education and are more likely to suffer from health issues, caregivers are forced to give up their livelihoods to take care of children, people living with disabilities are denied their livelihoods while families are pushed further into poverty due to catastrophic out of pocket costs spent on inappropriate solutions. Multiple factors contribute to the low access to AT in Kenya. The available AT devices are costly and not affordable to the population. On average, a family seeking to buy a wheelchair for a disabled relative must spend at least \$200 on average - without factoring in the cost of multiple trips to the source, yet 36.1% of the population lives below the poverty line of less than \$1.90 per day<sup>5</sup>. In many cases, inappropriate wheelchairs are sold to families which further leads to multiple purchases as

<sup>1</sup> WHO Notes on Assistive Technology, 2018 [www.who.int/news-room/fact-sheets/detail/assistive-technology](http://www.who.int/news-room/fact-sheets/detail/assistive-technology)

<sup>2</sup> UNICEF, November 2021: <https://news.un.org/en/story/2021/11/1105412>

<sup>3</sup>

<sup>4</sup> MOH Rehabilitative Services and AT Survey, 2019 (unpublished)

<sup>5</sup> World Bank National Poverty Line, 2015 <https://data.worldbank.org/indicator/SI.POV.NAHC?locations=KE>

they seek a better solution. AT such as prosthesis are always out of reach for majority of people in need of them. A locally made lower limb prosthesis will require a family to invest a minimum of \$2,000 on average while the imported products are more than double the price. The visual space is not any different as majority of children are not able to acquire numeracy and reading skills due to lack of access to visual screening and aids. Hearing aids too are seven times costlier than wheelchairs. A bilateral pair of hearing aids will cost at least \$1500. In addition, AT devices are not readily available in the Kenyan market and where available majority do not meet the appropriateness and quality standards. This is likely due to the high ex-factory costs and mark-ups applied upon entry into the market as well as limited policy and regulation in the space. Further, government hospitals do not stock and KEMSA does not procure AT since AT devices are not part of essential product list. As a result, majority of users procure AT devices from private facilities in a few major towns across the country. The lack of specialized and highly skilled providers further compounds the problem as does the limited awareness on specific AT and appropriateness that is attributed to users and caregivers. Some domains hardly any of the specialists required to offer services. The visual, hearing and language and speech domains are particularly disadvantaged when it comes to resourcing. For example, Kenya has less than 30 audiology personnel, of which only 15 are in public hospitals; also, there are only 12 providers offering speech and language therapy in the entire country. Other areas such as wheelchair provision have some level of personnel in place, but they lack the required skills to effectively offer the services. To significantly increase access to assistive technology and drive utilization, interventions must be contextualized and built around the highlighted gaps.

### **The Organization of Rehabilitation & Assistive Technology Services in Kenya**

Rehabilitation and AT services in Kenya are anchored under the constitution of Kenya where every Kenyan has the right to access the highest attainable standards of health care, education while at the same time requiring the state to provide social security to persons unable to support themselves and their dependants. To achieve this, various line ministries including the Ministry of Health, Ministry of Education and Ministry of Public Service, Gender, Senior Citizens Affairs & Special Programmes are mandated to fulfil these rights.

The Ministry of Health at the national level is responsible for providing equitable, affordable, accessible, and quality healthcare for all Kenyans. The Ministry's mandate covers policy, regulation, national referral hospitals, capacity building and Technical Assistance (TA) to counties. Health in Kenya is a devolved function where counties are mandated to offer quality health services. The Kenya healthcare service delivery system provides for delivery of services through a network of ~7k facilities at the primary healthcare level and at referral levels of care. The system has six levels of care: Level 1: Community Level 2: Dispensary: Level 3: Health Centres: Level 4: primary referral facilities: Level 5: Secondary referral facilities and Level 6: Tertiary Referral facilities.

The Ministry of Public Service, Gender, Senior Citizen Affairs and Special Programs hosts the State Department for Social Protection. The department is mandated to formulate, review, and implement programs for persons with disabilities. The Ministry executes this function through the National Council for Persons with Disabilities (NCPWD), which is a State Agency mandated to promote and protect the equalization of opportunities and realization of human rights for PWDs to live decent lives. The Council has programs covering education assistance, economic empowerment, assistive devices, infrastructure and equipment support and trainings.

### **Country progress in Rehabilitation Services and Assistive Technology**

Despite the challenges in the Rehabilitation and AT space, the Government of Kenya has embarked on an ambitious journey of improving Rehabilitation & disability services in the country. These efforts were intensified in recent years, after the Global Disability Summit of 2018. The GDS 2018, which was co-hosted by the Government of Kenya, the UK Government, and the International Disability Alliance (IDA), generated multiple commitments among them, increasing access to assistive technology and Rehabilitation services and availing equal opportunities to persons with disabilities in society. These commitments set the momentum for the Government to be intentional about work aimed at increasing access to AT in Kenya. Some of the notable achievements by the Government to date are:

1. Improved coordination between players in the ecosystem on matters disability (including AT), through an Inter-agency coordinating mechanism established in 2019.
2. Development of policies key to streamline provision of Rehabilitation services and increasing access to AT. Examples – (i) Rehabilitation Services and Assistive Technology Strategy 2022-2026 and the Disability Medical Assessment and Categorization Guidelines 2022. The strategy maps out the key access gaps in the country and provides strategic direction and interventions to enable Kenya increase access and utilization of rehabilitation and AT services.
3. Increased partnerships in the ecosystem. The Government has been at the centre of fostering partnerships and looking for new opportunities critical to increasing access to Rehabilitation services and assistive technology. Examples – (i) Collaboration between Ministry of Health, other Ministries, State Departments and Agencies (MDAs) e.g. State Department of Social Protection and National Council for Persons with Disabilities, private organizations and NGOs in the ecosystem in development of the policies, (ii) Increase partnership within MDAs in dissemination of the policy documents/ training of service providers and, (iii) Partnership discussions with key multilateral institutions such as the WHO, ATscale etc. on different works.
4. The President of Kenya led the commemoration of the International Day of Persons with Disabilities in Kenya in December 2021 and while addressing delegates, he gave multiple directives. The Presidential directives require the MOH to:

- Increase the number of rehabilitation staff at both national and country levels
- Support institutions of higher learning to develop capacity for training rehabilitation personnel - together with MOE
- Fast track the representation of rehabilitation services at all levels of health care delivery including policy and universal health coverage.

In addition to these directives which are to be spearheaded by MOH, other directives are: to the office of the Attorney General, Ministry of Public Service, Gender, Senior Citizens Affairs and Special Programmes to hasten the process of reviewing the Persons with Disabilities Act 2003 and have the bill enacted by Parliament during the life of the current Parliament, the Ministry of Public Service, Gender, Senior Citizens Affairs and Special Programmes ensures the process of registering persons with disabilities under the new registration system is provided at no cost.

At the Global Disability Summit 2021, the Government of Kenya emphasized its commitment to: implement the Rehabilitation Services and AT strategic plan, support the implementation of the Disability Medical Assessment and Categorization Guidelines, establish the National Assistive Technology Centre of Excellence and work towards ensuring that the National Hospital Insurance Fund (NHIF) provides all health-related needs to all PWDs.

### **Barriers to Accessing Rehabilitation & AT services in Kenya**

Kenya has made notable progress over the last 10 years in increasing access to rehabilitation & AT services. More PWDs are accessing health and education services through the Government's investments in Ministry of Education's special and integrated school programs as well as the National Council for Persons with Disabilities, who offer AT services. The government also has continued to channel technical and financial support to the Association for Persons with Disabilities (APDK) to manufacture and provide approximately 1000 wheelchairs annually across the country. Despite this progress, a huge population of PWDs need of rehabilitation & AT services are underserved. Access to rehabilitation and AT services is limited due to factors as outlined below:

#### **I. Absence of rehabilitation and AT services in level 2 and 3 facilities and other channels**

PWDs in Kenya access services from a limited number of facilities across the country. The coverage is not optimal for the level of need in Kenya. An assessment conducted by MOH & CHAI in 2019 established that all referral facilities assessed offer rehabilitation services; only 54% of these facilities assess for AT while only 28% provide AT. In addition, coverage is also limited in scope of services offered as not the entire range of rehabilitation & AT services are offered. Comprehensive services for visual, hearing, speech, language, and autism spectrum disorders are available in fewer than 10 facilities across the public

sector. Faith Based Organisations and private hospitals offer limited rehabilitation & AT services.

## **II. Lack of rehabilitation & AT policy**

To effectively implement on the Kenya Essential Package for Health, several policies are required. Currently Kenya does not have umbrella rehabilitation & AT policy addressing critical areas such as service delivery at various levels of care, donations, local production and more.

## **III. Limited competence and skills by Human Resources for Health in rehabilitation & AT services**

Rehabilitation & AT services are offered by a multiple set of cadres with the primary set being health professionals. In this category physiotherapists, occupational therapists, and orthopaedic technicians play a significant role. Teachers too have played a role in screening for disabilities in schools in some projects. Whereas the providers have the basic knowledge and skills from their training particularly in rehabilitation, knowledge and skills on AT as well as new approaches to services delivery is very limited. For example, only 118 personnel in the MOH facilities across the country are trained in assessing, prescribing and fitting of wheelchairs. Other rehabilitation services such as visual hearing, language and speech are not available due to lack of knowledge across existing cadres of providers in the absence of specialist providers.

## **IV. Shortage of staff for rehabilitation & AT services**

Scale up of interventions cannot be executed without adequate staffing across all levels of cares. Kenya has a sizeable shortage of providers across board in the healthcare system. The Rehabilitation & AT services specifically has one of the biggest gaps with under 1000 HCWs deployed across the MOH facilities. An additional 2250 staff are required per the national staffing norms and standards to be achieved. Some domains such as hearing, visual, language, speech & autism spectrum disorders have the biggest gaps. Only seven (7) facilities can appropriately diagnose and rehabilitate hearing, while all the 47 county facilities offer eye care services. Kenya has a total of 25 language and speech therapists. Seven of these support 3 national referral hospitals and 1 county hospital. There are only 75 audiology personnel in the country: with only 30 of these in the public sector and mainly in the national referral hospitals.

## **V. Lack of infrastructure and equipment**

Infrastructure and equipment are an integral part of service delivery. Clients with needs cannot be identified and managed without the screening, diagnosis, fabrication, assembling, and therapy tools being available. Levels 2 and 3 facilities lack the equipment and infrastructure necessary for rehabilitation & AT services while Level 4 and 5, the buildings are small and have no diagnostic equipment. For example, only 1 MOH facility has a brainstem evoked response audiometry (BERA) machine which is a critical diagnostic equipment for hearing disabilities; only 15 facilities have well equipped orthopaedic workshops, while none have communication boards for speech and language therapy.

Equally, no public facility in Kenya has an optical lab and shop. Facilities also require AT training infrastructure critical for ensuring that the dispensed AT is utilized properly by the users, adapted spaces for this training are not available across facilities.

#### **VI. High cost of AT products**

AT products in low- and middle-income countries are costly. As a result, only a few PWDs can access them limiting access to education and overall participation in socio-economic activities. Additionally, new, and innovative products are available in global markets however, their entry prices remain very high making it difficult for many governments in LMICs to afford them and serve for their populations. A basic lower limb prosthesis costs \$2000 while a below the knee prosthesis, locally produced, will cost \$1500 compared to \$3000 for imported products. The cost of these products is also driven by the high cost of the production inputs such as steel, thermoplastics, joints, and other components and, the NHIF (and most private insurance providers') reimbursements not covering assistive devices.

#### **VII. Inefficiencies in supply chain**

There are inefficiencies in supply chain for assistive devices in the country. Kenya Medical Supplies Authority (KEMSA), does not procure/ stock assistive devices due to lack of an AT products essential list, which is fundamental in providing guidance on product specifications. In addition, forecasting and quantification of assistive devices has not been done because of demand generation challenges.

#### **VIII. Low demand for AT**

There is a high prevalence of donations of inappropriate AT products across LMICs. This is largely driven by the lack of knowledge amongst the well-wishers/general population, users, and caregivers on their appropriateness, socio-cultural beliefs, and lack of diagnostic services. Mass donations of inappropriate assistive products (i.e. of poor quality/ do not meet user needs according to required prescription) is a common occurrence. Caregivers of children with disabilities also delay in seeking health services and lack the necessary knowledge on how to offer home therapy to children.

### **The Government of Kenya's Proposal to increasing access to rehabilitation and AT services**

With the current momentum and the Government having developed the Strategic Plan and revised the Disability Assessment and Categorization Guidelines, it is the right time to support the government to improve the Rehabilitation space and increase access to AT in the country. ATscale, the global partnership for assistive technology, being a key player in catalysing action to increase access to AT globally, is a key partner in this journey.

Through this Concept Note, the Government of Kenya is expressing interest to partner with ATscale to start implementing the Rehabilitation Services and Assistive Technology Strategy 2022-2026. This national strategy is the maiden Strategy for the country in Rehabilitation

services and AT and as such, is fundamental in shaping the future and how Rehabilitation services are provided countrywide. The strategy's mission is to build a progressive and sustainable Rehabilitation healthcare sub-system that enables individuals with functional limitations and participation restrictions to attain the highest quality of life.

## Goal

The overall goal is to:

- 1) Attain equitable, affordable, accessible, and quality Rehabilitation services and AT for all.
- 2) Create competent and responsive Rehabilitation human resource and,
- 3) Foster innovation and be at the forefront of evidence-based policy and practice.

## Objectives

The strategy is anchored on 6 strategic objectives/pillars which form the implementation framework as outlined herein:

- i. Increase accessibility of Rehabilitation services to all including PWDs
- ii. Implement existing policies/ guidelines and develop other policy frameworks that are key in scaling up rehabilitation services
- iii. Scale up and strengthen Rehabilitation service delivery at all levels of care
- iv. Increase access to appropriate assistive technology
- v. Enhance financing for Rehabilitation services and assistive technology
- vi. Secure political and leadership commitment to scale up Rehabilitation services and increase access to assistive technology

With the 5-year strategy ready for implementation, the main challenge is the limited resources available to roll out this ambitious plan at the stipulated timeframe – owing to the fact that historically, the financing of rehabilitation services (including this national strategy) has had limited budget allocations. The ATscale support to kickstart the implementation will be fundamental as the Government works towards inclusion of rehabilitation services in the subsequent development plans for the Ministry of Health and other state departments and also, continues to solidify partnerships that will be fundamental in catalysing implementation and illustrating impact.

The Government of Kenya is requesting for ATscale's partnership in providing support to the implementation of the Rehabilitation Services and Assistive Technology Strategy 2022-2026. The support from ATscale, to the tune of \$7.5 million covering a period of 3 years (July 2022-Jun 2025), will be fundamental in ensuring the start of implementation of the Strategy and will also catalyse action by different players to support the implementation – right from the national level of government incorporating Rehabilitation services in the budgets of the Ministry, County Governments factoring in Rehabilitation services and AT in county health



budgets for subsequent cycles and mobilizing private entities and NGOs/FBOs to support the implementation of the Strategy. With the Government's desire to increase access to Rehabilitation services and provide affordable and appropriate AT to those in need, these concerted efforts will contribute to realizing the ambition within a timeframe of five years.

### Theory of Change (Annexed I)

The Ministry of Health's goal is to increase the number of Kenyans with physical, visual, hearing, language and speech impairments accessing appropriate rehabilitation and AT services within the public sector by providing AT products to an estimated 275,000 persons with disability. To achieve this, the MOH in collaboration with stakeholders, will 1) develop and provide the right policy environment to support the establishment and scale up of services; 2) expand the network of facilities offering services and the range of services so that more people will have easy reach; 3) strengthen service delivery at all levels and ensure users are promptly screened, promptly diagnosed and managed appropriately; 4) increase the availability of 10 prioritized set of affordable assistive technology products across various domains and, 5) generate demand for services by increasing awareness on service availability and appropriate AT amongst users and their caregivers. Overall, enabling policies will be developed, the health workforce will be expanded and upskilled, facility infrastructure and equipment will be expanded, AT products will be easily accessible through the national centralized systems, locally manufactured products will be availed at a lower cost with shorter turnaround times and services will be brought closer to communities.

Ultimately, the number of persons with disability accessing appropriate rehabilitation and AT services will increase by over 275,000 with an additional significant but unquantified impact on livelihoods. Children who are unable to acquire a basic education will learn and grow while adults who are unable to participate in socio economic activities will get an opportunity to do so and support themselves and their families.

### Summary of the Concept Note:

In this Concept Note, the Ministry of Health is detailing 1) the prioritized list of AT products generated through a collaborative process with multiple stakeholders 2) interventions and activities across different disability domains that align to the national strategy and with ATscale's priority AT products – looking at it from the lens of products and health systems strengthening around the key thematic areas such as: human resources for health, ideal supply chain and procurement systems, sustainable financing, policy and guidelines necessary to anchor provision, infrastructure to support appropriate provision and local production/ innovation opportunities. 3) annual access targets per prioritized AT product and 4) the total cost of implementation per disability domain. In addition, the M&E framework, the associated risks and mitigation are detailed herein. Of note is the adopted collaborative approach to implementation of the AT scale supported products and associated interventions. The team of stakeholders agreed on the approaches to pursue as well as identified the key implementers based on established capacity and strengths. The key implementers selected for this program will be held accountable for results through the structures established under the Results Framework.

The five disability domains selected for this concept note are:

- Physical disabilities domain
- Visual impairments domain
- Hearing disabilities domain
- Speech and Language disorders domain
- Neurodevelopmental and mental health disorders domain

### Summary of 10 Prioritized AT devices for consideration by AT Scale:

A total of 10 AT products were prioritized for the AT Scale concept. The primary criteria for selection was: low access of AT, high cost of the product, potential for cost reduction, some level of service delivery systems and structures in place. This list was developed through a collaborative process that brought together stakeholders from different disability domains, state departments, academia, referral hospitals and NGOs active in the disability space. This process was coordinated by the Ministry of Health.

#### **Physical Domain:**

Across all disabilities, physical disability is the most prevalent at 46%. Access to AT for this category of PWD is limited. Demand surpasses supply by multiple times. Major FBO facilities have reported long waiting lists for registered users and can only meet a fraction of the demand. There is therefore need for an accelerated expansion of access for users of these physical disability ATs.

- 1. Lower limb prosthetics:** Above and below the knee prostheses were prioritized in this category. This decision was based on the current demand patterns for prostheses. The idea is to increase access to low-cost aids through the procurement of affordable and quality raw materials which are significant cost driver. The raw materials will be availed to the workshops currently producing the aids. A total of 500 prosthetic limbs will be locally manufactured and distributed at an average cost of \$350 for the below the knee and \$500 for the above the knee – introducing an estimated 30-40% cost saving in locally fabricated prostheses in the public sector. The procurement of the raw materials will be done through the national procurement system. Beneficiary facilities will include FBOs which meet a significant portion of the demand. Should more affordable prosthetics be available, Kenya will be open to benefiting from such an initiative. At the moment the global brands are averaging between \$3000-5000 per limb, which is costly for national scale up. With the proposed central procurement of materials, potential price reduction (owing to procuring in bulk) and negotiating tax waivers for consignments of materials/components for local fabrication of prostheses, prices could reduce greatly to the target average costs.
- 2. Adults & paediatric wheelchairs/tricycles:** It is estimated that a total of 100,000 PWDs with a physical disability will need a wheelchair, yet less than 5% of this access this mobility aid. Annually, a total of approximately 5,000 wheelchairs are distributed in the country annually which is a small drop in the ocean. To reduce this gap, a total of 30,000 wheelchairs will be acquired through the LSDC over the next 3 years i.e. 10,000 annually. Ideally, 40% of these will be paediatric wheelchairs and 60% for adults. Preference is given to knocked down kits since these can rapidly be fabricated. These will be procured centrally through the national supply chain system and distributed first to the current facilities with capacity to issue wheelchairs and the target is to scale up services to all county and sub-county hospitals, over a period of 3 years. The goal will be to ensure that all county referral hospital have the capacity to offer wheelchair services with referral networks established across lower-level facilities. Providers will be trained on the WHO wheelchair package and will be mentored for a period for effective practice. In addition, the country will look to leverage on the Centre of Excellence once complete to foster research, innovation, production and training on provision of wheelchairs. *An important note here is that the wheelchairs catalytic donation is dependent on LDSC's confirmation of their commitment.*

### **Visual Domain:**

Visual impairments/disabilities contribute to 37% of disability and are the second most prevalent in Kenya. The greatest need is with people with severe visual impairments especially blind children and learners who lack access to basic learning devices as well as

people with low vision and reading challenges. Overall, access to visual services are limited as there are fewer access points with limited range of services as well as limited products on offer. In this category, the following AT devices have been prioritized:

1. **Low vision devices:** Many children with low vision challenges either congenital or acquired are unable to see near or far objects including reading materials. For such children to thrive and acquire an education, they need low vision devices which are not widely available. Where available, the service points are limited to a few FBO eye units. Through the school outreach programs and public facility networks, children with low vision will be identified and have been prioritized to be supported with 30,000 low vision devices, to be passed through the Kenya Society for the Blind (KSB) to access tax exemptions applicable for these devices. This will complement the ongoing VIP program (implemented by MOH in collaboration with the KSB & CBM) in 10 centres across the country.
2. **Reading & Ready to clip glasses:** Children struggle with understanding concepts in school due to visual problems. Older people similarly experience lower quality of lives due to age related poor vision. Reading glasses can and have the potential to radically change the status as is currently. Through school programs, children with needs will be identified and provided with ready to clip glasses. Adults will access reading glasses and ready to clip glasses from either hospitals or through community linkages to be established. A total of 210,000 devices have been prioritized.
3. **Braille and Electronic Braille Devices:** There are approximately 45,000 blind learners in Kenya majority of whom lack the basic braille devices critical for their education. It is also estimated that approximately 15,000 blind people have no access to education. Braille is important as a foundation of learning for blind children and this prepares them for advancing into other technologies like electronic notetakers, orbit readers, dot mini devices etc. Without braille, majority of learners are unable to advance to higher levels of learning. In addition, even for those who transition to high schools and colleges, they lack simple digital tools and devices such as scientific talking calculators, Braille and notetakers critical for their level of learning. New innovations and technology have changed the way blind children and adults learn and work and therefore with these tools, learners can read more books, record lectures, do their assignments, access more educational resource and take and print notes more efficiently. These devices are however available only in a handful of schools and a few learners who can afford them. Through ATscale catalytic funding, Kenya can acquire 80 braille devices annually, prioritized for basic education (primary and high school learners), 10 notetakers for college students and specializing in STEM subjects as a start. These devices will be a shared resource in the institutions.
4. **Screening & diagnostic devices:** Users of the visual AT products will be identified from a mix of entry points across hospitals, schools and communities. To achieve this,

providers/assistants will need to be equipped with tools that will support the screening processes and correct diagnosis and where possible offer prescriptions for those requiring AT. There are several low-cost portable devices that have entered global markets and parts of Africa which would be a good match to the approach Kenya is taking. A package of 100 will be procured for this purpose.

*An important note here is that the wheelchairs catalytic donation is dependent on LDCS's confirmation of their commitment. This also applies to the optical labs.*

### **Hearing Domain**

- 1. Hearing aids (with accessories i.e. earmolds and batteries):** An estimated 17% of persons with disabilities have hearing impairments. A good majority of these lack access to comprehensive audiology services and affordable devices. Available devices in the market are costly and therefore only a few persons can be served. To expand coverage, low cost and approved hearing aids will be sourced to support 700 children and 300 adults annually. Children have been prioritized in this Concept as they make up an estimated 37.2% of the population (18.6 million people), with approximately 1% of these (i.e. 186,000) have hearing impairments. Majority of these have no access to AT and are therefore not achieving their developmental milestones, are delayed in school enrolment, their learning is affected and may not get quality education.
- 2. Screening & diagnosis devices:** This is similar to the visual domain approach. There is need for both portable and conventional screening devices. A set of 100 units of the portable devices will be procured for community outreaches while 15 hospitals will be equipped with audiometers to strengthen in-facility screening. Audiometers have been settled on to assist with enhancing capacity to assess hearing acuity across the country. The brainstem evoked response audiometry (BERA) machines could have been better at scale owing to objectiveness, more so in 1-3-year-old children, although they are expensive. 5 more hospitals will be equipped with BERA in next 3 years to serve different regions - Kenya will be keen to expand BERA availability in case more resources are available.

### **Speech & Neurodevelopmental and Mental Health Disorders Domain:**

Cognitive related impairments are largely missed, misdiagnosed, or incorrectly managed due to the lack of services and personnel. Language and speech impairments make up a good proportion of these. Specialized personnel are slowly increasing in numbers while a few public facilities have established centres to offer these services. Overall, 7 public sector facilities have a language and speech therapist offering services. The therapists however lack the critical tools of their trade – communication boards and smart gaze boxes which teach users how to express themselves through language.

1. **Communication boards:** None of the 9 facilities offering speech and language therapy services have widgets key to preparing communication boards which are visual representations of language. The boards are a tool for both the specialists and the caregivers. A total of 10 widgets with unlimited annual downloads will be purchased. Annually, unlimited number of communications boards will be printed at the 10 facilities with widget rights and distributed to caregivers for use at home. In addition to these widgets aimed at scaling up access, free augmentative and alternative communication software could be recommended to clients with internet access.
2. **Smart gaze boxes:** none of the facilities offering speech and language therapy services have smart gaze boxes. These AT devices are essential in assisting children with severe speech and language impairments with very limited mobility to express what they feel/ need through the coordinated smart gaze box system. The target is to have a total of 4 smart gaze boxes installed at designated facilities, to be used during therapy or learning at the designated facilities. 2 devices will be acquired in year 1 and 2 in year 2. This helps the children to communicate their emotions or needs.

### **Research & Innovation:**

The need for low cost, high quality and locally adaptable solutions in the AT space cannot be over emphasized. Majority of AT products across all domains of disability are overly costly resulting in many persons with disability being locked out of an opportunity to live dignified lives, productively and actively participate in society. Governments in low- and middle-income countries (LMICs) experience the greatest challenge in financing these expensive devices. A sustainable solution to this would be the increased investment in research and innovation to facilitate the development of new and affordable solutions. Validation of new solutions from the global markets is also a significant component in the efforts to scale up AT. Using the support from ATscale, an investment of \$450,000 over the 3 years (\$150,000 annually) will be set aside for research and innovation on the following areas:

- a) Electronic braille display devices with efficiency comparable to braille or higher
- b) Visual and hearing screening and diagnosis tools
- c) White canes
- d) Sports & play devices for the blind learners e.g., Goalball
- e) Scientific talking calculators
- f) Specialized wheelchairs e.g., using locally available power sources, for clients with specific conditions etc.

The desired targets/ reach with each of the fore mentioned AT products for the next 3 years is summarized below. Ideally, these targets would be realized through procurement of catalytic products through part of the ATscale funding and catalytic donations by partner



organizations already working in different disability domains, mentioned under Opportunities for Collaboration and Partnership with Government.

Summary of Priority Assistive Devices						
Source: ATscale and Partners						
Target units over 3 Years						
Domain	Assistive Device	Year 1	Year 2	Year 3	Total Units	Source of funds/ AT
Physical	<b>Lower Limb Prosthetics</b>	500	500	500	1,500	ATscale
	(i) Below Knee	300	300	300	900	
	(ii) Above Knee	200	200	200	600	
	<b>Wheelchairs/ Tricycles/ Paediatric wheelchairs</b> - adults: children = 3:2	10,000	10,000	10,000	30,000	LDSC
	<b>Low vision devices</b>	10,000	10,000	10,000	30,000	Kenya Society for the Blind
	(i) Hand held magnifiers	3,000	3,000	3,000	9,000	
	(ii) Stand magnifiers	4,000	4,000	4,000	12,000	
	(iii) Dome magnifiers	3,000	3,000	3,000	9,000	
Vision	<b>Spectacles</b>	50,000	60,000	100,000	210,000	Vision Catalyst Fund (VCF)
	(i) Reading glasses	25,000	30,000	50,000	105,000	
	(ii) Ready2Clip	25,000	30,000	50,000	105,000	
	<b>Orbit Readers</b>	40	40	40	120	ATscale
	<b>Braille Machines</b>	80	80	80	240	ATscale
	<b>Note-takers</b>	10	10	10	30	ATscale



<b>Hearing</b>	<b>Hearing aids</b>	1,000	1,000	1,000	3,000	ATscale
<b>Speech</b>	<b>Communication Board Widgets</b>	10	10	10	30	ATscale
	<b>Smart box eye-gaze</b>	2	2		4	ATscale

### Proposed Interventions for Increasing Access and utilization to the 9 AT priority products

#### Cross cutting interventions

##### *I. Strengthen HRH for health key to providing assistive devices*

- Sensitize counties on the program through regionalized county engagement forums
- Conduct baseline survey to understand: (i) staffing, potentially using the; and (ii) infrastructure gap across different disability domains, dissemination of findings and develop county specific action plans
- Advocate for development/ implementation/ review of schemes of service for rehabilitative services cadres

##### *II. Streamline supply chain to facilitate procurement of AT*

- Develop Essential List of Assistive Technology – whose adoption is key to informing procurement via KEMSA (comes with product specifications) as well as in-country registration with the regulator.
- Work with the national procurement agency-KEMSA to adopt AT products (with specifications) in their product portfolio and supply systems.
- Establish and roll out a forecasting and quantification mechanism for AT products starting from the national level down to facility level
- Pool AT products demand across counties and centralize procurement at the national level

##### *III. Advocate for sustainable financing for Rehabilitation services*

- Advocacy for national and county investments across all strategic pillars of Rehabilitation services and AT strategy
- Advocate for inclusion of rehab services and AT in national health financing mechanisms i.e. NHIF, UHC, NCPWD development fund
- Advocate for implementation of tax exemption and establishment of necessary mechanisms for AT devices, spare parts and raw materials used in local production.

##### *IV. Develop policy and guidelines to anchor provision of AT*

- Develop umbrella rehabilitation services and AT policy to guide service delivery at various levels of care, selection of products, donations, local production etc

- Develop rehabilitation and AT service delivery norms and standards that define type of services offered, levels of care where services are offered, providers of these services and appropriate skills set required, optimal infrastructure, referral networks etc. Specific policies & guidelines required are referenced in the domains sections.
  - Establish structures for routine support supervision and on the job trainings across all domains
- V. *Build local capacity to produce quality affordable assistive devices*
- Conduct domain specific market assessments to determine potential for local manufacturing, price reduction and redesigning of manufacturing processes to increase availability to quality and affordable AT products
  - Enhance collaboration in the ecosystem on research & innovation (training schools, private innovators etc.)
- VI. *Demand generation for AT provision services*
- Develop and roll out an awareness and demand generation package for persons with disability and caregivers on availability of services, benefits of early interventions and appropriate AT. The form of package/tools to be developed through a collaborative process.
- VII. *Enhance data and systems*
- Develop and disseminate primary service delivery tools at various levels of care and new entry points such as schools.
  - Support the inclusion of AT products into the national procurement and ordering systems
  - Develop and incorporate AT indicators into the Kenya Health Information System (KHIS) for routine reporting

## Domain specific interventions

### 1. Physical domain – Device 1 (lower limb prostheses):

#### I. *Strengthen HRH for health key to providing assistive devices*

- Train 30 Orthopaedic Technologists in Prosthetics over 3 years (10 per year) through a higher national diploma offered at Kenya Medical Training College (KMTC). These will be extended to orthopaedic technologists currently in service in the public sector to equip them with the specialized skills to provide prostheses. Currently, the few specialists available in the country are stationed in national referral hospitals. For purpose of ensuring they offer services post

training, the trained staff will be bonded to serve in respective counties as per the public service regulations.

- Improve the prosthetics and orthotics services in existing workshops by routinely training and mentoring county facility staff on proper fabrication and fitting of prostheses. This will be done by the National prosthetic specialists in collaboration with other experts in the space

*II. Build local capacity to produce quality affordable assistive devices*

- Assess current local manufacturing capacity, processes and generate a cost effective and efficient design package for implementation in existing factories
- Dissemination of restructuring designs to key decision makers and advocacy for investment in upgrading and establishment of new manufacturing centres
- Assessment of current cost structures and engaging of global & local suppliers of raw materials and parts for prosthetics for price negotiations
- Centralized catalytic procurement and supply of thermoplastics and parts to existing workshops for production of affordable prostheses
- Advocacy to national government and other government agencies to allocate additional resources to existing manufacturing facilities and for the procurement of more affordable prostheses for users across the country
- Work with research and innovation institutions in research, evidence gathering as catalyst for innovation on this area.

*III. Enhance infrastructure needed to support provision of AT*

- Invest in ideal infrastructure starting with level 5 and 6 facilities currently producing prosthetics that will cut down the production time potentially by 50% and reduce the turnaround times to clients. This is scheduled for year 3 based on recommendations from the manufacturing evaluation and will help kickstart the investments this area to cover remaining facilities and institutions.
- Introduce Community Based Rehabilitation for active measurement and fitting of prostheses + scheduled mobile outreaches in communities

*IV. Develop policy and guidelines to anchor provision of AT*

Develop and implement referral systems for amputees to link with Prosthetics and Orthotics (P&O) services

**2. Physical Domain – Device 2 (Wheelchairs/ tricycles/ paediatric wheelchairs):**

*I. Strengthen HRH for health key to providing assistive devices*

- Develop localized Wheelchair Training Packages
- Conduct WHO Basic Wheelchair Training to increase the pool of providers by 200 with capacity to offer basic appropriate wheelchairs services by conducting WHO Basic Wheelchair Training (**implemented in Year 1**) targeting

Physiotherapists, Occupational Therapists and Orthopaedic technologists. The additional capacity will cover county and subcounty facilities – an estimated 250 facilities.

- Conduct WHO Intermediate Training to increase the pool of providers by 150 with advanced capacity to offer basic wheelchair services as well as postural support by conducting WHO Intermediate Training (**to be implemented in Year 2**) targeting Physiotherapists, Occupational Therapists and Orthopaedic Technologists

II. *Streamline supply chain for wheelchairs in Kenya*

- Provide catalytic donation of different types of wheelchairs to mainstream wheelchairs in the national procurement and facility ordering systems through support from the LDSC (*commitment to be confirmed*)
- Establish a referral mechanism for the assessment, prescription, fitting and assembling of wheelchairs across the various levels of care
- Develop a wheelchair forecasting and quantification framework to form part of the overall AT forecasting and quantification
- Train both national and county staff on the F&Q process and rational ordering and supply of wheelchairs

III. *Build local capacity to produce quality affordable assistive devices*

- Assess and build capacity of local manufacturers i.e. APDK to scale production through creation of efficiencies in their production processes. To achieve this, a feasibility study, capacity assessment of APDK will be conducted and an investment case for local production upgrade developed for support by Government and other partners
- Foster partnerships in research and evidence gathering as catalyst for innovation on wheelchairs

### 3. Visual Impairment Domain– Device 1 (Low vision devices):

I. *Strengthen HRH for health key to providing assistive devices*

- Train at least two low vision therapists in 37 counties without trained staff. The remaining 10 counties have some support from the Vision Impact Project currently being implemented by the Ophthalmology Services Division at MOH with support from CBM/VCF support.
- Advocate for inclusion and hiring of optometrists into civil service schemes (this will enable hiring by government)

II. *Build local capacity to produce/assemble quality affordable assistive devices*

- Train technicians for assembly and maintenance of available devices

III. *Develop policy and guidelines to facilitate scale up of visual AT as part of umbrella policy*

IV. *Enhance infrastructure needed to support provision of AT*

- Establishment of an additional 10 optical labs in 10 counties to complement the VIP project. (if there is commitment from LDSC, this can increase to 37 to cover the entire country. 10 counties already have support from VIP.)
- Procure portable screening and diagnosis tool kits for all referral facilities across 47 counties. These will facilitate expanded identification of users in need beyond facilities into communities and schools

## II. **4. Visual Impairment Domain – Device 2 (Read to clip & reading glasses):**

I. *Strengthen HRH for health key to providing assistive devices*

- Enhance referral mechanisms for optical services to ensure that screening, scoring and prescriptions are offered at a lower level of care and only the advanced services are referred to the county referral hospitals
- Train at least 3 ophthalmic clinical officers specialized in low vision annually to be deploy in 9 county facilities – training offer by KMTC runs for 1.5 years

II. *Streamline supply chain to support provision of ready to clip and reading glasses*

- Provide catalytic donation of different types of eye glasses to mainstream within the national procurement and facility ordering systems through support from the Vision Catalyst Fund
- Roll out visual impairment screening at various levels of care including community and schools.
- Train key professionals on entire cycle of screening, scoring, prescription, handling of spectacle through the bulk procurement mechanism e.g. procurement officers, pharmacists in charge of essential medicines and AT ordering, optical technicians and other visual specialists

III. *Enhance infrastructure needed to support provision of AT*

- Set up and strengthen optical workshops in all 10 County Referral Hospitals (cross cutting)
- Enhance referral mechanisms for optical services to ensure that screening, scoring and prescriptions are offered at a lower level of care and only the advanced services are referred to the county referral hospitals

IV. *Build local capacity to produce/assemble quality affordable spectacles*

- Advocate for inclusion of optical technicians in public service scheme of service – to facilitate assembly in facilities

## 5. **Visual Impairment Domain – Device 3 (Braille/ Orbit readers):**

I. *Strengthen HRH for health key to providing braille/orbit readers*

- Train providers in different settings on new technology – digital orbit readers (schools are the entry point and will be done by the suppliers of the devices)

- Training of 3 technicians on repair and maintenance for Braille machines in institutions where the procured machines will be placed- to be coordinated by KSB, (few officers are needed for repair and maintenance)

*II. Streamline supply chain to support provision of braille/ orbit readers*

- Work with national procurement agency to procure and roll out 240 Braille and 120 Orbit Readers 20 Plus, over next 3 years. Placement will target 38 special and integrated primary and high schools and institutions of higher learning for the orbit readers
- Support the Kenya Society for the Blind (KSB) to update and print the braille books for primary, and secondary levels to align to the new national CBC educational curriculum which is yet to be done for the special schools

**6. Hearing Impairment Domain – Device 1 (Hearing aids with accessories - earmold &batteries):**

*III. Strengthen HRH for health key to providing hearing aids*

- Train 18 clinical officers in audiology and hearing specialization at higher national diploma level over 3 years. Program runs over 1.5 years and offered at KMTC
- Sensitization and mentorship of existing cadres of ENT surgeons & ENT clinical officers in basic and advanced services to support the establishment of services in target 15 facilities
- Train 15 earmold technicians to make moulds, fit and repair hearing aids. Trainees will be drawn from 15 national and county hospitals (former regional hospitals) and teachers from special schools

*IV. Enhance infrastructure needed to support provision of AT*

- Purchase and set up key audiology equipment for 15 national and county referral hospitals to support service delivery.

*V. Streamline supply chain to support provision of braille/ orbit readers*

- Identify suppliers of affordable hearing aids, negotiate for low cost devices and support the introduction into the country
- Work with the national procurement systems to adopt and procure hearing aids for facilities across the country

*VI. Enhance local capacity to produce quality affordable hearing aids and accessories*

- Work with local institutions to enhance research and innovation in the hearing aids space

**7. Speech, Language Disorders Domain, – Device 1 (Communication boards and books):**

*I. Strengthen HRH for health key to providing communication boards and books*

- Train an additional 10 speech and language therapists, at minimum of diploma level. Currently there are only 12 speech and language therapists

working in the public sector and only 4 of these are in county facilities -with 3 of these being volunteers.

- Advocate for inclusion in the public service scheme of service and employment of language & speech therapists by counties

*II. Enhance infrastructure needed to support provision of communication boards and books*

- Procure communication boards widgets (the software) for the 10 facilities currently providing speech and language therapy services. The widgets procured will have unlimited downloading access and will serve as many children as will present for care.

**8. - Speech, Language Disorders Domain Device 2 (Smart box – Eye gaze (Grid 3 software package):**

*I. Enhance infrastructure needed to support provision of smart box*

- Procure 4 smart box eye gaze devices for the severely non-verbal children and those with very limited hand coordination. These devices will be placed in 4 special schools and teachers and therapist skills updated.

**Government of Kenya Contribution to the rehabilitation & AT services**

Following the commitments made at the Global Disability Summit in 2018, the Ministry of Health & the State Department of Social Protection have continued to work towards strengthening the rehabilitation and AT services in Kenya. The development of the national strategy has been a key milestone for the country which sets the country at the nascent stage of transforming the way rehabilitation and AT services are offered and accelerating reach for the many unreached Kenyans. The support from ATscale couldn't have come at a better time.

The Government of Kenya through the Ministry of Health, State Department of Social Protection and other state agencies will maintain the current package of support while embarking on a process of securing additional funding from the national treasury for the holistic implementation of the national rehabilitation and AT strategy. Specifically, the Government of Kenya has over the years employed an estimated 1500 of rehabilitative services personnel across national and county facilities, pays rehabilitative personnel across the country and, through the county budgets, finances rehabilitative services, provides equipment and basic infrastructure and consumables at facilities. The partnership with the ATscale over the next 3-years to kickstart implementation of the national strategy will be fundamental and impactful since there already exist a solid structure for service delivery within government facilities and institutions, which will facilitate the implementation.

Specific to additional funding, the Directorate of Healthcare Services at the Ministry of Health has submitted a proposal for inclusion of several rehabilitative services programs in

the Medium-Term Plan IV (MTP IV) amounting to \$172 million. The process is still at preliminary stage and will go through multiple iterations before finalization. In this proposal, the following programs have been included: the construction of AT Center of Excellence, Community Based Rehabilitation (CBR) – which includes service delivery and provision of AT at primary health care and community level, staffing and capacity building. The process is currently ongoing and the MOH has included the following interventions: implementation of rehabilitative services in primary and community level, establishment, and operationalization of rehabilitative services departments in level 2 and level 3 health facilities and, implementation of the Rehabilitative Services and Assistive Technology Strategy 2022-2026. In addition, the inclusion of rehabilitative services into the MTPIV, the Ministry has also included the establishment of the National Centre of Excellence and is collaborating with other organizations such as the WHO, JKUAT on additional financing and technical support. So far, the Government has allocated 10 acres of land within JKUAT University for this establishment. The National AT Centre of Excellence is critical for the country since it will facilitate research and innovation, foster local manufacturing of AT and enhance upskilling of the health workforce on provision of rehabilitative services. The fore mentioned will complement the ATscale 3-year program, both aimed at increasing access to rehabilitative services and AT in Kenya.

Beyond the Ministry of Health led efforts to increase access to rehabilitative services, other government agencies such as the National Council for Persons with Disabilities and the Kenya Society for the Blind are fundamental in increasing access to AT and improving livelihoods of PWDs. The NCWPD gets a budget allocation from the national treasury and provides education scholarships, business financing and assistive technology devices among other services to PWDs. In the recent past, the council has been allocating over \$300,000 to purchase of assistive devices annually. In 2021, NCPWD provided AT to a total of 2490 PWDs. Among the AT devices provided were 1000 wheelchairs (through APDK), 146 hearing aids, 462 white canes and 88 prostheses. In the current financial year 2021/2022, a provision of \$300,000 is earmarked for AT devices. The government will continue allocating these resources in subsequent budgets.

Similarly, the Kenya Society for the Blind (KSB) has an allocation from the national treasury part of which is used to provide AT products for the visually impaired and other interventions for learners across schools. In 2021 approximately 1891 low vision devices were issued. The government will continue allocating these resources to KSB in subsequent budgets. In addition, KSB have also partnered with the Ministry of Health through the Division of Ophthalmology to support the implementation of the Visual Impact Project – an initiative of CBM/VCF. The KSB will continue offering the range of programs and AT devices they are currently offering and will be the procurement entity for visual devices to facilitate tax exemptions for procured products.

## VII. Opportunities for Collaboration and Partnership with Government in Implementation

As the Government of Kenya starts implementing the Rehabilitation Service and Assistive Technology Strategy 2022-2026 with the catalytic support from the ATscale, additional partnerships (financial and TA) and collaborations will be fundamental to realize full implementation of the national strategy over the next 5 years. In addition, the Government is looking at creating a robust ecosystem in the country that fosters collaborations and partnerships with the aim of accelerating access to assistive technology in a sustainable manner.

Through the process of developing the National Rehabilitation Services and AT Strategy and Disability Assessment and Categorization Guidelines as well as the development of the AT Scale concept, the Government has engaged with multiple stakeholders, each with potential solutions and specific skills set that could contribute to scaling Rehabilitation services and increasing access. Some of the partners have indicated their commitment to co-funding of the AT scale concept specifically around catalytic product donations critical for introducing and mainstreaming the products in the public sector supply chain. Below is an outline of the key partners:

- 1) **Jomo Kenyatta University of Agriculture and Technology (JKUAT)** is the main partner on the Government ambitious plan to build an AT centre of excellence that will incorporate research and innovation, training on provision of AT, facility for warehousing devices. JKUAT will be a key partner in development of AT curricula, building the pool of skilled providers of various AT services as well as research and innovation.
- 2) **Vision Catalyst Fund** will be a key partner in the Visual impairment domain (through their program with Essilor Luxottica aimed at donating over 200 million pair of lenses globally by the year 2030) with a preliminary consensus to donate 210,000 pairs of reading glasses and read2clip over the next 3 years.
- 3) **The Church of Jesus Christ of Latter-day Saints (LDSC)** are keen to support the Government on implementation workstream via in-kind support of 30,000 wheelchairs over 3 years, 30,000 low vision devices, 27 optical labs (year 2 and 3). *This LDSC investment is not confirmed yet as discussions are ongoing on the process of Kenya accessing this support.*
- 4) **Walkabout Foundation Kenya** has been providing wheelchairs services for a period of 8 years in Kenya. They are keen to continue and strengthen the collaboration with Government through the established mechanism. Walkabout will donate and additional 5,000 wheelchairs to Kenyans over the 3 years of implementation through their existing channels. Walkabout mainly donates knocked down kits of wheelchairs and therefore the program will take a lot of lessons from their model from importation, storage, assembling and fitting of wheelchairs.

- 5) **Motivation Charitable Trust Kenya** has been a key partner in the wheelchairs space providing wheelchairs and training providers across select public health facilities on wheelchair services. Motivation Kenya will be a critical partner in the roll out of trainings on wheelchair services
- 6) **InnovateNow** in Kenya have been pursuing innovation of AT products. InnovateNow will work with key learning institutions in the ecosystem, such as the JKUAT, to foster innovation in the AT space in Kenya.
- 7) **Kenyatta National Hospital Prostheses Department** has been a key partner in providing services as well as providing technical support in this area. As the country looks to provide better and more efficient products, KNH will be expected to offer their expertise in this area
- 8) **Association of the Physically Disabled Kenya (APDK)** has been the key primary producer and supplier of key AT products across the physical disability domain. APDK are the only institutions locally producing wheelchairs in Kenya and will be a key partner in the next phase where Government is looking to scale up on wheelchairs through local manufacturing bulk buying and assembling of imported wheelchairs
- 9) **The Clinton Health Access Initiative (CHAI)** has been the primary partner providing technical coordination support in development of the National Rehabilitation services and AT Strategy as well as the Disability Medical Guidelines. CHAI will be a key partner supporting MOH with coordination as well technical support throughout implementation and in areas of local manufacturing and strengthening the supply chain.
- 10) **The World Health Organization (WHO)** has been championing global efforts to give everyone, everywhere an equal chance to live a healthy life. In Kenya, the WHO has supported the Ministry of Health on response to health emergencies, validating public health guidance and, measuring progress through data and reports. The rapid Assistive Technology Assessment (rATA), whose global report was published recently, is one such area the WHO supported the Ministry of Health rehabilitative services on.

The Government is keen and committed to fostering partnerships aimed at increasing access to appropriate assistive technology in Kenya. Through working with ATscale, the Government is open to having follow up engagements with these organizations, and any other organization keen to support implementation, so as refine details on how the Government could partner work with the organizations to address the huge AT need in the country.

### Flow of Funds for the ATscale Program

The Ministry of Health recommends that the resources specific to MOH activities be channelled through a partner organization in the first year as the MOH will be working

towards establishing an ATscale Program specific account. The partner organization must have experience with Government passthrough grants, have in place systems to track the program specific costs and be able to plan activities and disburse resources in a timely manner. This will ensure that implementation of the interventions detailed herein would start as soon as possible, without much administrative hurdles.

### VIII. Monitoring and Evaluation Framework and Flow of Funds

To realize the desired scale up of Rehabilitation services and assistive technology in Kenya, the implementation of the proposed activities under this concept will be a multi-sectoral approach with Government and multiple organizations working together to drive impact. Overall deliverables, respective quantitative measures, frequency of monitoring and proposed implementers that would ensure achievement are summarized below:

Deliverable	Target (s)	Frequency of measure	Proposed implementers per domain
Total Assistive Devices Issued through ATscale support	Number of devices issued	Bi-annual	Government health facilities and/or  Physical – APDK + NCPWD + other organizations e.g. Walkabout Foundation, LDS Visual – To be determined+ NCPWD Hearing – To be determined Speech – to be determined + NCPWD + KISE
Additional HRH trained on appropriate provision	Number and proportion of HRH trained and rationally deployed	Bi-annual	Trainer records for On-the-job trainings (e.g. Motivation Charities)  Training institutions data for fulltime courses (KMTC etc.)
Streamlining supply chain of AT in the country	Availability of product specifications  Number of devices supplied through existing system	Annual	For specifications: spearheaded by MOH; inputs by other agencies (KEMSA, KEBS, PPB, NCPWD), professional associations and partners in ecosystem
Sustainable financing for AT	Written commitment by Government to	Annual	Ministry of Health NCPWD



	finance Strategy/ Rehab services		
	Annual budget allocation		
Building local capacity to produce/ provide appropriate AT	Number and proportion of technicians trained  Number of outputs from investment in research	Bi-annual	Ministry of Health Learning institutions contracted e.g. JKUAT, KMTC
Improvement in infrastructure needed to support provision of AT	Number and proportion of new infrastructure  Update with Rehabilitation service indicators on KHIS	Annual	Ministry of Health Physical – P&O workshops Visual – Optical shops Hearing – Audiometer machines Speech – Speech and Language therapy service points  Data and systems – update for indicators

The overall measure of achievement is the number of people who will have access to assistive technology devices in the country through the financing by ATscale. Investment in the different thematic areas are critical to supporting appropriate provision of AT in the country.

The proposal is for these indicators to be collected using hybrid methods: online for those which are published and through interviews/ direct reporting by responsible MDAs for those indicators whose data are not published at the desired intervals. For sustainability, the highlighted indicators need to be incorporated in a national reporting mechanism at the end of the program, and the Government will utilize this to build momentum for implementing the Rehabilitation Services and AT Strategy 2022-2026.

**IX. Program Risks and Mitigation**

For this multi-year program, there are a few risks which parties need to be privy to as the Government looks to work with ATscale to increase access to assistive technology in Kenya. The risks and mitigation strategies are summarized below.

Potential risk	Mitigation Strategy
Delays in implementation in Year 1 of program due to change in leadership at	The secretariat driving implementation will work to build rapport with new leadership



various levels of Government – stemming from the General Election to happen on 9 August 2022	(at national and counties) and sensitize them on the program as soon as they are settling into office to minimize the delay. This will be the 3 <sup>rd</sup> election since devolution of Government in Kenya, and the team at MOH, Government agencies and partners have experiences handling such transitions
Trained staff leaving public service for private practice or trained staff rotated to services points where their skills cannot be utilized	For longer courses (beyond on-the-job trainings), there is need to have bonding agreements between staff and country prior to training – this is to be guided by the existing laws. In addition, co-planning will be pursued with counties to ensure there is rational selection of trainees and deployment after trainees. The coordinating unit will also routinely track the work stations of trained staff during the support supervision and engage county leaderships for necessary action
Delayed implementation of activities tied to different partners therefore slowing down the roll out of key interventions	The accountability matrix will be initiated with clear deliverables for each of the partners engaged in this program.

### Summary Budget per Thematic Areas

In light of the potential financing by ATscale to the tune of \$7.5 million over the next 3 years, the Government of Kenya plans to utilize the funding as detailed in the summary budget below; all budget lines are aimed at contributing towards increasing access to rehabilitative services and AT in Kenya, while strengthening the health system with the outlook of utilizing the catalytic funding to trigger sustainable financing and institutionalizing reforms that will be implemented in the course of partnership with the ATscale.

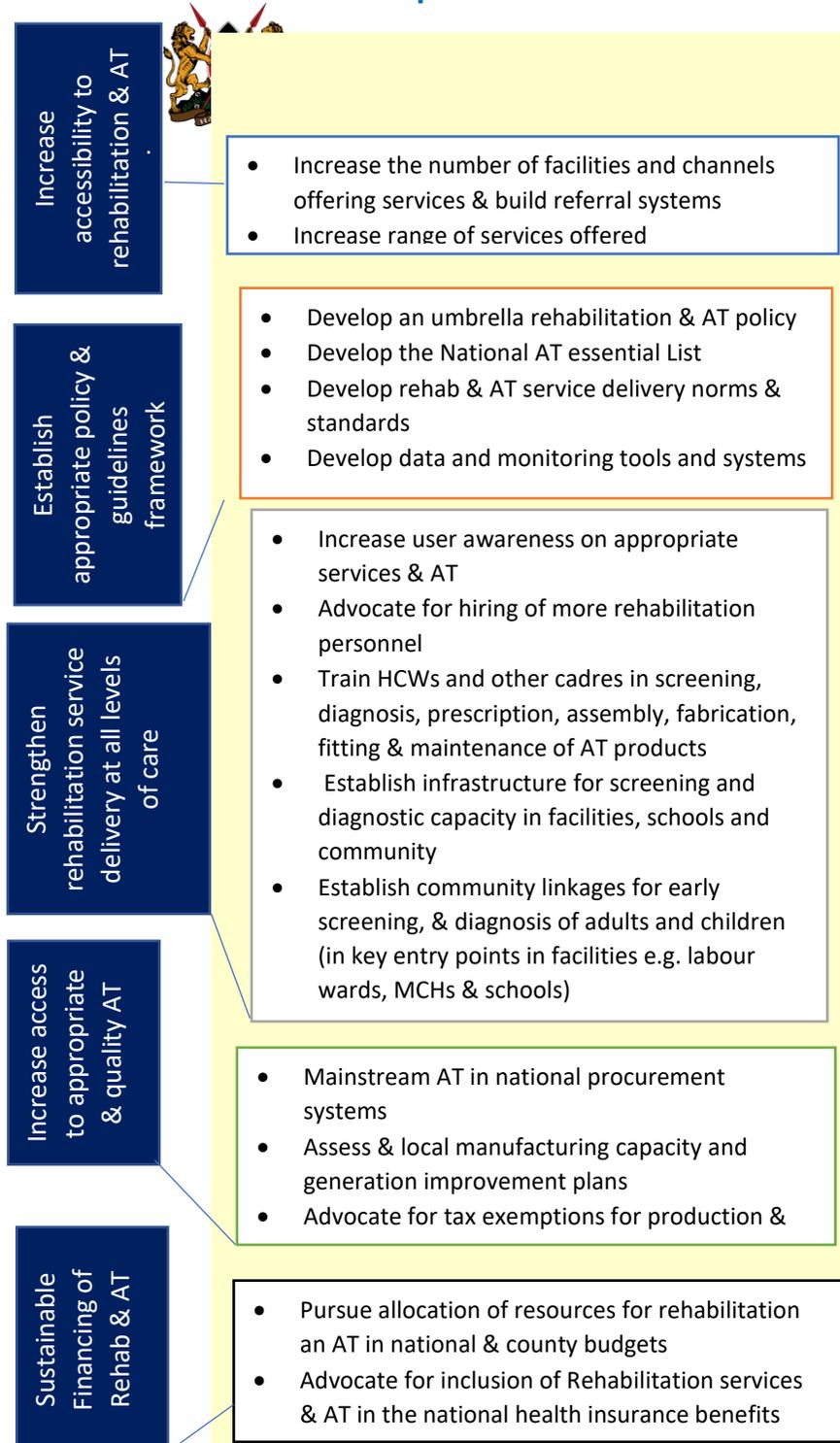
Strategic Area	Y1	Y2	Y3	Total
Human Resources for Health	\$ 646,467	\$ 571,517	\$ 284,667	\$ 1,502,650
Supply Chains	\$ 192,200	\$ 197,200	\$ 162,200	\$ 551,600
Sustainable Financing	\$ 3,043	\$ 3,043	\$ 2,000	\$ 8,085
Policy and guidelines	\$ 13,000	\$ 10,000	\$ -	\$ 23,000
Local capacity to produce	\$ 76,692	\$ 139,385	\$ 129,385	\$ 345,462
Data and systems	\$ 53,000	\$ 35,000	\$ 1,000	\$ 89,000
Enhance infrastructure	\$ 354,000	\$ 530,000	\$ 238,500	\$ 1,122,500



Demand Generation	\$ 85,000	\$ 85,000	\$ 85,000	\$ 255,000
Program Coordination	\$ 50,000	\$ 50,000	\$ 50,000	\$ 150,000
<b>Total Program Costs</b>	<b>\$ 1,473,402</b>	<b>\$ 1,621,144</b>	<b>\$ 952,751</b>	<b>\$ 4,047,297</b>
Assistive Devices	\$ 607,500	\$ 692,500	\$ 655,500	\$ 1,955,500
Assistive Devices incountry supply cost - 10%	\$ 60,750	\$ 69,250	\$ 65,550	\$ 195,550
				\$ -
<b>Total Program Budget</b>	<b>\$ 2,141,652</b>	<b>\$ 2,382,894</b>	<b>\$ 1,673,801</b>	<b>\$ 6,198,347</b>
<b>Admin Cost (10% of Program Budget)</b>	\$ 214,165	\$ 238,289	\$ 167,380	\$ 619,835
<b>Technical Assistance (TA) including 10% overheads</b>	<b>\$ 235,582</b>	<b>\$ 262,118</b>	<b>\$ 184,118</b>	<b>\$ 681,818</b>
<b>Total Budget (Program + Admin + TA)</b>	<b>\$ 2,591,398</b>	<b>\$ 2,883,302</b>	<b>\$ 2,025,300</b>	<b>\$ 7,500,000</b>
<b>Available Investment (per ATscale Guidance)</b>				<b>\$ 7,500,000</b>

From the proposed budget above, the Government of Kenya intends to utilize the potential financing to increase access to services and assistive devices across the different disability domains. Detailed breakdown for cost drivers under each of the domains are summarized in the Excel workbook, shared together with this Concept Note.

## Proposed Activities



## Outputs

- Expanded number of facilities offering optimal rehabilitation and AT services
- AT products specifications developed and enforced
- AT products on KEMSA product portfolio
- Rehabilitation & AT service, reporting tool developed
- PWDs and caregivers reached with messaging on early care seeking for appropriate rehabilitation & AT services
- More users seeking rehabilitation & AT services
- HCWs trained in various aspects of Rehabilitation & AT services
- Procurement & installation of rehabilitation & AT equipment and required infrastructure
- Procurement of products through catalytic donations and national and county budgets
- Local manufacturing assessment and recommendation report
- Rehab & AT allocation included in the national and county budgets

## Primary outcomes

- Increased coverage of rehabilitation & AT services
- Enabling policy environment for rehabilitation & AT
- Increase number of people living with disabilities /impairments accessing AT products
- Increase user knowledge and improve care seeking behaviours for both adults and children
- Improved prevention, timely diagnosis & management of disabilities/impairments
- Reduced cost of AT products
- Increased availability of key AT products
- Improve the quality and reduce turnaround times for locally manufactured AT products
- Increased financing of rehabilitation & AT

## Impact

- Increase the number of people with physical disability/impairment accessing AT products by an additional 31,500
- Increase the number of people with Visual disability/impairment accessing AT products & education services by an additional 240,390
- Increase the number of people with hearing disability/impairment accessing AT products by an additional 3,000
- Increase the number of people with language & speech impairments accessing AT & education services by (as many as will present)
- Ultimately, increase the number of children living with disabilities/impairments acquiring an education, achieving developmental milestones and number of adults participating in socio and economic activities