BUNGOMA COUNTY

HEALTH

SECTOR PLAN FOR THE PERIOD 2023-2032

'Accelerating the attainment of Universal Health Care'

KENYA VISION 2030

Towards a Globally Competitive and Prosperous Kenya

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HEALTH

SECTORAL PLAN FOR BUNGOMA COUNTY

Vision

'A healthy, productive and competitive County'

Mission

'To build a progressive, responsive and sustainable health care and sanitation system for accelerated attainment of the highest standard of health in the County'

FOREWORD

Development planning is paramount for proper utilization of scarce resources. The Public Finance Management Act, 2012, outlines the key stages for county governments planning and budgeting process and comprises integrated development planning process which should include both long term and medium-term planning; planning and establishing financial and economic priorities for the county over the medium term; and making an overall estimation of the county government's revenues and expenditures.

The County Government Act, 2012, requires that counties prepare ten-year County Sectoral Plans. The County Sectoral Plans shall be programme-based and will be used as the basis for budgeting and performance management and shall be reviewed every five years by the County Executive and approved by the County Assembly. The Act also requires that the County Sectoral Plans be updated annually.

County financial and institutional resources through this plan have been aligned to policies, objectives, and programmes. The plan is also aligned to National - Vision 2030, Regional -Agenda 2063 and Global Sustainable Development Goals among others for consistency and collaboration in economic development.

The Sectoral plan will stimulate distinct interest in policies, programmes and projects and allow feed- back to the executing CDAs so that they can keep their progress on track. The plans were developed based on public assessment of status of government service delivery, identified gaps therein and suggested interventions.

The Constitution of Kenya 2010 through Article 43, besides recognizing right to health as a fundamental element in economic and social right, also guarantees every citizen the highest attainable standards of health care service. Vision 2030 aims to provide an efficient and high-quality health care system with best standards. Kenya has adopted Universal health coverage (UHC) with a clear goal of ensuring that individuals and communities receive the health services they need without suffering financial hardship.

The Bungoma County Health Sector Plan for the financial year 2022 – 2032 follows the Kenyan Constitution of 2010, Vision 2030 as well as Universal Health Coverage Policy. Bungoma County Health Department will use this Sector plan to operationalize its activities towards the attainment of the Universal Health Coverage (UHC). The document has set out health sector priorities, targets, programmes, activities, and resource requirement for the period. It will be an operational document that will guide County Health Management Team (CHMT), Sub-County Health Management Team (SCHMT), and Health Facilities (HFs) on what they are planning to achieve for the medium term and long term.

The County Government will work with stakeholders to foster a broader use of the plan in ensuring efficiency, effectiveness, transparency and accountability in its implementation and resource utilization. I am confident that this collaboration will provide an effective feedback mechanism to the Government and where necessary, remedial actions will be undertaken to keep our development agenda on track.

It is my expectation that this Sectoral plan will be useful in providing a transformative development agenda for Bungoma County in the next ten years as well as fulfill the aspirations of Bungoma agenda 2040.

H.E. KENNETH MAKELO LUSAKA, EGH.
THE GOVERNOR
COUNTY GOVERNMENT OF BUNGOMA

PREFACE

This Sector Plan is a 10 year planning document that will set pace in allocation of resources in line with the identified gaps in policy formulation, infrastructure development and resource availability to spur county development.

The Plan has been prepared through a participatory and inclusive process involving Health and Sanitation sector departments at the county and national levels, County Budget and Economic Forum, NGOs, Academic Institutions, Research institutions, development partners, religious institutions, private sector, Public Benefit Organizations (PBOs) and County citizens amongst other stakeholders. Public Participation Fora, Key Stakeholders' Fora, Key Informant Interviews and Several Group Discussions were conducted to collect relevant Information and inputs from the stakeholders. The technical committee tasked with the preparation of this Sector Plan held various workshops, which came up with a draft copy as per the guidelines set out by national treasury issued in December, 2020. The drafts were then subjected to stakeholder's validation meetings including ratification by the County Executive Committee.

This Sector Plan places great emphasis on Curative and Rehabilitative Health care as well as Preventive and Promotive Health care services. These will be supported by enactment and enforcement of relevant legislations, strengthening of governance institutions, leveraging on cross-sector linkages and mobilization of more resources towards the sector to support inclusion and equitable allocation of resources to assure efficient service delivery across the County. The implementation of this plan will require continued support from all stakeholders including other County departments not in the transport and energy sector, national government MDAs, private sector, development partners, civil society and the wider public. I am hopeful that with the contribution of all stakeholders, the sector will realize its main vision of "A healthy, productive and competitive County."

HON DR. ANDREW WEKESA WAMALWA
COUNTY EXECUTIVE COMMITTEE MEMBER
DEPARTMENT OF HEALTH AND SANITATION

ACKNOWLEDGEMENT

The preparation and publication of the County Sectoral Plan (CSP) 2023-2027 benefited from inputs of different individuals and key institutions.

I wish to thank His Excellency the Governor Kenneth Lusaka and Her Excellency the Deputy Governor Jenifer Mbatiany for overall coordination and leadership in the preparation of this plan.

The department of finance and Economic Planning under the leadership of CECM Chrispinus Barasa, Chief Officers Edward Makhandia and Dina Makokha and Treasury Directors provided direction and tremendous support.

Further I wish acknowledge the Sector CECM(s), C.Os, Directors, SWGs, technical team and Wycliffe Matumbai the sector economist for providing their invaluable technical input.

The economic planning directorate under the leadership of Ag. Director James W Wafula and Ag. Deputy Director Metrine Chonge, senior economists Peter Cheworei, Beatrice Nyambane, Evans Kisika, Cyphren Sabuni, Humphrey Situma, Howard Lugadiru the health economist Edgar Barasa are highly appreciated for providing secretariat services and input to the preparation process.

Finally, I wish to thank most sincerely the various institutions (CBEF, CSOs, COG, KIPPRA, National Government MDAs, LREB and Development Partners), the County Citizenry and any other stakeholders that contributed in one way or the other to the development of this plan.

Thank you and God bless you all.

CHIEF OFFICER
HEALTH AND SANITATION

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ABBREVIATIONS AND ACRONYMS

APR – Annual Progress Report
ASDSP – Agriculture Sector Development Support Programme
ASTGS –
AU – African Union
CADP – County Annual Development Plans
CBA – Collective Bargaining Agreement
CBEF – County Budget and Economic Forum
CDH –
CDMSP –
CECM – County Executive Committee Member
CFSP – County Fiscal Strategy Paper
CHMT – County Health Management Teams
CIMES – County Integrated Monitoring and Evaluation System
CME - Continuous Medical Education
CO – Chief Officer
COH –
COMEC – County Monitoring and Evaluation Committee
CSO – Civil Society Organizations
CSP – County Sectoral Plans
CIDP – County Integrated Development Plan
GCP – Gross County Product
GESIP - Green Economy Strategy and Implementation Plan
HDU – High Dependency Unit
HIV – Human Immunodeficiency Virus
HMIS - Health Management Information Systems
IBEC - **Intergovernmental** Budget and Economic Council
ICT – Information Communication Technology
ICU – Intensive Care Unit
IGRTC - Intergovernmental Relations Technical Committee
KNBS – Kenya National Bureau of Statistics
LREB - Lake Region Economic Bloc
MDA – Ministries Departments and Agencies
MED - Monitoring and Evaluation Department
M & E – Monitoring and Evaluation
MTEF – Medium Term Expenditure Framework
MTP – Medium Term Plan
NHIF – National Housing Insurance Fund
NSP - National Spatial Plan
OAU – Organization of African Unity
OD – Open Defecation
ODF – Open Defecation Free
OJT – On Job Training
PBO - Benefit Organizations
PER –
PFMA – Public Finance Management Act
RMCAH – Reproductive Maternal Child Adolescent Health
SDG – Sustainable Development Goals
SWG – Sector Working Group
TB – Tuberculosis
UHC - Universal Health Coverage
UN – United Nations
WASH – Water Sanitation and Hygiene
WHO - **World** Health Organization

EXECUTIVE SUMMARY

County planning and development is one of the functions assigned to the County Governments in the Fourth Schedule of the Constitution of Kenya 2010. Article 174 of the Constitution provides the objects of devolution of government, which include, amongst others: to promote democratic and accountable exercise of power; to recognise the right of communities to manage their own affairs and to further their development; and, to promote social and economic development and the provision of proximate, easily accessible services throughout Kenya.

Part XI of the County Government Act, 2012 provides for amongst others, the principles of county planning and development facilitation; objectives of county planning; Obligation to plan by the county; integrating national and county planning; and types and purposes of county plans. Section 102 (h) of the Act underscores the relevance of planning at the county level with a view to aligning county financial and institutional resources to policies, objectives and programmes; providing a platform for unifying planning, budgeting and financing programme implementation, as well as performance review.

Counties align their development policies, programmes and projects to the national development framework. It is on this basis that this sectoral plan is prepared. The plan is organised into six chapters as follows;

Overview of the County; the section should give highlights on the county size, the overall demographics, a summary of major economic activities driving the economy of the county.

Situation analysis; discuss the environment within which the sector operates in terms of macro-economic, political (administration), socio-cultural, demographics, environmental, technological issues among others while giving factors influencing the performance of the sector. Resource management to finance its programmes for the previous ten (10) years is discussed showing clearly the sources of funds and the expenditures.

Sector Performance Trends and Achievements; an analysis of the sector performance trends based on the key sector outcomes, Sectoral Development Issues and their causes as well as any cross-cutting and emerging issues and how they affect the performance of the sector.

Sector Development Strategies and Programmes; the sector objectives and strategies in relation to development issues identified in the previous chapter.

Implementation Mechanisms; Institutions and their specific roles in the implementation of the sectoral plan. County Government institutions may include

County Executive Committee, County Assembly, County Planning Unit, Council Sectoral Committees, County Budget and Economic Forum (CBEF), Regional Economic Blocs, Intergovernmental Sectoral Committees under Intergovernmental Budget and Economic Council (IBEC), among others. A structure for effective coordination of the implementation of the sector plan as well as the potential financing mechanism is discussed.

Monitoring and Evaluation Framework; a framework that will enable tracking implementation of the CSP and its continual review and updating is highlighted in line with the County Integrated Monitoring and Evaluation system (CIMES) as well as the County Monitoring and Evaluation Policy.

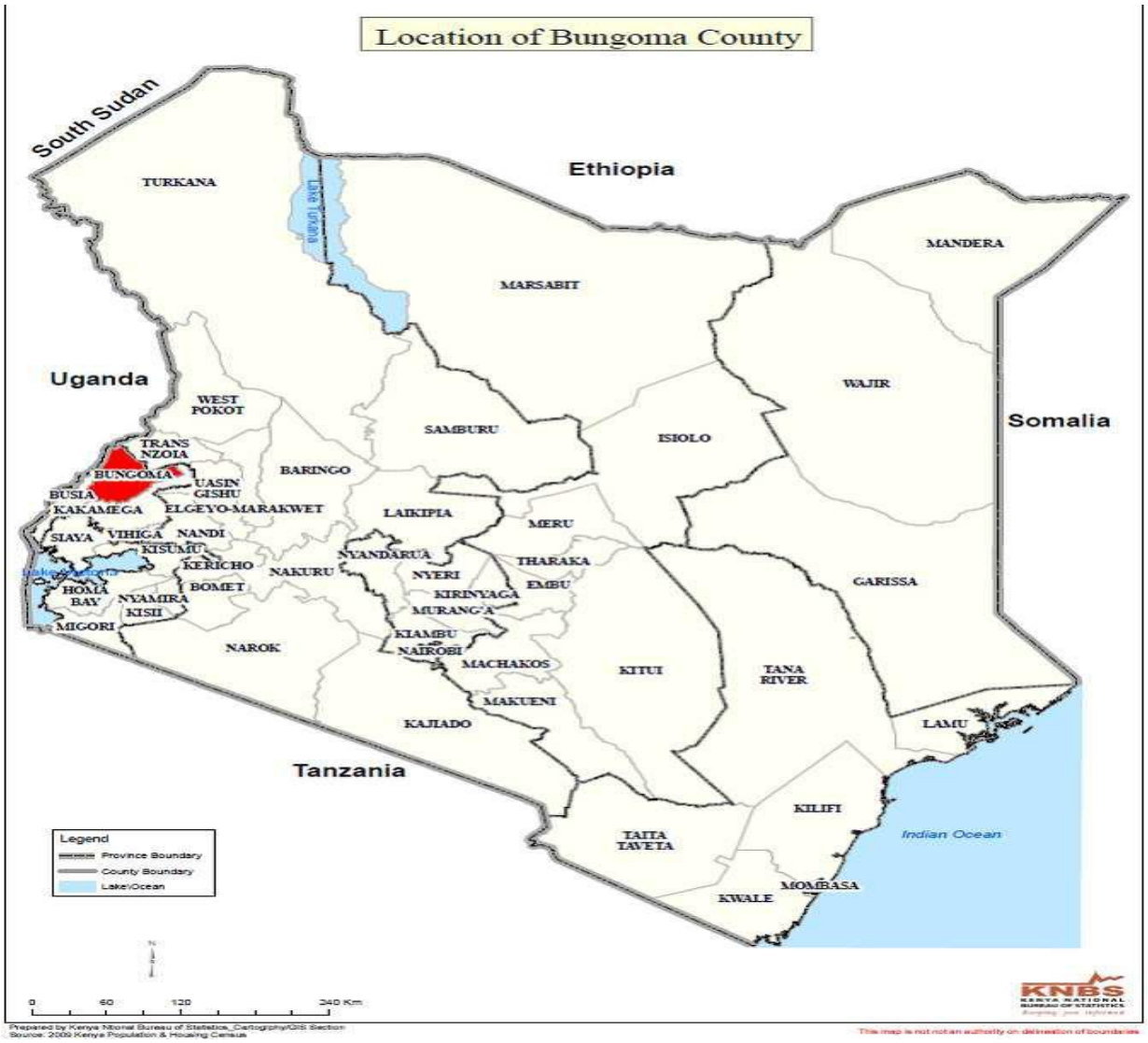
CHAPTER ONE: INTRODUCTION

1.1 Overview of the County

1.1.1 Size and Location

Bungoma County is one of the 47 County Governments in the Republic of Kenya created under the Constitution of Kenya 2010. It is located in the western part of Kenya. The County lies between latitude 00 28' and latitude 10 30' North of the Equator, and longitude 340 20' East and 350 15' East of the Greenwich Meridian. The County covers an area of 3032.4 Km². It boarders the republic of Uganda to the North west, Trans-Nzoia County to the North-East, Kakamega County to the East and South East, and Busia County to the West and South West.

Maps 1: Location of Bungoma County in Kenya



1.1.2 Physical and Topographic features

The county covers a land area of 3032.4 km2, of which 618 km2 is gazetted forest reserve (the Mt. Elgon Forest reserve), 61 km2 is non-gazetted forest, and 50.7 km2 is Mt. Elgon National Park. The altitude of the county ranges from 1,200m above sea level to 4,321m above sea level at the summit of Mt. Elgon. The County's major physical features include Mt. Elgon; Chetambe, Sang'alo, and Kabuchai hills; the Nzoia, Kuywa, Sosio, Kibisi and Sio-Malaba/Malakisi rivers; and waterfalls like Nabuyole and Teremi.

The county's topography is home to scenic tourist attraction sites for instance the highest point in the county, Mount Elgon forms one of Kenya's five water towers; wind energy can be tapped in the hills and mountain-top.

However, the steep terrain in the highland areas of the county constrains infrastructural expansion; there is soil erosion during heavy rains from Mount Elgon slopes and other hilly areas caused by human encroachment and poor farming practices on these fragile sites and the low-lying areas such as Bumula sub-county experience flooding from run-off from the hilly areas.

1.1.3 Ecological conditions

The county environment supports the interaction of a dynamic complex of plant, animal, micro-organism communities and their non-living components to form a functional unit. The most critical ecosystems in the County include forests, hills, wetlands, riparian areas, rivers and streams. These ecosystems are key natural and cultural heritage resources which support diverse biodiversity and provide natural capital for socio-economic development and support livelihoods.

Land is the basis of livelihoods for a vast majority and a foundation of economic development. Existing forest, hill ecosystems and vegetation provide energy, housing for flora and fauna and are important in conservation of soil, water catchment areas and biodiversity. High rainfall favors agricultural production.
Freshwater resources and wetlands form an important part of the county's natural resources including: the storage and retention of water for domestic, agricultural and industrial use; modifying water flows, recharging and discharging groundwater resources and diluting or removing pollutants; soil formation and retention as well as nutrient cycling as well as providing habitats for a great number of plant and animal species.

The ecosystems face numerous threats from human population pressure and land use changes for instance deforestation, housing developments, mining, uncontrolled

grazing, encroachment and the effects of climate change. About 90% of the households in Bungoma County report noticing changes in long-term environmental trends (ASDSP, 2014). These include; changes in average temperatures and amounts of rainfall (indicated by degraded soils, the drying up of wells and rivers, reduced water volumes generally, floods and landslides); deforestation; incidences of new pests and diseases; the disappearance of indigenous plants and animals; loss of biodiversity and the emergence of new plants and animals not previously found in the area.

With the ecosystems being vulnerable to natural shocks, mismanagement and unsustainable use, many are facing the threat of depletion and degradation. This will result in catastrophic and permanent change in the county's ecology with consequent loss of agricultural productivity, industrial potential development, living conditions and aggravated natural disasters such as floods and landslides. They also greatly influence the climate of the area hence the need for the conservation.

The County Government in Collaboration with relevant stakeholders shall formulate strategies to increase forest cover to a minimum of 18% by 2030, involve and empower communities in land utilization and management as well as management of forest/hill ecosystems and water catchment/wetlands areas.

1.1.4 Climatic conditions

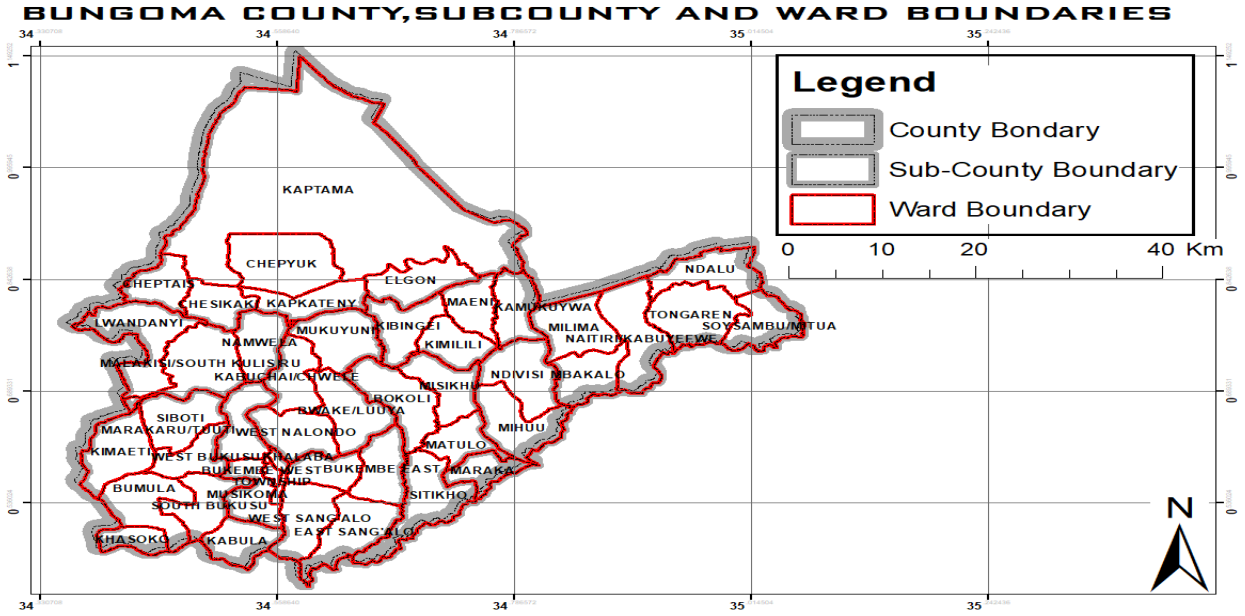
Historically, the County has had monthly temperatures of 15-29°C. The annual average temperature range for Bungoma is between 10-25°C, although elevation affects temperatures and most of the land area experiences an annual average temperature of more than 20°C while the highest point of Mt Elgon records less than 00C. The average wind speed is 6.1 km/hr.

The total annual rainfall has remained stable since 1985 and is expected to decrease slightly until 2040. The long rains season, which runs between February and June, is wetter than the second rainy season, experienced between late July and December. A dry season (characterized by fewer than 80 mm rainfall) is experienced from December to February. April and May receive the highest rainfall (more than 200 mm per month). The annual average precipitation in the county is 1100-1700 mm. Most of the County receives an annual average precipitation of more than 1400 mm. The eastern part of the county, primarily Tongaren and Webuye sub-counties, is the driest, receiving less than 1000 mm of average rainfall every year. The northern part of the county, covering the Mt. Elgon region, is significantly cooler than the southern parts (Mainly covering Bumula and Kanduyi sub-counties), with temperature differences on the order of 10°C or more.

1.1.5 Administrative Units

Bungoma County is divided into 9 Sub-Counties, 45 Wards and 236 Village Units. Map 2 shows Bungoma County administrative units.

Maps 2: Bungoma County Administrative Units



1.1.6 Demography

According to the Kenya Population and Housing Census report of 2019, the population of Bungoma County was 1,670,570 with female, male and intersex population of 858,389, 812,146 and 35 respectively, with a population growth rate of 2.1%. It has a population density of 552 people per sq.km. The total number of households was 358,796 with an average household size of 4.6.

The employable population (age 5 years and above) was 1,445,146 as at 2019. The working population was 629,607, the population seeking work was 40,627 while 774,779 were outside the labour force.

Table 1: Distribution of Population by Sex and Sub-County

National/ County	Sex			Total
	Male	**Female**	**Intersex**	
Kenya	**23,548,056**	**24,014,716**	**1,524**	**47,564,296**
Bungoma	**812,146**	**858,389**	**35**	**1,670,570**
Webuye East	55,775	58,771	2	114,548
Sirisia	58,225	61,649	1	119,875
Webuye West	74,180	78,331	4	152,515
Kimilili	78,560	83,475	3	162,038

Kabuchai	86,302	91,438	8	177,748
Bumula	103,368	112,523	1	215,892
Tongaren	107,475	114,183	2	221660
Mt. Elgon	108,556	109,964	9	218529
Kanduyi	139,705	148,055	5	287,765

Source: KNBS, Kenya Population and Housing Census Report, 2019

Table 2: Population projections by urban centers

Urban Centre	1999 Census	2009 Census	2019 Census	2022 population projection	2025 population projection	2027 population projection	2030 population projection	2032 population projection
Bungoma	44,196	54,469	68,031	72408	77066	80336	85505	89134
Kimilili	10,261	40,928	56,050	59656	63494	66188	70446	73436
Webuye	19,606	23,364	42,642	45385	48305	50355	53595	55869
Chwele	3,018	-	9,797	10427	11098	11569	12313	12836
Kapsokwony	5,687	3,663	7,077	7532	8017	8357	8895	9272
Cheptais	3,675	0	4,419	4703	5006	5218	5554	5790
Sirisia	-	-	2,096	2231	2374	2475	2634	2746

Source: KNBS, Kenya Population and Housing Census Report, 2019

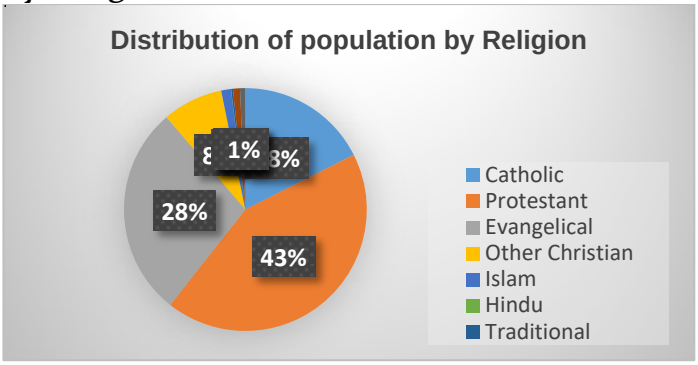
Table 3: Projection of Population by Age Group

Age Group	2019 KNBS Census population			2023 (Projections)			2027 (Projections)			2032 (Projections)		
	Male	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
0-4	109,105	110,069	219,174	118,563	119,610	238,173	128,840	129,978	258,818	142,948	144,211	287,160
5-9	126,822	126,486	253,308	137,815	137,450	275,266	149,762	149,365	299,126	166,161	165,721	331,882
10-14	133,033	133,921	266,954	144,565	145,530	290,094	157,096	158,145	315,241	174,299	175,462	349,761
15-19	109,337	106,485	215,822	118,815	115,715	234,530	129,114	125,746	254,860	143,252	139,516	282,768
20-24	65,615	74,162	139,777	71,303	80,591	151,893	77,483	87,576	165,060	85,968	97,166	183,135
25-29	49,457	59,132	108,589	53,744	64,258	118,002	58,403	69,828	128,231	64,798	77,474	142,272
30-34	46,615	57,000	103,615	50,656	61,941	112,597	55,047	67,310	122,357	61,075	74,681	135,755
35-39	35,762	35,486	71,248	38,862	38,562	77,424	42,231	41,905	84,135	46,855	46,493	93,348
40-44	32,035	34,866	66,901	34,812	37,888	72,700	37,830	41,173	79,002	41,972	45,681	87,653
45-49	26,584	26,841	53,425	28,888	29,168	58,056	31,393	31,696	63,089	34,830	35,167	69,997
50-54	19,025	22,101	41,126	20,674	24,017	44,691	22,466	26,099	48,565	24,926	28,957	53,883
55-59	18,428	21,266	39,694	20,025	23,109	43,135	21,761	25,113	46,874	24,144	27,863	52,007
60-64	14,478	16,289	30,767	15,733	17,701	33,434	17,097	19,235	36,332	18,969	21,342	40,311
65-69	9,746	11,977	21,723	10,591	13,015	23,606	11,509	14,143	25,652	12,769	15,692	28,461
70-74	6,750	8,655	15,405	7,335	9,405	16,740	7,971	10,221	18,191	8,844	11,340	20,183
75-79	4,028	5,840	9,868	4,377	6,346	10,723	4,757	6,896	11,653	5,277	7,652	12,929
80-84	2,841	3,896	6,737	3,087	4,234	7,321	3,355	4,601	7,956	3,722	5,105	8,827
85-89	1,629	2,503	4,132	1,770	2,720	4,490	1,924	2,956	4,879	2,134	3,279	5,414
90-94	555	848	1,403	603	922	1,525	655	1,001	1,657	727	1,111	1,838
95-99	253	465	718	275	505	780	299	549	848	331	609	941
100+	41	100	141	45	109	153	48	118	167	54	131	185
Not Stated	7	1	8	8	1	9	8	1	9	9	1	10
Total	812,146	858,389	1,670,535	882,545	932,797	1,815,342	959,047	1,013,655	1,972,702	1,064,066	1,124,654	2,188,720

KNBS, Kenya Population and Housing Census Report, 2019 (Annual Growth Rate, 2.1%)

Table 4: Distribution of Population by Religion	
Catholic	291,998
Protestant	715,732
Evangelical	467,570
Other Christian	133,854
Islam	21,687
Hindu	424.00
Traditional	3,884.00
Other Religion	15,342.00
No Religion	11,813.00

Figure 1: Distribution of population by Religion



KNBS, Kenya Population and Housing Census Report, 2019

1.1.7 Major Economic Activities

Agriculture contributes the most to the Gross County Product at 44.2% followed by Transport and Storage at 11.6% respectively. Other key economic activities include public administration and defense, education, water supply and waste collection, wholesale and retail, real estate activities, manufacturing and construction.

Human health and social work activities contributed 2.23% to the Gross County Product in 2020 having increased from 1.67% in 2017.

The table below highlights the contribution of the various economic activities in the County (KNBS, Gross County Product Reports, 2019 and 2021)

Table 5: Gross County Product (GCP) by Economic Activities in millions, 2017 and 2020

Economic Activity	GCP (In Kshs, millions)- 2017	GCP (In Kshs, millions)- 2020	Deviation	Percent contribution to GCP 2017	Percent contribution to GCP 2020	Deviation	% contribution to National GVA and GDP-2020s	% contribution to National GVA and GDP-2020	Deviation
Agriculture, forestry and fishing	107,829	91,795	(16,034)	58.76%	44.20%	(14.56)	3.8	3.7	(0.1)
Mining and quarrying	304	355	51	0.17%	0.17%	0	0.5	0.5	0
Manufacturing	1,720	8,162	6,442	0.94%	3.93%	2.99	0.3	1.1	0.8
Electricity supply	433	760	327	0.24%	0.37%	0.13	0.3	0.5	0.2
Water supply; waste collection	1,203	1,357	154	0.66%	6.53%	5.87	2.1	2.2	0.1
Construction	4,123	6,294	2,171	2.25%	3.03%	0.78	0.9	0.8	(0.1)

Wholesale and retail trade; repair of motor vehicles	6,650	10,327	3,677	3.62%	4.97%	1.35	1.1	1.2	0.1
Transport and storage	10,388	24,093	13,705	5.66%	11.60%	5.94	1.7	2.1	0.4
Accommodation and food service activities	394	1,349	955	0.21%	0.65%	0.44	0.7	1.7	1.0
Information and communication	1,576	4,031	2,455	0.86%	1.94%	1.08	1.4	1.4	0
Financial and insurance activities	9,933	2,381	(7,552)	5.41%	1.15%	(4.26)	1.6	0.3	(1.3)
Real estate activities	9,217	9,979	762	5.02%	4.80%	(0.22)	1.6	1.0	(0.6)
Professional, technical and support services	14	3,142	3,128	0.01%	1.51%	1.5	0.0	0.9	0.9
Public administration and defense	8,742	16,869	8,127	4.76%	8.12%	3.36	2.6	2.8	0.2
Education	15,730	16,571	841	8.57%	7.98%	(0.59)	4.9	4.1	(0.8)
Human health and social work activities	3,067	4,623	1,556	1.67%	2.23%	0.56	2.4	2.1	(0.3)
Other service activities	3,761	4,286	525	2.05%	2.06%	(0.24)	4.1	2.0	(2.1)
FISIM1	1,574	1,310	(264)	0.86%	0.63%	(0.23)	0.6	0.6	0.0
Total	**183,509**	**207,684**	**24,175**	**96.96%**	105.9%	8.94	2.4	2.1	(0.3)

Source: KNBS, Gross County Product Reports, 2019 and 2021

1.2 Background Information

1.2.1 Overview of the Sector

According to the World Health Organisation (WHO), health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO, 1978). WHO has further proclaimed that "the health of all the people is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and states", and that "the enjoyment of the highest attainable standards of health" is one of the fundamental rights of every human being. This has been further affirmed by the Kenyan Constitution 2010.

The benefits of having access to an improved drinking water source can only be fully realized when there is also access to improved sanitation and adherence to good hygiene practices. Beyond the immediate, obvious advantages of people being hydrated and healthier, access to water, sanitation and hygiene – known collectively as

WASH – has profound wider socio-economic impacts, particularly for women and girls. A WHO study in 2012 calculated that for every US$ 1.00 invested in sanitation, there was a return of US$ 5.50 in lower health costs, more productivity and fewer premature deaths.

The fact that WASH is the subject of dedicated targets within the Sustainable Development Goal (SDG 6) is testament to its fundamental role in public health and therefore in the future of sustainable development. Indeed, access to safe water and sanitation are human rights, as recognized in 2010 by the United Nations General Assembly. For fulfilment of these rights to become reality in the county, we will need the right systems: well-resourced, capable institutions delivering services and changing behaviour in resilient and appropriate ways.

The Constitution of Kenya 2010 provides the overarching legal framework to ensure a comprehensive rights-based approach to health services delivery. It provides that every person has a right to the highest attainable standard of health, which includes reproductive health rights. It further states that a person shall not be denied emergency medical treatment and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependants. The State has a further constitutional obligation under Article 46 of the Constitution to protect consumer rights, including the protection of health, safety, and economic interests. Under the environmental and sanitation rights guaranteed in Articles 42 and 43 (b) of the Constitution, the state is required to take legislative and policy measures including setting standards to achieve the progressive realisation of the rights to ensure their widest possible enjoyment.

The Constitution of Kenya 2010 assigns specific functions to the two levels of Governments, which are as follows: National government: leadership of health policy development; management of national referral health facilities; capacity building and technical assistance to counties; and consumer protection, including the development of norms, standards and guidelines. For Sanitation, the National Government retains responsibility for national policy, training, capacity building, technical assistance and standards formulation. County governments: responsible for county health services, including county health facilities and pharmacies; ambulance services; promotion of primary healthcare; licensing and control of undertakings that sell food to the public; cemeteries, funeral parlours and crematoria; and refuse removal, refuse dumps, solid waste disposal and storm water management in built-up areas.

Access to improved sanitation in the county predominantly consist of simple pit latrines providing varied degrees of safety, hygiene and privacy. Open defecation is still practiced in the county despite the government's ambitious Open Defecation Free (ODF) Rural Kenya 2013 Campaign Roadmap. Children's faeces are often not

contained, due to parental perception that children may fall in latrines, and also the perception that children's faeces are harmless. Some adults also continue to routinely defecate in the open at night and during the rainy season. It is estimated that only about 25% of the urban areas in the county have some form of sewerage coverage and only a small proportion of the sewerage is effectively treated.

Urban settlements in the county are characterized by uncontrolled, unsightly, and indiscriminate garbage disposal. Drains are clogged during the rainy season, while streams running through settlements carry polluted water from a combination of sources including sullage (refuse and dirt carried by drains), pit latrine wastes, and drainage. These polluted streams are also sources of drinking water to downstream users. Although there is no system in place to collect data on air quality in Kenya, pollution levels in urban areas is high. The high particulate matter in the air emanates from industrial activities concentrated in urban areas and from emissions by cars and other forms of transport. In rural areas, the quality of air is affected mostly by over-reliance on wood fuel, agricultural activities and poor housing. These have led to increased disease incidences in the county.

Solid waste management is a major environmental hazard. Food, paper and plastic waste make up the bulk of the county's solid waste and are projected to continue to be the leading solid waste in the future. Chemical and hazardous waste is mainly attributed to use of farm inputs. However, waste from hospitals and import of cheap counterfeit goods (especially electronics) are the main sources of hazardous waste. These types of waste are projected to pose a great danger to the population as the economy grows. Due to lack of appropriate disposal facilities, medical and hazardous wastes continue to pose a challenge in environmental management. This waste is disposed together with general municipal waste without segregation. This calls for the use of market-based instruments to improve waste management, as well as public awareness measures to promote sound waste disposal practice.

Kenya's healthcare system is structured in a hierarchical manner that begins with primary healthcare, with the lowest unit being the community, and then graduates, with complicated cases being referred to higher levels of healthcare. Primary care units consist of dispensaries and health centres. The current structure consists of the following six levels:

Level 1: Community
Level 2: Dispensaries
Level 3: Health centres
Level 4: Primary referral facilities
Level 5: Secondary referral facilities
Level 6: Tertiary referral facilities

1.2.1 Sub-Sectors and their Mandates

Medical services Sub-Sector

Medical services focus on curative and rehabilitative services through provision of quality, affordable, equitable, accessible, resilient and responsive health care services. This includes: provision of medical and biomedical services; nursing; emergency referral services; laboratory services; nutrition; pharmacy; diagnostic services; health infrastructure; medical equipment, drugs and other supplies; medical insurance; emergency referral services; community capacity building amongst others.

Public Health and Sanitation Sub-Sector

Public health and sanitation focuses on promotive and preventive services. The sub-sector provides for the prevention or early detection of diseases and other public health risks, provision of safe, clean, accessible and affordable sanitation through public awareness and enforcement of sanitation and hygiene standards; infrastructural development, solid waste management, waste-water management; development and management of sewerage infrastructure, amongst others.

1.2.3 Contribution of the Sector towards Social Economic Development

Human health has a major role to play in economic development. There is a direct link between the health of a population and its productivity, and this relationship has been demonstrated in industrial countries, which are now benefiting from years of investment in health services (Schultz, 1993). Achievement of good health is critical in enhancing human development. A sound healthcare delivery system, good nutritional status, food security and absence of epidemic diseases are the conditions that produce healthy people capable of participating in a country's economic, social and political development.

Provision of good health services satisfies one of the basic human needs and contributes significantly towards maintaining and enhancing the productive potential of the people. Improving health services reduces production losses caused by worker illness, permits the use of national resources that had been totally or nearly inaccessible because of disease, increases the enrolment of children in school, and increases learning ability. In Kenya, the central government, local authorities, church missions, industrial health units and private institutions and individuals are the main providers of health services.

Sanitation is a basic necessity that contributes to better human health, dignity and quality of life. The economic and social benefits of sanitation interventions create more time for productive pursuits, higher productivity, better performance at school

and work, lower medical costs. Closer access leads to a better living environment, dignity, safety, convenience, comfort and status. However, in Kenya, Bungoma County included, basic sanitation services are not accessible to the majority of the population. The result is that the poor are deprived of decent and dignified lifestyles leading to deterioration of health, wellbeing and human environment. Lack of sanitation is a major cause identified as a leading risk factor and contributor to mortality and morbidity in Kenya. Childhood stunting which can affect both educational and long-term productivity outcomes has been linked to poor sanitation, particularly to open defecation. Besides the burden of sickness and death, inadequate sanitation threatens to contaminate water sources and undermine human dignity.

1.3 Rationale for the County Sectoral Plan

The constitution of Kenya provides for a devolved system of governance that has led to development planning at both levels of government. County government development planning framework constitutes of County Sectoral Plans (CSPs), County Integrated Development Plans (CIDPs) and County Annual Development Plans (CADPs) which are linked to the Kenya Vision 2030 and its MTPs.

1.3.1 Linkage of County Sectoral Plans with Existing Legal and Policy Framework

The legal basis for the preparation of the county Sectoral plans include:

County Government Act, 2012

The County Government Act, 2012 Section 107 specifies the types and purposes of county plans. These plans include County Integrated Development Plans, County Sectoral Plans, County Spatial Plans, and Cities and Urban Area Plans. The plans shall guide, harmonize and facilitate development and shall be the basis for all budgeting and spending in a county.

Specifically, Section 109 of the Act states that a County department shall develop a ten- year county sectoral plan as component parts of the county integrated development plan. The County sectoral plans shall be programme based, the basis for budgeting and performance management and shall be reviewed every five years by the county executive and approved by the county assembly, but updated annually.

In order to strengthen development planning at the county level, Section 54 of the County Government Act, 2012 requires that the county establishes the county intergovernmental forum that will be in charge of harmonization of services rendered, coordination of development activities and intergovernmental functions in the county.

Public Finance Management Act, 2012

The Public Finance Management Act, 2012 Section 125 provides for stages in the county budget process. The key stages for county governments planning and budgeting process in any financial year shall consist of, among others: integrated development planning process which shall include both long term and medium-term planning; planning and establishing financial and economic priorities for the county over the medium term; and making an overall estimation of the county government's revenues and expenditures.

Section 126 of the Act provides that every county government shall prepare a development plan in accordance with Article 220(2) of the Constitution, that includes: strategic priorities for the medium term that reflect the county government's priorities and plans; a description of how the county government is responding to changes in the financial and economic environment; and programmes to be delivered with details for each programme of the strategic priorities to which the programme will contribute, the services or goods to be provided; measurable indicators of performance where feasible, and the budget allocated to the programme.

Section 137 of the Act provides for the establishment of County Budget and Economic Forum (CBEF) to facilitate county budget consultation process and provide means for consultation by the county government on the preparation of county plans. In addition, section 187 of the Act provides for the establishment of the Intergovernmental Budget and Economic Council (IBEC) that shall among others provide a forum for matters relating to budgeting, the economy and financial management and integrated development at the national and county level.

Urban and Cities Act, 2011

Section 37 (1) of Urban and Cities Act, 2011 states that a city or urban area integrated development plan shall be aligned to the development plans and strategies of the county governments. In addition, section 36(2) states that an integrated urban or city development plan shall bind, guide and inform all planning development and decisions and ensure comprehensive inclusion of all functions.

Intergovernmental Relations Act, 2012

Section 7 of the Intergovernmental Relations Act, 2012, establishes the Summit responsible for, among others, monitoring the implementation of national and county development plans and recommending appropriate action. Section 11 of the Act establishes the Intergovernmental Relations Technical Committee (IGRTC) while Section 12 gives its functions which include, among others, providing secretariat services to the summit.

Sections19 and 20 (1) (f), (1) (g), (3) of the Act establishes the Council of Governors and gives it, among other functions, to coordinate the receiving of reports and monitoring the implementation of inter-county agreements on inter-county projects. The Council of Governors is also mandated to establish sector working groups or committees for the better carrying out of its functions.

1.3.2 Domestication of Inter-County Regional and International Obligations and Commitments

For the County Sectoral Plan to be all inclusive there is a need to link it with other plans including international conventions. Such Plans include:

Lake Region Economic Bloc (LREB)

The counties that constitute the Lake Region Economic Bloc are Bungoma, Busia, Homa Bay, Kakamega, Kisii, Kisumu, Migori, Nyamira, Siaya, Trans-Nzoia, Kericho, Bomet, Nandi and Vihiga. They not only have similar ecological zones and natural resources; they have analogous cultural histories that date back to historical migrations and trading routes.

LREB was developed with the support of Deloitte East Africa and Ford Foundation in partnership with the county governments of the member14 counties. The objective of the BLOC was to have an integrated approaching bringing together all the available resources, identify the opportunities and purposefully have all policies, programs and activities in the Lake Region aligned towards raising and sustaining the quality of peoples' life and ecosystems.

During the process of developing the Blueprint, ten (10) strategic intervention areas emerged as follows: Productive Sectors, Social Sectors and Enablers;

- **PRODUCTION SECTOR**
  - Tourism Pillar
  - Agriculture Pillar
  - Trade & Industrialization Pillar
- **SOCIAL SECTOR**
  - Education Pillar
  - Health Pillar
  - Youth, Gender & PWDs Pillar
  - Water, Environment & Climate Change Pillar
- **ENABLING SECTOR**
  - Financial Services Pillar
  - Infrastructure Pillar
  - Information Communication Technology Pillar

Kenya Vision 2030 and Medium-Term Plans

Kenya's Vision 2030 is an economic blueprint that seeks to create "a globally competitive and prosperous nation with a high quality of life by 2030". The Vision aims to transform the country into a middle-income country providing a high quality of life to all its citizens in a clean and secure environment.

The Vision is anchored on three key pillars: economic; social; and political. Each pillar has a clearly set out objectives. The Economic Pillar seeks to attain and sustain a growth rate of 10% per annum on average with respect to the Gross Domestic Product (GDP) till 2030. The sectors that have been prioritized under this pillar include: Infrastructure; Tourism; Agriculture; Trade; Manufacturing; Business Process Outsourcing and Information Technology, and financial services.

The Social Pillar targets a cross-section of human and social welfare projects and programmes so as to improve the quality of life for all Kenyans. The sectors prioritized under this pillar include; Education and Training; Health, Environment; Housing; Gender, Children and Social Development; Labour and Employment; Youth and Sports.

The Political Pillar envisions a democratic system that is issue based, people centred, results oriented and is accountable to the public. The pillar is anchored on transformation of Kenya's political governance across five strategic areas; the rule of law – the Kenya Constitution 2010; Electoral and political processes; Democracy; Public Service delivery; Transparency and accountability Security, peace building and conflict management.

Kenya Vision 2030 is implemented through successive five years Medium Term Plans (MTP) at the national level while the CIDPs implement it at the county level. The first MTP covered the period 2008-2012, the second, 2013-2017 while the third MTP 2018-2022is coming to an end this year. The fourth MTP is in the final process of preparation and seeks to implement projects and programs identified under Vision 2030 over the five-year period.

County governments are thus envisaged to support implementation of Vision 2030 projects that may be domiciled in or cut across the counties and further identify specific projects and programmes for implementation towards achievement of the Kenya Vision 2030.

Constitution of Kenya 2010

The Constitution of Kenya, 2010 created a two-tier system of governance, the national and devolved governments that are distinct but interdependent, each with specific

functions as set out in the fourth schedule. It creates the national government and 47 county governments.

The Fourth Schedule delineates the functions of the national and county governments. A total of 14 functions have been devolved to the counties. The main ones being; county planning and development; agriculture; county health services; control of air pollution, noise pollution, other public nuisances and outdoor advertising; cultural activities, public entertainment and public amenities; county roads and transport; animal control and welfare; trade development and regulation; pre-primary education and village polytechnics; specific national government policies on natural resources and environmental conservation; county public works and services; firefighting services and disaster management; and, control of drugs and pornography. In view of this the Sector Plan is drawn from the fourth schedule of the Constitution.

The national government has since 2010 enacted Acts of parliament to address the issues of devolution. The main Acts include; Urban Areas and Cities Act, 2011; County Governments Act, 2012; The Transition to Devolved Government Act, 2012; The Intergovernmental Relations Act, 2012 and The Public Finance Management Act, 2012. These Acts have in effect operationalized the County Governments.

National Spatial Plan (NSP) framework

Kenya has prepared a thirty-year spatial plan (2015-2045) that aims at harmonizing development in the country. The plan envisages optimal productivity, sustainability, efficiency and equitability in the use of the scarce land in Kenya and the territorial space. The plan seeks to distribute the population and activities on the national space to sustainable socio-economic developmentas outlined in its Vision 2030 blue print in areas such as agriculture, tourism, energy, water, fishing and forestry.

In view of this, the County Government has developed a County Spatial Plan that is intended to serve as a broad-based and indicative framework for development coordination. It represents shared strategic direction regarding the spatial organization of the County as a whole, and relies on the agency of the adopted spatial structure in engendering sustainable growth and development of the County.

Green Economy Strategy and Implementation Plan (GESIP)

The plan seeks to guide Kenya's transformational path way in five thematic areas namely; sustainable infrastructure development, building resilience, sustainable natural resources management, resource efficiency, social inclusion and sustainable livelihood.

Implementation of GESIP will be guided by a set of principles meant to boost sustainable consumption and production, namely: equity and social inclusion; resource efficiency; Polluter-Pays-Principle; precautionary principle; good governance; and public participation. This will contribute to the national implementation of the Paris Agreement on climate change and the attainment of the Sustainable Development Goals.

The GEISP lays emphasis on mitigating the socio-economic challenges facing the achievement of the Kenya vision 2030.These are; food insecurity, poverty, inequalities, unemployment, poor infrastructure, environmental degradation, climate change and variability.

Transitioning to a green economy requires significant resources in terms of finance, investment, technology and capacity building. Therefore, integration of GE in the planning and budgeting processes is crucial at both the national and county level for successful implementation of GESIP.

Agenda 2063 of the African Union

Africans of diverse social formations and in the Diaspora in 2015 affirmed the AU Vision of "an integrated, prosperous and peaceful Africa, driven by its own citizens and representing a dynamic force in the international arena" as the overarching guide for the future of the African continent. Further, they reaffirmed the relevance and validity of the OAU/AU 50th Anniversary Solemn Declaration.

The converging voices of Africans of different backgrounds, including those in the Diaspora have painted a clear picture of what they desire for themselves and the continent in the future. From these converging voices, a common and a shared set of aspirations have emerged:

i. A prosperous Africa based on inclusive growth and sustainable development;
ii. An integrated continent, politically united, based on the ideals of Pan Africanism and the vision of Africa's Renaissance;
iii. An Africa of good governance, respect for human rights, justice and the rule of law;
iv. A peaceful and secure Africa;
v. An Africa with a strong cultural identity, common heritage, values and ethics;
vi. An Africa whose development is people-driven, relying on the potential of African people, especially its women and youth, and caring for children; and
vii. Africa as a strong, united, resilient and influential global player and partner.

The aspirations reflect the desire of Africans for prosperity and well-being, for unity and integration, for a continent of free citizens and expanded horizons, with freedom from conflict and improved human security. They also project an Africa of strong identity, culture and values, as well as a strong and influential partner on the global stage making equal, respected contribution to human progress and welfare.

The aspirations embed a strong desire to see a continent where women and the youth have guarantees of fundamental freedoms to contribute and benefit from a different, better and dynamic Africa by 2063, and where women and youth assume leading roles in growth and transformation of African societies. The County government through this plan will develop strategies that are in line with the Africa Agenda 2063.

Sustainable Development Goals

The Sustainable Development Goals (SDGs) are a comprehensive development plan with a set of 17 goals and 169 targets agreed upon at the UN General Assembly and adopted as the post development agenda in September 2015. The world will use them for strategic planning, policy review and action for sustainable development so as to bring about economic progress, social justice and inclusion, protection of the climate, environment and biodiversity while ensuring no one is left behind.

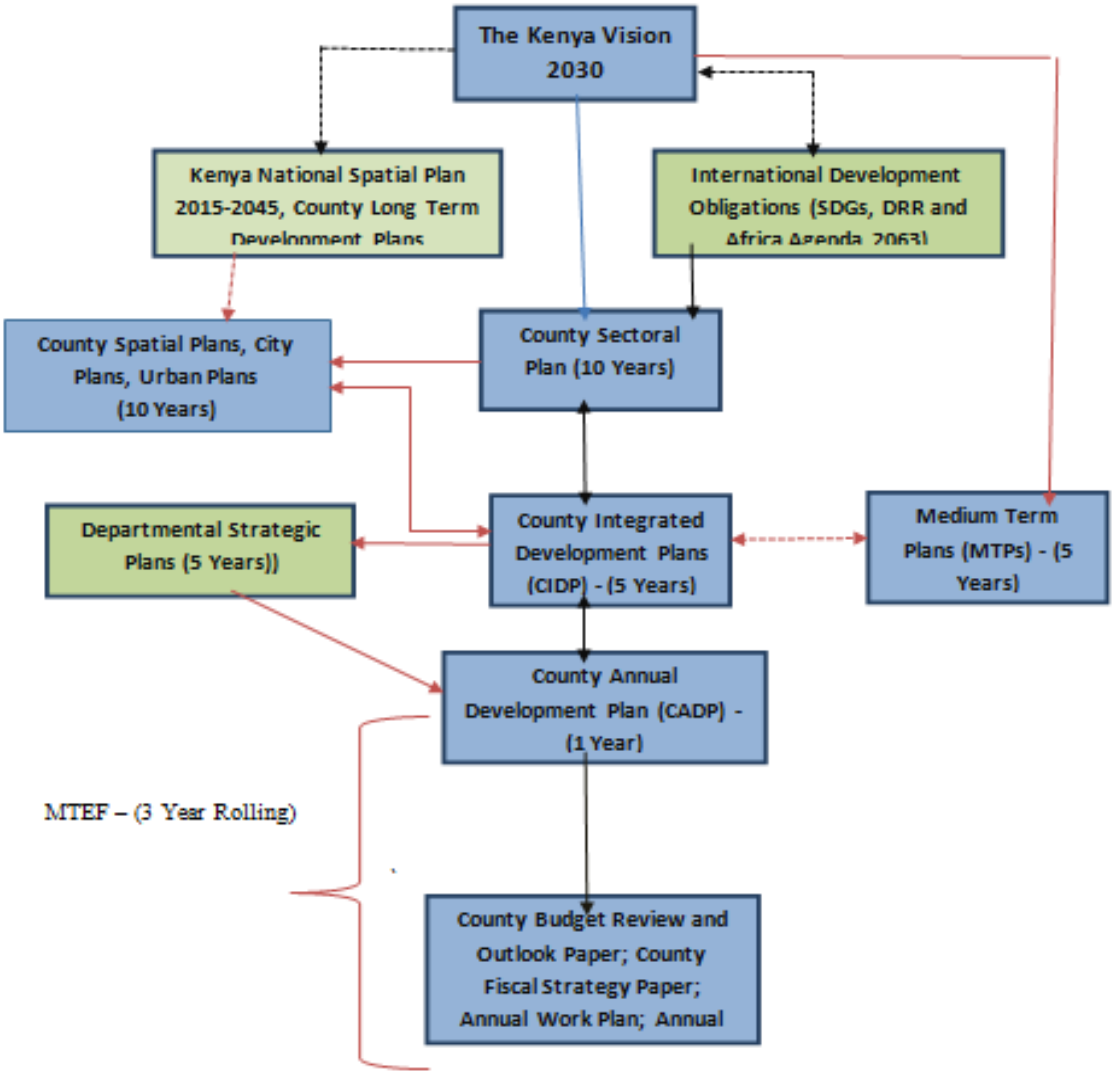
As the excerpt from the 2030 Agenda describes, the SDGs and targets are aspirational and global with each government called to decide how the SDGs should be incorporated into national/County planning processes, policies and strategies.

The country's Vision 2030 blueprint is in line with the goals and targets of the new agenda which undergoes review every 5 years. The national blueprint defines the strategies and programs that will translate into efficient, effective, and responsive actions that are achievable. In view of this, the County government will undertake the following steps in addressing the post 2015 agenda;

a. Identify SDGs relevant to the sectors and functions allocated to the counties via the schedule four of the constitution.
b. Mainstream and integrate in their strategies and plans the identified global SDGs considering the three dimensions of sustainable development: economic, social and environmental.
c. Set County-relevant targets: for County-adapted and inclusive SDGs that are achievable, yet ambitious.
d. Put in place an information management system that will support performance, monitoring and reporting of results and progress.
e. Appoint at least one officer to serve as the County's SDGs champion

The County Government will continue to create opportunities for real dialogue between people about the implementation of the post-2015 agenda, especially marginalized and excluded groups and authorities by institutionalizing dialogue structures, such as debates – at the County assembly, and also within communities and County conferences.

Figure 2: CSP Linkage with Other Plans



1.4 Approach/methodology in the preparation of the sector plan

1.4.1 Steps in Preparation of the CSP

Phase I: Preliminary stage

(i) The County Executive Committee (CEC) Member for Finance and Economic Planning issued a circular to initiate CSP preparation process. The circular clearly outlined county sectors, composition of sector working groups and their terms of

reference (TORs) and timelines for accomplishment of milestones in the preparing of the CSP.

(ii) The CEC member for Health and Sanitation constituted the Sector Working Group (SWG) for the Sector which was responsible for spearheading the Sector Plan preparation process. The Chair of the SWG was the Chief Officer for Health and Sanitation while the sector economist was the secretary to the SWG. The other SWG members included technical officers from the County Health and Sanitation Department and other state and non-state representatives.

(iii) Sensitization sessions on the CSP guidelines and the preparation process of CSP was conducted by the sector economist to the sector working group.

Phase II: Drafting Process

(i) Data collection and analysis

The SWG undertook a desktop and secondary data review on sector performance to determine the level of achievement, programmes implementation challenges and lessons learnt. Departmental reports, M&E Reports, sector related policies and laws, CIDP, Kenya Vision 2030, ASTGS, Previous Sector Plans, Community Social Audit Reports, Financial Statements, Controller of Budget Reports, Economic Surveys, National Government Agriculture Development Strategies, National and county Spatial Plans, Statistical Abstracts and other KNBS Publications were comprehensively reviewed for data collection and to generate content for the sector plan preparation process.

The SWG undertook stakeholder mapping that included relevant agriculture sector departments at the county and national levels, County Budget and Economic Forum, NGOs, Academic Institutions, Research institutions, development partners, religious institutions, private sector, Public Benefit Organizations (PBOs) and County citizens amongst other stakeholders. Public Participation Fora, Key Stakeholders' Fora, Key Informant Interviews and Several Group Discussions were conducted to collect relevant Information and inputs from the stakeholders.

(ii) The SWG retreated for drafting workshops and consolidation of the collected data and information. A draft Health Sector Plan was then developed as per the guidelines.

Phase III: Validation

The draft sector plan was further subjected to a key stakeholders' forum for input and comments for incorporation by the SWG.

Phase IV: Approval

The SWG presented the draft Sector Plan to the county executive committee member for Health for presentation to the County Executive Committee for consideration and adoption before submission to the county assembly for approval.

CHAPTER TWO: SITUATION ANALYSIS

2.1 Sector Context Analysis

This section discusses the environment within which the sector operates. This includes macroeconomic, political (administration), socio-cultural, demographics, environmental, technological issues among others. It highlights the intra-county data variations and key factors influencing the performance of the sector. The section also discusses the existing sector policy and legal framework and how they influence the performance of the sector. This include national and county policies, regional and international obligations.

Macro-Economic Analysis

High cost of healthcare resulting from the outbreak of COVID-19 in early 2020 affected the cost of living as supplies were obtained at higher prices. In 2021, the county in collaboration with the National Government enrolled 32,000 vulnerable households on National Hospital Insurance Scheme to cushion them against high cost of health care.

Increased unemployment levels in the county as a result of business closure due COVID-19 containment measures affected household income levels. This consequently led to low income for health care expenditure especially for the out of pocket expenditure.

Increased investment in health infrastructure due to the strain on existing capacity that resulted from increased number of COVID-19 patients diverted resources from other sectors.

Change in economic variables such as fluctuations in inflation rate, interest rates, taxation has adverse effect on general cost of living. Increasing inflation rates in the country partly occasioned by sharp increases in the cost of food and fuel largely affected by the COVID-19 Pandemic and the war in Ukraine. These have huge cost implications on Sectoral infrastructural projects and supplies.

Political (Administration) Context

The county is divided into 9 Sub-Counties, 45 County assembly wards, 149 sub locations and 236 village units. Wards and villages are the smallest units from which development initiatives are generated, a process that needs proper guidance and incubation. Political leadership play a key role in the life cycle of all development ideas by ensuring that there is sufficient funding as well as managing peoples' attitude towards the project through its life cycle.

Political goodwill is a major input in the success of the sector. The sector has enjoyed good political will which has enabled increased infrastructural investment for expansion and operationalization of health facilities in the county. The adoption of Universal Health Care will improve health outcomes not only nationally but also in the county.

The County government has a dedicated County Assembly, a political formation responsible for representation, oversight and implementation of the projects. This is done through engagements and enactment of relevant legal regulations/ policies to promote project identification and implementation.

The County Government, National Government and Partners have established county governance structures for sector development. Political goodwill towards functionality of established structures is important towards implementation of the planned programmes and projects.

There is an established framework for public participation and stakeholder engagement including the Constitution, County Government Act, 2012 and the PFM Act, 2012 that enables inclusivity in socio-economic development.

Enhanced support for functionality of institutions geared towards promoting transparency and accountability has led to establishment of M&E systems and improved accountability

Socio- Cultural Context

Some social cultural practices like the use of traditional medicine in parts of the county especially in Bumula and lower sides of Malakisi has led to delay of seeking health services as patients visit the health facility when their conditions have deteriorated. Further negative traditional beliefs and religious practices prevent some people in seeking health services in hospitals. To address this challenge the county incorporated the community health volunteers and traditional birth attendants in the payroll by giving them monthly stipend to sensitize the community on the need and advantages of hospital care.

Untreated or inadequately treated municipal sewerage is a major source of ground and surface water pollution in the county. This increases the incidences of diseases and healthcare costs.

High poverty index has led to informal settlements in urban areas and resource poor rural dwellers with low access to improved sanitation and essential healthcare. Social

protection measures such as supported enrolment to NHIF and provision of sanitation services will go a long way in improving the living standards of the poor.

Demographics Context

The County's population currently stands at approximately 1.72 million people. Age cohorts 15-34 represent 33.16% of the County's population thus raising the need to plan for their needs including nutrition, health services, and sanitation. Age cohorts 0-14 represent 48.49% of the County's population which calls for targeted investments in early quality schooling, quality paediatric health services, nutrition, safety, and well-being. The urban population in the County stands at 10% and could reach 15% in the medium term, with sustained rural-urban migration. The population projections, proportionately informing the current and future health and sanitation demand, clearly indicate the need for increased investments in health and sanitation infrastructure.

The increasing population and urbanization puts pressure on the healthcare system and environment. Rapid urbanization affects pollution levels and generation of larger quantities of solid waste. Anticipated growth in manufacturing will give rise to an increase in effluents discharged, which will require effective disposal management. More investment in health infrastructure, supplies and human resource will be needed to cope with population increase.

Environmental and Climatic Context

The County experiences two rainy seasons, the long rains from March to July and short rains from August to October. The annual rainfall in the County ranges from 400mm (lowest) to 1,800mm (highest). The annual temperature varies between 0°C and 32°C due to different levels of altitude, with the highest peak of Mt. Elgon recording slightly less than 0°C. The average wind speed is 6.1 km/hr. In the last decade, the County experienced increasing variability in rainfall and temperature patterns that have impacted on livelihoods especially for the most vulnerable. During rainy season there are more hospital visits compared to dry condition because of the multiplication of vectors like mosquitoes that spread malaria in the county. Increased weather variability due to climatic changes has affected predictability in health planning and response. Adaptation measures should be undertaken to combat impacts of climate change in the sector.

Technological Context

Health and sanitation sector operates in a dynamic environment with technological changes being adopted. Digitization of health services in all the hospitals and a few dispensaries and health centres has been undertaken with the support of development

partners such as the World Bank. Further the use of cashless systems such as Mpesa has enhanced efficiency in service provision. In addition, electronic messages for reminding mothers on their antenatal care and child monitoring have been adopted with support.

Adoption of E-health and Health Management Information Systems (HMIS): The use in the health sector of digital data—transmitted, stored, and retrieved electronically—in support of healthcare, both at the local site and at a distance.

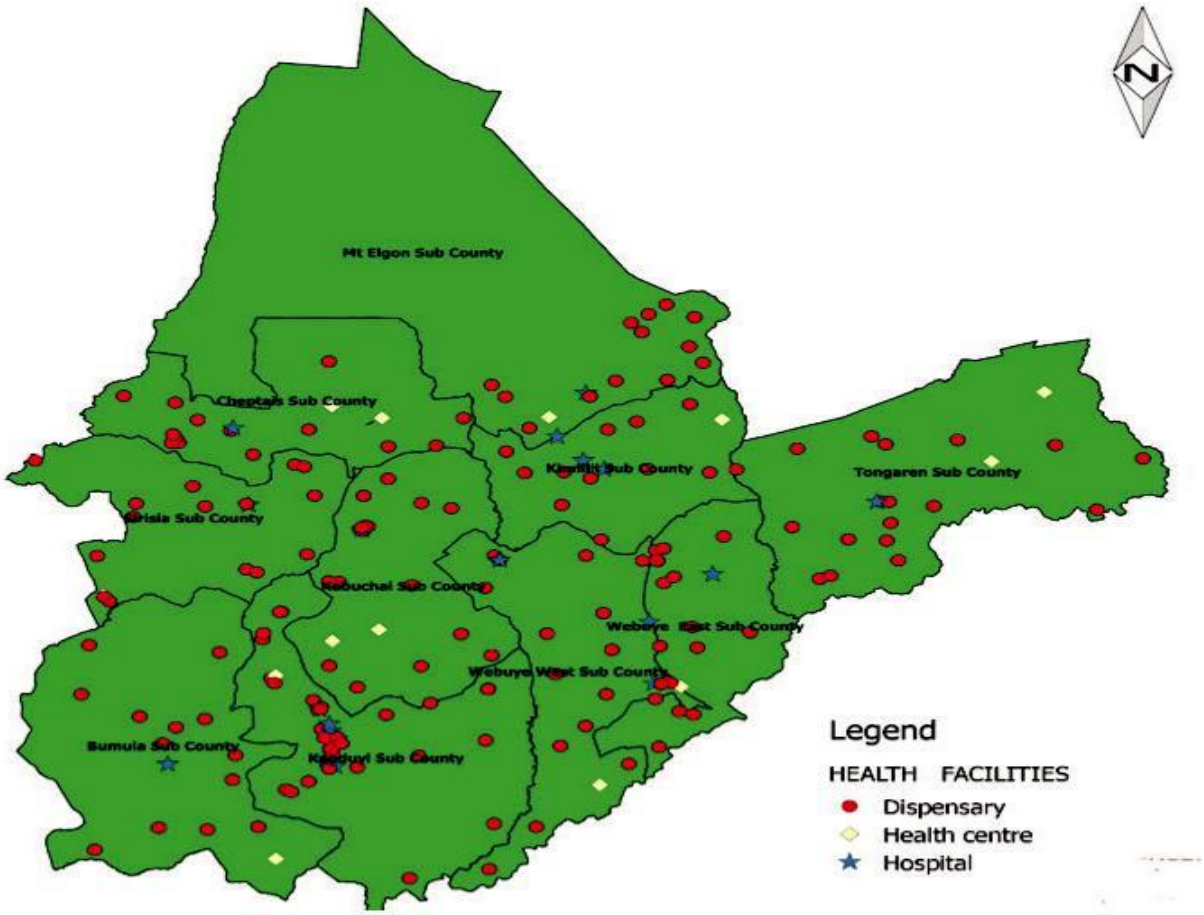
Health Facilities in the County

Bungoma County has a total of two hundred and sixty nine (269) functional health facilities. Those owned by the government area hundred and fifty four (154), faith based twenty six (26) and eighty nine (89) private facilities. In terms of level of care the county has two hundred and six (206) level two, forty three (43) level three and twenty (20) level four health facilities. Kanduyi sub-county has the highest while Webuye West sub-county has the least number of health facilities in the county. From the table below, it is worth noting that Bungoma county does not have a level five hospital as per the standard norms hence efforts must be put in place to have a level five hospital. The list of facilities is as indicated in table 2.1 while the detailed list of the facilities is shown in annex one.

Table 6: Distribution of Health Facilities in Bungoma County

SN	Sub County LEVEL	MOH			Total	Faith Based			Total	Private			Total	Total health facilities			
		2	3	4		2	3	4		2	3	4		2	3	4	Grand total
1	Bumula	11	4	1	16	3	1	0	4	3	1	1	5	17	6	2	25
2	Kabuchai	10	4	1	15	1	1	0	2	6	3	0	9	17	8	1	26
3	Kanduyi	16	1	1	18	4	1	1	6	20	6	3	29	40	8	5	53
4	Kimilili	11	1	1	13	0	0	1	1	6	2	1	9	17	3	3	23
5	Mt. Elgon	15	2	1	18	0	2	0	2	5	0	0	5	20	4	1	25
6	Cheptais	12	1	1	14	1	1	0	2	5	0	0	5	18	2	1	21
7	Sirisia	12	1	1	14	2	1	0	3	3	1	0	4	17	3	1	21
8	Webuye East	11	1	0	12	0	1	0	1	12	1	1	14	23	3	1	27
9	Webuye West	12	1	2	15	0	0	2	2	3	0	0	3	15	1	4	20
10	Tongaren	15	3	1	19	3	0	0	3	4	2	0	6	22	5	1	28
	Total	**125**	**19**	**10**	**154**	**14**	**8**	**4**	**26**	**67**	**16**	**6**	**89**	**206**	**43**	**20**	**269**

Maps 3: Map of Bungoma Showing Distribution Health Facilities



Note: The Northern part of Mt Elgon Sub County comprises of Mt Elgon Forest hence it does not have health facilities.

Health Personnel

The department of health and sanitation has a total of two thousand, two hundred and seventy one staff (2,271) staff. One thousand, seven hundred and forty seven (1747) are permanent employees while five hundred and twenty three (523) are casual employees. A further five hundred and eighteen (518) health staff are on contract basis. Of the five hundred and eighteen contractual employees, one hundred and seventy four (174) are county employees while three hundred and forty four (344) are National Government employees under the Universal Health Coverage (UHC) program. The county is also served with a total number of three thousand three hundred and fifty six community health volunteers and five hundred and forty eighty

birth companions. The department has a staff shortage of seven hundred and forty four personnel of different cadres as indicated in the table below:

Table 7: Health Staff Establishment

SN	Cadre	Current Total	Total required	Deficit
1	Consultants	13	20	7
2	Medical officers	75	100	25
3	Dentists	7	10	3
4	Dental Technologists	6	15	9
5	Public Health Officers	105	150	45
6	Pharmacists	22	23	1
7	Pharm. Technologist	26	40	14
8	Lab. Technologist	112	150	38
9	Clinical Officers (specialists)	85	100	15
10	Clinical Officers (general)	145	250	105
11	Nursing staff (KRCHNs)	637	800	163
12	Nursing staff (KECHN)	184	200	16
13	Orthopedic technologists	3	10	7
14	Nutritionists	18	25	7
15	Radiographers	8	15	7
16	Physiotherapists	16	20	4
17	Occupational Therapists	10	20	10
18	Plaster Technicians	7	20	13
19	HRIO	34	50	16
20	Medical Engineering technologist	9	20	12
21	Medical engineering technicians	8	0	0
22	Mortuary Attendants	6	20	14
23	Drivers	36	50	14
24	Accountants	13	20	7
25	Administrators	14	20	6
26	Laboratory technicians	13	0	0
27	Community Oral Health Officers	3	20	17
28	CHEW (PHT's, social workers,)	15	45	30
29	Secretarial staff / Clerks	42	50	8
30	Attendants / Nurse Aids	0	0	0
31	Cooks	2	20	18
32	Cleaners	0	50	50
33	Security	0	50	50
34	Casual workers/staff	523	500	13
35	Other (specify) HTS, Mentor mother	74		
36	**Total**	**2,271**	**2,883**	**744**
37	Community Health Volunteers	3,356	3,500	144
38	Birth companions	548	800	252
	Total	**3,904**	**4,300**	**396**

Major Causes of Morbidity in the County

The major health problems observed in the county is upper respiratory tract infections and malaria, interchanging in the under-five and over five as indicated in table below:

Table 8: Top Causes of Morbidity

SN	Health condition for the under 5 years	Health condition for the over 5 years	Elderly
1	Upper Respiratory Tract Infections	Confirmed Malaria	Arthritis
2	Confirmed malaria	Upper Respiratory Tract Infections	Hypertension
3	Diarrhoea with no dehydration	Urinary Tract Infections	Diabetes
4	Pneumonia	Diseases of the skin	Muscular skeletal conditions
5	Other injuries	Hypertension	Cardiovascular conditions
6	Lower Respiratory Tract Infections	Other injuries	Pneumonia
7	Eye Infections	Pneumonia	Confirmed malaria
8	Gastroenteritis	Arthritis, Joint pains etc.	Upper Respiratory Tract Infections
9	Ear infection	Diarrhea	Other injuries
10	Intestinal worms	Typhoid fever	Diarrhea

Major Causes of Mortality in the County

The major cause of death in Bungoma County is pneumonia both for the under-five and over five followed by malaria and other diseases of the digestive system as indicated in the table below. Malaria is the leading cause of both morbidity and mortality in the county hence more efforts ought to be directed at reducing the spread of malaria.

Table 9: Top Causes of Mortality

No	Under five years	No	Over five years
1	Pneumonia	1	Pneumonia
2	Other diseases of the digestive system	2	Malaria
3	Diarrheal diseases	3	Other perinatal conditions
4	Diabetes mellitus	4	Abortion
5	Other perinatal conditions	5	Anaemias
6	Other diseases of the nervous system	6	Hypertensive diseases
7	Other diseases of the genitourinary system	7	Other diseases of the genitourinary system
8	Malaria	8	Other diseases of the digestive system
9	Hypertensive diseases	9	Diarrhoeal diseases
10	COVID-19	10	HIV

2.2 Review of Sector Financing

With the onset of devolution the health sector financed its activities from the national exchequer which accounted for the higher allocation followed by its own revenue generation from the ten hospitals and conditional grants and the World Bank as indicated in the table below:

Table 10: Source of Sector Budget Financing

Source of Financing	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
County Government	1,671,472,0	1,992,422,	1,993,996,	2,225,199,8	1,768,259,8	2,740,243,784	2,898,882,538	2,833,961,477	2,851,294,511	3,361,844,875.54
National Government (Conditional Grants) – use fee	33,382,0	33,382,0	33,382,0	33,382,0	33,382,0	32,837,3	32,837,3	32,837,3		
Developmen Partners (Conditional grants)- Danida	14,750,0	14,750,0	14,750,0	14,750,0	14,750,0	29,362,5	26,718,7	25,290,0	25,290,0	25,290,0
World Bank					100,000,0	100,000,0	143,042,7	38,480,0	52,969,7	
AIA	N	N	341,564,	193,775,0	326,447,0	463,600,0	341,564,	516,974,0	542,823,4	642,823,

Table 11: Analysis of Sector Budget by Sub-Sector

Sub-Sector	Financing									
	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Health	2,725,574,0	2,040,555,227	2,042,129,213	2,467,107,728	2,702,721,863	3,366,043,591	3,443,045,539	3,447,543,471	3,472,377,718	
Sanitation						33,801,3	14,070,3	16,236,6	19,689,8	
Total Coun	6,363,299,90	8,124,453,247	8,611,959,227	8,922,329,081	10,675,512,384	11,253,060,757	12,901,600,120	11,902,328,884	12,907,280,379	

Financing										

2.3 Sector Performance Trends and Achievements

This section provides an analysis of the sector performance trends based on the key sector statistics (outcomes). It also highlights the key achievements of the sector for the last ten years as well as lessons learnt.

Table 12: Health and Sanitation Sector Outcome Performance

Sno	Key Outcome	Outcome Indicator	Unit of measure	Baseline Value	End term target	End term actual	Remarks
1	Programme : General Administration and Planning						
	Objective: Efficient direction for service delivery.						
	Improved County Population Health and well-being	% increase in client satisfaction	%	-	100	50	Patients visiting health facilities are satisfied with essential commodity provision and services offered however those not with NHIF complain higher costs.
	Attainment of universal health Coverage	%of populatio n covered by NHIF	%	30	100	39	Only 34,000 vulnerable households added on the 2018 target representing 9% increase.
2	Programme: Curative and Rehabilitative health						
	Objective: Provide essential health care that are affordable, equitable, accessible and responsive to client needs.						
	Improved Access to Essential Health Care Ree	% reduction in Facility based Death rate	%	No data	0	1	The increased access was attributed to availability of health personnel, essential supplies and increased investment in health infrastructure
		Increase of doctors (number) per100,000 Population	Ratio	2.99	4.0	2.99	
		Increase of nurses (number) per100,000 Population	Ratio	24.29	35	27	
		Number of inpatients (admissions) Under 5	No.	389,533	370,056	338,337	
		Number of inpatients (admissions) over 5	No.	33,661	31,978	65,222	
		No. of new outpatient	No.	2,774,503	2,635,778	2,556,571	

		female					
		No. of new outpatient male	No.	2,121,847	2,015,755	1,979,897	
3	Programme: Reproductive, Maternal, New- Born and Adolescent Health						
	Objective: Increase access to maternal and child health services						
	Improved maternal and child health services	Reduction in maternal and child death rate	%	No data	0	0.07	The decrease was attributed to increased skilled delivery, completion of 4th ANC visits provision of iron and folic acid to pregnant women and the under 5 attending child welfare clinics for growth monitoring
4	Programme: Preventive and Promotive Health						
	Objective: Halt, and reverse the rising burden of non-communicable conditions and eliminate communicable conditions						
	Reduced HIV-AIDS Prevalence.	% reduction in HIV prevalence	%	3.2	0	2.8	The 0.4 decrease attributed low investment as HIV is mostly donor support and Covid 19 outbreak affected donor funding
	Reduce TB prevalence	% of TB patients completing treatment	%	89	100	90	The 1% increase is attributed low defaulter tracing that is donor supported
	Reduced malaria	% reduction in malaria Prevalence	%	27.2	0	19	Mass net distribution to household and pregnant women supplied with nets reduces malaria infection
	IIncreased immunization coverage	% increase in children under one year fully immunized	%	72	100	68	Covid 19 pandemic led to movement restrictions and lock down that affected access and vaccines supplies
5	Programme: County referral and specialized health services						
	Objective: To offer quality specialized health services						
	Enhanced provision of specialized health	Increased no. of specialized health	No	-	2	Assorted	Casualty, ICU and HDU equipment procured for the Bungoma County

	services	services provided					Referral Hospital
6	Programme: Sanitation management						
	Objective: Improved Sanitation Standards in Urban and Rural areas						
	Enhanced sanitation management services	% increase in sanitation facility Coverage	%	67	100	75	Inadequate allocation Inadequate allocation
		% increase in sanitation facilities Functionality	%	67	100	80	
		% increase in population sensitized on WASH	%	80	100	80	

2.3.1 Lessons Learnt

This section presents the Lessons learnt during implementation of the planned policies, programmes, projects and initiatives. The learnt lessons include:

i. With the devolved system of governance, a closer collaboration between the National and County Governments is required on the issues of capacity development and policy development and implementation;
ii. There is need to continue with the efforts to enhance linkages and build stronger collaboration with all stakeholders particularly between the National and County Governments in order to ensure efficient service delivery;
iii. Monitoring, evaluation and communication should be strengthened through development and implantation of a comprehensive framework to ensure effective and efficient utilization of resources for timely achievement of the desired results, data and information sharing
iv. It is necessary to adopt an evidence based policy planning that would inform on impacts of policies
v. To ensure that buildings design adhere to health standards bill of quantities must be developed in consultation with the health personnel.
vi. All buildings in the county should be disability friendly.

2.4 Sectoral Development Issues

This section presents the sector development issues and their causes. The section further highlights available opportunities and the possible challenges that hinder achievement of the development objective in relation to each development issue.

Table 3 below highlights the Sub Sector development issues, causes of the listed issues, opportunities and challenges.

Table 13: Sectoral Development Issues, Causes, Opportunities and Challenges

Sub-Sector	Development issues	Causes	Opportunities	Challenges
Health	Access to Health Care	• Inadequate health infrastructure	• Existing health facilities • Availability of land • Existence of development partners • Existing ambulance	• Poor access roads • Poor referral system • Inadequate financial resource. • Inadequate equipment
		• Poor health seeking behaviour	• Existence of CHV • Skilled personnel • Existence of the media • Existence of Social institutions	• Negative Cultural beliefs, religion and myths • Inadequate funding • Financial constraints
		• High cost of health care	• UHC • National Hospital insurance fund	• Low income • Poor nutrition
		• Poor health service	• County Public service board in place • Qualified health personnel • Existence of essential commodities on the market • Availability of equipment though inadequate • Existence of health policies and regulations • Existence of Institutional framework • Existence of development partners	• Inadequate resources • Inadequate health personnel • Inadequate health products and technologies • Inadequate equipment • Inadequate enforcement of health standards • Inadequate guidelines dissemination
Sanitation Services	Sanitation	• Poor sanitation	• Existence of sanitation policy and regulation • County Public service board in place • Qualified health personnel • Existence of water points • Existence of water chemicals	• Inadequate resources • Inadequate sanitation facilities • Inadequate enforcement of sanitation standards • Inadequate water supply • Low public awareness of sanitation standards • Low investment in sanitation programmes and projects

2.5 Crosscutting Issues

This section discusses in brief the crosscutting issues in terms of: the current situation, how they are affecting the sector, measures in place to mainstream them and the existing gaps.

Table 14: Analysis of Sector Crosscutting Issues

Cross cutting issue	Current situation	Effects of the issue on the sector	Gaps	Measures for addressing gaps	Recommendations
Gender mainstreaming	• Low male involvement in health issues like family planning. • Increased prevalence of GBV • Most Health facilities are not gender responsive • Non conformity to gender laws	Low uptake of family planning services; higher incidence of gender based violence and un-access by the youths	• Inadequate Sensitization • Inadequate Gender friendly facilities	• sensitization • all gender in family planning department	• Scale up sensitization • Employ or deploy all genders in family planning department
Disability mainstreaming	• Most health facilities are not disability friendly • Low disability awareness	Low update by the disabled	• Inadequate disability friendly facilities • Inadequate disability friendly equipment	• Establishment of disability friendly facilities	• Development of disability friendly infrastructures • Availing of disability equipment in health facilities like wheel chairs • Recruitment of disabled persons
Culture	• Negative cultural practices preventing people seeking health services • Traditional male circumcision	Low uptake of health	• Ignorance • Inadequate IEC	• Sensitization • Provide IEC	• Scale up sensitization
Drugs and substance abuse	• Increased drugs and substance abuse		• Inadequate IEC •	• Sensitization • Provide IEC	• Scale up sensitization
Youth and Adolescents	• Weak morals	Inadequate youth friendly centres	• Inadequate youth friendly centres •	• Sensitization • Establish youth friendly centres	• Establish and equip youth friendly centres
Mental health	• High prevalence of mental health	Strain on the sector	• Lack of mental policy • Inadequate mental health facilities	• Customize the mental policy • Establish mental unit in sub county hospitals	• Fast track mental policy • Construct and equip mental units • Hire mental experts

HIV/Aids	• Unsafe sex • Ignorance • Cultural beliefs	High AIDs prevalence	• Inadequate HIV commodities	• Sensitization • Avail HIV commodities	• Scaling up screening. • Counselling • Adherence to ARVs
Climate change	Emergence of diseases like malaria, dysentery, diarrhea that are weather related	High prevalence of diseases	• Weak support supervision	• Spraying • Distribution and use of long lasting treated mosquito nets • Proper sanitation • Use of clean water	• Collaboration • Sleeping in LLTN • Water treatment

2.6 Emerging Issues

Emerging issues in health should be given necessary attention once they emerge. Some of the emerging issues include:

- Drugs and substance abuse has increased hence the need to establish rehabilitation centres to rehabilitate our youth.
- Gender based violence is on the rise therefore needs special clinics and recovery centres.
- Emerging and re-emerging diseases pose a risk to residents hence requiring more investments in surveillance and treatment
- Increase in teenage pregnancy have led to more young mothers requiring more attention on RMCAH.
- CBA on the increase of health risk allowance as a result of COVID-19 leads to higher budgetary allocation.

2.7 Stakeholder Analysis

This section highlights the different stakeholders relevant to the sector and their roles as indicated in table 5 below.

- ***Table 15: Stakeholder Analysis***

S/No	Stakeholder (Include as appropriate)	Roles	Possible areas of collaboration
1.	Public/Citizens	• Users of service • Service provision	• Public participation • Health care services
2.	Research and Training Institutions	Knowledge dissemination	• Proposal writing • Internship and attachments
3.	National Government Ministries, Departments and Agencies	Supplement service provision	• Financial • Human resource
4.	County Departments and Agencies	Supplement service provision	• Financial • Human resource
5.	Private Sector Organizations	Supplement service provision	• Financial

	and Professional Bodies	and provide professional advice	• Human resource • Health care services
•	• Civil Societies and Non-Governmental Organizations	• Supplement service provision and accountability mechanism	• Financial • Human resource • Health care services
6.	Development Partners and international Organizations	Provide financial support	• Financial • Human resource • Health care services
7.	Parliament	Legislation provision	• Financial • Policy formulation • Oversight
8.	Judiciary	Justice provision and interpretation of the law	• Public health and interpretation
9.	County Assembly	Legislative function	• Financial • Policy formulation • Oversight
10.	County Budget and Economic Forum	Accountability mechanism	• Public participation

CHAPTER 3: SECTOR DEVELOPMENT STRATEGIES AND PROGRAMMES

3.1 Sector Vision, Mission and Goal

3.1.1 Sector Vision

A healthy, productive and competitive County.

3.1.2 Sector Mission

To build a progressive, responsive and sustainable health care and sanitation system for accelerated attainment of the highest standard of health in the County.

3.1.3 Sector Goal

To attain responsive, equitable, affordable, accessible and quality health care and sanitation for all.

3.2 Sector Development Objectives and Strategies

The sector priorities are derived from the sector development issues documented in chapter two of the plan. Strategies to achieve sector priorities are proposed in relation to root causes of the development issues. The information in this section is presented in Table 15.

Table 16: Sector Development Issues, Objectives and Strategies

Sub-Sector	Development issues	Developmental Objectives	Strategies
Medical Services	Access to health care	Improve access to quality and affordable health services	• Strengthen Policy, Legal and Institutional Framework • Develop Health Infrastructure • Complete Blood bank at BCRH • Promote Primary Health Care • Provide Blood Transfusion Services • Promote Universal Health Care • Avail health products and technologies • Enhance referral services • Mainstream cross-cutting issues such as green growth and green economy; climate change; HIV and AIDS; Gender, Youth and Persons with Disability (PWD); Disaster Risk Management (DRM); Ending Drought Emergencies (EDE) among others.
Public Health and Sanitation	Public Health and Sanitation	Halt and reverse communicable and non-communicable ailments	• Strengthen Policy, Legal and Institutional Framework • Enhance HIV / AIDS management • Enhance TB Control and management • Enhance Malaria control and management • Promote Reproductive, Maternal, New-born, child and Adolescent healthcare • Improve Public health and sanitation management • Promote school health management • Support market sanitation management

			• Develop sanitation infrastructure • Promote quality food and water hygiene • Boost disease surveillance • Promote management of neglected tropical diseases • Promote management of non-communicable diseases • Mainstream cross-cutting issues such as green growth and green economy; climate change; HIV and AIDS; Gender, Youth and Persons with Disability (PWD); Disaster Risk Management (DRM); Ending Drought Emergencies (EDE) among others.

3.3 Sector Programmes And Interventions

This section presents the sector objectives and strategies in relation to development issues identified in the previous chapter. The information is captured as provided in Table 16

Table 17: Sector Programmes and Interventions

Programme	Objectives	Strategies/ Interventions
General Administration, Planning, Partnerships and Support Services	To enhance efficient service delivery	- Strengthen Leadership and Governance - Enhance Human resource management - Equitable and efficient Health care financing - Health Information System and Health Research - Regulatory and policy framework
Curative and rehabilitative health services	Improve access to quality and affordable health services	- Strengthen Policy, Legal and Institutional Framework - Develop Health Infrastructure - Complete Blood bank at BCRH - Promote Primary Health Care - Provide Blood Transfusion Services - Promote Universal Health Care - Avail health products and technologies - Enhance referral services - Mainstream cross-cutting issues such as green growth and green economy; climate change; HIV and AIDS; Gender, Youth and Persons with Disability (PWD); Disaster Risk Management (DRM); Ending Drought Emergencies (EDE) among others.
Preventive and Promotive Health care Services	Halt and reverse communicable and non-communicable ailments	- Strengthen Policy, Legal and Institutional Framework - Enhance HIV / AIDS management - Enhance TB Control and management - Enhance Malaria control and

		management - Promote Reproductive, Maternal, New-born, child and Adolescent healthcare - Improve Public health and sanitation management - Promote school health management - Support market sanitation management - Develop sanitation infrastructure - Promote quality food and water hygiene - Boost disease surveillance - Promote management of neglected tropical diseases - Promote management of non-communicable diseases - Mainstream cross-cutting issues such as green growth and green economy; climate change; HIV and AIDS; Gender, Youth and Persons with Disability (PWD); Disaster Risk Management (DRM); Ending Drought Emergencies (EDE) among others.

3.4 Sector Flagship Projects

The major flagship project to be implemented is the equipping of the 300 bed and 100 bed maternal and child blocks at Bungoma County Referral Hospital and Sirisia county hospital respectively as well as construction and equipping of a specialized health unit in Bungoma County as indicated in table 8.

Table 18: Health and sanitation flagship projects

Project Name: (Location)	Objective	Outcome	Description n of key Activities	Timeframe	Beneficiaries (No)	Estimated Cost	Source of Funds	Implementing Agency
Establishment of Bungoma county referral hospital facility	To provide specialized health services	Improved access to specialized health services	Land acquisition, construction, equipping, human resources, other supplies	10 years	4,000,000	5 billion	Partners and County Government	CGB

3.5 Cross – Sectoral Linkages

This section provides mechanisms/actions on how sectors will build synergies and address adverse effects that may arise from the implementation of the programmes. Indicated for each programme are the considerations that will be made in respect to harnessing cross-sector synergies arising from programmes, and mitigation measures that may be adopted to avoid or manage potential adverse cross-sector effects. The information is provided in Table 9

Table 19: Cross Sectoral Linkages

Programme Name	Linked Sector	Cross-Sector Linkages		Measures to Harness or Mitigate the Effects
		Synergies	Adverse Effects	
Curative and Rehabilitative Health Services	Agriculture, Public Works and Roads	Nutrition Access roads and food provision	Food safety Delay in food supply Demolition of health structures	Enforcement of food safety standards Coordination in road designs and implementation
Preventive and Promotive Health Services	Public Works and Roads, Education and Agriculture	Knowledge management	School closure	Blood drives in other population segment
	Housing, Water	Water, sanitation and housing provision	Mandate overlaps	Coordination framework to foster interdependence in service provision

CHAPTER FOUR: IMPLEMENTATION MECHANISMS

4.1 Institutional and Coordination Framework

4.1.1 Institutional Arrangement

Table 20: Institutional Arrangement

S/No	Institution	Role in Implementation of the Sectoral plan
1	County Executive Committee	• Policy formulation, implementation, and evaluation. • Preparation of plans and budgets • Coordination and facilitation of Program implementation, monitoring, evaluation, and reporting. • Coordinate with County Assembly for approval of plans and budgets.
2	County Assembly	• Legislation on policies, bills, and regulations • Oversight on program implementation • Representation of community on project identification and prioritization
3	County Government Departments	• Policy formulation, implementation, evaluation and reporting. • Program implementation, monitoring, evaluation, and reporting • Facilitates extension services • Provides technical services
4.	County Planning Unit	• Preparation of county plans (CIDP, Sectoral, Strategic, ADPs, etc) • Preparation of county budget documents (CBROP, MTEF, CFSP, CDMSP, Appropriation Acts) • Monitoring, evaluation, and reporting on program implementation. • Plans/Budget review • Collect county statistical data
5.	Office of the County Commissioner	• Coordinate peace and security of county citizens • Public sensitization on government projects in the county • Coordinate National Government's MDAs in the county • Monitor, evaluate and report on National Government projects in the county.
6.	National Planning Office at the county	• Technical backstopping • Streamlining National programs in the CIDP • Resource mobilization
7.	Other National Government Departments and Agencies at the county	• Collaborate with counterpart county departments and agencies on policy formulation, implementation and evaluation. • Collaborate with counterpart county departments and agencies on programs/project implementation in their respective departments. • Provide information concerning the programs in the department
8.	Development Partners	• Technical and Policy Support • Capacity Development • Project and Program funding
9.	Civil Society Organizations	• Advocacy and community sensitization • Resource Mobilization
10.	Private Sector	• Provide market for produce • Promote value addition • Resource mobilization
11.	Training and Research institutions	• Capacity building and Research • Knowledge dissemination • Policy formulation
12.	Regulatory Bodies	• Establishment of standards • Quality controls • Regulation of practices • Policy formulation

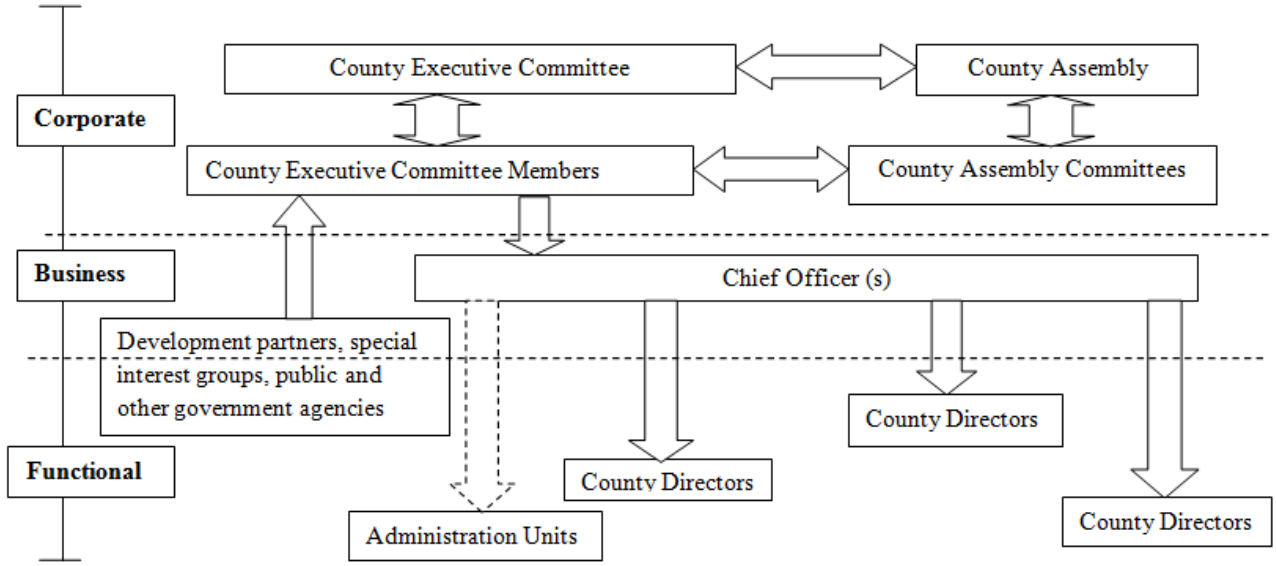
13.	Regional bodies/associations	• Resource Mobilization. • Capacity development • Value Addition
14.	Public/Citizens	• Participate in project identification, monitoring and evaluation. • Use of service/ Products • Service provision • Value addition
15	Special Interest Groups	• Provide technical support • Mobilization of funds • Advocacy • Spiritual and Counselling services
16.	Media	• Advocacy • Dissemination of information

4.1.2 Coordination Framework

The County Executive Committee member of Health will bear the overall responsibility to steer and oversee implementation of this Sectoral plan. The CECM will be supported by the Chief Officer of Health specifically on budgetary and accounting, with technical advisory being provided by the County directors of health. An executive committee chaired by the CECM, with representation of the COH and CDHs will be responsible for overall policy direction and accountability. The CDHs will guide the CHMT in implementing the Sectoral plan with actual implementation being undertaken by the sub-county, facility and community teams. Accountability and oversight to the department of health and sanitation will be provided by the County Assembly Health Committee through periodic monitoring and reports. The County Assembly Health Committee will also play an important role in terms of budget reviews and approvals as well as enactment of the health bills required to support service delivery. Facility management committees and hospital boards will be responsible for managerial oversight at the facility.

The figure below illustrates the coordination mechanism

Figure 3: Co-ordination mechanism



4.2 Financing Mechanism

The total cost of funding this Sectoral plan is approximately Fifty five billion that will come from the exchequer, own revenue generation, development and implementing partners. In addition the avenue of public – private partnership especially in the provision of specialized health services will be allowed

Table 21: Funding sources

Programme	Source of Funding	Amount
General Administration Planning and support Services	Exchequer	38,604,000,000
Preventive and Promotive Health Services	Exchequer	3,635,000,000
	AIA	60,000,000
Curative and Rehabilitative Health services	Exchequer	6,665,900,000
	AIA	5,200,000,000
	Danida	252,900,000
Total		54,417,800,000

4.3 Capacity Development

To ensure efficient and effective implementation of the sector initiatives health workers will be continuously updated on service provision through weekly Continuous medical education (CMEs), on job training (OJTs), mentorship, attending of scientific conferences & seminars and facilitation to attend specialized courses.

Table 22: Capacity Gaps and Proposed Interventions

S/no	Existing Gap	Proposed Interventions
1	Inadequate specialized health workers	Sponsor existing health workers for specialized health courses like nephrology Mentorship and on job training
2	Knowledge gap in service provision	Updates, continuous medical education and regular scientific conferences and seminars

4.4 Risk Management

Some of the possible risks that may hinder implementation of the sectoral plan and discuss proposed mitigation measures are as indicated in table 10 below:

Table 23: Risks, Levels, Owners and Mitigation Measures

Risk Category	Risk	Risk Owners	Risk Implication	Risk level (Low, Medium, High)	Mitigation measures
Financial	Limited financial resource	Implementing agencies	Scaled down, delayed or non-implementation of projects	High	Mobilization for more resources
	Volatile economic environment	Implementing agencies	Delayed implementation/utilization of projects Low investment levels	High	Prioritize projects according to community needs Develop measures to cushion citizenry.
	Supplier risk	Implementing agencies	Failure/Faulty/inadequate supplies	Moderate	Supplier sensitization/empowerment. Enforcement of legal framework
	Grants delay/failure risk	Implementing agencies	Slow /stalled implementation of projects	High	Enhancing compliance to MOUs/agreements
	Fraud	Implementing agencies	Loss of resources	Moderate	Enhanced internal control mechanisms.
Technological	Rapid technological changes	Operating agencies	Outdated systems	High	Keep updating systems to move with the times.
	Cyber attack	Operating agencies	Loss of information	High	Enhance data security.
Climate Change	Natural disasters such as floods, droughts, fires, Landslides, Thunderstorms and Lightning among others.	Implementing agencies	Slow project implementation. Destruction of infrastructure resources. Displacement of human settlements.	Moderate	Enhance emergency support. Developing early warning systems, capacity development of the actors/vulnerable, and insurance of enterprises
	Pests and diseases	Implementing agencies	Reduced production/productivity Loss of crops and	High	Developing early warning systems, farmer capacity development for pest and disease

			livestock.		management, facilitating insurance of the enterprises
	Increased weather variability	Implementing agencies	Slow project implementation. Environmental degradation Reduced production/productivity Loss of crops and livestock.	High	Promotion of Climate Smart Agriculture (CSA) and Green Growth (GG) technologies. Developing early warning systems, insurance of the enterprises
Organizational	Attrition of human resource	Implementing agencies	Loss of specialized knowledge	High	Continuous capacity building. Keeping government workers happy and motivated by; Use of modern technology; offer remote/hybrid job roles; highlight good work and provide feedback
	Workplace security (theft, terrorist attacks, degraded infrastructure)	Implementing agencies	Loss of human resource/assets	Moderate	Enhance security measures.
	Workplace injuries and infections	Operating Agencies	Low productivity	High	Provide protective gears to workers
	Liabilities arising from service provision	Implementing agencies	Loss of value for money	Low	Enforcement of professionalism Operationalize Risk fund
	Drugs and substances abuse	Implementing agencies	Low productivity	High	Enhance guidance, counselling and mentorship programs

CHAPTER FIVE: MONITORING AND EVALUATION FRAMEWORK

5.1 Overview

This chapter outlines how the plan will be monitored and evaluated during and after its implementation. The M&E processes, methods and tools are guided by Section 232 of the Constitution and all the legal provisions that provide for M&E, County M&E policy, CIMES guidelines, Kenya Norms and Standards for M&E and Kenya Evaluation Guidelines. This chapter also highlights the; the proposed M&E structure; data collection, analysis, reporting and learning; M&E outcome indicators tracking; dissemination and feedback mechanism.

5.2 County Monitoring and Evaluation Structure

This section summarizes established systems and structures in the county to organize the M&E process for implementing the plan. This includes the institutional arrangement of the M&E function (Directorate/Unit), various committees and coordination of M&E activities i.e., departmental focal persons, champions and stakeholder engagement fora as stipulated in the CIMES guidelines.

5.3 M&E Institutional Framework

This section provides the M&E institutional arrangements in the county. The institutional structures will strengthen coordination of the County M&E system. The institutions encompasses both levels of government, non-state actors (development partners working in the county, private sector and civil society organizations) and the citizens.

Figure 4: County Committees

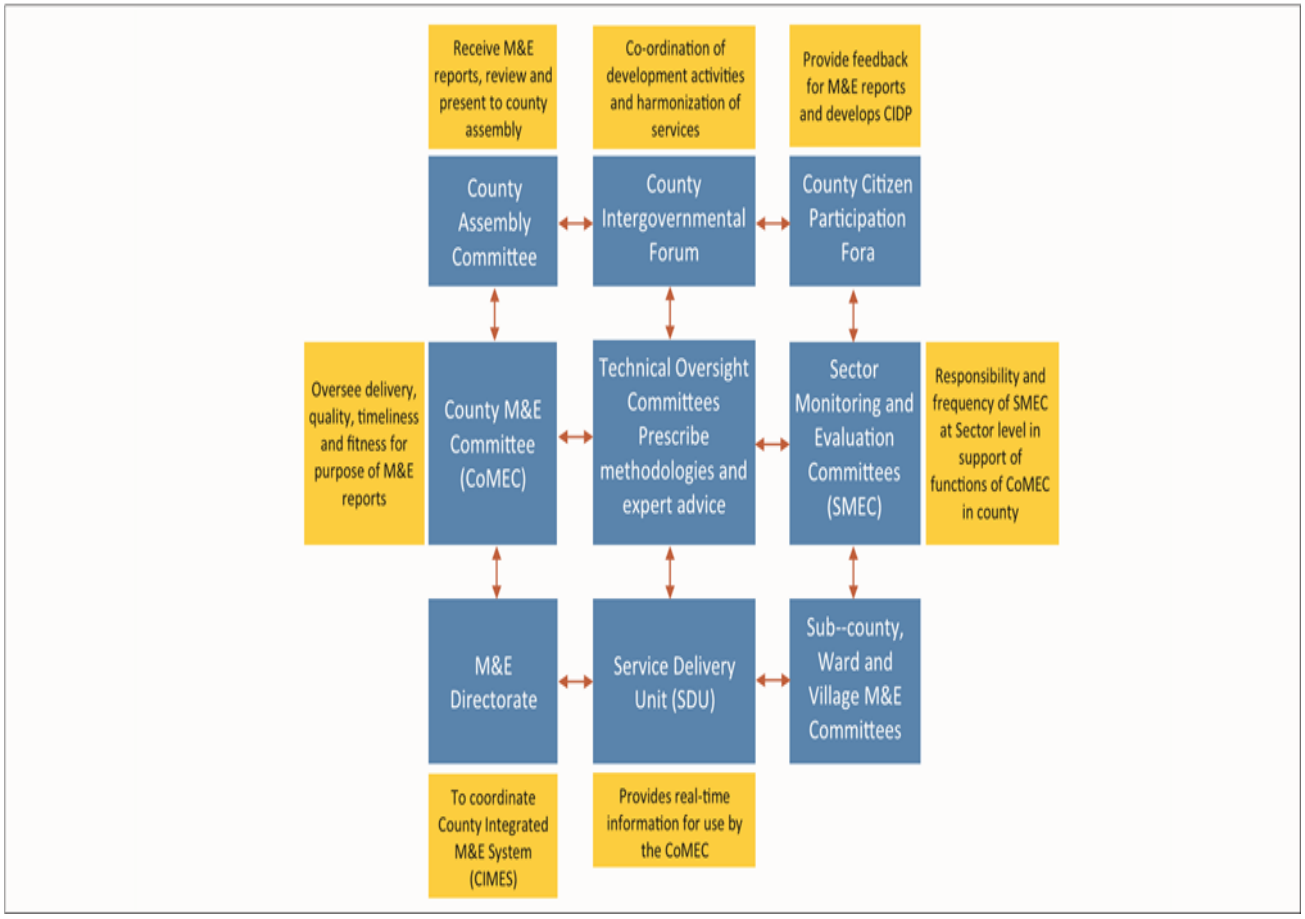


Table 24: Responsibilities of Major Committees on M&E Preparation and Reporting

Committee or Forum	Members	Responsibilities	Frequency of Meetings	Remarks
County Assembly Committee responsible for Finance & Planning	MCAs	• Receive county M&E reports, review and present to the County Assembly for approval • Authorize the governor to present the report at the summit	As per the county assembly calendar	The Committee is in place
County Inter-governmental Forum (CIF)	Chair: • Governor or Deputy Governor in Governor's absence, or member of Executive Committee nominated by the Governor (As per the IGRA 2012) Membership: • All Heads of Department of National Government	• Receive, review and endorse M&E reports from CoMEC • Present M&E reports to the County Assembly Committee responsible for • Economic Planning • Give policy directions on M&E at the county level	Quarterly	The Committee is in place

Committee or Forum	Members	Responsibilities	Frequency of Meetings	Remarks
	at • County level including County Commissioner • County Executive Committee members or their nominees in writing Convenor: • CEC member responsible for fi nance and economic planning functions at the county level			
County Citizen Participation Fora (As per the Public Participation Bill 2018)	Chair: • CEC or Chief Officer responsible for the topic of the forum Membership: • Representatives of NGOs, and Civil Society Organisations • Representative of Evaluation Society of Kenya • Representatives of rights of minorities, marginalized groups and communities • Representative of private sector business community. • Development partners' representatives in the county Convenor: • Responsible CEC or Chief Officer.	• Participate in development of M&E indicators to monitor and evaluate CIDP • Review and give feedback to M&E reports	Annually	The Committee is in place
County M&E Committee (CoMEC)	Co-Chairs: • County Secretary and senior representative of the national government nominated by the • County Commissioner in writing Membership: • Heads of technical departments of the national government at county level • County chief officers • County Assembly	• Oversee delivery, quality, timeliness and fitness for purpose of M&E reports • Drive service delivery through Results Based Management • Receive, review and approve county and sub-county M&E work plans and M&E reports • Convening County Citizen Participation	Quarterly	The Committee is in place

Committee or Forum	Members	Responsibilities	Frequency of Meetings	Remarks
	Clerk • Court Registrar • Representatives from devolved funds • Technical Representatives managing all other Non- • Devolved Funds in the County Convenor: • Chief Officer responsible for Economic Planning	fora to discuss M&E reports • Mobilization of resources to undertake M&E at county and sub-county level • Approve and endorse final county indicators • Submission of M&E reports to NIMES, CIF, CoG, constitutional offices and other relevant institutions • Dissemination of M&E reports and other findings to stakeholders, including to • County Fora		
Technical Oversight Committees (TOC)	Chaired by: • Chief Officer responsible for Economic Planning Membership: • Up to ten technical officers versed in M&E from a balanced group of county departments and non-devolved function department Convenor: • M&E Director	• Identify, commission and manage evaluations • Review of the M&E reports • Present M&E reports to CoMEC • Capacity building for M&E • Sets the strategic direction for CIMES • Approves M&E Directorate's work plan and advises M&E Directorate on actions to be taken on various M&E issues • Approves indicator reports for use by • CoMEC • Endorses M&E Directorate's reports to be presented to CoMEC	Quarterly	The Committees are in place
Sector Monitoring & Evaluation Committees (SMEC)	Chair: • Co-chaired between a Chief Officer from a relevant county government department and	• Produce sector M&E reports • Develop sector indicators • Undertake sector evaluations	Quarterly	The Committees are in place

Committee or Forum	Members	Responsibilities	Frequency of Meetings	Remarks
	Director from the relevant department of the National government at county Membership: • Sector relevant county departments' Chief Officers, equivalent national government representative from that sector and sector relevant CSOs. (The • County to define sector as per MTEF) Convenor: • Chief Officer responsible for the relevant department	• Present sector M&E reports to the TOC		
SCoMEC	Co-chair: • Sub-county administrator and • DCC Membership: • HODs at the sub-county level, development partners, CSOs etc. Convener: • Sub-county M&E officer	• Produce sub-county M&E reports • Present M&E reports to the TOC • Develop M&E indicators	Quarterly	The Committees are in place
Ward MEC	Co-chair: • Ward Administrator and ADCC Membership: • HODs at the ward level, development partners, CSOs etc. Convener: • Ward Administrator	• Produce ward M&E reports • Present M&E reports to the TOC • Develop M&E indicators	Quarterly	The Committees are in place
Village MEC	• As per the village council composition	• Participate in the development of indicators process • Participate in monitoring of projects in respective villages • Provide feedback on M&E reports	Quarterly	The Committees are in place

Responsibilities and Functions of Stakeholders in the Institutional Framework

The Responsibility and functions of the different stakeholders with relevance for M&E at county level are outlined in Table 62. Governance, monitoring and reporting of the CIDP implementation progress are prescribed in section 54 of County Government Act (2012), including committee structures, roles, responsibilities and memberships. Performance Management joins up all aspects of county operations and development within a single, integrated strategic process. The performance management framework connects activities from the M&E Results Matrix in CIDP III, MTP IV and Vision 2030, to the Performance Contracts of individual senior management staff members, and to the operation of service delivery and the implementation of projects and programmes in the county. The M&E system should generate reports to be shared between the project manager and the M & E director, who approves the project M&E information, the Performance Management System (PMS) Unit, and the governors' and county commissioners' offices, which uses the information. To support the Performance Management and M&E processes of the county, the CIMES organogram is presented in Figure 11.

Table 25: Responsibilities of Stakeholders in M&E Reporting

Stakeholder	Responsibilities
County Governor	• Chair of the CIF • Presents county M&E reports to the Summit • Provides vision and leadership and drives delivery of the CIDP • Holds county CEC Members to account for their M&E targets • Holds CEC Members and County Secretary to account for use of the PMS to provide realtime reporting on service delivery and results • Ensuring that M&E structures are established in the county • Championing M&E and Performance Management as tools for delivery of development and services in the county • Promoting the role of the M&E Directorate in advancing Results Based Management and public service delivery that ensures the CIDP objectives and outcomes meet the needs of citizens
County Commissioner	• Coordinate the national government agencies in the county
County Secretary	• Co-chair of the CoMEC • Responsible for coordination of activities in county government • Personally accountable for ensuring that all county government officers operate as required • Provide timely and accurate reporting according to the County PMS Policy • Ensure that the Chief Officer responsible for Economic Planning operationalizes the M&E function as a tool for delivery of development and services in the county
Chief Officers in Respective Sectors	• Co-chair respective SMEC • Develop sector specific M&E indicators • Oversee preparation of sector M&E reports • Present sector M&E reports to the TOC • Collaborate with M&E Directorate in undertaking sector evaluations

Stakeholder	Responsibilities
	• Liaise with sector heads of National government agencies at the county on M&E
Directors of National Government Agencies of Respective Sectors at the County	• Co-chair respective SMEC • Develop sector specific M&E indicators • Oversee preparation of sector M&E reports • Collaborate with M&E Directorate in undertaking sector evaluations • Liaise with sector heads at the county government level on M&E
Economic Planning Director	• Ensures that M&E is mainstreamed in county economic planning
Directors of Sector Departments at the County Government Level	• Prepare departmental M&E reports • Prepare M&E indicators for the department • Collaborate with M&E Directorate in undertaking evaluations in their respective departments • Present departmental M&E reports to the SMEC • Focal persons for M&E in their respective departments
County M&E Director	**A. Set up the monitoring and evaluation system:** • Develop the overall CIMES framework • Prepare the M&E plan with a detailed budget • Prepare county M&E framework • Supervise the work of the Monitoring and Evaluation office staff; provide guidance and technical support • Develop county M&E indicators in collaboration with KNBS and MED to ensure standard definition and classification • Establish contacts with national and other county monitoring and evaluation stakeholders • Review and provide feedback to programmes on the quality of methodologies established to collect monitoring data, and document the protocols that are in place for the collection and aggregation of this data • Establish an effective system for assessing the validity of monitoring and evaluation data through a review of CIDP implementation activities, completed monitoring forms/databases, and a review of aggregate-level statistics reported **B. Implementation of monitoring and evaluation activities** • Oversee the monitoring g and evaluation activities included in the CIDP, with particular focus on results and impacts as well as in lesson learning • Promote a results-based approach to monitoring and evaluation, emphasizing results and impacts • Coordinate the preparation of all monitoring and evaluation reports; guide staff and executing partners in preparing their progress reports in accordance with approved reporting formats and ensure their timely submission • Prepare consolidated progress reports for the CoMEC, including identification of problems, causes of potential bottlenecks in implementation, and provision of specific recommendations • Check that monitoring data are discussed in the appropriate committees, (including citizens participation fora), and in a timely fashion in terms of implications for future action • Undertake regular field visits to support implementation of monitoring and

Stakeholder	Responsibilities
	evaluation, check the quality of data produced, and identify where adaptations might be needed; monitor the follow up of evaluation recommendations with Programme Managers • Foster participatory planning and monitoring • Organize and provide refresher training in monitoring and evaluation for CIDP projects/ programmes and other agencies implementing staff, county-based NGOs and key county stakeholders with a view to developing local monitoring and evaluation capacity • Undertake evaluations in the county **C. Knowledge management** • Promote knowledge management and information sharing of best practices • Facilitate exchange of experiences by supporting and coordinating participation in network of CM&EOs among counties • Organize county M&E day to share experiences • Identify and participate in additional networks such as NIMES networks that may also yield lessons that can benefit implementation of CIMES
The National Treasury and Planning (MED)	• External Facilitator and neutral validator • Receive and consolidate county M&E reports • Capacity building for CIMES • Set evaluation standards • Update the CIMES Guidelines • Technical backstopping for CIMES
County M&E Directorate: With two sub-units (1 for county & 1 for national)	**Composition:** To be headed by a County M&E Director, assisted by several sector M&E officers/ Focal persons, each responsible for compilation of M&E data for a number of projects/ programmes of specified departments and national government: Several IT Officers assisting the county departments with M&E computerization activities. The M&E Officer and ICT Officer ensure that the PMS system is supported by projects in their county departments. M&E officer works with the M&E Technical Committee. **Responsibilities:** • The overall responsibility for ensuring use of the M&E system in the county lies with the Director of M&E, who works closely with all Directors in the county to ensure timely production of M&E reports • Provide technical support and coordination of CIMES, including its institutionalization within the county • Prepare periodic CIMES performance reports for presentation to CoMEC • Supporting the development of capacity for M&E through training, coaching and mentoring. • Coordinate regular M&E reports produced within the county departments and other agencies resident in county • Support the implementation of the CIMES Guidelines and Standards as the main M&E tool across the county • Maintaining the support systems that underpin reporting, such as the monitoring website and database of M&E (APR), comprehensive Public Expenditure Review (CPER), evaluations, Public Expenditure Tracking Surveys (PETS) and Metadata, etc.) • Systematically capture lessons learnt from successes, challenges and failures
Service	• Is located in the Office of the Governor, and provides the engine to drive

Stakeholder	Responsibilities
Delivery Unit (SDU)	priority projects and programmes for the Governor • To remove duplication of efforts from the M&E Directorate, SDU undertakes monitoring of county government activities • Is led and managed by a director • Provides timely reporting to the governor on service delivery • Conducts field visits on service delivery sites and stations to monitor the quality of services given to the citizens • Uses technology-supported Performance/M&E/Reporting systems for efficient, accountable and transparent working • Ensures programmes are implemented as per, the CIDP and the Annual Work Plans • Shares its findings with line departments to enhance service delivery • Monitors service charter to ensure citizens expectations are met • Provides a platform to address citizens' concerns e.g the governors hotline, website, social media etc.

Figure 5: CIMES Organogram

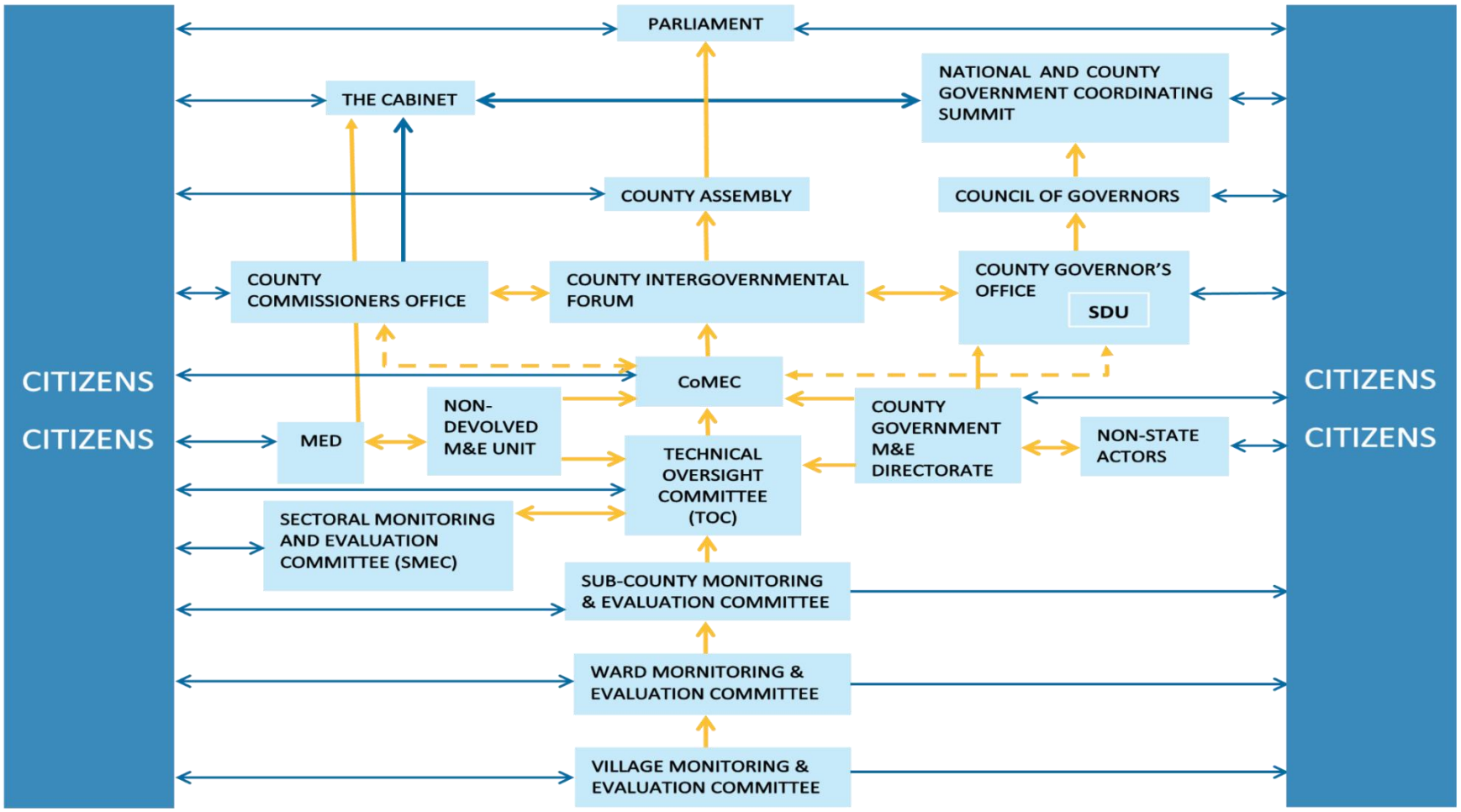


Figure 7: Proposed CIMES organogram

5.4 M&E Capacity

This section discusses M&E skills available, the resources allocated for M&E function and technological requirements to implement M&E function.

Capacity Development

The officers charged with overseeing M&E activities at all levels are equipped with skills and capacities to perform their roles effectively. To embrace automation for real time reporting, training on ICT platforms (e-CIMES, ODK, amongst others) was done to support data collection, uploading, downloading and data analysis for continuous updating of databases and use of M&E information by all stakeholders. The directorate responsible for M&E in collaboration with stakeholders shall develop a Capacity Development Strategy to guide M&E capacity development in the County.

Financing Arrangements

Effective implementation of the M&E function requires provision of adequate financial resources. The budget will cover staffing, external technical support, capacity building; capital expenses and operational expenses. The National M&E Policy requires Ministries, Departments, Agencies and Counties (MDACs) to have a separate budget component for M&E with adequate resources. In addition, all development programmes/projects will provide budgets earmarked for monitoring and evaluation. The Directorate responsible for M&E in the County in collaboration with stakeholders will develop a Resources Mobilization Strategy to enhance the capability to undertake M&E function.

5.5 M&E Outcome Indicators

This section presents programme outcome indicators by sectors as presented in chapter four. This is presented in Table 23.

Table 26: Outcome Indicator Reporting

Programme	Outcome	Outcome indicators	Baseline Year	Baseline value	MidtermTarget	End term Target	Reporting Responsibility
Curative and Rehabilitative health	Increased access to universal health care	% of population covered by NHIF	2022	39	100	100	Department of Health
		Doctors (number) per 100,000 Population	2022	2.99	4.0	4.5	Department of Health
		Nurses (number) per 10,000	2022	27	35	40	Department of Health

		Population					
		Average distance to the nearest health facility in KM	2022	9.2	5	3	Department of Health
		Number of inpatients (admissions) Under 5	2022	338,337	321,420	304,503	Department of Health
		Number of inpatients (admissions) over 5	2022	65,222	61,961	58,700	Department of Health
		No. of new outpatient female	2022	785,436	589,077	392,718	Department of Health
		No. of new outpatient male	2022	610,460	457,845	305,230	Department of Health
Preventive and Promotive Health care services	Reduced prevalence of communicable and non-communicable ailments	HIV prevalence	2022	2.8	2.4	2.0	Department of Health
		TB incidences per 100,000 population	2022	-	-	-	Department of Health
		TB treatment success rate	2022	-	-	-	Department of Health
		% of TB patients completing treatment	2022	90	95	100	Department of Health
		Climate related malaria incidence per 1000 population	2022	-	-	-	Department of Health
		% change in malaria Prevalence	2022	19	17	15	Department of Health
		% change in children under one year fully immunized	2022	68	70	75	Department of Health
		Maternal mortality rate/100,000	2019	238	180	100	Department of Health
		Neonatal mortality rate/1000	2022	-	0	0	Department of Health
		Under 5 mortality/1000	2019	49.2	40	30	Department of Health
		Infant	2019	30.5	25	20	Department

		mortality/1000					of Health
		% of DPT/Hib/Heb (penta 3) coverage	2022	97.3	99	100	Department of Health
		% of 4th ANC coverage	2022	72.5	80	90	Department of Health
		Modern Contraceptive Prevalence Rate (mCPR)	2022	63.7	75	85	Department of Health
		% unmet need for family planning	2022	14.6	10	5	Department of Health
		Proportion of population accessing specialized health care (cardiovascular, cancer, diabetes and renal diseases)	-	-	-	-	Department of Health
		% of births attended by skilled health personnel	2019	88.9	100	100	Department of Health
		% of fully immunized children under one year	2022	78.7	87	100	Department of Health
		% change in HPV vaccination in girls	2022	16	50	100	Department of Health
		% prevalence in stunted children	2022	24.4	22	20	Department of Health
		% prevalence in wasted children	2022	9	8	6	Department of Health
		% prevalence of underweight children	2022	1.8	1.0	0.5	Department of Health
		% change in Women of reproductive age screened for cervical cancer	2022	2.6	3.5	5	Department of Health

		% change in sanitation facility Coverage	2022	75	80	85	Department of Health
		% change in sanitation facilities functionality	2022	80	85	90	Department of Health
		% change in population sensitized on WASH	2022	80	85	90	Department of Health

5.6 Data Collection, Analysis and Reporting

This section provides the main methods and tools that will be used for data collection, archiving, analysis and reporting arrangements in line with the National M&E Norms and Standards. This includes development of CIDP Indicator Handbook, standard reporting templates based on the County Annual Progress Reports Guidelines. The County Government will also state how they integrate technology in M&E through the use of e-CIMES. The section also provides the types of M&E reports to be prepared and the frequency of reporting.

The CIDP monitoring strategy includes a clear data collection and analysis plan, detailing the following: units of analysis (for example, county, sub-county, village, department and section); sampling procedures; data collection instruments to be used: frequency of data collection; expected methods of data analysis and interpretation; those responsible for collecting the data; data collection partners, if any; those responsible for analyzing, interpreting and reporting data; for whom the information is needed; dissemination procedures; and follow up on findings. The system will provide an integrated platform for generating and sharing M&E data without duplication.

Monitoring &Evaluation Tools

i. M&E plan:

All projects and programmes shall include an M&E plan prior to approval. Minimum requirements for Monitoring and Evaluation plan shall include SMART indicators for implementation and results; Baseline data for the project or programme indicators; and identified reviews and evaluations to be undertaken.

County departments are accountable for establishing M&E plans for their individual departments, and also for the M&E results structure, which links all programmes/ projects of the department to the expected outcomes. This is the basis for performance

monitoring and reporting, to ensure adherence to the CIMES guidelines and the Kenya National M&E Policy

CIDP Indicator Handbook will be generated from the Programme Result Matrix and the Sectoral Outcome Indicator Reporting Section in Chapter 6. The Indicator Handbook will guide performance review and preparation of Results Based M&E framework.

ii. Results Based M&E Framework:

Effective monitoring and evaluation is based on a clear, logical pathway of results, in which results at one level lead to results at the next level. Results from 'one level flow towards the next level, leading to the achievement of the overall goal. If there are gaps in the logic, the pathway will not flow towards the required results. The major levels that the plan focuses on are: Inputs; Outputs, including processes; Outcomes and Impacts.

iii. Data Sources and Collection Method

The plan has highlighted data collection activities that will involve desktop data collation through participatory social activities from various media platforms, field surveys, daily observations and measurement sheets by project supervisors. Key data sources will include relevant institutions for administrative data, surveys and data documented by established government statistics agencies including KNBS and county statistics unit.

Table 27: Commonly Used Data Collection Methods

Recording Data Through Administrative Actions	Recording data through administrative actions is primarily a method of quantitative data collection.
Electronic Data Harvesting	• Electronic data harvesting encompasses data collection of electronically generated data. Electronic data harvesting is a method of quantitative data collection.
Survey	• A survey comprises a structured series of questions that respondents are asked according to a standard protocol. • Surveys are primarily a method of quantitative data collection, though survey questions can be either quantitative or qualitative in nature, and can measure coverage (i.e., who received an intervention), satisfaction, perceptions, knowledge, attitudes, and reported actions or behaviors.
In-depth Interview (IDI)	• An in-depth interview is usually conducted one-on-one by an interviewer who asks an interviewee about their knowledge, experiences, feelings, perceptions, and preferences on a certain topic. IDIs can also be conducted with a group though this may not always be appropriate or optimal. The interviewer relies on a structured, semi-structured, or unstructured question guide or list of themes/points to be discussed and often encourages a free flow of ideas and information from the interviewee. • A Key Informant Interview (KII) is a type of IDI, whereby an interviewee is selected for their first-hand knowledge of the topic of interest or geographical setting (e.g., community).

	• IDIs are a method of qualitative data collection.
Focus Group Discussion (FGD)	• A focus group discussion involves a skilled moderator who stimulates discussion among a group of individuals to elicit experiences, feelings, perceptions, and preferences about a topic. The moderator uses a list of topics to be discussed, ensures all voices are represented, and keeps the discussion on track. Typically, groups comprise 6-12 purposively selected participants; however, size and selection techniques may vary. Focus groups differ from group interviews in format, how they are facilitated, who may be chosen to participate, and the types of data that come out of the process. • FGDs are a method of qualitative data collection.
Observation	• Direct observation entails a trained (human) observer who records data based on what they see, hear, or touch, often based on a guided protocol. Examples include observation of skills-based performance and observations of a physical environment or setting of an intervention. • Participant observation involves a researcher participating in an activity and making observations informed by their experience interacting with others during the activity. • Remote observation or remote sensing entails gathering observational data through observation at a distance with the assistance of technology (e.g., satellite or aircraft-based imagery). Remote data collection is particularly useful in non-permissive environments. • Observation is more often used as a method of qualitative data collection but can also be used for quantitative data collection, especially when focused on the number of occurrences of a specific item, event or action.

iv. Reporting Structures

M&E reporting is essential because it is used to: (a) determine the extent to which the CIDP and other county plans are on track and to make corrections accordingly; (b) make informed decisions regarding operations, management and service delivery; (c) ensure the most effective and efficient use of resources; (d) evaluate the extent to which the programme/project is having or has had the desired impact; and (e) whether new information has emerged that requires a strengthening and/or modification to the project management plan.

Standard reporting templates will be used to collect data and other information that will be used in compiling M&E progress reports. Tracking of progress and reporting of results will focus on inputs, processes, outputs, outcomes, and impacts of development initiatives in the County.

Performance reports will be prepared in these categories:

- Monthly reports by implementing agencies
- Quarterly reports by implementing agencies
- Annual progress reports
- Field visits and observations of programme activities and projects
- End of programme/project reports by the implementing agencies and County Monitoring and Evaluation Unit.
- Mid -Term Evaluation (Review).
- End -Term Evaluation (Review)

The table 28 presents some of the reports to be prepared.

Table 28: Monitoring and Evaluation Reports

	Report	Frequency	Responsibility	Target Consumers
1	Project progress reports	Daily, Monthly, Quarterly, annually	Project Supervisor	• Project implementation committee • Funding agencies • Oversight agencies • Public
2	Monitoring and Evaluation Reports	Quarterly	Monitoring and Evaluation Agencies	• Implementation agencies • Funding agencies • Oversight agencies
3	Audit Reports	Annually	Internal audit directorate/ Kenya National Audit Office	• Implementation agencies • Funding agencies • Oversight agencies • Public
4	Review Reports(ADP, APR, CIDP Reviews and Sectoral plans reviews)	Yearly, Three year, Five Year	County Government of Bungoma	• Implementation agencies • Funding agencies • Oversight agencies • Public

Most of the existing M&E information is compiled manually hence the need to explore the possibilities of computerizing the existing manual systems for M&E operations. The e-CIMES will facilitate computerization of M&E data which will address issues of cooperative partnership in M&E information activities, systems compatibility and sustainability.

The respective departments, the county Intergovernmental Forum, and CoMEC should review these progress reports as a basis for decision making and for agreeing on action plans for development. To facilitate a smooth decision-making process, all agendas of relevant county meetings should include a review of indicators and sector progress reports as a standing item, with full reporting documents sent in advance to the

participants. Where possible, progress reports should be available in an electronic format, and should combine data and associated narrative commentary and evidence

5.7 Dissemination, Feedback Mechanism, Citizen Engagement and Learning

This section highlights how the County Government will disseminate, get feedback, and engage citizens in M&E process as well as learning. Specific means of communicating M&E information based on unique needs of various stakeholders will be identified. The section also presents how M&E reports produced will be used for evidence based decision making.

Dissemination of M&E Reports

The Constitution of Kenya requires that M&E Reports must be available to the public, and should be shared with county citizens and other stakeholders. Disseminating M&E results is also necessary: (i) to improve programme/project interventions; (ii) to strengthen projects/programmes institutionally; (iii) to advocate for additional resources; (iv) to create citizen awareness and ownership, and promote "people-friendly" policies; (v) to ensure that county development activities are captured in CIMES and NIMES; and (vi) to contribute to the county and national understanding of what works.

Channels for disseminating M&E Reports and information will include:

- Written reports
- Oral presentation
- Press releases
- Fact sheets
- Social and new media platforms
- Performance Dashboards
- Open Data Portals
- Ad-hoc analyses (comparison and benchmarking)
- E-mail, text messages and mobile notification messages
- County websites

The reports shall be utilized to inform policy actions, planning and budgeting. These reports shall be widely disseminated to key stakeholders including legislators, policy makers, research institutions, development partners and members of the public for their use.

Feedback Mechanisms and Citizen's Engagement

Public participation is a legal responsibility in implementation of the CIDP. In the spirit of the Constitution, citizen participation is about engaging, understanding and meeting

the needs of people in the county by mobilizing all the insight, energy and commitment of individuals and groups. Participation allows the county to understand what is needed and to gain commitment to a way forward. Participation will include dissemination and gathering feedback as part of a holistic development process.

The County Executive will mobilize more innovation, opportunity, commitment and resources through community participation in development planning. Participation in development, monitoring, review and evaluation of the CIDP will strengthen county citizen awareness and ownership of the CIDP programmes/ projects that will be implemented by the county government. It will also provide a check formula to ensure value for money, accountable spending and good governance.

Participation will be used to:

- Capture the ideas, attitude, voice and commitment of stakeholders;
- Ensure and provide evidence that the county executive has met the legal duty of participatory development;
- Strengthen accountability and good governance

Knowledge Management

Knowledge management is a process by which state and non-state actors generate value and improve their performance by gaining insights and understanding from experience, and by applying this knowledge to improve programmes' and projects' planning and delivery. Knowledge management is linked to performance enhancement and management for development results. The main purposes of knowledge management of monitoring and evaluation information are to: (a) promote a culture of learning and (b) promote application of lessons learned and evidence-based decision-making at all levels.

M&E Reporting systems and tools shall provide for documentation of success stories and best practice for cross learning (intra and inter agency peer learning at departmental levels).

5.8 Evaluation Plan

This section identifies key policies/programmes/projects for evaluations during or after the plan period. This may include rapid evaluations, impact evaluations, CIDP mid-term or end-term reviews or any other type of evaluation. The evaluations proposed are at program or sector level. Due to the cost implication of evaluations, the proposals are limited to key priority programs/Areas (The criteria for selecting programs to include in

this plan as well as template for presenting the plan are available in the Kenya Evaluation Guidelines, 2020).

The Plan is presented in Table 29.

Table 29: Evaluation Plan

No	Policy/ Programme/ Project	Evaluation Title (specifying the type)	Outcome(s)	Use of the Evaluation Findings	Commissioning Agency/ Partners	Anticipated Evaluation start date/end date	Evaluation Budget (Kshs.)	Source of Funding
1	Health Sector Programs	Rapid Evaluation of the establishment of level 5 hospital	Increased access to health Services	Inform decisions on design and implementation of project	CECM Health	June 2027	Kshs 5 million	CGoB

ANNEX 1: IMPLEMENTATION MATRIX

Table 30: Implementation Matrix

Programme	Objectives	Strategies/Interventions	Implementing agency(s)	Time Frame	Funding	
					Total Budget(Ksh in Millions)	Source(s)
General Administration	Enhance service delivery	Remunerate & Recruit health staff	County Public Service Board	2022-2032	37,700.00	GOK
		Capacity build health care workers	Health and Training institutions	2022-2032	222.00	GOK & Development partners
		Enact and customize health policies and regulations	Health	2022-2032	42.00	GOK & Development partners
		Advocacy meetings for higher budgetary allocation	Health, civil societies & Development partners	2022-2032	120.00	GOK & Development partners
		Acquire utility vehicles	Procurement	2022-2032	60.00	GOK & Development partners
		Implement reward and sanction system	Health-Human Resource	2022-2032	40.00	GOK & Development partners
		Strengthen support supervision	Health	2022-2032	60.00	GOK & Development partners
		Collaborate with development partners	Health-Liason office	2022-2032	40.00	GOK & Development partners
		Linkage with other related ministries and departments	Health-Liason office	2022-2032	30.00	GOK & Development partners
		Scale up the enrolment of clients in existing health insurance schemes	Health	2022-2032	10.00	GOK & Development partners
		Enroll the vulnerable on the Insurance schemes	Health	2022-2032	80.00	GOK & Development partners
		Budget for the vulnerable on Insurance schemes	Health	2022-2032	100.00	GOK & Development partners
		Payment of monthly stipends to CHVs	Health	2022-2032	100.00	GOK & Development partners
Curative and Rehabilitative Health Services	To provide quality health services	Construction of a comprehensive teaching and Referral hospital	Health and Public works	2022-2027	5,000.00	GOK & Development partners
		Construction of	Health and	2022-	3,998.80	GOK &

		Health buildings including maternal blocks, mental unit, theatres, radiology outpatient and inpatient etc	Public works	2032		Development partners
		Acquisition of equipment	Procurement	2022-2032	1,000.00	GOK & Development partners
		Acquisition of ambulance	Health	2022-2032	80.00	GOK & Development partners
		Capacity building of health care workers	Health	2022-2032	40.00	GOK & Development partners
		Procure health products and technologies	Health	2022-2032	1,200.00	GOK & Development partners
		Early diagnostic of ailments	Health	2022-2032	770.00	GOK & Development partners
		Formation of emergency response team in hospitals	Health	2022-2032	30.00	GOK & Development partners
Preventive and Promotive Health Services	Halt and reverse communicable and non-communicable ailments	Construct incinerators at sub county hospitals and major health centers	Health & Public works	2022-2032	120.00	GOK & Development partners
		Capacity building of health care workers	Health	2022-2032	40.00	GOK & Development partners
		Procure health products and technologies	Health	2022-2032	480.00	GOK & Development partners
		Linkage with other related ministries and departments	Health	2022-2032	20.00	GOK & Development partners
		Strengthen support supervision	Health	2022-2032	30.00	GOK & Development partners
		Collaborate with development partners	Health	2022-2032	20.00	GOK & Development partners
		Conduct regular outreaches and medical camps	Health	2022-2032	120.00	GOK & Development partners
		Empower the community with information on health	Health	2022-2032	25.00	GOK & Development partners
		Strengthen school health education	Health	2022-2032	60.00	GOK & Development

						partners
		Provide Funds to purchase land for provision of cemetery	Health	2022-2026	30.00	GOK & Development partners
Reproductive, Maternal, Adolescent and Child Health	To provide quality maternal child health services	Construction of maternal blocks, and theatres,	Health & Public works	2022-2032	300.00	GOK & Development partners
		Equipping of maternity blocks	Health	2022-2024	400.00	GOK & Development partners
		Renovation of existing maternal blocks	Health & Public works	2022-203220 22-2032	120.00	GOK & Development partners
		Procurement of ambulance	Health	2022-2032	60.00	GOK & Development partners
		Capacity building of health care workers	Health	2022-2032	50.00	GOK & Development partners
		Strengthen support supervision	Health	2022-2032	100.00	GOK & Development partners
		Procure health products and technologies	Health	2022-2032	500.00	GOK & Development partners
		Conduct regular outreaches and medical camps	Health	2022-2032	300.00	GOK & Development partners
		Strengthen kangaroo mother care (KMC)	Health	2022-2032	50.00	GOK & Development partners
		Formation of emergency response team in hospitals	Health	2022	40.00	GOK & Development partners
		Enact and customize health policies and regulations	Sanitation	2022-2032	30.00	GOK & Development partners
		Capacity building of health care workers	Sanitation	2022-2032	40.00	GOK & Development partners
		Strengthen support supervision	Sanitation	2022-2032	30.00	GOK & Development partners
		Implement reward and sanction system	Sanitation	2022-2032	60.00	GOK & Development partners
		Conduct regular outreaches	Sanitation	2022-2032	80.00	GOK & Development partners
		Linkage with other related ministries and departments	Sanitation	2022-2032	20.00	GOK & Development partners
		Community	Sanitation	2022-	360.00	GOK &

		sensitization		2032		Development partners
		Strengthen school sanitation	Sanitation	2022-2032	120.00	GOK & Development partners
		Provide Funds to purchase land for provision of cemetery	Sanitation	2022-2032	90.00	GOK & Development partners