DEPARTMENT OF HEALTH SERVICES

SECOND SAMBURU COUNTY HEALTH STRATEGIC AND INVESTMENT PLAN

2018/2019 - 2022/2023

SEPTEMBER 2018

Universal Health Coverage for All

Samburu County Sector Strategic and Investment Plan 2018/19 – 2022/23

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LIST OF ACRONYMS AND ABBREVIATION

ART	*Anti-Retroviral Drugs*
AIDS	*Acquired Immune Deficiency Syndrome*
ASAL	*Arid and Semi-Arid Lands*
AWP	*Annual Work Plan*
BeMONC	*Basic Emergency Obstetric and Newborn Care*
BFCI	*Baby Friendly Community Initiative*
BSN	*Bachelor of Science in Nursing*
CA	*County Assembly*
CA-PSB	*County Assembly – Public Service Board*
CDF	*Constituency Development Fund*
CDH	*County Director of Health.*
CDPO	*County Development Planning Officer*
CEC	*County Executive Committee*
CEC	*County Executive Member.*
CeMONC	*Comprehensive Emergency Obstetric and New-born Care*
CG	*County government*
CHA	*Community Health Assistant*
CHC	*Community Health Committee.*
CHEW	*Community Health Extension Worker.*
CHMT	*County Health Management Team.*
CHU	*Community Health Unit*
CHV	*Community Health Volunteers*
CIDP	*County Integrated Development Plan*
CIDP	*County integrated development plan*
CLTS	*Community Led Total Sanitation*
COH	*Chief Officer of Health.*
CPSB	*County Public Service Board*
CRA	*Commission of revenue allocation*
CSO	*Civil society organization*
DHIS	*District Health Information Software*
DQA	*Data Quality Audit*
ECDE	*Early childhood development education*
EFA	*Education for all*
EMR	*Electronic Medical Record*
EPWH	*Environmental protection, water and housing*
FBO	*Faith-Based Organisation*
FGM	*Female genital mutilation*
FY	*Financial year*
GOK	*Government of Kenya*
HF	*Health Facility*
HIV	*Human Immunodeficiency Virus*
HMT	*Hospital Management Team.*
HR	*Human Resource*
HRH	*Human Resource for Health*
HRIO	*Health Records and Information Officer*
ICT	*Information communication technology*
IFAS	*Iron and Folic Acid Supplementation*

IFMIS	*Integrated financial management systems*
Ihris	*Integrated Human Resource Information System*
IMR	*Infant mortality rate*
KDHS	*Kenya demographic and health survey*
KECHN	*Kenya Enrolled Community Health Nurse*
KEMSA	*Kenya Essential Medical Supplies Agency*
KEPH	*Kenya Essential Package for Health*
KNBS	*Kenya national bureau of statistics*
KRCHN	*Kenya Registered Community Health Nurse*
LLITN	*Long Lasting Insecticide Treated Nets*
LMIS	*Logistical Management Information System*
MAWASCO	*Maralal water services company*
MCA	*Member of county assembly*
MDG	*Millennium development goals*
MEDS	*Mission for Essential Drugs Supplies*
MOE	*Ministry of education*
MoU	*Memorandum of Understanding*
MTP	*Medium term plan*
NCD	*Non-Communicable Diseases*
NDMA	*National drought management authority*
NEMA	*National environmental management authority*
NG	*National government*
NGO	*Non-governmental organization*
NHSSP	*National Health Sector Strategic Plan*
NMR	*Neonatal-mortality rate*
NPHL	*National Public Health Laboratory*
NWSB	*Northern water services board*
O&M	*Operation and Management*
OJT	*On-the-Job Training*
OVC	*Orphan and vulnerable children*
PMTCT	*Prevention of mother-child transmission*
PPP	*Public, Private Partnership*
RBMS	*Result-based management system*
SBCC	*Social and Behaviour Change Communication*
SCG	*Samburu county government*
SCHMT	*Sub County Health Management Team.*
SSCHSSIP	*Samburu County Health Sector Strategic and Investment Plan*
SDG	*Sustainable Development Goal*
SGBV	*Sexual Gender Based Violence*
SID	*Society for international development*
SOPs	*Standard Operating Procedure*
SPCR	*Social protection, culture and recreation*
SWOT	*Strength, Weakness, Opportunity and Threats*
TBA	*Traditional Birth Attendant*
TWG	*Technical Working Group*
UHC	*Universal Health Coverage*
USAID	*United States agency for international development*
VCT	*Voluntarily and Counseling Centre*
WASH	*Water Sanitation and Hygiene*
WFP	*World food programme*
WHO	*World Health Organisation*

PREFACE

I am delighted to present to you the Samburu County Health Sector Strategic and Investment Plan 2018– 2022. The plan carries the strategic vision and goal of the county health department. The overarching goal of this plan will enable the county to fulfil its promises to the residents of Samburu county by ensuring the provision of quality integrated quality health services for all.

The Health Sector is key in ensuing the citizens remain healthy and productive to contribute to the socio-economic development of the county and the nation. The process of formulating this Strategic Plan has given us the opportunity to learn and build on our past successes and failures. We have identified strategic interventions to respond to emerging diseases and meet the health needs of our growing population.

The strategic areas of focus confirm our commitment towards establishing a strong health system. This is through strengthening our core functions of offering effective and efficient prevention, promotion, curative, rehabilitative and palliative services. It is our duty to robustly coordinate and engage stakeholders and the community to enhance the health sector governance. The strategic plan incorporates priorities of the national health sector including the Universal Health Coverage spearheaded by the President's Big Four Agenda.

Our health strategies have been well articulated after taking into consideration inputs and feedback obtained from various county health stakeholders. Let me take this opportunity to thank all of them for giving us so much food for thought during the process of consultation and drafting of the Strategic Plan. I would like to thank the Department of Health for taking up the responsibility of overseeing the strategic plan process. The County Government will provide the necessary platform for monitoring its implementation.

In order to implement and achieve the health policy objectives, we need to develop an enabling environment in which our human, financial and physical resources are appropriately allocated and deployed. This will help us attain sustainable excellence in the provision of safe and quality health care. We are investing in building a better future for the Citizens of Samburu County.

Please join Samburu County Government in the implementation of this strategic plan that will go a long way in ensuring the Vision and mission of the county 'free from preventable diseases' has been realized. Thank you for supporting the aspirations of the Samburu County and the communities we serve.

His Excellency Moses Kasaine Lenolkulal
Governor
Samburu County

FOREWORD

As guided by the robust health sector strategic plan, Samburu County is committed to providing quality healthcare to its residents. In envisioning a County that is free from preventable diseases and ill health through the implementation of programs embedded in the universal health care goal, a situational analysis was conducted in a comprehensive and participatory manner to review the 2013-2018 County Health Sector Strategic Plan (CHSSP) and guide the development of a contextualized 2018-2022.

In implementing the 2013-2018 CHSSP, situational analysis divulged significant investments in strengthening county health systems to improve access and quality of health services were made in the first term of the County Government (2013-2018). Notably, the County constructed 1 health center, 26 dispensaries, 26 staff houses, and nine maternal units"; strengthened ambulatory and referral services with 11 new ambulances and two mobile clinics; recruited 300 clinical and non-clinical staff; and established 35 community units. In addition, the budget for essential medicines and medical supplies was progressively increased to 70 million shillings up from 45 million (35%) over the period. Equally, the situational analysis affirmed that the county health system continues to experience significant challenges including inadequate financing characterized by high out of pocket spending; shortages in critical technical staff cadres; sub-optimal health infrastructure and equipment; connectivity in terms of road and telephone network coverage; and poor health seeking behavior.

The situational analysis informed priorities for the 2018-2022 CHSSP. Specifically, this strategy priorities in all the health systems strengthening pillars geared to achieving reduced maternal mortality rate, under 5 mortality rate and neonatal mortality rate. The County acknowledges the various synergies contributed by the various stakeholders in the attainment of the vision in this plan. During the implementation period, a detailed implementation arrangement (M&E, stakeholder coordination, resource mobilization) is inscribed.

I am delighted for the support and thank all individuals and partners for their contribution and commitment in making this exercise a success and I look forward to the greater partnership during the implementation and review of this plan.

Stephen Lekupe
CECM-Healthcare Services,
Samburu County

ACKNOWLEDGEMENT

The development of the Samburu SCHSSIP 2018-2022 involved four months of a participatory and consultative process involving many stakeholders including state, non-state external actors and; individuals. I wish to thank those who worked tirelessly to provide technical and financial input, and institutions and individuals who participated and contributed in the development of this strategic plan. These include Government Ministries and Agencies, Faith-based organization, Non-Governmental Organizations, and the private sector.

I acknowledge the Director of Health Services for his coordination, leadership, and stewardship. Special gratitude to all department heads, programme managers, County and Sub-County Health Management Teams for their technical input and commitment during the process of developing the Strategic Plan. In addition, I recognize the efforts of the Strategic Plan Technical Working Groups (TWGs) – that brought together some of our technical staff and those from the health sector partners organizations within the county to steer the review and improve the draft plan and ensure its linkage with the County Integrated Development Plan (CIDP). The TWGs worked tirelessly; through several consultative meetings, to ensure that this plan was responsive to the needs of Samburu county.

The Department of Health would like to appreciate the technical role and acknowledge the financial support provided by the USAID-funded County Measurement, Learning and Accountability Project (CMLAP II), Afya Timiza, World Vision Kenya and Safaricom Uzazi Salama project. Without this support, it would have been impossible to undertake the review, development and complete this strategic plan.

I now appeal to our partners and all stakeholders to support the implementation of the Strategic Plan through collaboration and partnership to enable us to achieve Universal Coverage for all.

Mr. Samuel Nakope
Chief Officer
Department of Healthcare Services,
Samburu County

Dr. Martin Thuranira
County Director of Health
Samburu County

EXECUTIVE SUMMARY

The overarching goal of the plan is to accelerate attainment of health impact targets as defined in the Health Policy, 2014 - 2030 and contribute to the attainment of Departmental Vision of having 'A County free from preventable diseases and ill health.' The strategies detailed in this document have been thought through and designed in a manner that contributes, wherever possible, to Kenya Vision 2030, the broader, longer-term country development agenda. The plan has mainstreamed the health-related Sustainable Development Goals and cross-cutting issues of gender equality and social protection.

The second Samburu County Health Sector Strategic and Investment Plan (SCHSSIP II) for 2018-2022 will guide the department's strategic directions and priorities over the coming five years. It highlights key areas where the department seeks to make significant improvements in the delivery of health services. The priorities under each programme area have been set within the context of emerging challenges and opportunities presented by a devolved health system. The plan emphasizes improving the county's response to the prevailing disease burden and maintaining a focus on vulnerable populations and highlights key areas where to target investments for optimal impact in the coming five years.

The key strategic objectives and outcomes have been aligned to the Kenya health policy 2014-2030 objectives and policy orientations which provide the policy framework to progress towards attainment of vision 2030 goal for the health sector and universal health coverage. The strategic plan is anchored on the six policy objectives seeking to eliminate communicable diseases, halt and reverse burden of non-communicable diseases, reduce the burden of violence and injuries, provide essential health care, minimize the exposure to health risk factors, and strengthen collaboration with other sector actors. In addition, the plan has also been aligned to aspirations of the second Samburu County Integrated Development Plan (CIDP) 2018-2022, health sector Medium Term Plan (MTP III) and Sustainable Development Goal (SDG 3), National Big Four Agenda, Governors Big 3 agenda, and Agenda 2063.

With an engaged government, small and diverse population, Samburu has the potential to make significant progress on the strategic plan aspirations despite the complex challenges that exist within the county. The Department of Health Services will work with other county government departments and entities; donors, and other non-state actors implementing health programmes in Samburu County to achieve the department's aspirations.

SECTION 1: INTRODUCTION

This chapter provides an overview on the purpose of this investment plan, the National and County health sector planning framework in Kenya, SCHSSIP linkages with global, national, and County health policies, describes County health functions as per the constitution, linkage to Kenya vision 2030 and Medium-Term Plans, Kenya Health Policy 2014-2030, CIDP 2018-2022, The Sustainable Development Goals (SDGs), National Big 4, Governors Big 3 Agenda and Africa Union Agenda 2063 and the process of development and adoption of the SCHSSIP.

1.1 PURPOSE OF THIS INVESTMENT PLAN

The coming to an end of implementing the first Samburu County Health Strategic and Investment Plan (SCHSSIP 2013 – 2017) made it necessary for the County to develop the next strategic plan. Compared to the first SCHSSIP, this second (2018 – 2022) has taken a strategic detour to lay greater emphasis on preventive, promotive, community health services and improving the functionality of the existing health facilities to meet the required standards. This plan is an overall framework for planning and implementation of county health priorities to realize the county vision and establishes the departmental priorities for the strategic period 2018-2022 and outlines the strategic actions that the CDOH will undertake to achieve them.

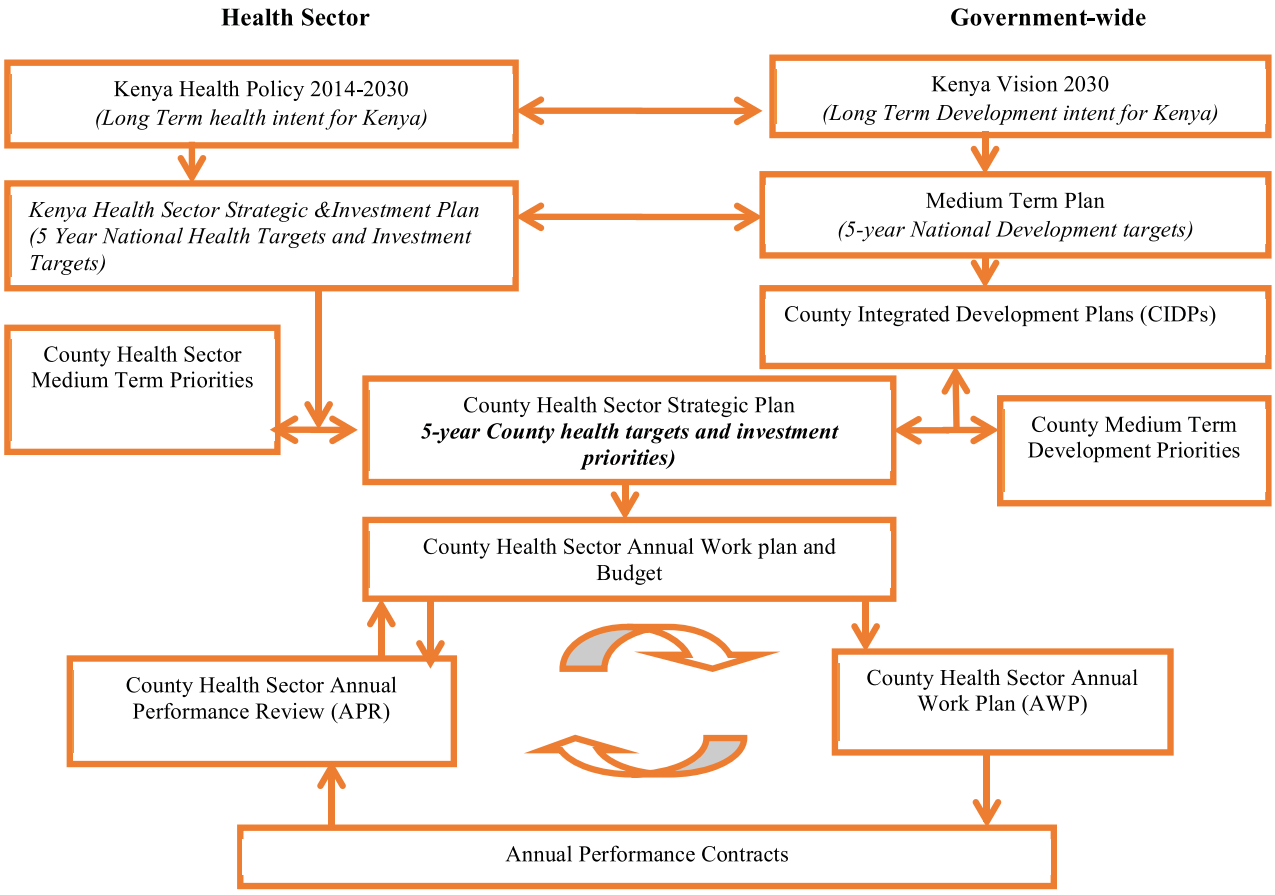
Health, being one of the big four priority pillars, the county is strategically positioning itself to accelerate the realization of Universal Health Coverage and the provision of highest attainable quality of services responsive to the needs of the people and improve the overall health status of the Samburu populace in line with the national and global commitments, as well as addressing the new, re-emerging and contextual health issues within the County. This strategic plan represents the second strategic plan of Samburu County Department of Health for the period 2018-2022, intended to support the attainment of Universal Healthcare Coverage.

1.2 THE NATIONAL AND COUNTY HEALTH SECTOR PLANNING FRAMEWORK IN KENYA

The county health sector planning processes occur within the broader government and health sector specific planning framework. The health sector agenda within the national long-term strategic direction is outlined in the Kenya Health Policy (KHP) 2014-30 and translated into five-year medium-term agenda within the implementation of the Kenya Health Sector Strategic Plans (KHSSPs).

At the county level, the five-year medium-term county government agenda is typically outlined within the broader County Integrated Development Plan. The health sector specific agenda is then elaborated within the County Health Sector Strategic Plan which in turn informs the Annual Work Plans. This Samburu CHSSP 2018 - 2022 thus outlines the county health sector strategic agenda in line with the CIDP 2018-2022 and as part of the GoK MTP III. Figure 1 outlines the National and County health Sector Planning framework.

Figure 1: Schematic Illustration of the County Health Sector Planning Framework



Source: Constitution of Kenya, Public Financial Management Act, 2012.

1.3 SCHSSIP linkages with Global, National, and County Health Policies

The Samburu Health Sector Strategic and Investment Plan 2018-2022 is guided by principles drawn from health, economic, social and political goals, highlighted in the Kenyan constitution, national policy documents and international declarations. These include; social solidarity; the right to health, equity; effectiveness and efficiency; appropriateness and responsiveness; and transparency and accountability. Specifically, the strategic plan is guided by the tenets highlighted in the CIDP 2018-2022, KHSSP II 2018-2022, Vision 2030, Constitution of Kenya, Sustainable Development Goal and other regional and international goals. This will assist the county to operate in harmony with the rest of the country in service delivery and contribute to the attainment of national and global aspirations as we strive to improve health outcomes. The various policies have been described below:

1.3.1 County Health Functions as per the Constitution

The Constitution of Kenya introduced a devolved system of government which would enhance access to services to all Kenyans, especially those in rural and hard-to-reach areas. Article 43 grants every citizen unchallengeable rights that include: right to life, right to the highest attainable standard of health including reproductive health and emergency treatment, right to be free from hunger and to have food of acceptable quality, right to clean, safe and adequate water and reasonable standards of sanitation and the right to a clean healthy environment.

The Fourth Schedule defines the functions of the national and county governments. A total of 14 functions have been devolved to the counties including health. Premised on the County Governments Act, 2012; The Samburu County Department of Health services responsibilities include:

a) County health facilities and pharmacies
b) Ambulance services and referral system
c) Promotion of primary health care
d) Licensing and control of undertakings that sell food to the public;
e) Cemeteries, funeral parlours, and crematoria
f) Medical waste removal and disposal
g) County Human Resources for Health

1.3.2 Linkage to Kenya Vision 2030 and Medium-Term Plans

The Country's economic blueprint details the long-term national development agenda that aims at transforming Kenya into a globally competitive and prosperous industrialized middle-income country by the year 2030. In this endeavor, health is a critical component of delivering the vision's social pillar given the key role it plays in maintaining a healthy and skilled workforce necessary to drive the economy.

Through the Kenya Vision 2030 social pillar, the county aims to provide an efficient integrated and high-quality affordable health care to all citizens. It gives priority to preventive care at community and household levels, through a decentralized national health-care system. Behind the vision's intention is the knowledge that improved access to health care will be achieved through:

a) Provision of a robust health infrastructure network;
b) Improving the quality of health service delivery to the highest standards;
c) Promotion of partnerships with the private sector; and
d) Providing access to those excluded from health care for financial or other reasons.

This Strategic Plan for Samburu Department of Health comes in the onset of the third phase of Vision 2030 implementation plan referred to as MTP III which will carry forward and complete the programs and projects initiated during MTP II which were:

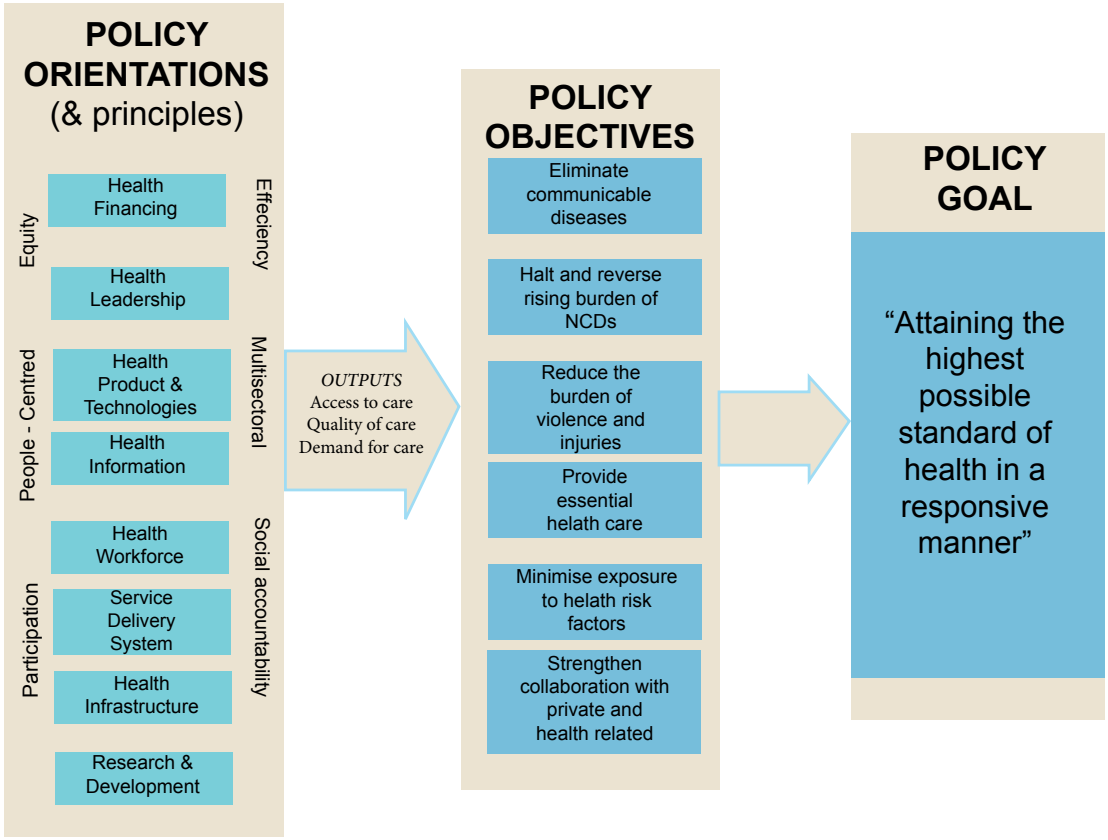
a) Improvement of access to quality reproductive health, family planning and gender-based violence services, People living with disability (PWD) and other health care services;
b) Rehabilitation of rural health facilities to enable provision of integrated and comprehensive health care by constructing health centers and dispensaries, recruiting health personnel and development of a human resource strategy for health;
c) Implement policy framework for public-private-partnerships; and
d) Development of a financing strategy for the entire sector; and enhance uptake of the National Hospital Insurance Fund (NHIF) to be in line with a wider-based financing strategy for universal health Coverage (UHC). (Encourage uptake of insurance models through the private sector, community models).

MTP II has recorded progress in health outcomes. This includes operationalization of model health centers, recruitment of health workers and upgrading of health centers. The county department of health intends to upgrade three health centers (Suguta Marmar, Wamba, and Kisima). The health sector realized significant achievements during the MTP II implementation phase. The rollout of Universal Health Coverage in the county is expected to further transform health care delivery by addressing quality, access, and coverage.

1.3.3 Kenya Health Policy 2014-2030

The Kenya Health Policy 2014- 2030 aims to provide the long-term intent of government towards attaining its overall goal of 'attaining the highest possible health standards in a manner responsive to the population needs'. The Policy aims at consolidating the gains attained in health services delivery so far while guiding the achievement of further health gains in an equitable, responsive and efficient manner. Figure 2 below shows the Kenya health Policy framework.

Figure 2: Kenya Health Policy 2014-2030 Framework



1.3.4 Linkage to CIDP 2018-2022

The County has finalized development of its second County Integrated Development Plan (CIDP), 2018 – 2022. The SCHSSIP II, 2018-2022 has been aligned to the County government aspiration that envisages to reduce the infant mortality rates, halt and reverse declining child nutrition indicators enhance immunization coverage and eradicate preventable causes of morbidity in the County. This will be achieved through improved access to quality healthcare services, narrowing health personnel shortages: patient ratios and improvement of working conditions and ensure reliable availability of medical and pharmaceutical commodities for both communicable and non-communicable diseases in all county public health facilities.

1.3.5 The Sustainable Development Goals (SDGs)

During the implementation of Millennium Development Goals (MDGs), the country achieved significant progress with the introduction of free maternal care in public health facilities which resulted in an increase of birth deliveries by skilled providers from 43% to 62% and a decline in maternal mortality rates by 26% and child vaccination coverage at 63%. The Sustainable Development Goals (SDG) are internationally accepted standards for measuring progress towards poverty alleviation. Kenya is a signatory to the SDGs and has made commendable efforts to achieve the 17 goals although some are still facing challenges.

The county government will play a key role in the achievement of SDGs through integrating the goals into its development planning process, availing adequate resources to the sectors with programmes addressing, monitoring and evaluating key SDG indicators. The SDGs have been mainstreamed in the Second County Integrated Development Plan (2018- 2022) and will continue to be mainstreamed in future departmental plans. SDGs are interdependent and therefore most of the 17 sustainable goals have implications on health agenda, either directly or through social determinants. The critical SDG that contribute to the realization of health targets are listed below:

Goal 1: End poverty in all its forms everywhere.

Goal 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture.

Goal 3: Ensure healthy lives and promote well-being for all at all ages.

Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

Goal 5: Achieve gender equality and empower all women and girls.

Goal 6: Ensure availability and sustainable management of water and sanitation for all.

Goal 17: Strengthen the means of implementation and revitalize the global partnership for sustainable development.

1.3.6 National Big Four and Governor's Big Three Agenda

This plan is aligned to the National Big 4 Agenda anchored on enhancing and accelerating food security, manufacturing, affordable health care and affordable housing and Governor's Big 3 Agenda on food security, affordable access to health services and access to education. The county will leverage on resources and good will from the national government in ensuring the key pillars are realized in Samburu County.

1.3.7 Agenda 2063

Agenda 2063 is a strategic framework for the socio-economic transformation of the continent over the next 50 years. It builds on and seeks to accelerate the implementation of past and existing continental initiatives for growth and sustainable development. Under the four aspirations, the Samburu Strategic plan responds to the first aspiration of establishing a prosperous Africa based on inclusive growth and sustainable development. Specifically, for health, the county will guarantee that every person has access to basic services including health, nutrition, education, shelter, water, and sanitation. The county will implement key health priorities that aim at improving the quality of life, sound health and well-being for Samburu citizens.

1.4 The process of development and adoption of the SCHSSIP

This strategic plan was developed through a comprehensive strategic objectives-based process adopted comprising the following nine steps:

1. Situation analysis was conducted to identify areas that needed focused input, emphasis and enable prioritization of strategic objectives;
2. The strategic directions were defined beginning with a review of mission, vision, and values;
3. Outlining of major implementation strategies (by programs) to achieve the strategic objectives;
4. Outlining of implementation arrangements necessary to support the strategic plan, including organization structure and coordination arrangements;
5. Defining performance and monitoring framework for the strategic plan including the performance indicators, baselines, targets, and milestones.
6. Costing of the strategic plan in terms of programs, sub-programs, outputs and activities;

7. Determination of the projected available resource envelop from all sources by investment areas and sources; and
8. Estimation of the financing gap by health investment areas and documentation of resource mobilization strategies for bridging the financing gap.
9. Development of monitoring and evaluation matrix to enable Mid-term and end-term review of the strategic plan.

This plan was developed through in-depth analysis of available data and a highly participatory process involving a wide range of stakeholders from government; civil society including non-governmental organizations, faith-based organizations, private sector and development partners. Key aspects of the development process including end term review which identified the achievements, strengths and weaknesses of the current health sector investments and service delivery indicators which contributed to identifying success and weaknesses relevant to the department of health that need to be addressed under this current strategic plan.

The review contributed to collation of information including priority strategies and interventions to be considered to inform the draft plan. Representatives from all working groups participated in a 5-day strategic planning workshop to compile the zero draft. The draft generated was shared among the stakeholders for further inputs before validation, approval and adoption by the County Government.

SECTION 2: SITUATION ANALYSIS

2.1. OVERVIEW

This chapter provides the background information on Samburu County in terms of the County profile, size, demographic profiles as well as the administrative and political units. It also provides information on the county health sector context and the institutional framework of the department of health services (DoHS) including county health status, health investments (health systems building blocks), SWOT and PESTEL as well as other strategic issues that have informed the development of the second Samburu County Health Sector Strategic and Investment Plan (SCHSSIP II) 2018 – 2022.

2.2. COUNTY PROFILE

2.2.1 Geographical location

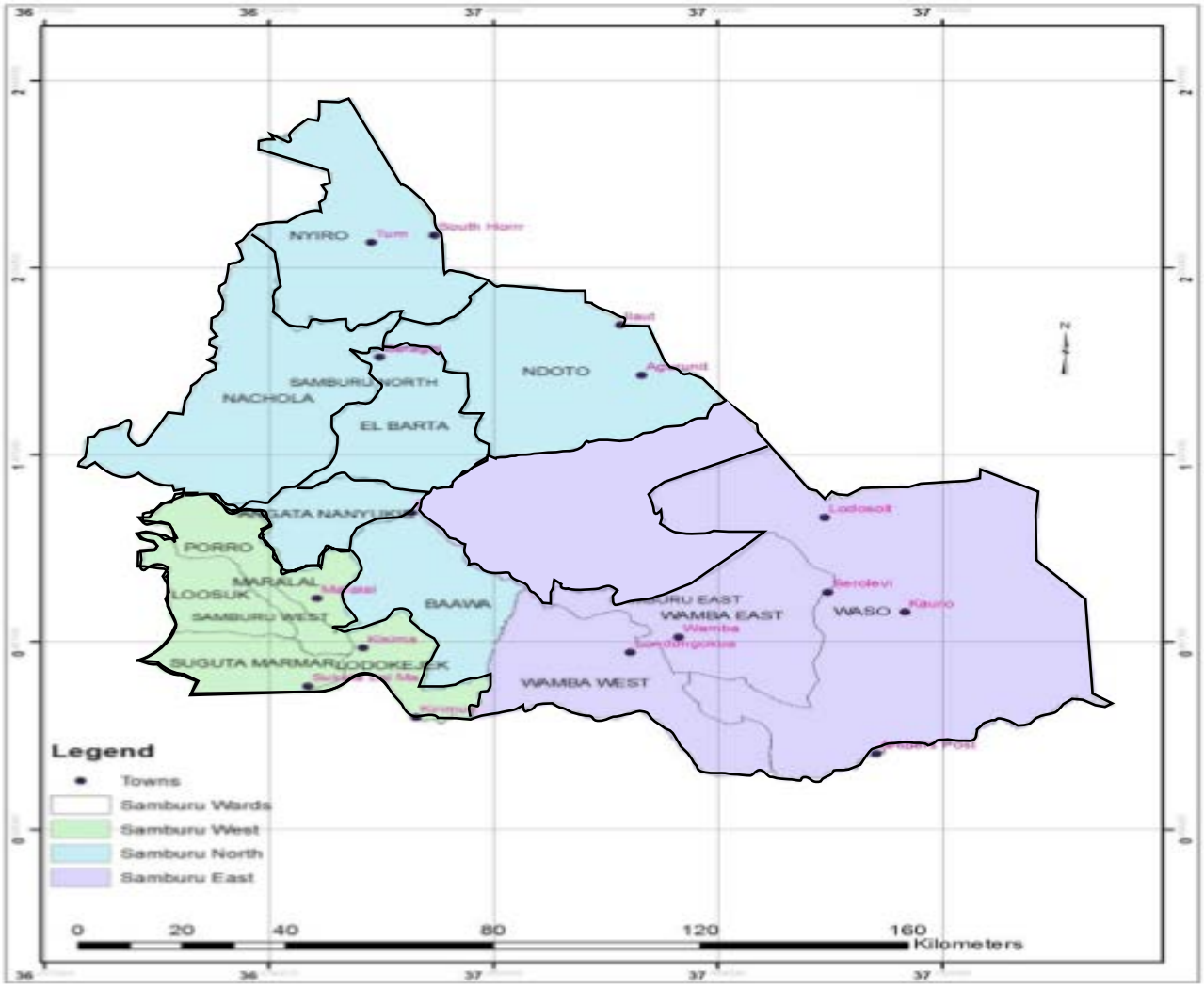
Samburu County is among the 47 counties in the Republic of Kenya. The County borders Marsabit County to the East and North East, Isiolo County to the South East, Laikipia to the South, Baringo County to the South West and Turkana County to the West and North West. The County has a land area of approximately (21,022) Km^2 and is administratively divided into three Sub Counties namely Samburu Central, Samburu North, and Samburu East. The county has three constituencies, 15 wards, 7 divisions, 39 locations, and 108 sub-locations. Geographically, the county is divided into lowland and the plateau. Vegetation is mainly grassland with scattered shrubs, while deciduous forests dominate the mountainous ranges.

The Lorroki and Kirisia plateaus do also have mountains and indigenous forests. The zone serves as a water catchment area and grazing area for livestock during dry seasons. The area is fairly served by earth dams, water pans, and boreholes. The county is generally a water deficit area as there are no permanent rivers except Uaso Ng'iro, which marks the southern boundary with Laikipia and Isiolo counties. The lowland range is composed of dwarf shrub grassland with deciduous bushes. Water sources are main streams, shallow wells, and a few boreholes and rock catchments.

The rainfall pattern of the county falls into two distinct seasons, whose occurrence is determined by geographical location. The highlands receive their long rains between March and May and the short rains between July and August. The lowlands receive long rains between March-May and short rains in October and November. Rainfall is erratic and therefore drought is a common phenomenon. However, average rainfall in the county is about 500mm annually. Temperatures in the County vary with altitude and ranges between 21^oC to 35^oC. In terms of economic activities, the largest part of the County's population are pastoralists while others are agro-pastoralists and a small population of the business community. The pastoralists mainly keep cattle, sheep, goats, camels, and donkeys, while the agro-pastoralists produce maize, beans, potatoes and vegetables. Wheat is grown by large scale commercial farmers in the Lorroki Plateau in Samburu Central Sub County.

The County is served by three main weather roads, Nyahururu -Maralal road, Maralal -Baragoi road and Isiolo - Wamba-Maralal road. There are other small weather feeder roads leading to various local centers and villages. Mobile telephone communication only covers a small part of the county being provided by Safaricom, Airtel, and Telkom/Orange mobile service providers. The three Sub County headquarters are supplied with electricity from the Kenya Power and Lighting Company. Figure 3 shows the county administrative structure.

Figure 3: Samburu Administrative Map



2.2.2 Population Demographics

According to the 2009 census, Samburu County had a population of 223,947 persons of which 109,734 and 114,213 were male and female respectively. Using County population growth rate of 4.45% per annum, the population of Samburu County was projected to be 331,376 persons by 2018. The population cohorts have been adopted nationally for purposes of estimating requirements for health services delivery in line with the Kenya Essential Package for Health (KEPH). For example, the population under 15 years of age (children) constitutes the largest population proportion at 50.72% while pregnant women constitute 4.48% of the population. Each population cohort has its unique health services needs and requirements that this strategic plan has taken into consideration. Throughout this document, 2018 is adopted as the baseline year for planning and projection. This section shows Samburu county population trends and projections by County and Sub-County from 2018 up to the year 2022 based on the 2009 population census. Table 1 shows the county's population by cohort and key population indicators. Each Population cohort has its unique health services needs and requirements that this strategic plan has taken into consideration.[3]

3 *2009 KNBS Census*

Table 1: Samburu County Catchment Population Trends and Projection

Description	Population estimates	Samburu County	2018	2019	2020	2021	2022
Total population	4.45%	223,947	331,376	346,122	361,525	377,613	394,416
Total Number of Households	5per HH	44,789	66,275	69,224	72,305	75,523	78,883
Population Female	51.00%	114,213	169,002	176,522	184,378	192,582	201,152
Population Male	49.00%	109,734	162,374	169,600	177,147	185,030	193,264
Children under 1 year (12 months)	3.60%	8,062	11,930	12,460	13,015	13,594	14,199
Children under 5 years (60 months)	18.93%	42,393	62,730	65,521	68,437	71,482	74,663
Under 15-year population	50.72%	113,586	168,074	175,553	183,365	191,525	200,048
Women of child bearing age (15 – 49 Years)	21.19%	47,454	70,219	73,343	76,607	80,016	83,577
Estimated Number of Pregnant Women	4.48%	10,033	14,846	15,506	16,196	16,917	17,670
Estimated Number of Deliveries	3.93%	8,801	13,023	13,603	14,208	14,840	15,501
Estimated Live Births	3.93%	8,801	13,023	13,603	14,208	14,840	15,501
Total number of Adolescent (15-24)	20.23%	45,304	67,037	70,021	73,136	76,391	79,790
Adults (25-59)	28.06%	9,898	14,647	15,299	15,979	16,690	17,433
Elderly (60+)	4.42%	9,898	14,647	15,299	15,979	16,690	17,433
Estimated Emergency obstetric complications	0.75%	1,680	2,485	2,596	2,711	2,832	2,958
Estimated of post abortion cases	0.75%	1,680	2,485	2,596	2,711	2,832	2,958
0 -6 Months	50% < 1yr	4,031	5,965	6,230	6,507	6,797	7,099
6 - 11 Months	10% < 5yrs	4,239	6,273	6,552	6,844	7,148	7,466
12 - 59 Months	80% < 5yrs	33,915	50,184	52,417	54,749	57,186	59,730
6 - 59 Months	90% < 5yrs	38,154	56,457	58,969	61,593	64,334	67,197
0 - 11 Months	20% < 5yrs	8,479	12,546	13,104	13,687	14,296	14,933
0 - 28 Days.	10% of <1yr	806	1,193	1,246	1,301	1,359	1,420

Source: KNBS Population Projections 2017.

Table 2 shows the Samburu Central county population by cohort and key population indicators. Each Population cohort has its unique health services needs and requirements that this strategic plan has taken into consideration.

Table 2: Samburu Central Sub-County Population Projection

Description	Population estimates	Samburu County 2009	2018	2019	2020	2021	2022
Total population	4.45% Growth Rate	103,850	153,668	160,506	167,648	175,109	182,901
Total Number of Households	5per HH	20,770	30,734	32,101	33,530	35,022	36,580
Population Female	51.00%	52,964	78,371	81,858	85,501	89,305	93,280
Population Male	49.00%	50,887	75,297	78,648	82,148	85,803	89,622
Children under 1 year (12 months)	3.60%	3,739	5,532	5,778	6,035	6,304	6,584
Children under 5 years (60 months)	18.93%	19,659	29,089	30,384	31,736	33,148	34,623
Under 15-year population	50.72%	52,673	77,940	81,409	85,031	88,815	92,767
Women of child bearing age (15 – 49 Years)	21.19%	22,006	32,562	34,011	35,525	37,106	38,757
Estimated Number of Pregnant Women	4.48%	4,652	6,884	7,191	7,511	7,845	8,194
Estimated Number of Deliveries	3.93%	4,081	6,039	6,308	6,589	6,882	7,188
Estimated Live Births	3.93%	4,081	6,039	6,308	6,589	6,882	7,188
Total number of Adolescent (15-24)	20.23%	21,009	31,087	32,470	33,915	35,424	37,001
Adults (25-59)	28.06%	4,590	6,792	7,094	7,410	7,740	8,084
Elderly (60+)	4.42%	4,590	6,792	7,094	7,410	7,740	8,084
Estimated Emergency obstetric complications	0.75%	779	1,153	1,204	1,257	1,313	1,372
Estimated of post abortion cases	0.75%	779	1,153	1,204	1,257	1,313	1,372
0 -6 Months	50% < 1yr	1,869	2,766	2,889	3,018	3,152	3,292
6 - 11 Months	10% < 5yrs	1,966	2,909	3,038	3,174	3,315	3,462
12 - 59 Months	80% < 5yrs	15,727	23,271	24,307	25,389	26,518	27,699
6 - 59 Months	90% < 5yrs	17,693	26,180	27,345	28,562	29,833	31,161
0 - 11 Months	20% < 5yrs	3,932	5,818	6,077	6,347	6,630	6,925
0 - 28 Days.	10% of < 1yr	374	553	578	604	630	658

Source: KNBS Population Projections 2017.

Table 3 shows the Samburu North county population by cohort and key population indicators. Each Population cohort has its unique health services needs and requirements that this strategic plan has taken into consideration.

Table 3: Samburu North Sub-County Population Projection

Description	Population estimates	Samburu County 2009	2018	2019	2020	2021	2022
Total population	4.45% Growth Rate	59,094	87,442	91,333	95,397	99,643	104,077
Total Number of Households	5per HH	11,819	17,488	18,267	19,079	19,929	20,815
Population Female	51.00%	30,138	44,595	46,580	48,653	50,818	53,079
Population Male	49.00%	28,956	42,847	44,753	46,745	48,825	50,998
Children under 1 year (12 months)	3.60%	2,127	3,148	3,288	3,434	3,587	3,747
Children under 5 years (60 months)	18.93%	11,186	16,553	17,289	18,059	18,862	19,702
Under 15-year population	50.72%	29,972	44,351	46,324	48,386	50,539	52,788
Women of child bearing age (15 – 49 Years)	21.19%	12,522	18,529	19,353	20,215	21,114	22,054
Estimated Number of Pregnant Women	4.48%	2,647	3,917	4,092	4,274	4,464	4,663
Estimated Number of Deliveries	3.93%	2,322	3,436	3,589	3,749	3,916	4,090
Estimated Live Births	3.93%	2,322	3,436	3,589	3,749	3,916	4,090
Total number of Adolescent (15-24)	20.23%	11,955	17,689	18,477	19,299	20,158	21,055
Adults (25-59)	28.06%	2,612	3,865	4,037	4,217	4,404	4,600
Elderly (60+)	4.42%	2,612	3,865	4,037	4,217	4,404	4,600
Estimated Emergency obstetric complications	0.75%	443	656	685	715	747	781
Estimated of post abortion cases	0.75%	443	656	685	715	747	781
0 -6 Months	50% < 1yr	1,064	1,574	1,644	1,717	1,794	1,873
6 - 11 Months	10% < 5yrs	1,119	1,655	1,729	1,806	1,886	1,970
12 - 59 Months	80% < 5yrs	8,949	13,242	13,831	14,447	15,090	15,761
6 - 59 Months	90% < 5yrs	10,068	14,897	15,560	16,253	16,976	17,732
0 - 11 Months	20% < 5yrs	2,237	3,311	3,458	3,612	3,772	3,940
0 - 28 Days.	10% of < 1yr	213	315	329	343	359	375

Source: KNBS Population Projections 2017.

Table 4 shows the Samburu East county population by cohort and key population indicators. Each Population cohort has its unique health services needs and requirements that this strategic plan has taken into consideration.

Table 4: Samburu East Sub-County Population Projection.

Description	Population estimates	Samburu County 2009	2018	2019	2020	2021	2022
Total population	4.45% Growth Rate	61,003	90,267	94,283	98,479	102,861	107,439
Total Number of Households	5per HH	12,201	18,053	18,857	19,696	20,572	21,488
Population Female	51.00%	31,112	46,036	48,085	50,224	52,459	54,794
Population Male	49.00%	29,891	44,231	46,199	48,255	50,402	52,645
Children under 1 year (12 months)	3.60%	2,196	3,250	3,394	3,545	3,703	3,868
Children under 5 years (60 months)	18.93%	11,548	17,087	17,848	18,642	19,472	20,338
Under 15-year population	50.72%	30,941	45,783	47,821	49,949	52,171	54,493
Women of child bearing age (15 – 49 Years)	21.19%	12,927	19,127	19,979	20,868	21,796	22,766
Estimated Number of Pregnant Women	4.48%	2,733	4,044	4,224	4,412	4,608	4,813
Estimated Number of Deliveries	3.93%	2,397	3,547	3,705	3,870	4,042	4,222
Estimated Live Births	3.93%	2,397	3,547	3,705	3,870	4,042	4,222
Total number of Adolescent (15-24)	20.23%	12,341	18,261	19,074	19,922	20,809	21,735
Adults (25-59)	28.06%	2,696	3,990	4,167	4,353	4,546	4,749
Elderly (60+)	4.42%	2,696	3,990	4,167	4,353	4,546	4,749
Estimated Emergency obstetric complications	0.75%	458	677	707	739	771	806
Estimated of post abortion cases	0.75%	458	677	707	739	771	806
0 -6 Months	50% < 1yr	1,098	1,625	1,697	1,773	1,852	1,934
6 - 11 Months	10% < 5yrs	1,155	1,709	1,785	1,864	1,947	2,034
12 - 59 Months	80% < 5yrs	9,238	13,670	14,278	14,914	15,577	16,271
6 - 59 Months	90% < 5yrs	10,393	15,379	16,063	16,778	17,525	18,304
0 - 11 Months	20% < 5yrs	2,310	3,417	3,570	3,728	3,894	4,068
0 - 28 Days.	10% of < 1yr	220	325	339	355	370	387

Source: KNBS Population Projections 2017.

Table 5 shows the Samburu county population projection by age cohort for the period 2018 to 2022.

Table 5: Catchment Population projection by Age Cohort

Age	2018			2019			2020		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
0-4	27,864	28,288	56,156	28,533	28,970	57,510	29,225	29,649	58,874
5-9	23,670	23,430	47,103	24,411	24,236	48,652	25,089	24,920	50,009
10-14	20,770	19,362	40,134	21,241	19,892	41,137	21,741	20,392	42,133
15-19	18,294	15,977	34,273	18,770	16,455	35,230	19,245	16,889	36,134
20-24	14,037	13,332	27,371	14,508	13,722	28,233	14,925	14,079	29,004
25-29	10,616	11,551	22,161	11,170	11,893	23,048	11,546	12,204	23,750
30-34	8,305	9,900	18,206	8,733	10,394	19,129	9,027	10,732	19,759
35-39	6,937	8,413	15,344	7,287	9,062	16,336	7,531	9,362	16,893
40-44	5,050	5,810	10,860	5,310	6,151	11,461	5,488	6,358	11,846
45-49	4,231	4,112	8,344	4,511	4,365	8,876	4,667	4,512	9,179
50-54	3,244	3,672	6,917	3,417	3,876	7,294	3,533	4,005	7,538
55-59	2,220	2,440	4,660	2,343	2,597	4,940	2,423	2,685	5,108
60-64	2,172	2,438	4,611	2,280	2,566	4,847	2,356	2,651	5,007
65-69	1,530	1,452	2,982	1,611	1,520	3,130	1,665	1,568	3,233
70-74	1,191	1,269	2,460	1,242	1,323	2,565	1,281	1,364	2,645
75-79	718	739	1,457	744	769	1,513	766	792	1,558
80+	714	851	1,565	710	848	1,558	711	849	1,560
Total	**151,563**	**153,039**	**304,602**	**156,820**	**158,639**	**315,458**	**161,219**	**163,011**	**361,525**

Source: KNBS Population Projection.

2.2.3 Health Status

The County's key health challenges include the burden of communicable diseases such as HIV and AIDS, respiratory tract infection and diarrheal diseases. The top five causes of mortality in the County are HIV and AIDS, Tuberculosis, Malaria, Pneumonia, Diarrheal diseases while the major risk factors contributing to these mortalities are health factors such as malnutrition and low immunity; exposure to unfavorable conditions such as poor housing, pollution, and unsafe water as well as behavioral factors such as poor hygiene and unsafe sex. As highlighted in table 6, the ETR findings show key health impact indicators overall significant improvement in some impact level health indicators over the past five years in comparison to the National level.

Table 6: Key Health Impact Indicators

Impact level Indicators	National KDHS (status as at 2017)	County estimates
Life Expectancy at birth (years)	65	52**
Male Life Expectancy at birth (years)	63	52
Female Life Expectancy at birth (years)	65	55
Annual deaths (per 1,000 persons) – Crude mortality	8.9	2*/1000,6/100,000
Neonatal Mortality Rate (per 1,000 births)	15	11*/1000
Infant Mortality Rate (per 1,000 births)	39	34*/1000
Under 5 Mortality Rate (per 1,000 births)	52	50*/1000
Maternal Mortality Rate (per 100,000 births)	488/100,000	362*/100,000
Adult Mortality Rate (per 1000 population)	60/1000	183*/1000
Children under five years stunted	6/100	35/100
Children fully immunized	79%	63%
Fertility rate	3.9	6.3
HIV prevalence Rate	4.9%	5%
Health Insurance Coverage	88.4	6.7%
Poverty Index	44%	29%
Contraceptive Prevalence	58 %	20

*Source: KDHS 2014. National Estimates, * AWP*

2.2.4 Major causes of morbidity and mortality in County

Health status of the people in Samburu County is influenced by factors such as environmental, social-cultural, negative cultural practices and beliefs, low literacy levels and high fertility rates as per the KDHS 2014. Although no comprehensive data exists; cancer, diabetes, and cardiovascular diseases are emerging as the leading causes of mortality and morbidity. Sedentary lifestyles of smoking and alcohol consumption continue to be a major risk factor contributing to the prevalence of these diseases. The prevalence of the three major communicable diseases in the county stands at 5% for HIV/AIDs, 6% for TB and 2% for malaria. Poor hygiene and waste disposal practices have also led to increased incidences of diarrheal and chronic lung diseases, contributing to the breeding of vectors and infectious micro-organisms. This has, in turn, led to a sporadic outbreak of communicable diseases. Table 7 and 8 show the top over and under 5 year's morbidity cases reported in 2017 by policy objective.

Table 7: Top Five Commonest Health Conditions/Challenges/Problems

Top Five Commonest Health Conditions/Challenges/Problems						
	Under 5 Years			Over 5 Years		
Health Policy Objectives	**Condition**	**(Prevalence -%)**	**Associated Risk Factors**	**Condition**	**(Prevalence -%)**	**Associated Risk Factors**
Linked to communicable conditions	HIV/AIDS	5	• Home delivery	HIV/AIDS	5	• Unprotected sex • Multiple sex partners
	Malaria	2	• Stagnant water • Climatically changes	Malaria	2	• Stagnant water • Climatic changes
	Tuberculosis	11	• Overcrowding • Poor ventilation • Poor hygiene	Tuberculosis	6	• Overcrowding • Poor ventilation • Poor hygiene
	Pneumonia	7.7	• Low immunization • Malnutrition	Pneumonia	5.3	• Low immunization • Malnutrition
	Diarrheal diseases	12.9	• Poor hygiene • Poor sanitation • Unsafe water	Diarrheal diseases	4.6	• Poor hygiene • Poor sanitation • Unsafe water
Linked to the increasing burden of non-communicable diseases	Hypertension	0	• Poor feeding habits • lack of exercises	Hypertension	0.5	• Poor feeding habits • Sedentary Lifestyle
	Cancers	0 ***	• Poor lifestyle	Cancers	0.006	• Poor lifestyle (smoking, alcohol consumption)
	Diabetes	0.02	• Poor nutrition	Diabetes	0.14	• Poor nutrition • Stress
	Heart diseases	0.006	• Congenital condition • Untreated chronic infections.	Heart diseases	0.03	• Untreated chronic hypertension. • Untreated Diabetes • Tuberculosis
	Mental disorders	0.07	• Congenital disorders	Mental disorders	0.09%	• Drug & Alcohol abuse • Stress • Untreated syphilis
Linked to Violence & Injuries	Road accidents (Boda-boda)	0.05	• Untrained drivers • Poor roads • Alcohol abuse	Road accidents (Boda-boda)	0.17	• Untrained drivers • Poor roads • Alcohol abuse
	Sexual violence	0.03	• Unemployment • Parochial society	Sexual violence	0.06	• Unemployment • Parochial society
	Suicide/ Poisoning	0.06	• Depression	Suicide/ Poisoning	0.09	• Depression • Drug abuse • Infidelity • Diseases
	Violence related injuries	0	• Cattle Rustling • Highway robbery • Domestic violence • Political interference • Human-animal conflicts	Violence-Related Injuries	0.12	• Cattle Rustling • Highway robbery • Domestic violence • Political interference • Human-animal conflicts
	Robbery	0		Robbery	No data	• Unemployment • Poverty • kleptomaniac

Top Five Commonest Health Conditions/Challenges/Problems						
	Under 5 Years			Over 5 Years		
Health Policy Objectives	**Condition**	**(Prevalence -%)**	**Associated Risk Factors**	**Condition**	**(Prevalence -%)**	**Associated Risk Factors**
Linked to essential Medical services	Pregnancy/ childbirth events	N/A	N/A	Pregnancy/ childbirth events	No data.	• Lack of parental care. • Unprotected sex • Poor knowledge • Inadequate health care worker • Inadequate health facilities • Poor referral system distance from Health facilities
	Newborn events	No data	• Home deliveries • Inadequate workers • Inadequate health facilities • Poor referral system.	Newborn events	N/A	N/A
	Adult women health events	N/A	N/A	Adult women health events	No data	• Poor health-seeking behavior. • Distance from facilities. • Poverty. • Lack of equipment. • Poor referral system.
	Adolescent events	N/A	N/A	Adolescent events	No data	• Peer pressure • Cultural practices, • Misuse of technology • Early marriages • Drug abuse.
	Elderly events			Elderly events		• Neglected by society • Poor lifestyle • Stress and depression. • Degenerative disorders
Linked to common health risk factors	Obesity	0.0009%	• poor lifestyle • Poor feeding habits • Inactivity.	Obesity	No data	• poor lifestyle • Poor feeding habits • Inactivity.
	Smoking	N/A		Smoking	No data.	• Peer pressure • Substance abuse
	Underweight children	31.6%	• Mixed feeding in under months • poor maternal nutrition • Not attending ANC Clinic	Underweight children	N/A	N/A
	Underweight mothers	N/A	N/A	Underweight mothers	No data	• Poverty • Cultural barriers. • Heavy domestic task.
	Poor breastfeeding practices	No data	• Maternal death • Lack of breastfeeding facilities. (BFHI)	Poor breastfeeding practices	N/A	• Lack of knowledge • Poverty • Working population
	Lack of contraception	N/A	• Malnutrition	Lack of contraception	No data	• Un intended pregnancies • Poor child spacing • Inadequate commodities. • Knowledge gap.
	Alcohol and drug use		• Congenital malformation • Low birth weight • Prematurity	Alcohol and drug use	No data	• HIV and Syphilis Infections.
	Unsafe sex	No data	• Infections intrauteral.	Unsafe sex	No data	• Substance abuse • Knowledge gap • Early marriage. • Age mixing (Young girls married to old men • Sex work.
	Lifestyle	No data	• Low immunization • Low skilled deliveries	Lifestyle	No data	• Nomadic lifestyle. • Poor health-seeking behavior.

Top Five Commonest Health Conditions/Challenges/Problems						
	Under 5 Years			Over 5 Years		
Health Policy Objectives	**Condition**	**(Prevalence -%)**	**Associated Risk Factors**	**Condition**	**(Prevalence -%)**	**Associated Risk Factors**
Linked to collaboration with health-Related Sectors	Unsafe water	No data	• Water scarcity • Low latrine coverage • Cultural beliefs	Unsafe water	No data	• Water scarcity • Low latrine coverage • Cultural Beliefs. • Lack of treatment plants • Poor storage
	Unemployment	N/A	N/A	Unemployment	No data	• High illiteracy level. • High poverty level. • Lack of required skills. • Negative Attitude. • Nepotism
	Insecurity	N/A	N/A	Insecurity	No data	• Poverty • Cultural belief (cattle rustling).
	Low female Education	N/A	N/A	Low female Education	44	• Cultural practices • Gender based violence • Teenage pregnancies • Early marriage. • Inequity in education.
	Poor housing designs	N/A	N/A	Poor housing designs	No data.	• Poverty • Culture • Nomadic lifestyle. • Poor housing designs. • Poor ventilation and lighting.

**** Data not available from DHIS2. Data collection tools will be developed and used to collect this information as part of routine M&E.*

2.2.5 Morbidity: Major Conditions causing death

Table 8: Major causes of Morbidity for Under and Over five years.

Rank	Under Five years	Over Five years
1	Pneumonia, unspecified	Anaemia, unspecified
2	Diarrhea and gastroenteritis of presumed infectious origin	Pneumonia, unspecified
3	Bacterial sepsis of newborn, unspecified	Tuberculosis of lung, without mention of bacteriological or histological confirmation
4	Anemia, unspecified	Other parasitological confirmed malaria, NEC
5	Birth asphyxia, unspecified	Diarrhea and gastroenteritis of presumed infectious origin
6	Septicemia, unspecified	Peptic ulcer, site unspecified, unspecified as acute or chronic, without hemorrhage or perforation
7	HIV disease resulting in mycobacterial infection	Organophosphate and carbamate insecticides
8	Other parasitological confirmed malaria, NEC	HIV disease resulting in mycobacterial infection
9	Volume depletion	Inflammatory liver disease, unspecified
10	Burns of multiple regions, no more than second-degree burns mentioned	Neoplasm - Lip, oral cavity and pharynx

Sources: DHIS 2 (2016//2017)

2.2.6 Status of Health Investments

This section reviews the health investment areas in the county including service delivery, health infrastructure, health workforce, health information, health products, health financing, leadership and governance as at the end of 2017. There is need to improve all health outputs in terms of access and quality of care within the county as will be discussed in more details in each of the health investment areas.

2.2.6.1 Leadership and Governance

The county leadership and governance team are responsible for ensuring that the department for health is adequately guided, led, managed and governed for effective and efficient delivery of quality health services. County policies, guidelines, and procedures exist with the need to contextualize county specific policies by adopting more from the national government. A good number of health leaders and managers in the county have also been trained in leadership, management and governance courses including senior management.

One of the key priorities is to further strengthen the stakeholders' engagements and enhance the capacity of hospital boards and facility management committees to provide strong leadership and governance to hospitals and facilities. However, there has been a challenge with developing new health policies and advocate for their adoption there is a need to ensure greater focus and effectiveness in resource mobilization targeting the department. As proposed in the 2013-2018 strategic plan, there is still a need for a county resource mobilization team with clear terms of reference and performance targets to be constituted to support resource mobilization efforts. Table 9 capture the assessment of the health leadership level performance indicators for the period 2017/18.

Table 9: Status of Health Leadership & Governance

Item #	Main Health Intervention Areas/Performance Indicators	Target (A)	Achieved (B)	Performance
		2017/18 SCHSSIP	**2017/18 APR**	**B/A*100**
1.	# of new health policies reviewed and customized	1	0	0
2.	# of health strategies reviewed and developed	4	3	75
3.	# Community units with trained CHCs	32	32	100
4.	# of health facilities with functional boards/management committees	74	73	98.6
5.	# monthly CHCs meetings held	128	104	81
6.	# of quarterly Health Facility Board/Committee meetings held	12	12	100
7.	# of monthly Health Facility management Committee meetings held	71	64	90.1
8.	# of monthly Hospital Management Teams meetings held	24	24	100
9.	# of monthly CHMT meetings held	12	6	50
10.	# of monthly SCHMT meetings held	36	13	36
11.	# quarterly multi-disciplinary support supervisory visits carried out by CHMTs/ SCHMTs	12	03	25
12.	# quarterly multi-disciplinary support supervisory visits by SCHMTs to facilities	12	12	100
13.	# of AWP quarterly review meetings held and reports written and disseminated	04	01	25
14.	# of Annual Performance Review meeting held and reports written and disseminated	01	01	100
15.	% of Health facilities that completed AWPs on time	100	100	100
16.	# of Sub County and County AWPs completed on time	4	4	100
17.	% of Health facilities displaying updated service charters	100	80	0
18.	# of Sub Counties stakeholder forums held	12	5	42
19.	# of County stakeholder forums held	4	4	100

2.2.6.2 Health Infrastructure

Samburu County has 96 Health facilities distributed amongst GOK, FBO, NGO and private referral hospitals, health centers', dispensaries, medical clinics and CUs within the County and six sub-counties. The County has 42 Government facilities, 12 Faith-Based Organization, two Non-Governmental Organizations, one Community Based Organization, 21 private clinics and 37 Community units. Samburu County requires 60 CHUs based on its population and the KEPH standards against 32 available representing a population coverage of 53 % (159,000) and a gap of 47 % (141,000), 57 (190 %) dispensaries are available against a requirement of 30, 15 (150%) health centers against a requirement of 10. Three (100%) sub-county hospitals against a requirement of 3. There is no (0%) county referral hospital Level 5 against a requirement of 1. Table 10 and 11 show the distribution of health infrastructure by ownership.

Table 10: Status of Health Infrastructure comparable to facility norms

Tier of care	Infrastructure	Number functional, by type of provider				Total	Required	Gap
		Public	Faith Based	NGO	Private			
County Referrals	Total facilities	02	1	0	0	**3**	**5**	**2**
	Total beds	230	200	0	0	**430**	**530**	**100**
	Total functional Community Units	**03**	0	0	0	**3**	**08**	**5**
	Total with functional boards	01	01	0	0	**02**	**3**	**1**
Primary Care facilities	Total facilities	67	10	4	14	**95**	**104**	**9**
	Total beds	193	51	13	10	**267**	**509**	**242**
	Total functional Community Units	25	2	02	0	**29**	**79**	**50**
	Total with functional management committee's	95	12	05	0	**112**	**185**	**73**
Overall total for County	Total facilities	69	11	04	14	**98**	**109**	**11**
	Total beds	423	251	13	10	**697**	**1039**	**342**
	Total functional Community Units	28	2	2	0	**32**	**87**	**55**
	Total with functional Governance structure	96	13	05	0	**114**	**187**	**73**

Table 11: Average populations expected to be served with different facility types

Catchment populations	Hospitals			Primary Care Units		Community Units
	Tertiary (level VI) referral hospital	Secondary (level V) referral hospital	Primary (level IV) hospital	Health Centre (level III) services	Dispensary (level II) services	
44,000,000 (National)	5,000,000	1,000,000	100,000	30,000	10,000	5,000
Required Numbers of Facilities (Nationally)	9	44	440	1,468	4,404	8,808
319,708 (Samburu 2018)	0	1	3	11	32	64
292,200	0	0	100,000	30,000	10,000	5,000
Gap in HFs	0	0	01	02	0	28
Minimum No of Staff per facility level	0	0	642	134	36	32

Source: The Kenya Essential Package for Health, 2013

The table 12 below shows the analysis of key infrastructure units in the county. Health delivery system between the financial period 2017/18.

Table 12: Health Infrastructure

Item #	Main Health Intervention Areas/Performance Indicators	Target (A)	Achieved (B)	Performance
		2017/18 SCHSSIP	2017/18 APR	B/A*100
1.	Number of functional community Units	87	32	36.8
2.	Number of functional bicycles in community units	1397	322	23
3.	Number of functional motorbikes supporting integrated outreaches, disease surveillance, environmental health	43	16	37.2
4.	Number of sub-counties with functional utility vehicles	6	0	0
5.	% of facilities with the required number of beds per facility forms	18	1	5.6
6.	% of facilities accessing telecommunications network coverage	75	41	54.7
7.	% of facilities with running water	75	22	29.3
8.	% of facilities with title deed of their allocated land parcels	75	09	12
9.	% of facilities that have a perimeter fence to improve security and work environment	75	49	65.3
10.	Number of health facilities with functional operating theatres	04	02	50
11.	Number of health facilities with functional maternity	75	33	44
12.	Number of health facilities with functional burning chambers	75	11	14.7
13.	Number of health facilities with functional laboratories	18	11	61.1
14.	Number of health facilities with functional mortuaries	18	1	5.6
15.	Number of facilities linked to functional ambulatory services	75	10	13

The County continues to experience shortage of health workers across all cadres hindering the delivery of health care at all levels. As at September 2018, the county had a total of 475 or 16% staff against the staffing norm of 2,996; the county department for health is understaffed by about 81%.

This implies that there were minimal efforts to increase the staffing of critical cadres. Another key challenge deduced from ETR HRH analysis is the unequal distribution of available staff. The total number of staffs executing the administration role is 18 representing 4% of the total headcount. Table 13 shows the distribution of HWs by cadre, Table 14 shows the distribution of HWs by the level of care.

Table 13: Health Workforce per IHRIS 2018

Cadre Name	Available	Norms	Gap
Support staff	44	560	516
Rehabilitative staff	3	326	323
Nutrition staff	14	259	245
Nurses and specialist nurses	233	462	229
Clinical Officers	37	236	199
Environmental Health staff	38	231	193
Medical Laboratory Scientists	14	206	192
Dental staff	3	176	173
Health Administrative staff	18	182	164
Health Information ICT	7	93	86
Pharmacy Staff	13	97	84
Medical Social Workers	4	83	79
Medical Officers & Specialists	20	44	24
Diagnostics & Imaging	6	22	16
Hospital Maintenance Staff	2	11	9
Plaster Staff	2	8	6
HTS Counselor	2	0	-2
Community Health Service Staff	15	0	-15
Grand Total	**475**	**2996**	**2521**

Source: Integrated Human resource information system (iHRIS)

Table 14: Health Workforce per Tier of Care.

	Cadres	Required	Total available	Number by tier of care					
				Public	**FBO**	**Private**	**Referrals**	**PHC**	**Community**
1	Medical Consultants	17	3	2	1	0	3		
2	General medical officers	29	12	8	4	0	8		
3	Specialized clinical officers	18	7	8		0	1		
4	General clinical officers	50	25	19	4	1	5		
5	Community Oral Health officers	6	1	1	0	0	0		
6	Dentists	4	2	2	0	0	0		
7	Dental Technologists	8	0	0	0	0	0		
8	Nursing officers (BSN)	13	9	7	2	0	9		
9	Kenya Registered community Health Nurses	422	188	152	36	2	102		
10	Kenya Enrolled community Health Nurses	278	36	29	9	1	17		
11	Public Health Officers	87	20	20	0	0	0		
12	Public Health Technicians	87	22	22	0	0	1		
13	Radiographers	8	6	2	0	0	2		
14	Pharmacists	15	4	3	0	0	3		
15	Pharmacist Technologists	23	6	5	1	0	3		
16	Orthopedic Technologists	4	0	0	0	0	0		
17	Nutritionists	62	12	9	3	0	4		
18	Physiotherapists	11	2	1	0	0	1		
19	Medical Laboratory Officers	24	5	4	0	1	4		
20	Laboratory Technologist	64	14	8	3	0	6		
21	Laboratory Technicians	36	6	1	3	0	2		
20	Health Record & Information Officers	30	5	5	0	0	2		
21	Health Record & Information Technicians	49	0	0	0	0	0		
22	Occupational Therapists	9	1	0	0	0	0		
23	Medical Engineering Technicians	11	0	0	0	0	1		
24	Medical Engineering Technologists	11	2	2	0	0	2	0	
25	Trained Community Health Workers	2500	1116	842	33	0	219	897	
26	Community Health officers/Assistants	96	24	22	2	0	4	20	
27	All others technical officers(specify)	0	0	0	0	0	0	0	
1	Mortuary attendants	10	2	1	1	0	2		
2	Cleaners	147	50		30	0	31	19	
3	Cooks	36	15	2	7	0	7	7	
4	Drivers	27	25	21	4	0	14	5	
5	Security officers	184	23	20	3	0	3	20	
6	All others non-technical HR.	0	0	0	0	0	0	0	

Source: Integrated Human resource information system (iHRIS)

2.2.6.3 Health Products and Technologies

KEMSA remains the primary source for health products, because of competitive prices, extensive distribution system and quality of the products; but alternate sources can be utilized when a commodity is not available at KEMSA. The County conducts an annual Forecasting and Quantification to estimate its annual commodities and financial requirement. There also exists a functional County Commodity Security Technical Working Group (CSTWG) which meets on a quarterly basis to monitor the quality of commodity reports and address issues of redistributing of essential drugs based on need. County reporting rates for program commodities remain above 100% while procurement of commodities for level II and III facilities is done through the County upon quantification by the individual facilities while procurement for level IV and V facilities is done directly by the facilities through KEMSA.

However, challenges still exist including inadequate storage facilities and storage conditions at service delivery points; inadequate and inconsistent supply of health commodities (both funding and procurement); inadequate redistribution and poor disposal mechanisms; inadequate support supervision, inadequate pharmaceutical personnel to manage health commodities at level II and III facilities; inadequate and weak documentation of commodity transactions and limited utilization of electronic inventory management systems. There is also reported irrational use of commodities and weak detection and reporting of ADRs (Adverse Drug Reactions). Further, the supply of essential commodities is not adequately meeting the demands of the population due to inadequate funding for health products and technologies.

Existing gaps in commodity management and security must be strengthened as the priority by ring-fencing funds and building capacity of staff targeting order processing, forecasting, inventory management, stores management, reporting, and use. However, the improvements in the management of health products and technologies over the past 5 years cannot be overlooked. Table 15 shows the status of health products and technologies comparable to KEPH norms.

Table 15: Status of Health Products & Technologies comparable to KEPH norms

Item #	Main Health Intervention Areas/Performance Indicators	Target (A)	Achieved (B)	Performance
		2016/17 SCHSSIP	2017/18 APR	B/A*100
1	# of facilities with over 7 days Episodes of stock-outs of any of the 22 tracer Essential medicines and Medical supplies	0	60	0
2	# of facilities with adequate storage space for health commodities (meeting the minimum standards)	75	07	09
3	# of monthly or Quarterly commodity security meetings held	16	16	100
4	# of commodity support supervisions conducted	16	16	100
5	# of facilities with the capacity to store cold chain health products (vaccines and blood products)	75	69	92
6	# of Health facilities with the capacity to offer the 7 signal functions for BeMONC	75	69	92
7	# of facility utilizing Logistics Management Information system (LMIS)	75	75	100

2.2.6.4 Service Delivery

The county rolled out several service delivery initiatives to improve the provision of essential services. These initiatives included strengthening of community unit services, establishing quality improvement teams, holding hospital therapeutic committees, conducting in reach and outreach services, supportive supervision, patient safety initiatives, on the job training among others. Although a large set of milestones were achieved some of the challenges cited include inadequate funding, industrial unrest, erratic disbursement of funds and weak clinical audits, and support supervision mechanisms. In addition, there is a weak emergency and referral system. Most cases of deaths reported arose from "referrals" from private clinics which seem not well regulated. Table 17 shows the status of Service delivery comparable to Service delivery norms and standards.

Table 16; Status of Health Information Systems (previous year) comparable to HIS standards

Item #	Main Health Intervention Areas/Performance Indicators	Target (A)	Achieved (B)	Performance
		2016/17 SCHSSIP	2016/17 APR	B/A*100
1.	% of facilities using a complete set of updated reporting tools	100	90	90
2.	% of Health facilities submitting quality reports (Accurate, complete, Timely)	100	84	84
3.	Number of quarterly performance review meetings held	16	8	50
4.	% of Health facilities using data for decision making (look for evidence of use)	100	30	100
5.	Number of Quarterly DQAs Conducted	16	8	50
6.	Number of facilities utilizing Electronic Medical Records (EMRs)	24	1	4
7.	% of sub-counties effectively reporting through DHIS2 on a timely basis	100	3	100
8.	% of facilities that are accessing and using their data in DHIS2	100	10	10
9.	% of community Units utilizing community-based health information systems	100	81	81
10.	Number of operation researches reports disseminated	4	0	0

2.2.6.5 Health Information and Research

The county depends on the sub-county and facility health records and information management staff to record, analyze, report on health services using the national monitoring and evaluation tools and guidelines before submitting into DHIS. Over the past five years, there has been an improvement in quality and accuracy of information generated and use, however, there is need to strengthen data demand and use at the facility level to improve quality of data and decision making.

Funding for Health Information M&E activities is limited and there is often erratic development, dissemination, and orientation of HMIS tools that also impact on the number of health indicators being captured. Lack of funding also hinders advancement in critical health research to inform program implementation. Table 16 provides an illustration of key HIS effectiveness and efficiency indicators.

Table 17: Status of Service Delivery Systems comparable to SD norms and standards

Item #	Main Health Intervention Areas/Performance Indicators	Target (A)	Achieved(B)	Performance
		2016/17 SCHSSIP	2017/18 APR	B/A*100
H	**Efficient Service Delivery System that maximizes health outcomes (Including Community Unit indicators)**			
1.	Number of Persons referred to facility, from Community Units	18,160	8551	47
2.	Number of Persons referred to the community from the facility	18160	2842	17
3.	% of referred clients reaching the referral unit	100	70	70
4.	Number of Quarterly Community dialogue days held	120	109	90
5.	Number of monthly Community action days with in-demand messaging held	360	106	29
6.	Number of Hospital Therapeutic committee meetings held	0	192	0
7.	Number of clinical audit meetings held	12	0	0
8.	Number of outbreaks investigated within 48 hours	17	14	82.3
9.	Number of Integrated Outreaches from the facility to the community	150	88	59
10.	Number of client's complaints registered	0	3	0
11.	Number of client's complaints resolved	0	0	***
12.	Number of sub-counties with functional Quality Improvement teams (QITs)	3	3	100
13.	% of Facilities with functional work improvement teams (WITs)	75	18	24

*** *The county plans to actualize the use of complaint registers.*

2.2.6.6 Health Financing

The department's budget is usually funded from four main sources, namely; allocation from national shareable revenue, conditional grants from the National Government, external grants and loans, and local revenue mainly user fees from county public hospitals.[4] Table 18 below depicts key sources of funds for the Samburu County health sector.

The County's FY 2016/17 Approved Supplementary Budget was Kshs.4.67 billion, comprising of Kshs. 3.21 Billion (68.7 %) and Kshs. 1.46 Billion (31.3 %) allocation for recurrent and development expenditure respectively. The Health Sector received a total allocation of Kshs. 700.13 Million which catered for recurrent (77%) and development (23%), while actual exchequer issued totaled 688.63 Million.

Table 18: shows a summary of budget estimates and budget performance by department in FY 2016/17

Health Services	RECURRENT (Kshs).		DEVELOPMENT (Kshs)		TOTAL(Kshs)		Recurrent %		Development %	
	537,807,443		162,325,000		700,132,443		77%		23%	
	Annual Budget Allocation (Kshs. Million)		FY 2016/17 Exchequer Issues (Kshs. Million)		FY 2016/17 Expenditure (Kshs. Million)		FY 2016/17 Expenditure to Exchequer Issues (%)		FY 2016/17 Absorption rate (%)	
	Rec	Dev	Rec	Dev	Rec	Dev	Rec	Dev	Rec	Dev
	648.33	96.5	594.35	94.28	619.72	67.99	104.3	72.1	95.6	70.5

Source: Samburu County Treasury

During the same period the analysis of budget performance shows that the health department had attained the absorption capacity of recurrent at 95.6 % while development budget at 70.5%.

2.2.7 SWOT Analysis

A comprehensive analysis of the county health sector environment, within which the SCHSSIP 2018 – 2022 would be implemented, was carried out using the Strengths, Weaknesses, Opportunities and Threats (SWOT) analytical framework. This analysis was aimed at identifying key health sector internal (SW) and external (OT) factors that would affect and/or influence implementation to identify appropriate strategies for capitalizing on (SO) or managing/mitigating against (WT).

2.2.7.1 Health Sector SWOT Analysis

The following SWOT analysis matrix highlights key strengths, weaknesses, opportunities and threats in the sector. Table 19 and 20 highlights the key issues identified in the internal environment analysis of the SWOT. These issues are highlighted along the SCHSSIP investment areas, and their strategic implications identified.

4 Source: County Budget Implementation Review Report 2017/18

Table 19: SWOT Analysis of the Samburu County Healthcare System

Strengths	Weakness
▪ Available knowledge and skills within the department. ▪ Staffing levels are in place and on permanent and pensionable terms. ▪ Leadership and governance structure in place. ▪ Continuous professional development ▪ Having a shared common vision mission and shared values. ▪ Availability of guiding policies, documents, work plans etc. ▪ Established coordination mechanisms. ▪ Free health care services in level 1and 2. ▪ Functional HMIS and M&E. ▪ The existence of supportive community structures.	▪ Staff shortage ▪ Lack of human resource policy ▪ Human resource department fails to promote and designate as advised by the department of health. ▪ Recruitment of Unskilled staff ▪ Lack of computer management software and computer hardware to manage medical commodities in facilities. ▪ Low budgetary allocation to the department to support staff issues. ▪ Lack of disability, gender and inclusivity in programming ▪ Illiterate HFMCs ▪ Lack of equity in funds appropriation. ▪ Inadequate funding and slow procurement of essential health products and supplies. ▪ Long and delayed procurement bureaucracies. ▪ Lack of proper health infrastructure development master plans and maintenance. ▪ Poor utilization and handling of equipment, products and supplies by health personnel. ▪ Poor and inconsistent implementation of planned activities in key documents e.g. QIPs, APR, CIDP etc.
Opportunities	**Threats**
▪ Health partners presence to support health system strengthening ▪ Scholarship for continuous education ▪ Availability of trained personnel in the county. ▪ Good political will. ▪ A receptive and responsive community ▪ Identified reliable, cost-effective procurement and supply agencies (KEMSA, MEDS) ▪ Availability of a functional health referral system.	▪ High staff attrition rates ▪ Frequent industrial actions ▪ Political interference ▪ Un procedural hiring of personnel ▪ Insecurity ▪ Poor health-seeking behaviors arising out of cultural practices and gender-based barriers. ▪ Not itemized health budgets and ring-fencing of the same. ▪ High dependency on donor or partner support. ▪ Lack of adequate funds to support health programme management ▪ Low literacy levels in the community.

2.2.8 Key Challenges/ Problems Analysis

Table 20: In Health Services Delivery (Top 5 challenges per condition)

Health Policy Area	Priority Health Condition	Key challenges- (Relate to access to care, and/or quality of service delivery)	Root Causes of the Key Challenges (factors behind the key challenges)	Priority Interventions to address identified root causes of the key challenges
Eliminate Communicable conditions	Diarrhea	- Unsafe water - Poor Hygiene and sanitation - lack of lab equipment's.	- Low latrine coverage - Unprotected water sources - Low hygiene education	- CLTS, - Water quality analysis and routinely monitor or surveillance - Health education, - Household Water treatment and purification Invest in behavior change communication
	Confirmed Malaria	- Mosquito breeding, - Delayed health seeking behavior - Inadequate lab staffing. - Few diagnostic centers.	- Stock out of diagnostic kits, drugs - Categorized as low malaria zone	- The prompt ordering of commodities. - Public education on prevention and control, - Vector control, Prompt treatment of cases - Mosquitoes survey and mapping - Lab construction and staffing. - Map out malaria hot spots to be targeted. - Invest in behavior change communication
	TB	- Overcrowding - Poor Health seeking behavior - Poor housing, - Inadequate modern diagnostic equipment - Under staffing and few labs	- Lost following, - MDR, - Stigma and culture, - HIV burden - Poverty. - Noncommunicable conditions DM - Late diagnosis	- Improved housing - Strengthen defaulter tracing. - Health education - Early diagnosis and treatment Procurement of diagnostic equipment and construction of labs - Sample networking
	HIV & AIDS, STI	- Unsafe sex - Multiple sex partners, - High defaulters - Illiteracy - SGBV, Cultural practices, and beliefs,	- Stigma and discrimination, - Low uptake of HTS Services. - Lack of involvement in key population - Early marriages	- Establish current status for 90.90.90 to guide in the upscaling to 95.95.95 approaches. - Contact tracing on STIs - Health education. - Roll out youth friendly services - Integrated outreaches. - Partner notification services. - Address SGBV - Inclusion of the clergy local leaders and other community structures

Health Policy Area	Priority Health Condition	Key challenges- (Relate to access to care, and/or quality of service delivery)	Root Causes of the Key Challenges (factors behind the key challenges)	Priority Interventions to address identified root causes of the key challenges
Halt, and reverse increasing burden of Non-communicable conditions	Cancer	- Late diagnosis/screening - Low public awareness - Lack of Palliative service	- Lack of diagnostic equipment/machines. - Staff capacity to do screening and diagnosis inadequate. - Lack of specialist's oncologists - Lifestyles (smoking, drunkenness, Khat chewing) - Early sexual debut	- Procure diagnostic equipment and machines - Routine targeted screening, - Staff training - Health education - Employ specialists
	Diabetes	- Poor health seeking behavior - Hereditary - Poor maternal Nutrition - Drugs and substance abuse. - Non-adherence to treatment	- Late diagnosis and treatment. - Low awareness - Lifestyle - Stock-outs of drugs	- Routine screening - Health education and counseling - Prompt treatment and management. - Logistic management mechanisms.
	Hypertension	- Poor health seeking behavior - Hereditary - Poor maternal Nutrition - Drugs and substance abuse. - Non-adherence to treatment	- Late diagnosis and treatment. - Low awareness - Lifestyle - Sedentary Lifestyle - Stock-outs of drugs	- Routine screening - Health education and counseling - Prompt treatment and management. - Logistic management mechanisms.
	Mental disorders	- Poor health seeking behavior - Hereditary - Risky health behavior - Non-adherence to treatment. - Untreated Syphilis - Unmet needs	- Late diagnosis and treatment. - Low awareness - Lifestyle - Stress and depressions - Drug and substance abuse - Lack of rehab services and psycho-social support - Lack of Mental Health Specialists	- Psycho-social support mechanisms - Health education and counseling - Prompt treatment and management. - Establishment of Rehabilitation services - Recruitment of mental health specialists
	Acute & Chronic Malnutrition	- Inadequate dietary food diversity intake/ - Diseases - Food access and availability. - Gender disparities	- Poor hygiene - Inadequate care for children, women and the aged. - High poverty indices - Lack of good nutritional education - Lack of sustainable routine screenings at communities - Food insecurity - Poverty	- Sustained mass screening. - Integrated outreaches - Immunization - Health education. - BFCI - Prompt disease diagnosis and management - Increase food production - Gender empowerment

Health Policy Area	Priority Health Condition	Key challenges- (Relate to access to care, and/or quality of service delivery)	Root Causes of the Key Challenges (factors behind the key challenges)	Priority Interventions to address identified root causes of the key challenges
Reduce the burden of Violence & Injuries	Gender-based violence	- Inadequate capacity of health care providers - Lack of multi-sectoral approach to GBV prevention and response - Socio-cultural beliefs and practices - Gender-based barriers - Weak linkages and referral system - Lack of reporting tools - Limited community awareness on GBV - Community alternative dispute solution mechanisms are biased towards the perpetrator - Drug and substance abuse	- Lack of GBV integration in service delivery - Lack of gender norms advocacy - Lack of prioritization of GBV prevention and response - Lack of coordination - Fear to report - Lack of documentation and reporting tools	- Promote positive gender norms - Create awareness through existing structures - Training of health care providers and other GBV actors - Coordination of GBV actors - Strengthen referral and linkage - Produce, disseminate and distribute - GBV data tools - Lobbying and advocating with relevant sectors for GBV prevention and response prioritization - Dissemination of guidelines, SOPs, Policies and Frameworks for GBV management
	Injuries	- Lack of appropriate trauma and emergency centers - Inadequate response to emergencies related to injuries	- Inadequate fund for setting up an emergency and Trauma Centre - Lack of knowledge and skills - Lack of appropriate equipment - Lack of health workers capacity to respond to emergencies related to injuries	- Prioritize setting up an emergency and trauma center. - Capacity building of health care workers - Recruitment of critical care specialists (Critical care physicians, clinical pharmacists critical care sub-specialty, critical care nurses).
	Violence against children	- Inadequate capacity of health care providers - Lack of multi-sectoral approach to child protection - Socio-cultural beliefs and practices - Gender-based barriers - Weak linkages and referral system - Lack of reporting tools - Limited community awareness on violence against children - Community alternative dispute solution mechanisms are biased towards the perpetrator - Drug and substance abuse	- Inadequate child protection services integration - Lack of child-friendly centers - Lack of gender norms advocacy - Lack of prioritization of GBV prevention and response - Lack of coordination - Fear to report - Lack of documentation and reporting tools	- Promote positive gender norms - Create awareness through existing structures - Training of health care providers and other Child protection actors - Coordination of child protection actors - Strengthen referral and linkage - Produce, disseminate and distribute GBV data tools - Lobbying and advocating with relevant child protection stakeholders - Dissemination of child protection and Anti FGM policies
	Injuries related to road traffic accidents	- Lack of appropriate trauma and emergency centers - Inadequate response to emergencies related to injuries - Inadequate multi-sectorial approach	- Inadequate fund for setting up an emergency and Trauma Centre - Lack of knowledge and skills - Lack of appropriate equipment - Lack of health workers capacity to respond to emergencies related to injuries - Lack of involvement of all stakeholders	- Enhance the multi-sectoral approach - Prioritize setting up an emergency and trauma center. - Capacity building of health care worker - Recruitment of critical care specialists (Critical care physicians, clinical pharmacists critical care sub-specialty, critical care nurses).

Health Policy Area	Priority Health Condition	Key challenges- (Relate to access to care, and/or quality of service delivery)	Root Causes of the Key Challenges (factors behind the key challenges)	Priority Interventions to address identified root causes of the key challenges
Provide essential Medical services	Community health services	- Low health service uptake - High CHV attritions	- Low CHU coverage/ - Demotivated CHVs - Influence from TBA, - Strong cultural health habits	- Establishment of more CHUs - Provide funds for Incentivization of CHVs - Community health education and sensitization
	General outpatient and inpatient.	- High workloads - Poor infrastructure	- Shortage of staffs - Inadequate service provision space.	- Recruitment of staffs - Staff motivation - Expansion of infrastructure
	Integrated RMNCAH/FP	- Low uptake and utilization - Poor access to health care services	- Ignorance - Stigma and discrimination - Social-cultural practices and gender norms - Low male involvement - Inadequate supply of commodities - Inadequate staff capacities and shortage	- Recruit more staffs and training. - Enhance health education and awareness. - Integrated outreaches. - Good forecasting and timely procurement of commodities.
	Referral and emergency services	- Weak referral system and linkages	- No motivation for CHVs. - Inadequate ambulatory services. - Poor coordination and supervisions/ - Harsh terrains and poor road networks - Lack of active contingency plans - Lack of skills by staffs. - Poorly equipped ambulances	- Incentive to CHVs - Regular support supervision and follow-ups - Develop active and reliable contingency plans. - Increase the number, maintain and equip all the ambulances - Establish ambulance command center - Train HW on emergency p preparedness and response.
	Pharmaceutical and Non-medical supplies	- Shortage of supplies - Shortage of staffs. - Low staff capacities on LMIS protocols and procedures. - Low storage capacity. - Poor solid waste handling and disposal infrastructure - Lack of lab equipment's	- Low budgetary allocation. - Long procurement bureaucracies. - Inadequate storage space in the facilities - Lack of waste disposal infrastructure	- Increase the medical commodities, products and equipment budgets. - Recruit more Pharmacists and Pharmaceutical technologists. - Train staff on LMIS. - Construct commodity stores in the facilities - Construction of modern waste disposal infrastructure. - Integrated RMNCAH services
	Maternity	- Low uptake and utilization. - Inadequate modern maternity facilities. - Staff shortage	- Ignorance - Stigma and discrimination - Social-cultural practices and gender norms - Low male involvement - Inadequate supply of commodities - Inadequate staff capacities and shortage - Lack of enough well-equipped maternity facilities - Cultural beliefs and practices	- Recruit more staffs and training - Enhance health education and awareness. - Integrated outreaches - Good forecasting and timely procurement of commodities.

Health Policy Area	Priority Health Condition	Key challenges- (Relate to access to care, and/or quality of service delivery)	Root Causes of the Key Challenges (factors behind the key challenges)	Priority Interventions to address identified root causes of the key challenges
	Laboratory service	- the low number of equipped diagnostic laboratories - Inconsistent supply of consumables and or reagents	- Lack of adequate functional laboratories - Staff shortage	- Establish adequate laboratories. - Recruit more staffs. - Procure adequate and consistently replenished commodities and supplies - Establish and initiate blood donor services - Equip and maintain the diagnostic equipment and or machines - Establish a special lab.
	Rehabilitative	- Poor rehabilitation services. - Staff shortage	- Lack of adequate funding	- -Construct, equip and operationalize it - Staff recruitment and motivation
Minimize exposure to health Risk factors	Health Promotion including health Education	- SBCC package - Culture and taboos - Unhealthy habits & practices - Lack of biosafety cabinets and firefighting equipment's	- Limited knowledge and information - Limited radio coverage Language barriers	- Intensified Health education and awareness - Health surveys to gauge perceptions and attitudes - Provision of firefighting gears and hoods
	Sexual education	- Early pregnancy - Abortions - HIV/AIDS & STIs	- Lack of knowledge on sexual education - Stigma and cultural taboos	- Initiation of Youth-friendly services - Health education
	Substance abuse	- Early exposure to drugs - Addiction and dependency	- Social decadence-norms - Family conflicts–divorce/separation - Unemployment - Poverty	- Establishment of drug-free zones in schools - Social and counseling support - Enforcement of laws to protect the public – SCADA - Enroll in youth support activities. - Rehabilitation services
	Micronutrient deficiency control	- Low uptake of micronutrients supplements	- Inadequate support to strengthen Micronutrient deficiency control - Ignorance - Inadequate sensitization and community awareness on micronutrients - Inadequate storage space - Poor documentation by health workers. - Continuous stock-outs of Vitamin A & other supplements. - Staff shortage (particularly the nutrition department)	- Create awareness on the importance of good nutrition. - Sensitization of fortified food in the market - Procure enough micronutrient supplies in the county - Sensitize pregnant mothers on the use and importance of IFAS. - Upscaling supplementation of micronutrient activities. - Streamline micronutrient supply
	Physical activity	- Limited physical activities	- Lack of facilities and equipment (No physiotherapy department) - Inadequate staff	- Physical activity Formation of health clubs in schools, workplaces and in the community - Create awareness on the importance of physical activities - Procurement and provision of sports/ recreational facilities
	Rehabilitation	- Low rehabilitation services	- Lack of rehabilitative service	- Establish rehabilitative services. - Recruit staffs - Construct infrastructure.

Health Policy Area	Priority Health Condition	Key challenges- (Relate to access to care, and/or quality of service delivery)	Root Causes of the Key Challenges (factors behind the key challenges)	Priority Interventions to address identified root causes of the key challenges
Strengthen collaboration with Health-Related Sectors	Safe water	- Water shortage - Lack of water treatment - lack of funds to employ technical people and lab equipping	- Lack of water treatment equipment and chemicals - Lack of enough safe water points/ storage facilities - Lack of lab equipment in our county referral Hospital do water quality sampling and analysis	- Drill more safe water points - Participate in water stakeholder forums - Adopt simple household water treatment methods. - Strengthen the water user's association committees. - Carry out regular water surveillance taking samples to government laboratories - Enhance safe water through the distribution of P&G water purifiers through a market approach
	nutrition services	- Poor coordination structures for nutrition specific and sensitive interventions	- Inadequate coordination meetings for nutrition activities. - Lack of multi-stakeholder platform to address underlying causes of malnutrition. - Inadequate funding to routine surveillance.	- Integrate nutrition into health services - Mapping out areas of nutrition need where partners can supplement government efforts - Strengthen monthly/quarterly nutrition technical forum - Formation of nutrition fields days committee - Strengthen the surveillance system by conducting nutrition surveys - Strengthening of Multi sectorial Platform for Nutrition (MSP) - Observe nutrition key thematic days in the year. - Capacity building to HW and CHVs on SBCC Using OJT, Mentorship, HINI, BFCI. - Conduct quarterly DQA and Joint supportive supervision
	Public, Private Partnership	- Not in place	- No steering and coordination mechanisms	- Establish coordination mechanisms to engage PPP as an integral player in all sectors in the service delivery.
	Community participation and involvements	- Lack of meaningful and satisfactory participation of beneficiaries on different services	- Up hazard and weak planning and communication mechanisms	- Develop strong and reliable community participation approaches
	Community Social Accountability and Feedback.	- Not currently available	- Frameworks and guidelines are unavailable	- Implement Social Accountability processes to enhance the feedback mechanisms and improve service uptake
	County WASH stakeholders' forum.	- Currently, established from the original WESCORD	- TOR to be broadened to be inclusive and multi-sectoral to facilitate wider participation	- Conduct meeting as due and ensure implementation of the agreed interventions, follow-ups/ - Develop a Monitoring and Evaluation framework

Health Investment Area	Priority Health Condition	- Key challenges* - (inhibiting optimum operation of the health system area)	- Root Causes of the Key Challenges (factors behind the key challenges)	- Priority Interventions to address identified root causes of the key challenges
Health Leadership & Governance	County Organogram	- No clear organogram	- No clear policy at the national and county governments - People want to maintain the status quo - Inadequate finance	- County govt to come up with their own policy on organogram with guidance from national govt - Promote transformational leadership - Lobby/advocate for more resource allocation
	Leadership capacity building.	- Inadequate leadership skills	- Inadequate capacity building - Poor selection of the leaders to be capacity built - No capacity assessment on training needs - No clear guideline on minimum requirement for one to be a leader in a certain area	- All leaders to be trained in management and leadership courses - Continuous assessment of training needs - Formulate clear guidelines
	Managerial roles	- Multiple roles assigned to managers/leaders	- Inadequate staffing - Biases/nepotism	- Employ enough staff/deploy - Assign duties according to one's qualification
	Policy and Guidelines development and dissemination.	- national policies and guidelines not disseminated to counties	- inadequate budgetary allocation for policy dissemination - Poor feedback by county managers to the department	- Allocate adequate resources to policy dissemination - Formulate SOPS for training/policy dissemination
	Resource allocation	- Inadequate resource allocation (financial, vehicles etc.)	- Misplaced priorities - Lack of health bill on the use of resources collected by the department - The poor revenue collection mechanism	- Evidence-based priorities. - Formulate and implement health bill - Digitalize revenue collection e.g. EMR use
Health Infrastructure	Working condition.	- Inadequate health department offices - Lack of satellite blood bank, reference malaria lab and modern Labs at Maralal CRH, Baragoi SCRH, Swari H/C and Poro H/C	- Devolution affected the available offices and the county health management team compete for office space. - Commodity storage is a challenge at facilities.	- Construction of new buildings and offices. - Construction of commodity stores at all facilities.
	Equipping health facilities	- Inadequate equipment for service deliveries	- Procurement of equipment takes long	- Accelerate procurement process - purchase appropriate equipment promptly
	Master plans	- Poor planning of health facilities infrastructures' by lacking a master plan	- The building physical infrastructure without consulting the concerned departments (public works and public health)	- Develop a master plan for every facility. - Formation of a health committee to oversee construction activities in the department
	Staff specialization	- Inadequately skilled health workers to operate specialized equipment.	- Inadequate specialized skilled health workers. - Changing technology - Inadequate refresher courses	- Employ trained and specialized health workers to operate available specialized equipment and machines. - Train the available health workers on how to operate the equipment.
	Maintenance and renovations	- Inadequate funds to renovate the existing old infrastructures, servicing equipment and ambulances	- Misplaced priorities in utilizing the available funds.	- Increase the available funds to renovate the existing infrastructure and servicing of equipment and ambulances.

Health Investment Area	Priority Health Condition	- Key challenges* - (inhibiting optimum operation of the health system area)	- Root Causes of the Key Challenges (factors behind the key challenges)	- Priority Interventions to address identified root causes of the key challenges
Human Resources for Health Investments	Staffing	- Staff shortage	- No replacement for staff exiting the services. - More facilities constructed with no recruitment of staff	- Replacement of staff exiting the services - Implement standard norms in staffing of health facilities.
	Competency and professionalism	- Employment of none Clinical staff	- No consideration of the service needs in employment - Nepotism in Employment - Political pressure	- Always consider service need in employment - Competitive recruitment and selection of staff. - -Engage the political on the need of employing the right personnel - -Full autonomy of the CPSB
	Human resource management.	- Poor HRH management.	- Unqualified human resource managers. - Inadequate knowledge of health managers on iHRIS and Human resource management	- Competitive recruitment of HR manager with the required qualification and experience at the county and department of health. - Capacity Build the health Managers on iHRIS
Health Products & Technologies	Health products procurement	- Inadequate funding of health products and technologies	- Lack of priorities in resource allocation	- Allocate more funds for health products and technologies. - CA committee of health to lobby for more funds
	Supply chain	- Weak supply chain system	- Knowledge gap of staff on LMIS	- Resource mobilization from the CG and Partners to strengthen supply chain - Capacity building on LMIS to all staff handling commodities
	Logistic management	- Inadequate Computers and Smartphones for LMIS	- Low allocation of ICT resources to lower level facilities	- Allocate at least one computer per facility - Capacity build the personnel on the use
	Access to network.	- Low network coverage for most health facilities to support the LMIS platform	- The remoteness of the county and low or sparse population - No political good will.	- Lobby with network subscribers (Safaricom, orange etc.) to set up a network in all areas with facilities - Advocate for political support and goodwill
	Access	- Poor Road infrastructures	- Poor tendering procedures for road contractors - Poor workmanship of roads	- Proper tendering and allocations contracts by the CG - All constructed roads to be supervised and approved before paying the contractor

Health Investment Area	Priority Health Condition	- Key challenges* - (inhibiting optimum operation of the health system area)	- Root Causes of the Key Challenges (factors behind the key challenges)	- Priority Interventions to address identified root causes of the key challenges
Service Delivery Systems	Storage capacity	- Inadequate space for health Products	- Poor design of facilities during construction (does not cater to the commodity space)	- Provide Standard design of facilities (to Include storage space)
	Cold chain management	- Inadequate Cold chain storage of commodities requiring refrigeration	- No power sources - No Supply of required type and model of equipment(fridges) - Breakdowns	- Lobby for power supply - Provide an alternative power supply - Frequent and routine maintenance of fridges
	Access and utilization of health system.	- Underutilization of Health facilities	- Uncoordinated development plans among various stakeholders - Vastness of the county	- Equipping of the newly constructed facilities - Continuous demand creation at level one - Consistency in rolling out integrated outreaches - Operationalize beyond Zero facilities
	Referral systems.	- Weak referral systems	- Lack of Ambulance management policy - Political influence of leaders. - Inadequate Funding for O&M for Ambulances. - Ambulance drivers not trained on basic maintenance and first aid	- Enforcement of ambulance management policy. - Procurement of enough Ambulances. - Provide adequate funding for O&M. - Train drivers on Defensive Driving and Basic life support skills
	Surveillance systems.	- Weak disease surveillance systems	- Inadequate funding - Lack of enough vehicles - Distance from National public health laboratory laboratories (NPHL)	- Adequate funding for surveillance activities. - Decentralization of NPHL
	Doctor – Patient relationship.	- Lack of customer care services	- Negative Attitude - Lack of Orientation on health care workers - Lack of motivation scheme for well-performing health care workers	- Training on attitude change - Training on customer care skills - Institute a performance-oriented scheme to recognize well-performing workers.
Health Information Systems	Staffing	- Inadequate HMIS staff	- Poor prioritization of employment of Health Staff.	- Recruitment of qualified adequate HMIS staff
	HMIS Tools.	- Inadequate HMIS tools (Updated Registers, Summary sheets etc.)	- Lack of adequate finance print enough HMIS tools.	- Since it is a devolved County should allocate adequate finance for printing HMIS tools.
	M&E unit	- Lack of Monitoring and Evaluation unit	- Lain lack of M&E policy	- Establish the M&E unit and actualize the M&E policy.
	Data reviews.	- Inadequate finance for quarterly and Monthly review meetings	- Heavy funding by implemented partners which is not sustainable.	- County Government to support Quarterly and monthly review meetings etc.
	Information archiving.	- Inadequate space digital infrastructure e.g. EMR, archives etc.	- Budget constraints from the County government.	- County government and implementing partners to support infrastructure development.

Health Investment Area	Priority Health Condition	- Key challenges* - (inhibiting optimum operation of the health system area)	- Root Causes of the Key Challenges (factors behind the key challenges)	- Priority Interventions to address identified root causes of the key challenges
Health Financing	Resources allocation.	- Inadequate funds	- Low budgetary allocation	- County governments to honor policies and declarations that specify the % of the budget to be allocated to health (Abuja)
		- Competition with other departments for the limited funds	- No ring-fencing of health department funds	- The revenue collected to be plowed back to the department - Money allocated to health to be ring-fenced and secured
		- Late disbursement of funds by the national government	- A lot of bureaucracy - Late remittance of resource use by the counties	- Establish and implement clear timelines on when money is to be disbursed to counties - Counties to remit their financial returns on time
		- No decentralization of funds	- No clear policy on money disbursement to the lowest unit/level	- Formulate policy on decentralization of funds to the lowest level
		- Inadequate revenue collection	- Inefficient revenue collection methods	- Put up efficient methods of revenue collection e.g. EMR, digital methods

SECTION 3: STRATEGIC DIRECTION

3.0 OVERVIEW

This health investment plan aims to progressively move the Samburu County health sector towards the attainment of universal health coverage by the year 2022. It defines health services and interventions to be provided to achieve the desirable outcome of each policy objective, by levels of care (community, primary care, County and referral) and by critically addressing each cohort (pregnancy/newborn, childhood, children /youth, adults, elderly) where applicable.

3.1 VISION

A County free from preventable diseases and ill health.

3.2 GOAL

To guarantee all Samburu residents access to a defined package of essential health services without the risk of financial hardship by accelerating attainment of health impact targets as defined in the Health Policy.

3.3 MISSION

To provide effective leadership and participate in the provision of quality health care services that are equitable, responsive, accessible, and accountable in Samburu County

3.4 GUIDING PRINCIPLES AND VALUES

Samburu County Health Strategic Plan 2018-2022 is guided by principles drawn from health, economic, social and political goals, highlighted in the Kenyan constitution, national policy documents and international declarations. These include:

- Equity and fairness
- Client-Oriented
- Professionalism
- Accountability and transparency
- Innovativeness
- Integrity
- Team spirit

3.4.1 Strategic objectives and Sector Targets

The sector aims to attain the vision, by focusing on implementation of a broad base of health and related services that will impact Samburu residents. It places the main emphasis on implementing interventions and prioritizing investments relating to maternal and newborn health conditions as a result of high illiteracy rates, poverty, and inadequate accessibility to health care services, poor sanitation, insecurity, understaffing and poor infrastructure. It is designed to provide information on:

a) The scope of health and related services the health sector in the county intends to focus on, to ensuring all people in the county are provided with quality health care as outlined in the Kenya Essential Package for Health (KEPH),

b) The investments required to provide the above-mentioned services – outlined across the 7 investment areas for health – and

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

During the implementation of this strategic period, the Samburu County Health Sector seeks to prioritize the following key strategic areas of focus as outlined below in Table 21:

Table 21: Policy and Strategic Objectives

Policy Objective	Specific Strategic Objectives
Eliminate Communicable diseases	• To increase the number of under one year fully immunized • To increase the number of the population receiving MDA for Trachoma • To increase the cure rate for TB • To increase the number of people tested for HIV • To increase the number of clients receiving ARVs • To increase under-fives treated with ORS and Zinc • To increase the percentage of school-age children dewormed.
Halt, and reverse increasing burden of Non-communicable diseases	• To reduce the burden of non-communicable diseases
Reduce the burden of Violence & Injuries	• To reduce morbidity and mortality associated with violence and injuries
Provide essential health services	• To increase the provision of quality essential health services • To increase population accessing essential health services
Minimize exposure to health Risk factors	• To minimize the percentage of the population who smoke • To reduce the population consuming alcohol regularly • To increase populations awareness to health risks • To reduce exposure to health risk factors
Strengthen collaboration with health-related Sectors	• To increase the population with access to safe water • To reduce the percentage of children malnourished • To improve safe excreta waste disposal • To increase the percentage of households with improved housing • To increase the percentage of schools providing complete health package
Health system strengthening	• To increase the health workforce offering quality health services • To strengthen data management processes in the county • To strengthen data use for decision making • To increase availability and access to health commodities • To strengthen leadership and governance capacity • To increase the number of people enrolled in health insurance

Specifically, in relation to the above, the aim of the Samburu County Health Sector Strategic and Investment Plan is to:

- Reduce, by at least half, the neonatal and maternal deaths,
- Reduce, by at least 25%, the time spent by persons in ill health,
- Improve, by at least 50%, the levels of client satisfaction with services,
- Improves accessibility to quality health services by 80%, and
- Reduce, by at least 30% catastrophic health expenditure at the household level.

The Samburu county strategic plan has been designed to reflect the above focus. Specific interventions have been defined in each strategy and policy objective for attainment, and services around which the interventions are clustered to guide the implementation level and communities on what needs to be provided.

3.4.2 Sector targets

The Samburu County Department of Health shall implement priority strategies outlined in the CHSSP 2018-2022 focusing on ensuring the capacity to provide essential services and interventions across the service delivery units as outlined in the KEPH. Considering the current state of these service delivery units, the implementation of this strategic plan shall focus on strengthening and improving strategic investments to ensure the delivery and realization of the KEPH service package.

Table 22 outlines the current state of the respective KEPH service packages and indicates the strategic plan targets and Table 23 outlines the service outcome and output targets for the achievement of county objectives.

Table 22: Scaling up the provision of KEPH services targets

Policy Objective	KEPH Services	# units currently providing service			Strategic Plan targets		
		Community	Primary care	Hospitals	Community	Primary care	Hospitals
Eliminate Communicable Diseases	**Immunization**	0	65	3	0	81	7
	Child Health	32	72	3	42	81	7
	Screening for communicable conditions	32	72	3	42	81	7
	Antenatal Care	32	71	3	42	81	7
	Prevention of Mother to Child HIV Transmission	32	22	3	0	81	7
	Integrated Vector Management	32	72	3	65	96	7
	Good hygiene practices	32	72	3	42	96	7
	HIV and STI prevention	32	72	3	42	81	7
	Control & prevention neglected tropical diseases	32	72	3	42	81	7
	HTS	24	72	3	58	81	7
Halt, and reverse the rising burden of non-communicable diseases	**Health Promotion & Education for NCD's**	32	72	3	42	81	7
	Institutional Screening for NCD's	0	72	3	0	81	7
	Rehabilitation	0	0	3	0	81	7
	Workplace Health & Safety	0	72	3	0	81	7
	Food quality & Safety	0	72	3	0	81	7

Policy Objective	KEPH Services	# units currently providing service			Strategic Plan targets		
		Community	Primary care	Hospitals	Community	Primary care	Hospitals
Reduce the burden of violence and injuries	**Health Promotion and education on violence/ injuries**	32	72	3	42	81	7
	Pre hospital Care	32	72	3	42	81	7
	OPD/Accident and Emergency	0	72	3	0	81	7
	Management for injuries	032	72	3	65	81	7
	Rehabilitation	0	0	2	0	5	7
Minimize exposure to health risk factors	**Health Promotion including health Education**	32	72	3	42	81	7
	Sexual education	32	72	3	42	81	7
	Substance abuse	32	72	3	42	81	7
	Micronutrient deficiency control	32	72	3	42	81	7
	Physical activity	0	72	3	0	81	4
Provide essential health services	**General Outpatient**	0	72	3	0	81	4
	Integrated MCH / Family Planning services	0	65	3	0	81	4
	Accident and Emergency	0	72	3	0	81	4
	Emergency life support	0	0	0	0	0	2
	Maternity	0	71	3	0	81	4
	Newborn services	0	4	3	0	20	4
	Reproductive health	0	72	3	0	81	4
	In Patient	0	10	3	0	15	4
	Clinical Laboratory	0	12	3	0	15	4
	Specialized laboratory	0	0	0	0	0	2
	Imaging	0	0	3	0	0	4
	Pharmaceutical	0	72	3	0	81	4
	Blood safety	0	0	2	0	0	7
	Rehabilitation	0	0	2	0	0	4
	Palliative care	0	0	3	0	0	4
	Specialized clinics	0	0	3	0	0	4
	Comprehensive youth friendly services	0	0	0	0	10	7
	Operative surgical services	0	0	3	0	0	7
	Specialized Therapies	0	0	1	0	0	4

Policy Objective	KEPH Services	# units currently providing service			Strategic Plan targets		
		Community	Primary care	Hospitals	Community	Primary care	Hospitals
Strengthen collaboration with health-related sectors	**Safe water**	32	72	3	42	81	4
	Sanitation and hygiene	32	72	3	42	81	4
	Nutrition services	32	72	3	42	81	4
	Pollution control	32	72	3	42	81	4
	Housing	0	0	3	0	0	4
	School health	0	72	3	0	81	4
	Water and Sanitation Hygiene	32	72	3	42	81	4
	Food fortification	0	0	0	0	0	0
	Population management	32	72	3	42	81	4
	Road infrastructure and Transport	0	0	0	0	0	1

Table 23: Sector input and process targets for the achievement of County objectives

Orientation area	Intervention area	Milestones for achievement					
		Milestone	Annual targets				
			2018	2019	2020	2021	2022
Service delivery	Community services	Increasing the number of CUs from 32 to 60	37	42	47	64	60
		Increasing the number of fully functional CUs from 27 to 60	33	39	45	51	60
		Increase the no. of CHUs trained on BFCI from 16 to 60	16	24	33	43	60
		Upscale mass screening for malnutrition from 6 to 30	6	9	18	25	30
		Upscale community targeted TB screening from 9 to 50	9	18	28	40	50
	Outreach services	Upscale outreaches from 140 to 500 per year	212	284	356	428	500
		Conduct quarterly medical camps	3	6	9	12	15
		Customize the checklist to County indicators	1	1	1	1	1
	Supportive supervision to lower units	Quarterly Supervision for CHMTS	4	4	4	4	4
		Quarterly Supervision for SCHMTS	12	12	12	12	12
	On the job training	Monthly supervision through program areas	12	12	12	12	12
		The program shall include, Malaria, TB/HIV, Commodity management, Nutrition, FP/RMNCAH, NTDs and Disease surveillance					
	Emergency preparedness planning	Develop an emergency preparedness plan	1	1	1	1	1
		Training CHMT/SCHMT on disaster and emergency preparedness	0	1	1	1	1
		Training of Health workers	0	1	0	1	0
		Formation of functional committees	1	1	1	1	1
		Equipping high volume facilities with drugs and reagents, crash boxes and equipment in place	11	3	6	6	6
		Establish an accident and emergency department in 2 level 4 hospitals	0	1	2	0	0
	Patient Safety initiatives	Capacity build all staff (600) on Infection Prevention Control		150	300	450	600
		conduct 12 blood campaigns/year					
		(Health workers training on Biosafety, Waste management training)	12	12	12	12	12
	Therapeutic committee meetings and follow up	Decentralize therapeutic committees to the Sub County level (Hospital)	0	12	12	12	12
		Establish Health commodity security committee at County level	0	0	1	1	0

Orientation area	Intervention area	Milestones for achievement					
		Milestone	Annual targets				
			2018	2019	2020	2021	2022
	Clinical audits (including maternal death audits)	Formation of 3 functional clinical audit teams	0	3			
		Establish community verbal clinical audits through community units	37	42	47	53	60
	Referral health services	Establish one county referral system/protocol/strategy in line with national one	0	1	0	0	0
		Purchase 8 more ambulances		2	4	6	8
		Purchase 3 motorcycles	1	1	1	1	1
		Establish one fully functional ambulance command center	0	1	0	0	0
		Establish, equip and operationalize 9 laboratories		2	5	7	9
Health Infrastructure (physical infrastructure, equipment, transport, ICT)	Construction of new facilities	Construct 9 dispensaries facilities in the county	2	6	8	9	
		Upgrade 13 dispensaries to H/C	0	3	7	11	13
		Upgrade 4 high volume facilities to sub-county hospitals	1	3	4		
		Upgrade SCRH to a full-fledged level 5 referral hospital	1	1	1	1	1
		Set up KMTC in SCRH	1	1	1	1	1
	Expansion of existing facilities	Upgrade 2 sub-county Hospitals to meet standards and norms (Baragoi, proposed Archers SCH)	0	1	2	0	0
		Upgrade 2 health centers to sub-county hospital (Wamba, Suguta)		1	2	0	
		Upgrade 16 h/c to meet standards and norms	0	4	8	12	16
	Maintenance	Allocation of funds	1	1	1	1	1
	Equipment: Purchase	Budget reallocation	1	1	1	1	0
		Inventory physical assessment					
		Biosafety Cabinets	1	3	3	3	3
		Fire extinguishers	1	6	7	5	5
		Hematology Analyzers	2	4	2	2	
		INR Machines	0	5	1	1	1
		Chemistry and Electrolyte analyzers	1	2	1	1	1
		Water Baths	2	3	2	2	1
		Hb Meters	10	15	15	15	15
	Equipment: Maintenance and repair	Service contracting of diagnostic machines	1	1	1	1	1
		Budget reallocation					

Orientation area	Intervention area	Milestones for achievement					
		Milestone	Annual targets				
			2018	2019	2020	2021	2022
	Transport: purchase	Purchase of 8 ambulances	0	2	4	6	8
		Purchase of 6 utility vehicles	0	2	4	6	
		Purchase of 27 motorbikes	0	7	14	21	27
		Purchase of 1080 buffalo bicycles	0	270	540	810	1080
	Transport: Maintenance and repair	Allocation of funds	1	1	1	1	1
	ICT equipment: Purchase	Purchase 20 laptops for CHMT	0	5	10	15	20
		Purchase 21 laptops for SCHMT	0	5	10	15	21
		Purchase of 60 desktops for facilities for EMR services	0	15	30	45	60
	ICT equipment: Maintenance and repair	Allocation of funds	5	5	10	15	20
Health Workforce	Recruitment of new staff	MOs	12	16	20	24	29
		Consultants	3	7	11	15	17
		Dentist	2	3	4	4	8
		Dental technologist	0	2	3	6	6
		Community oral health officers	1	2	0	4	0
		PHO	20	40	60	87	62
		Pharmacist	4	5	6	7	8
		Pharmaceuticals Technologists	6	14	18	23	11
		Lab technologist	25	37	49	61	60
		Lab Technicians	14	23	30	40	40
		Medical Lab Officers	7	7	7	7	7
		Orthopedic Technologist	0	1	2	3	0
		Nutritionists	5	5	5	5	5
		Radiographers	12	24	36	48	0
		Physiotherapist	6	7	7	8	10
		OT	2	5	7	9	30
		Plaster technicians	1	2	4	6	9
		Health records information officers	2	4	6	8	10
		Medical engineers	5	11	17	23	

Orientation area	Intervention area	Milestones for achievement					
		Milestone	Annual targets				
			2018	2019	2020	2021	2022
		Mortuary attendants	2	4	6	8	11
		Drivers	2	4	6	8	
		Accountants	25	27	0	0	10
		Administrators	3	5	7	9	17
		CO (specialists	0	0	0	0	50
		CO (general)	5	7	8	9	10
		KRCHN	7	10	13	14	276
		KECHN	25	31	37	43	
		Secretaries/clerks	197	256	315	374	435
		Cooks	36	96	156		35
		Cleaners	0	0	0	216	150
		CHAs	5	7	8	9	96
		Trained CHVs	15	20	25	30	2500
		Medical social workers	50	75	100	125	25
	Pre-service training In-service training	Sponsorship	1	1	1	1	1
		Study leave					
		Full payment of salary					
	Staff motivation	Trainings	1	1	1	1	1
		Promotions					
		Recognition allowance					
Health information	Data collection: routine health information	Data capture tools and reporting tools	1	1	1	1	1
		Lap top Computers	4	14	24	34	41
		Desktop computers	12	24	36	48	60
		Air time	1	1	1	1	1
	Data collection: health related sectors	Collaboration with other ministries	1	1	1	1	1
	Data collection: Surveillance	Printing of the IDSR tools	1	1	1	1	1
	Data collection: Research	Conducting surveys	4	4	4	4	4
		Finance allocation, Air time and Computer	1	1	1		
	Information dissemination	IEC materials, PAS, Roadshow, Radio stations Billboards and LCD Projector	1	1	1	1	1

Orientation area	Intervention area	Milestones for achievement					
		Milestone	Annual targets				
			2018	2019	2020	2021	2022
Health Products	Procurement of required health products	Non-pharmaceuticals	1	1	1	1	1
		Pharmaceuticals					
		Procurement of lab reagents					
		Laboratory					
	Warehousing/storage of health products	Construction of two big warehouses for Samburu North and Samburu East	1	2	3	1	1
		Construction of a lab store at Maralal CRH and Baragoi SRH	1	1	1	1	
	Distribution of health products	Funds for allocation	0	1	2	3	
		Purchase of three trucks for commodity distribution					
	Monitoring rational use of health products	Supervision	1	1	1	1	1
		Stock ledgers					
		Inventories					
		Order and re-order forms					
		Lab top up forms					
		Monthly facility inventory data					
		EMMS Reports					
		Pharmacovigilance reports					
Health Financing	Costing of health service provision	Budgeting,	1	1	1	1	1
		Procurement plan and					
		Recruiting health workers					
	Resource mobilization	Collaborating with partners and the private sector or spirit of partnership	1	1	1	1	1
	Health expenditure reviews	Conducting quarterly audits	4	4	4	4	4
Leadership and Governance	Annual health stakeholders for a	Holding annual stakeholder's forum	1	1	1	1	1
	Quarterly Coordination meetings	Holding quarterly coordination meetings	4	4	4	4	4
	Monthly management meetings	Holding monthly county management meetings	12	12	12	12	12
	Annual Work Planning and reporting	Preparing AWPs annually	1	1	1	1	1

SECTION 4: ORGANIZATION AND INSTITUTIONAL IMPLEMENTATION ARRANGEMENTS

4.1 OVERVIEW

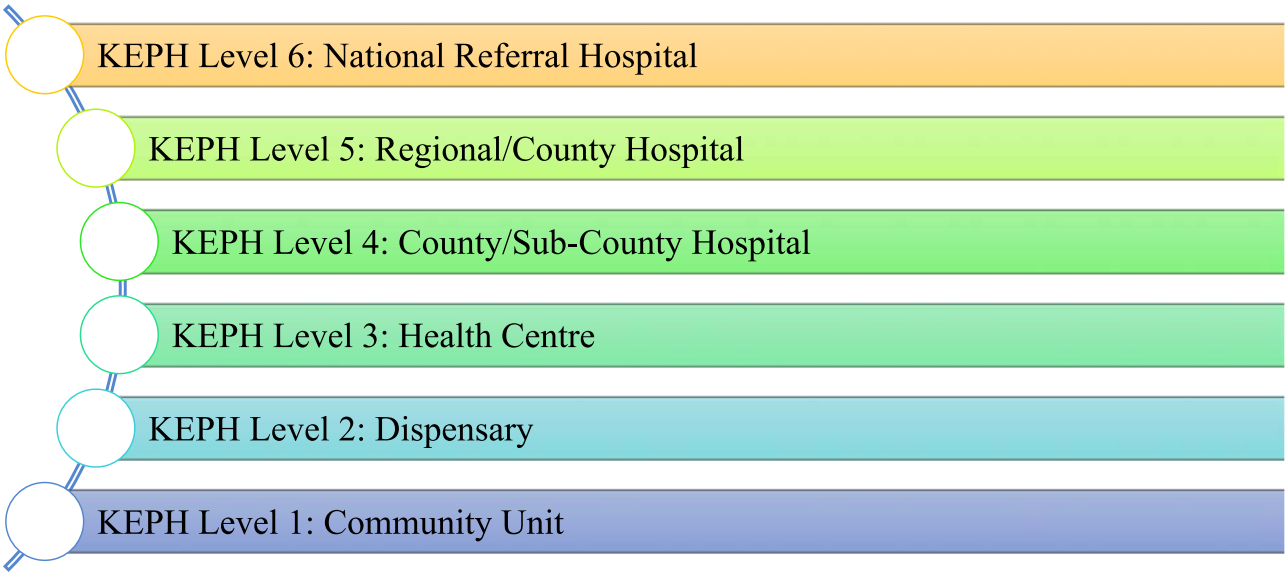
This section provides an overview on the organization of health Services in the County, Governance structures for County health services, the Management Structure (Organogram), Stakeholders and Partners Coordination, linkage to Annual Work Planning and Budgeting Process and Linkage to Annual Work Planning and Budgeting Process.

4.2 ORGANIZATION OF HEALTH SERVICES IN THE COUNTY

The health services in Samburu County is organized in accordance with the KEPH which guides health sector strategic investments for health service delivery in the county around two pillars. The first pillar is a classification of the citizenry into six cohorts namely pregnancy and newborn, early childhood, late childhood, adolescence, adult and the elderly.

The second pillar is the organization of the health service delivery system into a six-level pyramidal structure of care called KEPH levels of care. It is envisaged that citizens will seek/enter into care at the lowest possible level of care for their specific health needs, and based on their needs, would be referred up the systems appropriately. Health services in the county shall thus be organized around this structure as illustrated in Figure 4.

Figure 4: KEPH Levels of Care



The functions of each level of delivering health care services are outline below in table 24.

Table 24: Functions of KEPH Levels of Care

Level	In Charge	Function
Community Health Services	Community Health extension worker	- Facilitates individuals, households and communities to carry out appropriate healthy behaviours - Provides agreed health services - Recognizes signs and symptoms of conditions requiring referral; - Facilitates community diagnosis, management and referral.
Dispensary/ Clinic	Nurse or clinical officer.	- This is a health facility with no in-patient services and provides consultation, treatment for minor ailments; - provides rehabilitative services; - Provision of preventive and promotive services.
Health Centre	Clinical officer or medical officer with at least two years managerial experience	- It provides out-patient care; - Provision of limited emergency care; - Maternity for normal deliveries; - Laboratories, oral health and referral services; - Provision of preventive and promotive services; - In-patient observations.
Primary Hospital	Registered medical practitioner with a Master's degree in a health-related field.	- Clinical supportive supervision to lower level facilities; - Referral level out-patient care; - In-patient services; - Emergency obstetric care and oral health services; - Surgery on in-patient basis; - Client health education; - Provision of specialized laboratory tests; - Radiology service; - Proper case management of referral cases through the provision of four main clinical specialties (i.e. internal medicine, general surgery, gynae obstetrics and paediatrics) by general practitioners backed by appropriate technical devices; - Proper counter referral; - Provision of logistical support to the lower facilities in the catchment area; - Coordination of information flow from facilities in the catchment area.
Secondary Hospital	registered medical practitioner with a master's degree in a health-related field.	- Provision of specialized services including general and county specific specialized services; - Training facilities for cadres of health workers who function at the primary care level (paramedical staff); - Serves as an internship centre for all staff, up to medical officers; - Serves as a research centre, that provides research services for issues of county importance;
Tertiary Hospital	registered medical practitioner with a master's degree in a health-related field and with training and experience of over ten (10) years in senior management.	- Provides highly specialized services. include- (i) general specialization; (ii) discipline specialization; and (iii) geographical/ regional specialization including highly specialized healthcare for area/regional specialization; - Research centre, provides training and research services for issues of national importance.

4.3 GOVERNANCE STRUCTURES FOR COUNTY HEALTH SERVICES

The County Department for Health Services is headed by the County Executive Committee who is responsible for the overall political and policy direction of the county health sector assisted by the Chief Officer for Health (COH), who has the overall accounting and administrative responsibility for the department. The CECM is appointed guided by the Constitution of Kenya and the County Government Act, 2012. The county department also has a County Director for Health (CDH). This position was established under the Health Act 2017 and is responsible for technical leadership for the county health sector.

The director and health management team's main responsibilities are to mobilize the resources, give technical directions, enforce the use of guidelines and policies, steward capacity building of staff, follow up on the implementation of the County Health Strategic and Investment Plan and Annual Workplans (AWP) at the respective level of responsibility.

Primary health care facilities are headed by technical staff while community health units are managed by community health extension officers who supervise the community health workers and volunteers involved in the provision of health services at the community level. Table 25 describes the key roles for the main departmental positions:

Table 25: Responsibilities of different actors in the County planning committee

Actors	Responsibilities
County Executive Committee - Health	According to section 36 highlights: - (1) In addition to the functions provided under Article 183 of the Constitution, a county executive committee shall— (a) Supervise the administration and delivery of services in the county and all decentralized units and agencies in the county; (b) Perform any other functions conferred on it by the Constitution or national legislation; and (c) Carry out any function incidental to any of the assigned functions. (2) In the performance of its functions, a county executive committee shall have the power to determine its own programme of activities and every member of the committee shall observe integrity and disclosure of interest in any matter before the committee.
Chief Officer - Health	According to the County Government Act under Section 45 designates8 a. The County chief officer shall be responsible to the respective county executive committee member for the administration of a county department as provided under section 46. b. The county chief officer shall be the authorized officer in respect of the exercise of delegated power. c. Leadership in the mobilization of resources and partners in the process.
County Director of Health	According to the Health Act 2017, The County Director of health shall- a. Be the technical advisor on all matters relating to health within the County; b. Be the technical advisor to the County Health Executive Committee member and the Governor; c. supervise all health services within the County; d. Promote the public health and the prevention, limitation or suppression of infectious, communicable or preventable diseases within the County; e. Prepare and publish reports and statistical or other information relative to the public health within the County; f. Report periodically to the Director-General for health on all public health occurrences including disease outbreaks, disasters and any other health matters; and g. Perform any other duties as may be assigned by the appointing authority and any other written law.

Actors	Responsibilities
County Health Management Team members	a. Coordinating implementation of national and County health policies in the b. Providing supervision and support to the management of the county health facilities and the sub-county health management teams; c. Exercising disciplinary measures over health personnel working in the county as may be prescribed under subsection (6); d. Reviewing and monitoring the implementation of this Act and advising the Department on appropriate measures to be adopted for the effective implementation of this Act e. Facilitating county health facilities in the sub-county to comply with the established standards in accordance with section 33; and f. Carrying out any other Sub-county Health function as may be assigned by the Executive Member. g. Convene at least one quarterly meeting with the sub-county health management team. h. Prepare and submit a quarterly report of its operations to the Department, which shall inform the preparation of the reports under section 38. i. Carrying out any other function as may be assigned by the Executive Member.
Sub-County Health Management Team members	a. Coordinating implementation of this Act other health policies in the sub-county; b. Providing supervision and support to the management of the county health facilities in the sub-county; c. Reviewing and monitoring the implementation of this Act; advising the department on appropriate measures to be adopted for the effective implementation of this Act; d. Exercising disciplinary measures over health personnel working in the sub-county as may be prescribed under subsection (6); e. Carrying out needs and capacity assessment for county health facilities; f. In consultation with the county health management team, facilitating capacity building of health personnel at the sub-county; g. Facilitating county health facilities in the sub-county to comply with the established standards in accordance with section 33; and h. Carrying out any other function as may be assigned by the County Health Management Team
Referral facility in charges	i. Take leadership of collating information for the assigned area of responsibility of the County referral facility j. Overall management of the referral facility. k. Secretary of the health facility management board l. Carrying out any other function as may be assigned by County Director for Health
Representatives of primary care facilities	a. Ensure primary care specific inputs are captured in the area of responsibility
Representatives of NGO's / CSO's	a. Ensure NGO's / CSO's inputs are captured in the respective areas of responsibility b. Technical and Financial support to different program areas
Hospital Boards	a. The Board shall be responsible for- b. Providing oversight over the administration of the hospital; c. Promoting the development of the hospital; d. Approving plans and programmers for implementing county health strategies in the hospital e. Approving estimates before submission to the Executive Member, and f. Carrying out any other function assigned by the Executive Member.

4.4 THE MANAGEMENT STRUCTURE (ORGANOGRAM)

To facilitate the implementation of this strategic plan and the attendant provision of health services, a revised organizational structure is proposed. The structure is guided by the core functions of the county health services department, designed programs for delivery of health services and the following principles:

- Need to align the three main technical programme areas: Curative and Rehabilitative Health Services; Preventive and Promotive Health Services and General Administration, Planning, Management Support and Coordination to the planning and budgeting agenda
- Need to strike a reasonable balance between core and non-core functions;
- Delegate authority to the lowest possible level, Clarity of roles, responsibilities, accountabilities, authority levels, communication channels, and conflict resolution mechanisms.

Figure 5 shows the County health Management Team organization layout.

Figure 5: County Health Management Team Organogram

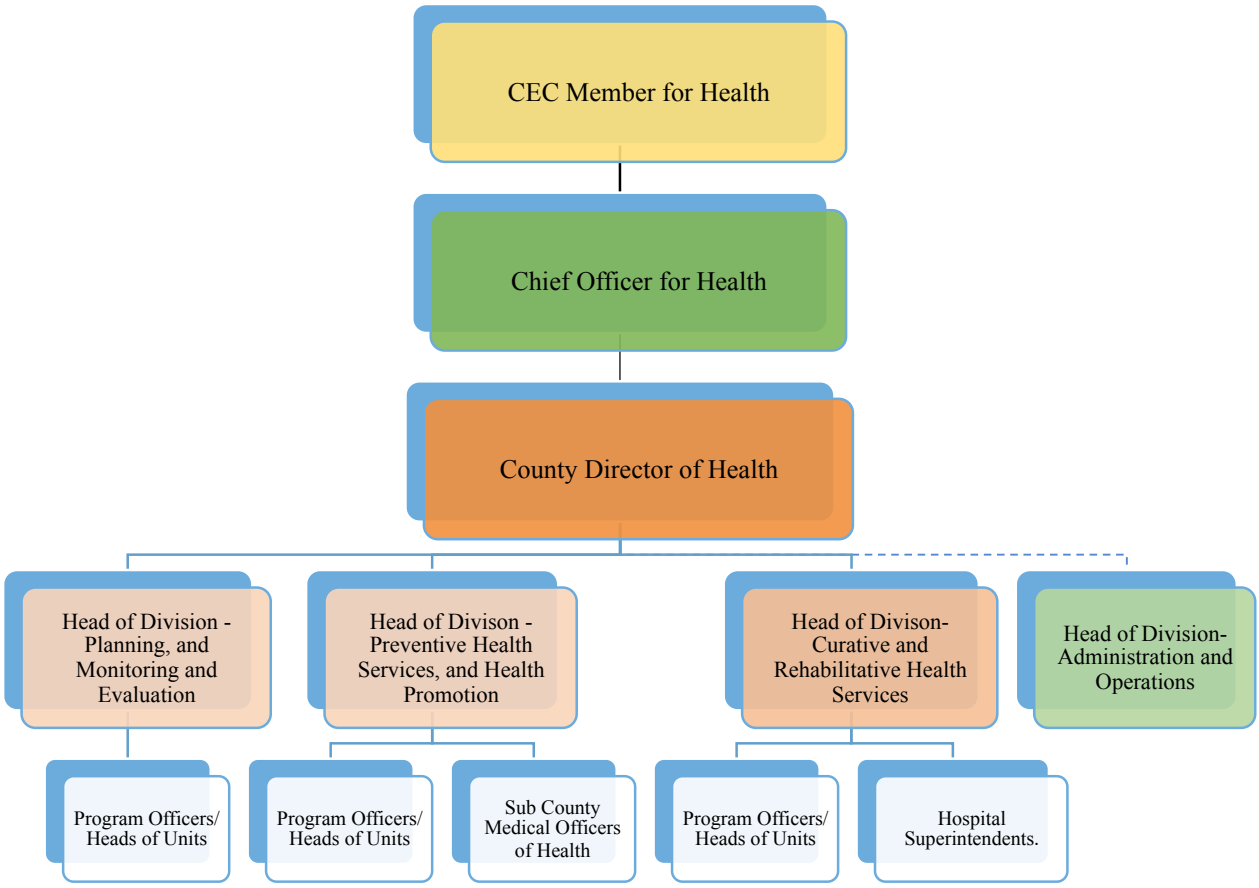
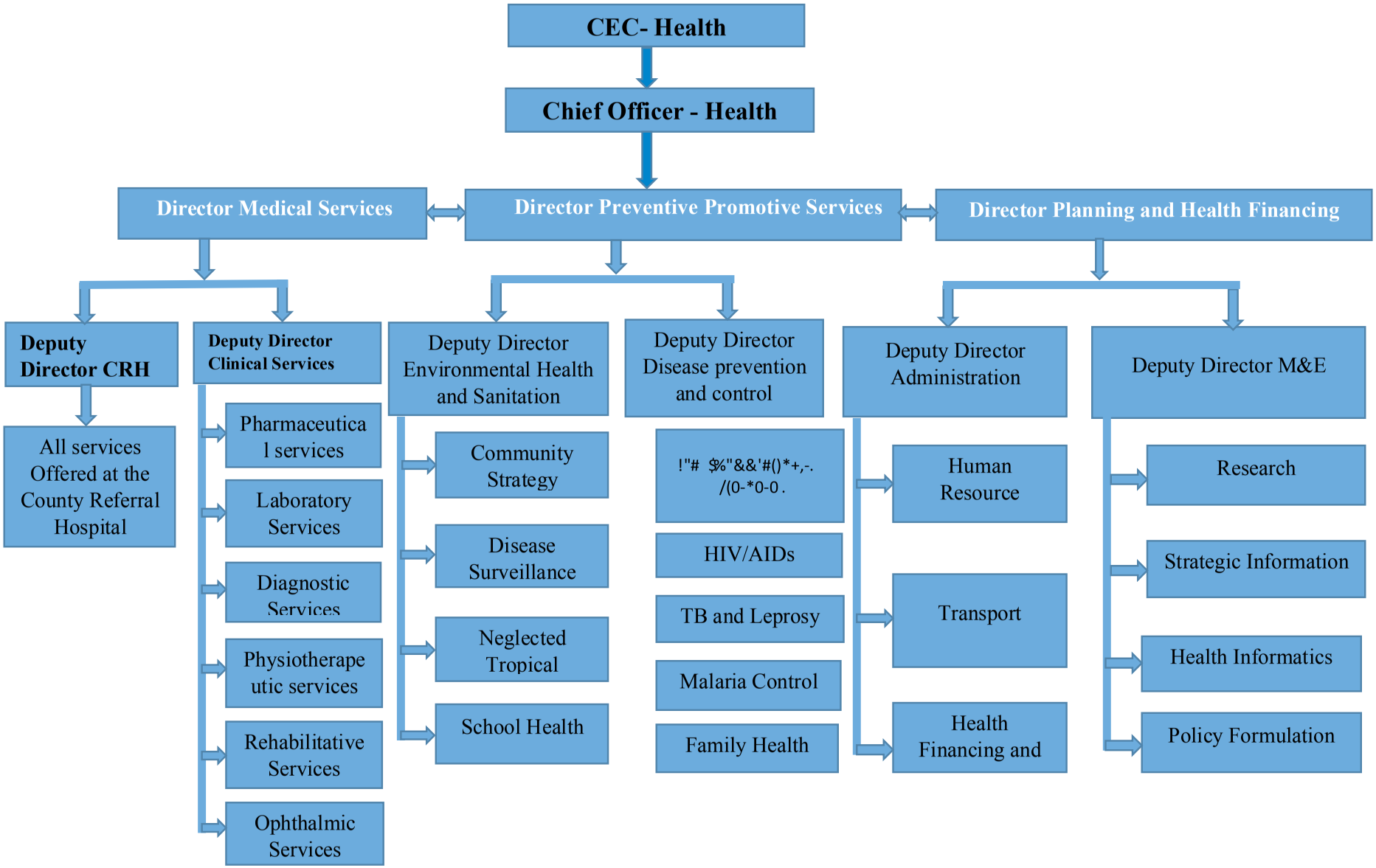


Figure 6: County and Sub-County Health Management Team Organogram



For governance and social accountability to the community, the county government incorporates community representatives in the leadership of the county facilities at various levels. County hospitals, at county and sub-county levels, are governed by hospital management boards that include members from a broad range of stakeholders. The same practice is replicated at the primary care facilities, with the health facility management committees comprising members of the community served by the facilities.

At the lowest level of healthcare provision, community healthcare units, there are community health committees that oversee service provision. All these governance organs are responsible for enhancing accountability by overseeing implementation of activities, mobilizing communities to utilize services, approving budgets and mobilizing resources for the provision of health services.

Hospital management boards and heath facility management committees are responsible for advising the facility and community on matters related to the promotion of health services; represent and articulate health facility and community interests on matters pertaining to health in local development forums; facilitate a feedback process to the community pertaining to the operations and management of the health facility; implement community decisions pertaining to their own health and mobilize community resources towards the development of health services within the area.

4.5 STAKEHOLDERS AND PARTNERS COORDINATION

The county will encourage the participation of stakeholders and partners in delivering the strategic objectives in this plan, in line with the principles of the Health Sector-Wide Approach (SWAp) of joint planning, implementation and monitoring and evaluation. For this purpose, the County will establish a County Health Stakeholders' Forum (CHSF). The CHSF shall serve as the coordinating mechanism for health sector partners' activities and will be chaired by the County Executive Committee Member for Health Services (CECHS). The CHSF will have the following objectives:

- Create an environment for learning, sharing information amongst health stakeholders in the county;
- Enhance coordination of all health programs and activities within the county;
- Coordinate mobilization and utilization of resources for health activities within the county;
- Facilitating linkages amongst the stakeholders.

The membership of the CHSF shall be drawn from all state and non-state actors in the county health sector. The CHSF shall be governed by a leadership development /coordination committee with the CDH serving as the secretary to the committee. Collaboration with stakeholders will be achieved through the following

- Convening of quarterly stakeholder's forum under the leadership of the CEC Member for Health Services.
- Fostering collaboration opportunities in the county for capacity building to improve service delivery.
- Minimizing duplication of activities through joint planning, implementation and monitoring and evaluation.
- Co-option of partners into appropriate thematic Technical Working Groups.
- Collaboration in convening the annual county health forum to strengthen accountability.

Table 26 shows the expected outputs and outcomes from interactions with health partners in Samburu County.

Table 26: Coordination with other Public Stakeholders at the National and County Level

Partners	Intervention Areas	Outputs	Outcomes
National Ministry of Health	• Policy, Guidelines, Standards and Norms Development • Training and Capacity Building • Regulation • Monitoring and Evaluation	• Uniformity of Health Services • Skilled Health Workforce • Safe Health Care • Progress Review	• Client Satisfaction • Quality Health Care • Timely Interventions
Development Partners (WHO, USAID, World Bank, DANIDA, SIDA, Global Fund, Bill and Melinda Gates Foundation)	• Support Strategic Plan Development • Monitoring and Evaluation • Capacity Building • Infrastructure Development • Program Funding	• Investment Plan • Improved Monitoring Capacity • Skilled Health Workforce • Improved Access to Quality services	• Achievement of Health Sector Goals
Implementing Partners (Afya Timiza, Palladium Group - CMLAP II, FHI 360, NHP Plus, World Vision, Afya Ugavi, AMREF, Feed the Children, Action Against Hunger, Uzazi Salama, Red Cross, JSI /in supply-SCALE) Intrahealth, Safaricom Foundation.	• Supporting community strategy implementation • Capacity building in health systems strengthening • Capacity building in service delivery	• Empowered Community • Skilled health workforce • Improved access to health services • Improved quality of data • Availability of health products	• Quality healthcare • Improved Access to Healthcare • Improved capacity of evidence-based decision making
Government Ministries and Departments (Agriculture, Water, Roads, Environment, Education etc.)	• Provision of safe water • Technical support e.g. Plan approvals, inspections, health education	• Availability of safe water • Safe environment	• Reduction of morbidity and mortality due to water-borne diseases • Healthy population
Political Leadership (Governor, County Reps, Members of Parliament, Senate and County Assembly,	• Political Goodwill • Oversight, Legislation and Policy • Resource mobilization/ allocation	• Increased Political goodwill • Improved Resources allocation	• Achievement of health sector goals and service delivery set targets.
National Coordination Ministry	• Social and community mobilization • Security • Resource mobilization • Emergency response • Intergovernmental linkage	• Community empowerment • Resource availability • Timely interventions in security emergencies	• Informed decision making. • Improved intercommunal peaceful co-existence • Healthy population • Emergency preparedness • Improved service delivery
Business Community (Hotels, Banks, Ranches etc.)	• Financial and material aid • Projects support (Social responsibility)	• Availability of resources	• Improved quality of care

4.6 LINKAGE TO ANNUAL WORK PLANNING AND BUDGETING PROCESS

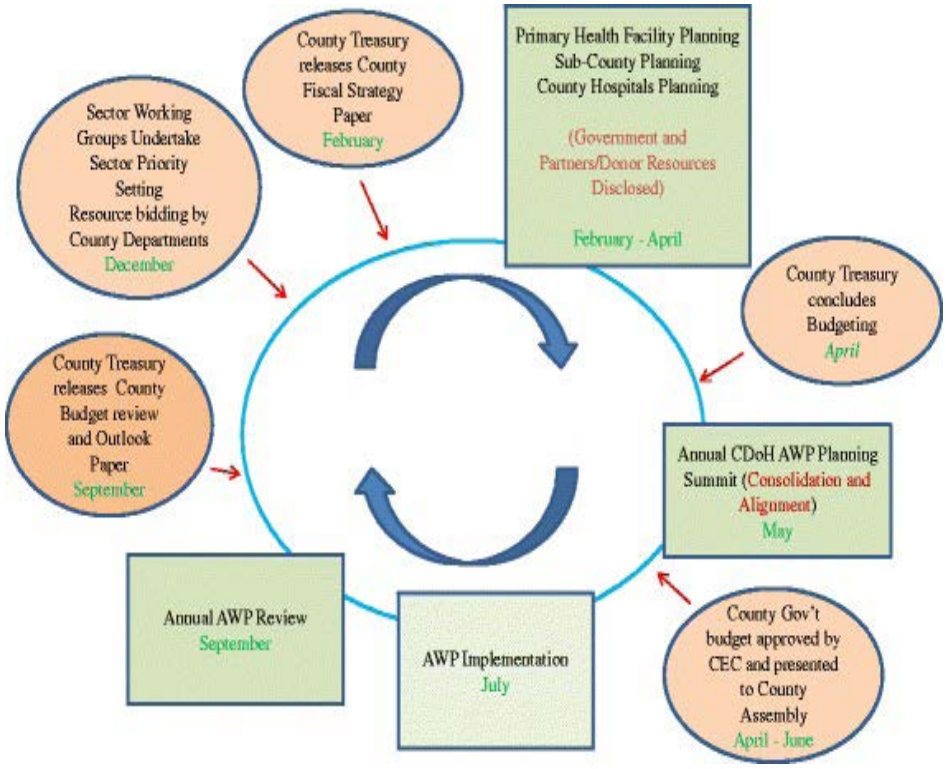
The strategic plan shall be operationalized through the County Health Sector annual performance report (APR), Annual Work Plans (AWPs) and Program Based budgets. The AWPs provide a vital link in the county health results chain, ensuring a logical and coherent implementation of health priorities and provide a framework for the CDoH to effectively and efficiently deliver on its health service delivery mandates.

This process will provide a logical process of translating the County health sector medium-term objectives into annual actionable plans leading to attainment of the County Health Objectives as outlined in the Health Sector Strategic Plan and CIDP. The output from this process should be able to:

1. Document the achievements the County attained in the previous year, with reference to the different health sector objectives and targets;
2. Provide clear priorities for the County to focus on in each financial year operations, guided by its provided resource envelope, and the recommendations from the previous year, including documentation of responsibilities of different actors;
3. Give guidance to the County on crucial health sector priorities to focus on in the MTEF discussions for the next financial year for inclusion in the County Fiscal Strategy Paper that outlines Overall County's priorities and financial allocations.

Figure 7 outlines the County Health Sector AWP and Budgeting Cycle within which this CHSSP and the planning requirement timelines must be adhered to make the planning and budgeting process seamless and operational.

Figure 7: County Health Sector AWP and Budgeting Cycle



Source: Public Financial Management Act, 2012

SECTION 5: PERFORMANCE MONITORING AND EVALUATION FRAMEWORK

This section provides an overview of the strategic plan monitoring and evaluation system, mechanism, data architecture and the strategic plan performance management framework.

5.1 OVERVIEW OF THE MONITORING AND EVALUATION SYSTEM

Monitoring and evaluation is key to all aspects of the SCHSSIP II, 2018-2022 and provides direction on performance monitoring and evaluation during the implementation of this strategic plan as guided by the National Health Sector Monitoring and Evaluation policies and guidelines.

The M&E systems will be given priority and will be more accessible to all stakeholders with a renewed focus on improving data quality, demand and use for decision making across all levels. Monitoring and evaluation will be steered by the Division of Health Information and M&E Unit within the county health sector organizational structure in collaboration with health sector partners. It also focuses on how the department will facilitate the achievement of the health information system investment priorities and overall M&E mechanisms that will support the achievement of the strategic plan objectives.

Samburu County seeks to establish a mechanism to routinely capture and report data on all aspects of the health system using a comprehensive M&E framework which has been developed and will be the basis for:

- Guiding decision making in the sector, by characterizing the implications of progress (or lack of it) being made by the sector
- Guiding the implementation of plans by providing information on progress and results.
- Guide information dissemination and use by the sector stakeholders and the public.
- Providing a unified approach to monitoring progress by all stakeholders in the sector, programs, SAGAs, and others.
- Providing a framework for evaluating the effectiveness of SCHSSIP strategies.

An M&E plan has been developed to facilitate performance measurement and provide a basis for accountability and evidence-based decision making at all levels by all actors in the County Health Sector. This shall be further enhanced by strengthening the country capacity for generating information, validating data, conducting analysis and translating results to useable form to be disseminated and utilized for decision making and programme management through addressing the priorities as outlined in the Health Information System investment section.

The HIS investment priorities will be achieved by realizing the following stewardship goals, including:

a) Supporting the establishment of a common data architecture

b) Improving the performance monitoring and review processes

c) Ensuring data quality systems are in place

d) Laying structures for evaluation of the strategies

e) Establishing the Learning and Accountability framework mechanism

The County will ensure all facilities have integrated automated HMIS and ensure the EMR and DHIS capture all indicators at all level in service delivery and to come up with a proper feedback mechanism. In addition, strengthen inter-sectoral collaboration with other stakeholder's e.g. Civil Registration Department and the County will adopt the national policy and guidelines on M&E processes.

5.2 PERFORMANCE MONITORING AND EVALUATION

The successful implementation of this strategic plan will require a robust monitoring and evaluation framework which was previously developed but not exhaustively utilized. The county has ensured during development of the new plan an up to date strategic plan is available for use in monitoring progress of agreed indicators. This chapter addresses the M&E gaps and covers the implementation framework, monitoring and evaluation mechanisms and service outcome and output targets for the achievement of the overall county objectives.

The monitoring and review process will measure the extent to which the objectives, core indicators, and their targets have been achieved. The implementation of the agreed actions will be monitored by the Division of Health Information and M&E with coordination and oversight from CHMT. Stakeholder collaboration is paramount to the successful implementation of this plan and establishing a common monitoring and evaluation plan with clearly defined responsibilities for each actor and stakeholder.

All performance reviews and evaluations will contain specific, targeted and actionable recommendations; the process will be outlined in the County Health M&E framework. The framework for reviewing health progress and performance covers the M&E process from routine performance monitoring, quarterly reviews, annual review, and mid-term and end-term reviews of the SCHSSIP. Monitoring and evaluation will be carried out at all level of service delivery. The approach to monitor and evaluate will, therefore, be done through:

(a) Monthly meetings to monitor the implementation of the programme plan.

(b) Quarterly management meeting to monitor the implementation of the Annual Work Plan.

(c) Bi-Annual evaluation of the impact of the Strategic Plan in each project at all levels. This evaluation will take part during the review meetings involving the stakeholders, consultants, and County Health Team.

(d) Focusing on strategic processes as defined in the Strategic Plan which is instrumental in annual health budget formulation as it will be used to derive the activities included therein. The annual work plan will not be an end, but rather a tool for implementation of the strategic plan. In addition, M&E will be verified through demographic health surveys.

Table 27 highlights essential monitoring and evaluation process to be adhered to in implementing the M&E framework.

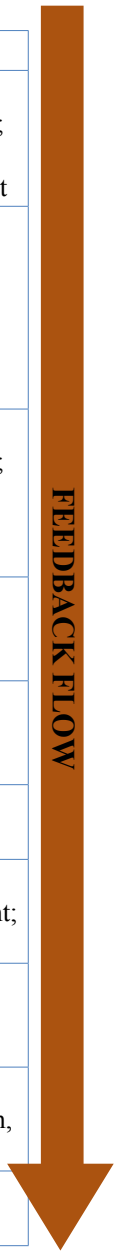
Table 27: Monitoring and Evaluation Mechanism

Type of Report	Purpose	Frequency	Responsibility	Report to Who
Annual Reports	To avail detailed annual achievements of the health department vis-à-vis the implementation plan, outlining the targets met, challenges and recommendations for the subsequent programs/ plan cycle	Annual	CHMT	CEC/ COH
Bi-annual reports	To provides mid-year evaluation of the department's activities and programmatic performance,	Twice a year	CHMT	CEC/ COH
Quarterly Reports	To avail detailed department's status regarding the achievement of the activities outlined in the strategic plan expressed through annual plans, providing an opportunity for amendments and recommendations based on the evaluation.	Quarterly	CHRIO/CHMT	CEC/ COH
Bi-Monthly work plan reviews	To provide the progress made in meeting the set activities in the work plan, highlighting the timelines met, challenges and possible recommendations	Bi-monthly	Director	COH
Monthly activity reports (All departments)	These will provide information regarding various departmental activities undertaken in the month as per the work plan and public participation, e.g. tracking reports, workshop reports, policy status reports, investor enquiry reports,	Monthly	Program officers	COH
Weekly work plan reviews (consolidated for CEC)	Regular status reports by officers on the progress of the activities under each unit to give feedback on the progress being made towards achieving the work plan goals and objectives and revise where applicable	Weekly	Program officers	COH
Institutional information	Information to staff on the status of the institution, achievements, and expectations including Human Resource management	Monthly	HRM&D	COH
Public Satisfaction Report	Conduct a public satisfaction survey to gauge the level of service delivery and satisfaction	Annually	Health Promotion officer	COH
Clients satisfaction report	Conduct client exit interview to gauge the level of service delivery and satisfaction	Bi-annual	Facility in charge	Director
Performance Contract annual evaluation report	The annual performance contract report provides the status of achievements attained by the institution annually This details actual performance against target contained in the performance contract	Annually and Quarterly	COH	CEC

5.3 DATA ARCHITECTURE

Common data architecture is needed to ensure coordinated information generation, data and information sharing, and efficiencies are maximized in data and information management. The county M & E unit shall be set up and will be mandated of establishing and overseeing the common data architecture. The common data architecture will provide the data sources for these indicators, which have been defined in the 2nd edition of the Health Sector M&E Framework.

	Data Collection	Compilation	Storage	Analysis	Reporting	Use
National	Indicator definition; Tools development	Data aggregation	Data warehousing	National level	National reports; Donor reports	Policy formulation; Resource management
Person(s) responsible	M&E TWG	HMIS department; Divisional heads	HMIS department; Divisional heads	HMIS department; Divisional heads; National TWGs	HMIS department; Divisional heads	Policy makers
County	Indicator definition; Customization; Tools development	Data aggregation	Data archiving	County level	County level	Policy formulation; Resource allocation
Person(s) responsible	CHMT, TWGs	CHRIO and M&E Coordinator	CHRIO and M&E Coordinator	CHRIO and M&E Coordinator	CHRIO and M&E Coordinator	County government
Sub County	Data verification and audit	Data entry and tabulation	Data archiving	Sub county and facility level	Sub county level	Indicator monitoring
Person(s) responsible	SCHRIO, SCHMT	SCHRIO, SCHMT	SCHRIO	SCHRIO	SCHRIO	SCHMT
Facility	Data Capture	Collation and transmission	Data archiving	Facility + Community	Departmental and facility data	Resource Management; Health talks
Person(s) responsible	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers	HRIO, facility managers
Community	Data Capture	Collation and transmission	Data archiving	Community Unit	CHEW	Community mobilization, planning
Person(s) responsible	CHEW	CHEW	CHEW	CHEW	CHEW	CHEW



5.4 STRATEGIC PLAN REVIEW AND EVALUATION

The health sector has identified sector indicators for monitoring and evaluating the implementation of Samburu SCHSSIP. The strategic plan will be reviewed after two years of implementation to access overall performance over the period against the expected results to assess the strategies and indicators to inform subsequent implementation. The table below details the baseline data, and mid and end term target as well as the sources for these indicators. This framework will be implemented alongside the County M&E Plan for tracking and evaluating performance status against the set indicator targets.

Table 28: Health Services Delivery Indicators, baselines, Targets (by Year) and Sources

Objective	Indicator	Baseline 2017/18	Mid Term 2020/2021	End Term 2022/2023	Data Sources
Eliminate Communicable Conditions	% Fully immunized children	67	88	96	DHIS2
	% of the target population receiving MDA for trachoma	0	100	100	Survey
	% of TB patients completing treatment	86	100	100	DHIS2/ TIBU
	% HIV + pregnant mothers receiving preventive ARV's (HAART)	108/128 84	100	100	DHIS2
	% of eligible HIV clients on ARV's	100	100	100	DHIS2
	% of under 5's treated for diarrhea	41	26	16	DHIS2
	% School age children dewormed	24.6	39.6	49.6	DHIS2
Halt, and reverse the rising burden of non-communicable conditions	% of the adult population with BMI over 25	3980/81991 5	2	0.5	DHIS/ KNBS
	% Women of Reproductive age screened for Cervical cancers	0.05 (32/61917)	60	100	DHIS2
	% of new outpatients with mental health conditions	162/103278 0.2	0.2	0.2	DHIS2
	% of new outpatient's cases with high blood pressure	842/103278 0.8	0.5	0.3	DHIS2/ KNBS
	% of patients admitted with cancer***	-	-	-	DHIS2
Reduce the burden of violence and injuries	% of new outpatient cases attributed to gender-based violence	221/103278 0.2	0.15	0.05	DHIS2
	% of new outpatient cases attributed to Road Traffic Injuries	329/103278 0.3	0.15	0.05	DHIS2
	% of new outpatient cases attributed to other injuries	4914/103278 4.8	1.8	0.05	DHIS2
	% of deaths due to injuries	-	-	-	DHIS2
Provide essential health services	% deliveries conducted by a skilled attendant	149/4 37	60	70	DHIS2/ KNBS
	% of women of Reproductive age receiving family planning	143/4 36	60	70	DHIS2
	% of facility-based maternal deaths	6/3924 0.02	0		DHIS2
	% of facility-based under-five deaths	-	-	-	
	% of newborns with low birth weight	27.5	12.5	2.5	DHIS2
	% of facility-based fresh stillbirths	5.25	2.25	1.25	DHIS2
	The surgical rate for cold cases	NO DATA			
	% of pregnant women attending 4 ANC visits	109.6/4 27.4	57.4	77.4	DHIS2
Minimize exposure to health risk factors	% population who smoke	14.3(RVP)	5.3	1.3	KDHS/ Survey
	% population consuming alcohol regularly	27	21	17	KDHS/ Survey
	% of infants under 6 months of exclusive breastfeeding	344.3/4 85	91	95	KNBS/ SMART Survey
	% of Population aware of risk factors to health	80.3	80.3	80.3	KNBS/ Survey
	% of salt brands adequately iodized	100 (SURVEY)	100	100	KEBS/ Survey
	Couple year protection due to condom use	41.9	71.9	91.9	DHIS2/ Survey

Objective	Indicator	Baseline 2017/18	Mid Term 2020/2021	End Term 2022/2023	Data Sources
Strengthen collaboration with health-related sectors	% population with access to safe water	17	48	68	KNBS
	% under 5's stunted	2.5	1..6	1.0	KNBS/ DHIS SMART Survey
	% under 5 underweight	10.2	4.2	0.2	SMART Survey
	School enrollment rate	60.1	75.1	85.1	MOE
	% of households with latrines	33.4	48.4	58.4	KNBS, DHIS2(MOH 515)
	% of houses with adequate ventilation	50.9	65.9	75.9	KNBS
	% of the classified road network in good condition	? How many roads			MOT
	% Schools providing complete school health package	32.4	47.4	57.7	MOE, DHIS2
INVESTMENT OUTPUTS					
Improving access to services	Per capita Outpatient utilization rate (M/F)	F=4.8, M=3.91.2/0.98	2	2	HIS
	% of population living within 5km of a facility	21.5	51.5	71.5	KNBS/ KDHS
	% of facilities providing BEOC	34/95 35.8	68.8	88.8	DHIS2/ NCPD/ Assessment Reports
	% of facilities providing CEOC	2/6 33	83	100	DHIS2/ NCPD/ Assessment Reports
	Bed Occupancy Rate	60	75	80	DHIS2
	% of facilities providing Immunization	62/95 65	80	90	DHIS2
Improving the quality of care	TB Cure rate	85	91	95	DHIS2
	% of fevers tested positive for malaria	No data			DHIS2
	% maternal audits	50	100	100	DHIS2
	Malaria inpatient case fatality	-			DHIS2
	The average length of stay (ALOS)	4	2	2	DHIS2

*** *The county is planning to develop a tool to capture all neoplasms.*

SECTION 6: REQUIRED FINANCING & RESOURCE MOBILIZATION

This Section provides an overview on financing objectives, Costs of Implementing the Strategic Plan, Resource requirements for Samburu Strategic Plan by Programme and Sub-Programme and the funding gap.

6.1 BACKGROUND

The SDGs call for countries to adopt a broader, and results-oriented perspective of health. This requires a paradigm shift from the traditional approach to financing health, which has proved to be inadequate to meet the growing health demand and need of the county. The planning framework requires the health sector to engage with stakeholders to identify and address the challenges they face relating to how they live, work and socialize.

The change from focusing on disease programs towards a focus on ensuring health is attained and sustained by calls for counties to identify cost-effective and efficient interventions to scale up coverage of high impact interventions. In addition, the global and country ambition focusing on attainment of Universal Health Coverage, calls for counties to ensure all persons and communities access and use the preventive, promotive, curative and rehabilitative health and related services they need, in a sufficient level of quality and ensuring this use does not expose them to catastrophic health expenditure further exposing them to financial hardships.

The approach to financing for health has a major implication on the attainment of health and development objectives of Samburu County. As a result, the health sector has undertaken to review and plan a comprehensive approach to financing health services to enable attainment of the health goals as outlined in Vision 2030 Kenya Health Policy 2014-2020 and Sustainable Development Goals in Kenya.

6.2 FINANCING OBJECTIVES

The main goal of the Kenya Health Strategic and Investment Plan is to facilitate attainment of the vision that seek to 'ensure County free from preventable diseases and ill health' to guarantee all Samburu residents access to a defined package of essential health services without the risk of financial hardship by accelerating attainment of health impact targets as defined in the Kenya Health Policy.

In line with the planning and budgeting process outlined in the PFM Act, 2012 and the requirement to align health sector priority programmes using the Programme Based Budgeting approach, the health sector resources in the county shall be invested around the identified three priority programmes namely:

1. Curative and rehabilitative health services,
2. Preventive and promotive health services,
3. General administration, operations, planning, budgeting and monitoring, and evaluation.

The overall Samburu County CIDP 2018-2022 has adopted these three programs in its MTEF budgetary projections. To this extent, this CHSSP 2018-2022 will also adopt the PBB framework in costing its projections.

6.3 COSTS OF IMPLEMENTING THE STRATEGIC PLAN

The sector has very limited resources, and it's in the light of this that the sector has prioritized the health sector budget to caters for three programmes; Promotive and Preventive, Clinical / Curative services and General Administration, planning and support services. The Programme and sub-Programme resource requirements are as shown in the table below:

The health sector's resource requirement for the three programmes is anticipated to increase from KES 2.281 to 2.535 billion between FY 2018/19 and 2022/23 respectively to finance the operations of the sector in the delivery of its mandate. The specific amount allocated to each Programme is contained in the table below showing the health sector resource requirements by economic classification for the FY 2019/20, 2020/21 and 2021/22 respectively. Based on inputs considerations and calculations from the CDoH PBB for FY 2018/19, the projected costs for this strategic plan is outlined in Table 29.

Table 29: Analysis of Resource Requirement by Programme

PROGRAMME		ESTIMATES	PROJECTIONS			
		2018/19	2019/20	2020/21	2021/22	2022/23
P1	**General Administration, Planning and Support Services**	2,135,872,798	2,231,843,799	2,291,184,800	2,314,215,980	2,373,194,953
P2	**Promotive and Preventive**	80,007,500.00	91,157,500.00	101,740,000.00	111,810,750.00	122,781,075.00
P3	**Curative**	65,590,000	70,149,000	75,163,900	80,680,290	39,427,819
	Total vote:	2,281,470,298	2,393,150,299	2,468,088,700	2,506,707,020	2,535,403,847

6.4 RESOURCE REQUIREMENTS FOR SAMBURU STRATEGIC PLAN BY PROGRAMME AND SUB-PROGRAMME

Table 30 below shows the estimates of the total gross resources needed to implement the Framework. It is because of these needs that resources shall be mobilized from government, its development partners and other stakeholders.

Table 30: Breakdown of budget projections by Programme and Sub-Programme

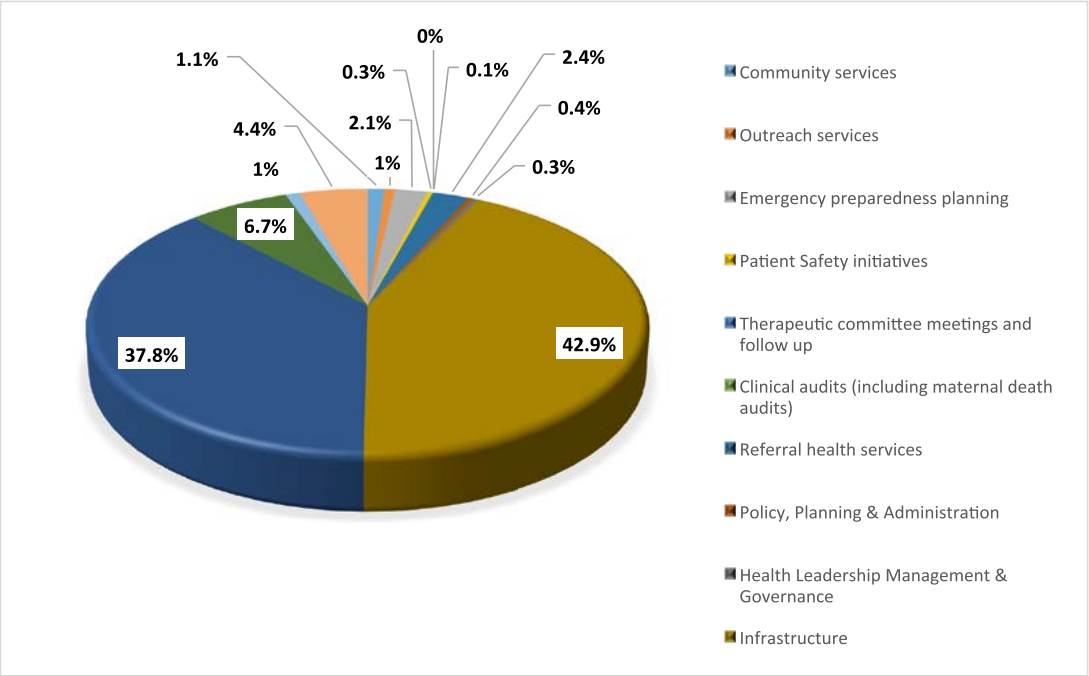
Programme	Sub--Programme	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Preventive & Promotion Services	**Community services**	21,407,500	25,932,500	29,107,500	31,607,500	34,107,500	142,162,500
	Outreach services	12,950,000	15,010,000	17,396,000	19,443,100	21,837,410	86,636,510
	Emergency preparedness planning	45,650,000	50,215,000	55,236,500	60,760,150	66,836,165	278,697,815
Total		**80,007,500**	**91,157,500**	**101,740,000**	**111,810,750**	**122,781,075**	**507,496,825**
Curative & Rehabilitative Services	**Patient Safety initiatives**	6,500,000	7,150,000	7,865,000	8,651,500	9,516,650	39,683,150
	Therapeutic committee meetings and follow up	70,000	77,000	84,700	93,170	102,487	427,357

Programme	Sub--Programme	2018/19	2019/20	2020/21	2021/22	2022/23	Total
	Clinical audits (including maternal death audits)	1,520,000	1,672,000	1,839,200	2,023,120	2,225,432	9,279,752
	Referral health services	57,500,000	61,250,000	65,375,000	69,912,500	54,238,250	308,275,750
Total		**65,590,000**	**70,149,000**	**75,163,900**	**80,680,290**	**66,082,819**	**357,666,009**
General Administration, Planning, Management Support services	**Policy, Planning & Administration**	7,500,000	8,250,000	9,075,000	9,982,500	10,980,750	45,788,250
	Health Leadership Management & Governance	7,375,000	7,700,000	8,300,000	8,800,000	9,300,000	41,475,000
	Infrastructure	870,000,000	1,126,040,000	1,206,300,000	1,206,300,000	1,206,300,000	5,614,940,000
	Human Resource for Health	1,129,140,000	963,880,000	943,006,000	962,998,600	947,344,045	4,946,368,645
	Health Products and technology	109,600,000	117,600,000	117,600,000	117,600,000	407,600,000	870,000,000
	Health Management Information System	20,457,798	24,573,799	23,103,800	24,734,880	27,870,158	120,740,435
	Health Financing	101,400,000	101,400,000	101,400,000	101,400,000	171,400,000	577,000,000
Total		**2,245,472,798**	**2,349,443,799**	**2,408,784,800**	**2,431,815,980**	**2,780,794,953**	**12,216,312,330**
Grand total		**2,391,070,298**	**2,510,750,299**	**2,585,688,700**	**2,624,307,020**	**2,969,658,847**	**13,081,475,164**

The total gross resource needs are estimated at KES. 13.081 billion for the next five-year period. The cost will rise from Ksh. 2.391 billion in 2018/19 to Ksh. 2.969.7 billion in the final year of the plan. This increasing trend in estimated resource needs is largely due to planned to scale up of health interventions.

Figure 8 presents the percentage share of the estimated resources between various programmes and sub-programmatic areas. Health infrastructure will account for the highest share of the total resources (42.9%), followed by Human Resource for health (37.8%), health products and technology (6.7%), health financing (4.4%), referral health services (2.4%) and emergency preparedness (2.1%). In a context of limited resources, to maximize allocative efficiencies, it is critical that resource allocations shall be aligned to these key priorities to ensure effective delivery of services with minimal disruption.

Figure 8: Proportion of resource needs per sub-programmatic area



6.5 SCHSSIP FUNDING GAP

The above resource in table 30 needs when compared with projected resources available as projected in the recently released County Fiscal Strategy Paper 2018 released in February, as shown in table 31, reveals a significant and growing funding gap. The growing needs of the sector and projected rising costs necessitates the need for the department to identify sustainable mechanisms for financing of the health sector. Limited resources will remain a considerable challenge requiring the department to mobilize domestic resources from health partners operating within the county.

Table 31: Estimated Samburu Health Sector funding gap

	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Baseline Funding based on MTEF projections	1,123,140,427	1,179,297,448	1,238,262,321	1,300,175,437	1,365,184,209	6,206,059,842
Gross Resource Needs	2,391,070,298	2,510,750,299	2,585,688,700	2,624,307,020	2,969,658,847	13,081,475,164
Funding Gap	(1,267,929,871)	(1,331,452,851)	(1,347,426,379)	(1,324,131,583)	(1,604,474,638)	(6,875,415,322)

6.5.1 CRITICAL ASSUMPTIONS IN COSTING, FINANCING AND FINANCING GAP

Several assumptions were employed in determining and elaborating the cost for implementing this strategic plan. The critical ones include:

- That the county government will maintain the current financing of the CDoH at as similar ratio to the overall county budget – with reference to the Samburu County 2018/19 financial year allocations.
- The annual county population growth will fall within the population projections that were based on the 2009 national population and housing census.
- Costs of goods and services will remain as they were budgeted for in the 2018/19 FY.

With these assumptions, it is expected that the CDoH will implement 75 percent of the strategic priorities in this plan using government financing – and will have to raise the 25 percent financing gap from other partners.

Considering the above context, this strategy shall promote innovative and domestic financing by initiating concerted efforts to sustain the financing of health programmes. The following actions are critical to achieving success in sustaining the available resource basket. This strategy aims to address the resource gap achieve through targeted financing interventions including mobilization, allocation, and utilization strategies.

Its specific objectives are to:

a) To mobilize the resources required to provide the essential health services people need the county will adopt the following approaches:
   1. Evidence-based advocacy and lobbying for support from the County Assembly committee for health and partners.
   2. CECM and COH to Advocate for a progressive increase in budget allocation to health.
   3. Develop and adopt a policy to be developed to allow for retention and utilization of revenue collected at the facilities.
   4. Initiate and strengthen Public Private Partnership (PPP) engagements
   5. Expand NHIF coverage, benefits and accredit more facilities.
   6. Implementation of Health Insurance Subsidy Program (HISP) for the poor and the elderly
   7. Embrace Community health insurance cover to the vulnerable population through the constituency development fund (CDF) e.g. Samburu West Constituency
   8. Construct modern and well-equipped facilities to offer quality health service to attract more client's thus high revenue based.

b) To maximize efficiency and value for money in the management and utilization of available health resources, the department will adopt Strategies to ensure available resources are sustained through
   1. Utilizing resource as per the Annual Work plans.
   2. Ring fence the available resources
   3. Sustain lobbying with the committee of health in the County Assembly.
   4. Provide a conducive environment and good coordination for health partners to play a role in budget allocation and utilization
   5. Generate evidence on budget absorption to guide future programme planning and budgeting.

c) To ensure equity in mobilization and allocation of health funds to guarantee fairness in the use
   1. Social accountability by those entrusted with funds through establishing a clear public consultative forum to collect views.
   2. CEC and CO to engage county treasury to influence the timely release of funds by the county governments.
   3. Ensuring mechanisms that ensure donor support is aligned to the sector goals and objectives.
   4. Equity in resource utilization (according to need).

REFERENCES

1. Afrcian Union Agenda 2063: The Africa we want. African Union Commission September 2015
2. End Term review report for Samburu Health Sector Strategic and Investment Plan 2013-2017.
3. Government of Kenya, "National Health Accounts, 2015/16".
4. Government of Kenya, "National Health Accounts, 2016/17".
5. United Nations, "Transforming our world: the 2030 Agenda for Sustainable Development," New York, 2015.
6. Government of Kenya, Kenya Vision 2030- A Globally Competitive and Prosperous Kenya, October. Nairobi, 2007.
7. Governors Big Three Manifesto, 2017
8. Kenya National Bureau of Statistics, "Economic Survey 2017", Nairobi, Kenya, 2017
9. Republic of Kenya, "Kenya Health Policy 2014-2013." Ministry of Health, Nairobi, p. 49, 2014.
10. Republic of Kenya, Big Four Agenda, 2017.
11. Republic of Kenya, Kenya Health Sector Strategic and Investment Plan 2013-2017
12. Republic of Kenya, The Big Four Agenda. Nairobi, Kenya, 2017.
13. Republic of Kenya, The Constitution of Kenya. Nairobi, Kenya, 2010.
14. Republic of Kenya, The Health Act, 2017. Nairobi, Kenya: Laws of Kenya, 2017.
15. Samburu County Fiscal Strategy Paper, 2018
16. Samburu County Programme Based Budget, FY 2018/19
17. Samburu Health Sector Strategic and Investment Plan 2013-2017.
18. World Health Organization, Health Systems Strengthening for attainmnet of Universal Health Coverage and the Sustainable Development Goals: An Action Framework,"Brazzavile, Congo, 2017

ANNEXES

Annex 1: Summary of M&E Outcome Indicators

Objective	Indicator	Targets					
		Baseline 2016/17	Yr. 1 2018/2019	Yr. 2 2019/2020	Yr. 3 2020/2021	Yr. 4 2021/2022	Yr. 5 2022/2023
Eliminate Communicable Conditions	% Fully immunized children	67	80	84	88	92	96
	% of target population receiving MDA for trachoma	81(Year 2015)	84	84	90	95	100
	% of TB patients completing treatment	86	100	100	100	100	100
	Number of pregnant mothers tested HIV +	190	170	150	130	110	90
	% HIV + pregnant mothers receiving preventive ARV's(HAART)	84	100	100	100	100	100
	% of eligible HIV clients on ARV's	100	100	100	100	100	100
	% testing	12	90	90	90	90	90
	% viral suppression	55.8	90	90	90	90	90
	% of targeted under 1's provided with LLITN's	0	0	0	0	0	0
	% of targeted pregnant women provided with LLITN's	0	0	0	0	0	0
	% of under 5's treated for diarrhea	41	36	31	26	21	16
	% School age children dewormed	24.6	29.6	34.6	39.6	44.6	49.6
Halt, and reverse the rising burden of non-communicable conditions	% of adult population with BMI over 25	5	4	3	2	1	0
	% Women of Reproductive age screened for Cervical cancers	0.05	15	30	45	60	75
	% of new outpatients with mental health conditions	0.2	0.2	0.2	0.2	0.2	0.2
	% of new outpatient's cases with high blood pressure	0.8	0.7	0.6	0.5	0.4	0.3
	% of patients admitted with cancer	5	0	0	0	0	0
Reduce the burden of violence and injuries	% new outpatient cases attributed to gender-based violence	0.2	0.19	0.18	0.15	0.10	0.05
	% new outpatient cases attributed to Road traffic Injuries	0.3	0.25	0.2	0.15	0.1	0.05
	% new outpatient cases attributed to other injuries	4.8	3.8	2.8	1.8	0.8	0
	% of deaths due to injuries		-	-	-	-	-
Provide essential health services	% deliveries conducted by skilled attendant	37	50	55	60	65	70
	% of women of Reproductive age receiving family planning	143/436	50	55	60	65	70
	% of facility based maternal deaths	0.02	0	0	0	0	0
	% of facility based under five deaths		-	-	-	-	-
	% of newborns with low birth weight	27.5	22.5	17.5	12.5	7.5	2.5
	% of facility based fresh still births	5.25	4.25	3.25	2.25	2.25	1.25
	Surgical rate for cold cases	29	35	40	45	50	60
	% of pregnant women attending 4 ANC visits	27.4	37.4	47.4	57.4	67.4	77.4

Objective	Indicator	Targets					
		Baseline 2016/17	Yr. 1 2018/2019	Yr. 2 2019/2020	Yr. 3 2020/2021	Yr. 4 2021/2022	Yr. 5 2022/2023
Minimize exposure to health risk factors	% population who smoke	14.3[3]	11.3	8.3	5.3	2.3	1.3
	% population consuming alcohol regularly	27	25	23	21	19	17
	% infants under 6 months on exclusive breastfeeding	85	87	89	91	93	95
	% of Population aware of risk factors to health	80.3	80.3	80.3	80.3	80.3	80.3
	% of salt brands adequately iodized	100 (SURVEY)	100	100	100	100	100
	Couple year protection due to condom use	41.9	51.9	61.9	71.9	81.9	91.9
Strengthen collaboration with health-related sectors	% population with access to safe water	17	28	38	48	58	68
	% under 5's stunted	35.8*	2.2	1.9	1..6	1.3	1.0
	% under 5 underweight	10.2	8.2	6.2	4.2	2.2	0.2
	School enrollment rate	60.1	65.1	70.1	75.1	80.1	85.1
	% of households with latrines	33.4	38.4	43.4	48.4	53.4	58.4
	% of houses with adequate ventilation	50.9	55.9	60.9	65.9	70.9	75.9
	% Schools providing complete school health package	32.4	37.4	42.4	47.4	52.4	57.7
	% of school girls who have undergone FGM	-	Survey	-	-	-	-
INVESTMENT OUTPUTS							
Improving access to services	Per capita Outpatient utilization rate (M/F)	F=4.8 M=3.9 1.2/0.98	2	2	2	2	2
	% of population living within 5km of a facility	21.5	31.5	41.5	51.5	61.5	71.5
	% of facilities providing BeMONC	34/95 35.8	45.8	55.8	68.8	78.8	88.8
	% of facilities providing CEmONC	2/6 33	50	67	83	100	100
	Bed Occupancy Rate	60	65	70	75	80	80
	% of facilities providing Immunization	62/95 65	70	75	80	85	90
Improving quality of care	TB Cure rate	85	87	89	91	93	95
	% of fevers tested positive for malaria	31	26	21	16	13	10
	% maternal audits	3/6 50	100	100	100	100	100
	Malaria inpatient case fatality	-					
	Average length of stay (ALOS)	4	2	2	2	2	2

3 Rift Valley Province target

Annex 2: Health-Related Constitutional Clauses and Implications on Health

Articles	Implication on Health
Rights and Fundamental Freedoms	
26 (1-3) Rights to life	The County Government of Samburu will create an enabling environment to ensure every Kenyan is healthy. It will ensure health services are available, accessible, acceptable, equitable, affordable and responsive to the societal needs. The health sector will work collaboratively with other sectors such as water, education, agriculture, justice, immigration, roads etc. to ensure health rights are realized. Citizens are empowered to demand services by law as enshrined in the Constitution of Kenya 2010.
43(1) Right to the highest attainable standard of health, right to housing, sanitation, food, clean and safe water	
43 (2) Right to emergency treatment	
43 (3) Right to social protection	
46 (1) Consumer rights with respect to health	
53 (1) Child rights with respect to health	
56 (e) Rights of minorities and marginalized groups with respect to health	
Devolved Governments	
6 (2) Relationship between the two levels of government	The Ministry of Health (national) and the Samburu County Department of Health shall strive to work in a collaborative manner to ensure the achievement of health goals.
175 Objectives of devolution	The Samburu County Department of Health shall ensure that it brings services closer to the people, improve allocation efficiency, promote transparency, accountability and put citizens at the drivers' seat to determine their health agenda
176 (2) Principles of devolved government	Samburu County health department shall transfer functions to the smallest capable unit that can deliver that service
186 (2)187 Functions of county governments	Concurrent functions require the cooperation of both levels of government for their successful implementation. There is room for the transfer of functions between either level of government if it makes sense from the efficiency of service delivery.
Fourth Schedule-Assignment of functions Part 1- National Government Functions 23. National referral facilities 28. Health Policy 32. Capacity building and technical assistance to counties Part 2-County Government	The two levels of government shall: • work harmoniously to ensure a smooth referral system is in place • formulate and implement health policies County health services shall include in particular: - a) county health facilities and pharmacies; b) ambulance services; c) promotion of primary health care; (d) licensing and control of undertakings that sell food to the public; and cemeteries, funeral parlors and crematoria and (f) Refuse removal, refuse dumps and solid waste disposal.

Source: The Constitution of Kenya, 2010, pp 31 -38

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