REPUBLIC OF KENYA

KAKAMEGA COUNTY

COUNTY GOVERNMENT OF KAKAMEGA

COUNTY HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN

2018 – 2023

MAY 2019

KAKAMEGA COUNTY

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County Government of Kakamega. County Health Sector Strategic and Investment Plan, 2018 –2023

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List of Acronyms

AIA	Appropriations-in-Aid
AIDS	Acquired Immune Deficiency Syndrome
AIE	Authority to Incur Expenditure
AMREF	African Medical Research Foundation
ANC	Antenatal Care
APHIA	AIDS Population and Health Integrated Assistance
ARVs	Antiretroviral Drugs
AWP	Annual Work Plan
BEOC	Basic Emergency Obstetric Care
BMI	Body Mass Index
CBHMIS	Community Based Health Management and Information System
CDF	Constituency Development Fund
CHMT	County Health Management Team
CHSF	County Health Stakeholders Forum
CLTS	Community-Led Total Sanitation
CSO	Civil Society Organization
CSSD	Central Sterilizing Supply Department
DANIDA	Danish International Development Agency
DFID	Department for International Development
DHIS	District Health Information Software
EMOC	Emergency Management Obstetric Care
FBHIS	Facility Based Health Information System
FBO	Faith Based Organization
GAVI	Global Alliance for Vaccines and Immunization
HIV	Human Immunodeficiency Virus
HMIS	Health Management and Information System
HPT	Health Products and Technology
HRH	Human Resources for Health
HSSF	Health Sector Service Fund
ICD	International Classification of Diseases
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Prophylaxis Treatment
JICA	Japanese International Corporation Agency
KAIS	Kenya AIDS Indicator Survey
KCHSSP	Kakamega County Health Sector Strategic Plan
KCIDP	Kakamega County Integrated Development Plan
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
LATF	Local Authority Transfer Fund
LLITNs	Long Lasting Insecticide Treated Nets
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MEDS	Mission for Essential Drug Supply
MTC	Medical Training College
NCDs	Non-Communicable Diseases
OJT	On Job Training
OPD	Outpatient Department
PESTEL	Political, Environmental, Social, Technology, Economic and Legal
PPP	Public Private Partnership
SOPs	Standard Operating Procedures
SWOT	Strength, Weakness, Opportunity and Threats
TB	Tuberculosis
TBAs	Traditional Birth Attendants
UNAIDS	United Nations Agency for International Development
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Foreword

The Constitution of Kenya 2010 under the Bill of rights prescribes attainment of the highest standard of health for all citizens. Health services is a devolved function, and it is the responsibility of the County government to ensure quality health services for its population.

I am delighted to present to you the Kakamega County Health Sector Strategic and Investment Plan (CHSSIP) 2018-2023, which outlines the strategic vision and goals that will enable fulfilment of our mission and mandate under devolved system of government.

This document is a product of extensive stakeholder engagement and consultation. The Strategic Plan is informed by lessons learnt from our achievements and challenges as a sector including key findings from the End Term Review of the first CHSSIP 2013-2017. Alongside the Strategic Plan is a Monitoring and Evaluation Framework to track the achievement of milestones.

The implementation strategies outlined in this plan are based on sound evidence while policy orientations are informed by the Kenya Health Policy 2014-2030. The health investments are organized in the six health building blocks which have been further translated into programs that fall in the various health investment areas. In the context of global trends and other emerging issues in health, this plan has factored Universal Health Coverage as one of the key flagship projects.

The Department of Health Services is fully committed to the full realization of this Plan. Implementation of the plan will require concerted efforts of all the stakeholders in the health sector. To fully implement this Strategic Plan, the Department of Health Services will require KES 39 billion against a projected allocation of KES 23 billion by the County Government. Given the financing gap, I call upon all stakeholders to partner with the Department of Health to ensure realization of the goals and objectives of this Plan.

Hon. Rachel J. Okumu OGW
County Executive Committee Member for Health Services
Kakamega County

Preface

The County Health Sector Strategic and Investment Plan (CHSSIP) 2018-2023 is in line with the Constitutional and other statutory obligations for County entities to have medium-term plans. This plan has incorporated the priorities in the County Integrated Development Plan 2018- 2022 (CIDP) and will be implemented through Annual Work Plans (AWP). All health stakeholders were involved in the development of the Plan through consultation, dialogue, drafting and validation. The Department would like to thank USAID Tupime Kaunti project for their technical and financial assistance and mobilizing all stakeholders to participate in the development, compilation and costing of this Plan.

This is a living document amenable to revisions as new ideas, innovations, programs and policies will be considered during implementation. It will be promulgated from time to time to align with stakeholders' obligations, expectations and aspirations. Accordingly, stakeholders will familiarize themselves with the contents of this plan and align their activities.

The Department of health will put in place robust mechanisms for resource mobilization and budget monitoring to enhance transparency and accountability.

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Acknowledgements

The Department wishes to acknowledge all who contributed and participated in the development process of this Strategic Plan. First, we wish to acknowledge the CEC Member for Health Services Hon. Rachel Jaluha Okumu OGW, EGJ for providing leadership; the contributions and stewardship of all the Chief Officers - Medical Services, Public Health and Sanitation and Health Projects and the County Directors in the Department of Health Services.

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Dr. Arthur Andere
Acting Director Public Health
Kakamega County

Dr Ayub Misiani
Acting Director Medical Services
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Executive Summary

This is the second five-year County Health Sector Strategic and Investment Plan 2018-2023 for Kakamega County. It outlines the vision and strategies for the Department towards attaining the goal of attaining equitable, affordable, accessible and quality health care for all. Development of this Plan was informed by findings of the End Term Evaluation of the CHSSIP 2013-2017. It is anchored on the WHO health system building blocks and is expected to contribute to the achievement of Universal Health Coverage by 2022 and contribute to realization of Kenya's Vision 2030.

This CHSSIP envisions attainment of Universal Health Coverage for all residents by 2022. To this end, the Plan outlines various strategies to address existing and emerging health problems and challenges. Implementation of UHC to scale is aimed at improving access to health services and specifically to protect vulnerable households from catastrophic health expenditure. The Plan also prioritizes scale up of KEPH services at all levels to improve uptake and access to health services. This will be achieved through implementation of the objectives, priorities and targets specific to service orientations adopted in this plan.

This Plan aims to accelerate and sustain gains realized and reverse negative health performance trends observed during implementation of CHSSIP 2013-2017. In this period, the sector recorded remarkable achievements in provision of physical infrastructure, availability of health products and technologies, capacity building of health care workers, investment in preventive and promotive health services and provision of ambulance services.

To ensure full realization of the health sector goals, the Department of Health Services will align the County Health Sector priorities to stakeholders' priorities. This alignment will be realized through strengthening of stakeholders' coordination mechanisms to enhance joint planning, coordination of programs and activities, monitoring, and evaluation. Thematic Technical Working Groups (TWGs) will also be strengthened to enhance implementation of this plan.

Cognizant of the importance of health data, the Department of Health has prioritized various data quality initiatives. These include sensitization on data management standard operating procedures (SOPs) at all levels (facility, Sub County and County level). This is anticipated to further improve data demand and use.

Implementation of this Plan will be further be enabled through targeted leadership and governance priorities including strategic planning which has been categorized as a key strategy for leveraging on available resources. This will be realized through institution and implementation of enabling policies and plans. The County Executive Committee Member for health services shall exercise the overall responsibility of ensuring full implementation of this plan. The County Assembly Committee of Health Services on the other hand shall lobby for increased allocation of resources to health in the County Assembly in addition to providing oversight role during implementation

To support effective implementation, monitoring of this Plan will be undertaken in line with the Monitoring and Evaluation (M&E) plan. The M&E Plan which is based on logical flow of processes shall be used as a tool for tracking implementation progress. Further, the Plan will support realization of a unified approach to monitoring and evaluation by all sector players.

A total of KES 34,935,658,200 is required to fully implement the strategies and programs proposed in this plan. This translates to an estimated KES 6,987,131,640 annually. The required financial resources to implement this plan will be sourced mainly from government exchequer allocation and development partners. Opportunities for public private partnership (PPP) arrangements exist to leverage on external capital potentials. The County exchequer is expected to fund about 60% from the equitable shareable revenue, 10% as conditional grants from national government while the remainder shall be sourced from other development partners.

1 INTRODUCTION

1.1 Purpose of this Strategic and Investment Plan

The primary purpose of this County Health Sector Strategic and Investment Plan (CHSSIP) 2018–2023 is to provide strategic direction for implementation of health interventions. The strategy will also be used as a resource mobilization tool for health service delivery. The Plan builds on the successes achieved during the implementation of the CHSSIP for the 2013–2017 period.

This strategy is aligned to Sustainable Development Goals (SDGs), the Kenya Constitution, 2010, the Kenya Health Policy 2014–2030 and the Kenya Health Sector & Investment Plan 2018–2023. It was informed by other key strategic policy documents such as the End Term Review Report for the CHSSIP 2013–2017, the Governor's Manifesto and the County Integrated Development Plan (CIDP) 2018–2022. The strategy outlines the health sector objectives and priorities to enable it move towards attainment of the Kenya Health Policy directions.

This Plan is also aligned to the national government's Big Four Agenda; Kenya's priority projects which include enhancing food security and universal healthcare (UHC) towards realization of the national development goals. In particular, the strategy aims to boost access to universal health care and improve the physical infrastructure that will improve housing for the Department of Health.

This Plan is a critical tool for health sector planning. It will guide the County to use evidence to identify health priorities for implementation and financing. It will also guide the Department of Health budgeting processes and facilitate efficiency in resource allocation and utilization towards attainment of the health sector goals. It also articulates County health priorities and therefore provides framework for effective collaboration with health partners in addressing its health gaps.

The strategy aims to address the health challenges facing the County. The County is the second most populous in the Republic of Kenya (1,941,663) after Nairobi County (projected in KNBS, 2009). The County has a high population density of 637 persons/km2 and high poverty index level which stands at 35.8% (KIHBS) 2015/2016). Whereas the County has recorded remarkable improvements in some of the key health indicators, there is still need for concerted efforts to reverse the negative trends observed for some health indicators.

1.2 County Mission and Vision

Vision

"Quality health services for all"

Mission

"County dedicated to delivering accessible, equitable, efficient health care services through promotive, preventive, curative and rehabilitative health services to all".

Goal

"Improved access to quality and affordable health services to all"

Core Values

- **Professionalism and ethics**: All staff shall uphold the highest moral standards and professional competence in service delivery
- **Transparency and Integrity**: To be responsible, accountable and devoid of corrupt practices in service delivery
- **Communication**: To ensure smooth information flow for both internal and external stakeholders
- **People-centered and customer satisfaction**: To treat customers with courtesy and respect and delight in their satisfaction
- **Commitment**: To devote all our official time to our duties and undertake to serve customers without unnecessary delays
- **Teamwork**: To encourage team spirit, collaboration and consultation as a way of maximizing the synergy of working together for improved service delivery
- **Innovativeness and creativity**: To be open and proactive in seeking better and more efficient methods of service delivery
- **Social justice and equity**: Human rights approach and equitable access are fundamental guiding principles to inform delivery of health services in the County
- **Partnership and Collaboration**: Close working relationship with all stakeholders to promote synergy
- **Result oriented**: Meant to achieve results for people of Kakamega
- **Confidentiality**: Attending to patients/clients in privacy and protecting client's information

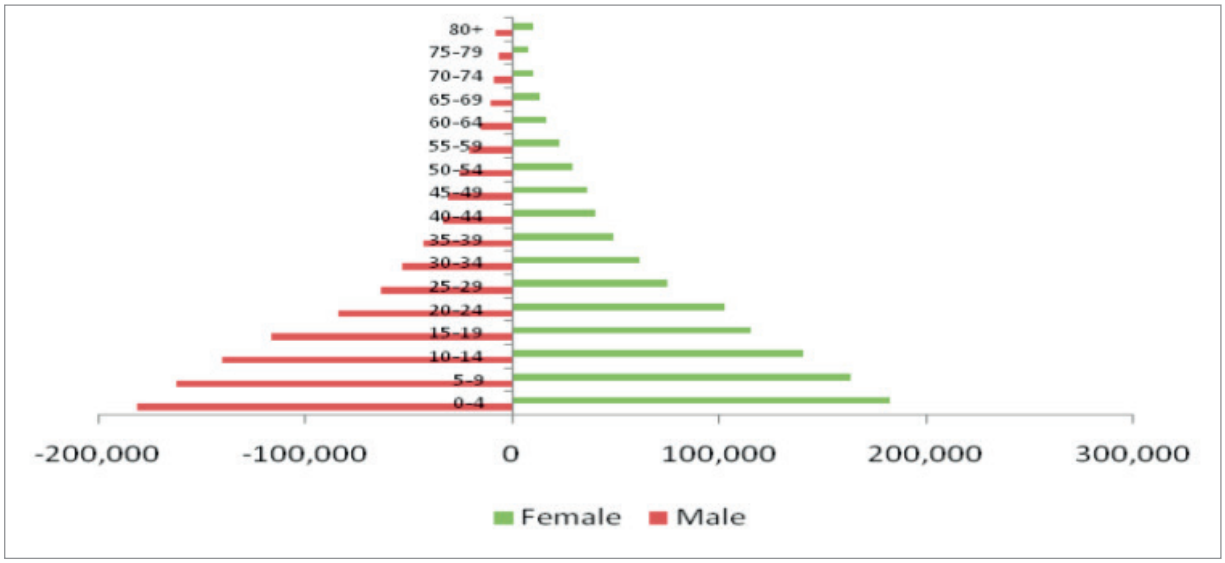
1.3 Demographics

1.3.1 Population Status and Projection

The County population based on the 2009 Kenya population and housing census is estimated at 1,660,651 and comprises of 800,896(48%) males and 859,755(52%) females. This population is projected to grow at an annual rate of 2.5%. Based on this annual growth rate, the County population was expected to rise to 1,941,663 by the year 2018 and further grow to 2,007,597 and 2,109,232 by the year 2020 and 2022 respectively. Majority of the people (75%) are Christians while the rest (25%) are Muslims, Hindus and others.

Maternal Mortality Ratio is 316 per 100,000 live births (UNFPA, 2014) which is slightly below the National average of 362 per 100,000 live births (KDHS 2014). The fertility rate is 4.4% while skilled delivery is 57% (DHIS2, 2017). Neonatal mortality and infant mortality rates are 19 and 40 per 1000 live births respectively. Malnutrition is the major underlying cause of high infant and child morbidity and mortality with stunting, underweight and wasting rates of 28.4%, 10.3% and 1.18% respectively (KDHS 2014). Figure 1 highlights the projected 2018 Kakamega County population pyramid.

Figure 1: Population Pyramid



Source: KNBS 2009 estimates

Table 1 illustrates population projections and expected trends in the Sub Counties over a five-year period

Table 1: Population Projections and Expected Trends in the County

	Sub Counties	Population trends					
		2009	2018	2019	2020	2021	2022
1	Lurambi	160,229	187,343	190,618	193,705	198,547	203,511
2	Navakholo	137,165	160,376	163,179	165,822	169,967	174,216
3	Ikolomani	104,669	122,380	124,520	126,536	129,700	132,942
4	Shinyalu	159,475	186,461	189,721	192,793	197,613	202,553
5	Malava	205,166	239,884	244,077	248,030	254,231	260,587
6	Butere	139,780	163,433	166,290	168,983	173,207	177,538
7	Khwisero	102,635	120,002	122,100	124,077	127,179	130,359
8	Mumias West	111,862	130,792	133,078	135,233	138,614	142,079
9	Mumias East	100,956	118,039	120,103	122,048	125,099	128,226
10	Matungu	146,563	171,364	174,359	177,183	181,612	186,153
11	Likuyani	125,137	146,313	148,870	151,281	155,063	158,940
12	Lugari	167,014	195,276	198,690	201,907	206,955	212,129
County		**1,660,651**	**1,941,663**	**1,975,605**	**2,007,597**	**2,057,787**	**2,109,232**

Source: KNBS, 2019 estimates

Farming, particularly sugarcane and maize farming, is the main economic activity in the County. Subsistence farmers grow mainly beans, groundnuts, sweet potatoes, cassava, millet, finger millet and peas. Other livelihood activities include small-scale trade, transport and gold mining.

1.3.2 Population Description

Table 2: Target Population by Age Cohort Proportion Over the Next 5 Year Period

	Description	Population estimates	Target population				
			2018	2019	2020	2021	2022
1	Total population		1,941,663	1,975,605	2,007,597	2,057,787	2,109,232
2	Total Number of Households		388,333	395,121	401,519	411,557	421,846
3	Children under 1 year (12 months)	3.59%	69,706	70,924	72,073	73,875	75,721
4	Children under 5 years (60 months)	17.48%	339,403	345,336	350,928	359,701	368,694
5	Under 15 year population	47.10%	914,523	930,510	945,578	969,218	993,448
6	Women of childbearing age (15 – 49 Years)	26.40%	512,599	521,560	530,006	543,256	556,837
7	Estimated Number of Pregnant Women	3.60%	69,900	71,122	72,273	74,080	75,932
8	Estimated Number of Deliveries	3.59%	69,706	70,924	72,073	73,875	75,721
9	Estimated Live Births	3.49%	67,764	68,949	70,065	71,817	73,612
10	Total number of Adolescent (15-24)	18%	349,499	355,609	361,367	370,402	379,662
11	Adults (25-59)	25.3%	491,241	499,828	507,922	520,620	533,636
12	Elderly (60+)	4.7%	91,258	92,853	94357	96,716	99,134

1.3.2 Demographic Dividend Potential

Demographic dividend is defined as the accelerated economic growth that a County can experience as a result of declining fertility levels that occasion a reduction in the dependency levels and an increase in the proportion of the population in the working ages (15-64 years).

With fewer dependents to support, those in the working ages will have more savings that can be invested to drive economic growth in the County therefore improving the wellbeing of the County residents. However, the attainment of a demographic dividend is not automatic. As the fertility levels decline, the County needs to make simultaneous strategic investments in the health, education, economic and governance sectors.

The aim of these investments is to ensure that as children and youth age, they remain healthy, are able to access education and training opportunities. Ultimately, this ensures more young people become part of the labor force and access employment opportunities and income, invest for retirement and participate productively in matters affecting the County.

Table 3: Kakamega County Demographic Projections

Indicator	2014	2017	2022	2030
County Population Size	1,855,850	1,908,309	2,109232	2,569,894
Proportion of Population Below Age 15 (%)	43.0%	40.8%	37.2%	35.6%
Proportion of Population in the Working Ages (15-64) (%)	53.9%	56.2%	59.7%	61.1%
Proportion of Population Above Age 65 (%)	3.1%	3.0%	3.1%	3.3%
Dependency Ratio	85.6	78.1	67.4	63.9
Fertility (Average No. of Children Per Woman)	4.4	4.2	3.9	3.4

Source: National Council for Population and Development

1.3.4 Service Provision Capacity

This section shows the community units and health facilities that serve County population as at 2018.

Table 4: Number of Community Units and Health Facilities

Description	Numbers	Ownership		
		Public	Faith Based	Private
Number of community units	422	422		
Fully functional units	28	28		
Partially functional units	394	394		
*Units not functional	0	0		
Number of health facilities by type Levels of care	275	174	24	77
Hospitals	16	12	3	1
Nursing homes/Health Centers	57	44	7	6
Dispensaries	137	118	14	5
Clinics	66	0	0	66

Source: DHIS2, 2018

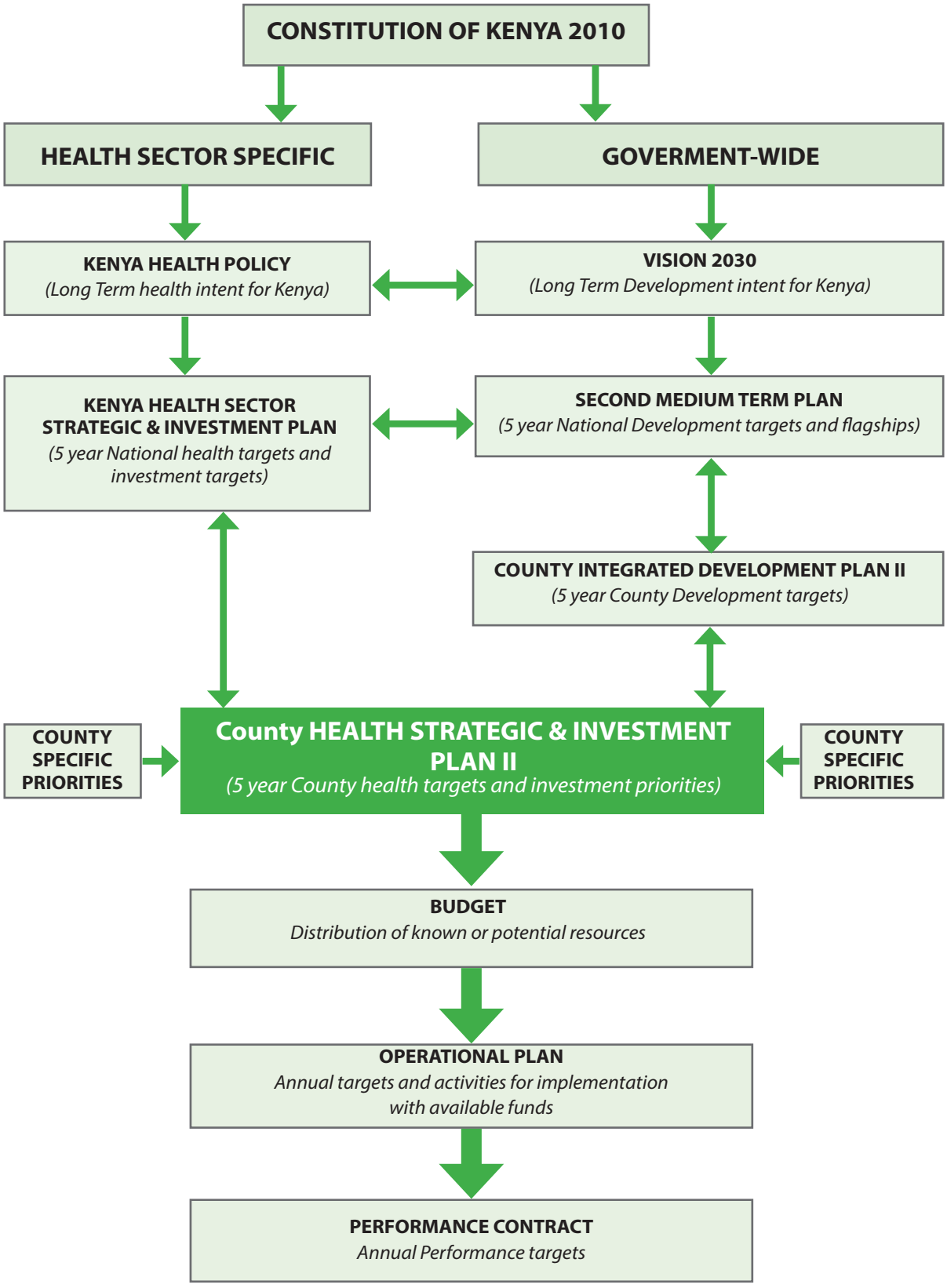
Functionality categorization as indicated in the table above was informed by DHIS2, 2018. This is based on reporting rates (85%), frequency of conducting community health dialogues and community action days at 90%. The functionality index was guided by the national Community Health Units (CHU) functionality assessment tool revised (2018). However, the last survey on functionality conducted in 2016 with support from World Vision reported 422 total County CHUs of which 28 were fully functional, 291 were partially functional and 103 non-functional. There is need to conduct a new survey using the revised CHU functionality assessment tools get the status of community health services in Kakamega County.

1.4 Rationale for Strategic Planning

Schedule Four (4) of the Constitution assigns to the County Governments the function of delivering County health services with the National Government steering health policy and oversight of national referral health facilities. This, therefore, calls for both levels of Government to develop health strategic plans as per their mandates to implement the Constitution 2010, Kenya Health Policy 2014-2030, KHSSP 2018-2023 and Medium-term Plan (MTP) 2018/2019 – 2021/2022. This strategic plan is thus expected to support realization of Vision 2030 and MTP 2018/2019 – 2021/2022, along with the broad goals of the Kenya Health Sector Strategic and Investment Plan KHSSP 2018-2023. This County Health Sector Strategic Plan 2018–2023 which is also aligned to the County Integrated Development Plan 2018–2022 therefore forms a basis for health prioritization and investment for the next five-years.

1.5 Planning Framework

Figure 2: Planning Framework



Source: Kenya Health Sector Strategic Investment Plan 2013-2017

1.6 Focus and Mandate

This Strategic Plan outlines the strategies the County Department of Health will employ to provide quality, accessible, sustainable, equitable and efficient health services. The department has aligned these strategies to the World Health Organization (WHO) health system building blocks below:

- Health service delivery.
- Health products and technologies.
- Health leadership and governance.
- Health information systems and monitoring and evaluation.
- Health research development.
- Health financing.
- Health infrastructure.
- Human Resource for Health (HRH).

This Plan therefore sets forth measures aimed at improving infrastructure, health information data, human resources, service delivery, research and development by resource mobilization and ensuring security of supplies and commodities. At the core of this Plan is implementation of Universal Healthcare which is at its formative stages in Kakamega.

1.7 Process of Development and Adoption of this Strategic and Investment Plan

Development of this CHSSIP 2018–2023 was undertaken through a consultative process involving various stakeholders and representatives from the community, facilities, Sub County Health Management Teams (SCHMTs), County Health Management Team (CHMT) and partners. A taskforce with select representatives of the stakeholders was instituted to develop a roadmap and lead the drafting process. A stepwise approach was followed in the development of the CHSSIP and involved the following steps:

- Comprehensive End-Term Review of CHSSIP 2013-2017.
- Meeting with the County leadership to harmonize the Strategic Plan with the County's Vision, Mission and the County Integrated Development Plan (CIDP).
- Engagement with all stakeholders in the County to incorporate their inputs.
- Public participation.
- Consolidation of the County Health Sector Strategic Plan (CHSSP 2018-2023).
- Sharing of the draft document with the County Assembly Health Committee.
- Validation by stakeholders.
- Editing and printing of the final document.
- Official launch of the Plan.
- Dissemination.

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2 SITUATION ANALYSIS

This chapter outlines the health access, health service delivery and health status in the County. These are all important in informing interventions and influencing policy making among decision-makers.

2.1 Health Access

Access to healthcare refers to the ease with which an individual can obtain needed medical services. Access has three dimensions:

- Physical accessibility.
- Financial affordability.
- Acceptability.

Physical Accessibility

The sector recorded remarkable achievement in construction and renovation of health facilities, availability of health products and technologies, capacity building of healthcare providers, investments in preventive and promotive health services, investments in quality improvement and implementation of referral system networking across the County.

Most of the population are within a five-kilometer distance to the nearest health facility. The Community Units (CU) coverage is optimal with all villages having access to CUs. It is also expected that Kakamega County Teaching and Referral Hospital (KCTRH), which is currently under construction, will provide comprehensive tertiary care and will be the teaching hospital.

Financial Affordability

In an effort to achieve Universal Healthcare (UHC), the National Government initiated reforms and programme towards UHC which include:

- Free maternity services in all public health facilities.
- Free primary healthcare in all public primary healthcare facilities.
- Major programmes to equip major public hospitals across the Country with modern diagnostic equipment and health insurance subsidies through NHIF targeting disadvantaged groups i.e. Health Insurance Subsidy Programme (HISP) for 5,011 older persons and 1,081 persons with severe disability (OPWSD) (currently enrolled 1139) and 23,672 and Inua Jamii programme for the aged 70+ years.

The County Government of Kakamega on its part conducted an inventory of households already registered with NHIF that are contributing to NHIF voluntarily, either directly or through the employer (Government sector 57,719, Private sector 56,355, Informal sector 86,627 and Sponsored programme 22,546). However, the Government initiated a process and identified 8,000 vulnerable households which were not falling under the categories mentioned above registered and paid for them NHIF monthly contributions for one year.

Acceptability

The willingness to seek services is determined by how clients perceive available health services. This directly affects utilization of healthcare services. To address acceptability of health services, the Department has put several measures in place. This include advocacy forums through the public service week, devolution conference, ASK shows, celebration of national health days and use of community dialogue days as platforms for the Department to create awareness and engage the community on health matters.

2.2 Universal Health Coverage

The County Government in liaison with NHIF office Kakamega conducted a desk review of an inventory for Secondary school Students medical scheme (PSSP) Programme who are benefiting from NHIF. The government is also collaborating with the Ministry of Labor to enforce the registration of all employees with NHIF scheme by their employers and has sensitized beneficiaries of Imarisha Afya ya Mama na Mtoto programme to enroll with NHIF.

Some of the challenges to the delivery of UHC include; high population living below the poverty line, shortage of health workers to manage the increased workload, poor health seeking behaviours inadequate financial resources among others.

Table 5: Flagship/County Transformative Projects for Health

PROJECT NAME	LOCATION	OBJECTIVE	OUTPUT/ OUTCOME	PERFORMANCE INDICATORS	TIMEFRAME (START/ END)	IMPLEMENTING AGENCIES	COST (KSH.)
County Teaching	Lurambi	Improve access to quality and affordable health services	Reduced incidents of curable diseases and ill health	No. of patients treated in the referral unit	2018-2022	CGK-Health services	6.2B
Imarisha Afya Ya Mama na Mtoto Programme	County Wide	Improve maternal and child healthcare	Reduced maternal and child morbidity and mortality	% maternal and child mortality and morbidity	2018-2022	CGK-Health services	600M
Kakamega Eye Hospital	Lurambi	Improve access to specialized eye care services	Reduced incidences of complications emanating from eye conditions	Proportion of patients with cataracts who have undergone cataract surgery	2018 - 2022	CGH – Health Services	160M

Source: Kakamega CIDP 2018 - 2022

2.3 Service Delivery

The performance assessment of selected service delivery indicators showed they were at different levels of achievement. For instance, measures of skilled birth delivery, HIV care, and ANC attendance had surpassed their respective set targets while malaria prevention, immunization, and exclusive breastfeeding had achieved over 80% of their targets. However, it was also observed that family planning, malnutrition, and health workforce indicators were performing below average; far from achieving their targets.

The End-Term Report also identified indicators pertaining to support systems whose implementation was meant to support delivery of health care services. The County has continued to invest in strengthening health delivery systems and structures for effective and quality health services, which included health financing, health workforce, health products, leadership and governance, coordination and partnership. This was done through allocation of resources to facilitate implementation of planned activities whose impact was felt at all service levels.

2.3.1 Policy Objective: Eliminate Communicable Conditions

The Kenya Health Sector Strategic Investment Plan 2013-2017 aimed to achieve better health by reducing the burden of communicable diseases through eradication of diseases such as polio, eliminate malaria, Mother-child HIV transmission, maternal and neonatal tetanus, measles and neglected tropical diseases. It also aimed to eliminate communicable conditions with focus on HIV and TB treatment, and malaria prevention among children and mothers. Table 6 shows the achievement of the priority indicators under this policy objective.

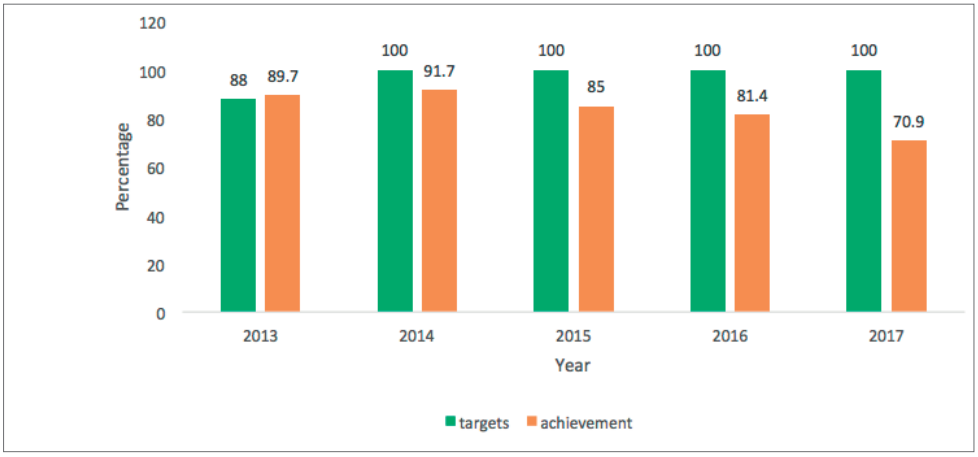
Table 6: Tracked Indicators on Communicable Conditions

OBJECTIVE	INDICATOR	BASELINE	PERFORMANCE FOR 2016-2017	
Eliminate communicable conditions			Target	Achievement
	% of fully immunized children	85	100	71
	% of TB patients completing	80	95	90.4
	Treatment			
	% of HIV+ pregnant mothers	59	79	95
	receiving preventive ARVs			
	% of eligible HIV clients on	43	73	66
	ARVs			
	% of targeted under-1s	66	96	52
	provided with LLINs			
	% of targeted pregnant	68	96	71
	women provided with LLINs			
	% of under-5s treated for	8	2	12
	Diarrhea			
	% school age children	62	92	Not tracked
	Dewormed			

Proportion of children under 1 year fully immunized

The County Department of Health aims to improve delivery of routine health and nutrition services targeting children. Universal immunization of children against six common vaccine-preventable diseases namely; tuberculosis, diphtheria, whooping cough (pertussis), tetanus, polio, and measles, is crucial to reducing infant and child mortality. The immunization performance between 2013 and 2017 is presented in figure 3.

Figure 3: Proportion of Children Under 1 Year Fully Immunized



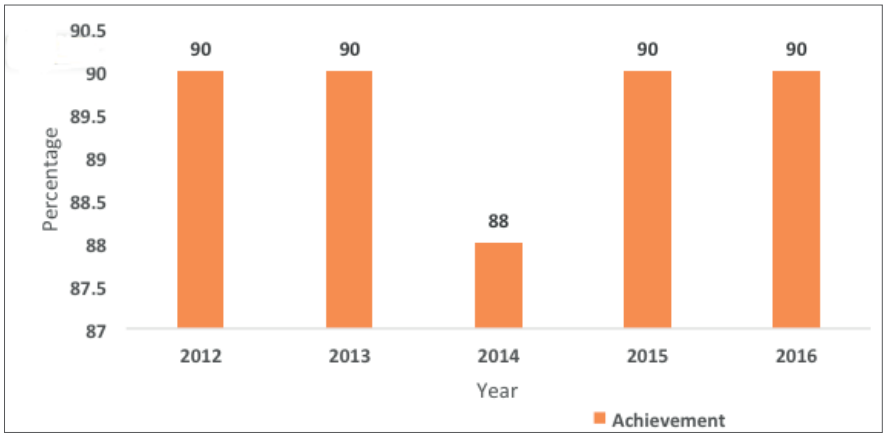
Sources: Kakamega CHSSIP End Term Review Report, 2018

During the period under review, the proportion of children under 1 year who were fully immunized marginally increased from 90 percent to 92 percent in the 2012-13 to 2013-14 period and dropped thereafter. There was a significant drop in 2017, which was attributed to the industrial strikes that disrupted service delivery.

TB treatment success rate

All diagnosed TB patients should complete treatment. The County TB treatment success rate is well above the target of 90% with the exception of 2014 as show in 4.

Figure 4 : TB Treatment Success Rate, 2012-2016 (TIBU System)



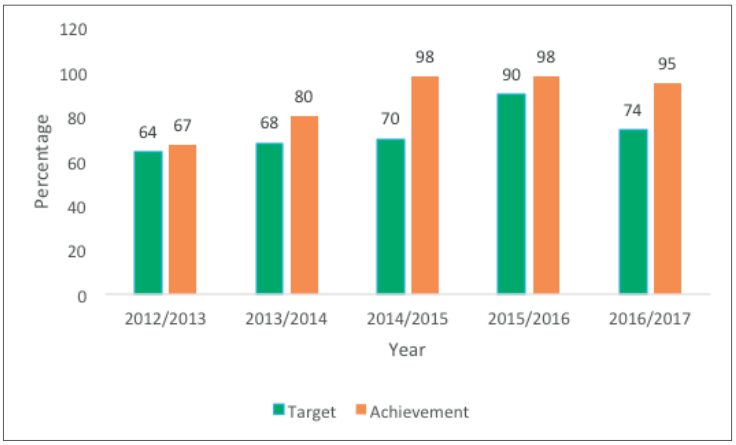
Sources: Kakamega CHSSIP End Term Review Report

Among the patients registered in 2014, five patients failed treatment, two were diagnosed to have Multi Drug resistant (MDR) TB and were started on MDR treatment, while three patients failed treatment and were restarted on treatment with expected completion of treatment in 2015.

HIV Positive mothers receiving ART

HIV counselling, testing and treatment is influenced by the socio-economic determinants of health such as education and wealth, etc. According to the KDHS 2014 findings, the likelihood of HIV counselling and testing during ANC increases with increasing level of education and wealth. For example, the variance between proportion of educated and uneducated women who received HTC services at ANC was 75% and 38% respectively. Likewise, women in the lowest wealth quintile (52%) were less likely than women in the highest wealth quintile (79%) to have been counselled, tested and receive their HIV test results. The % of HIV positive mothers that received preventive ARVs is shown in figure 5:

Figure 5: Percentage HIV Positive Mothers Receiving Preventive ARVs



Sources: Kakamega CHSSIP End Term Review Report, 2018

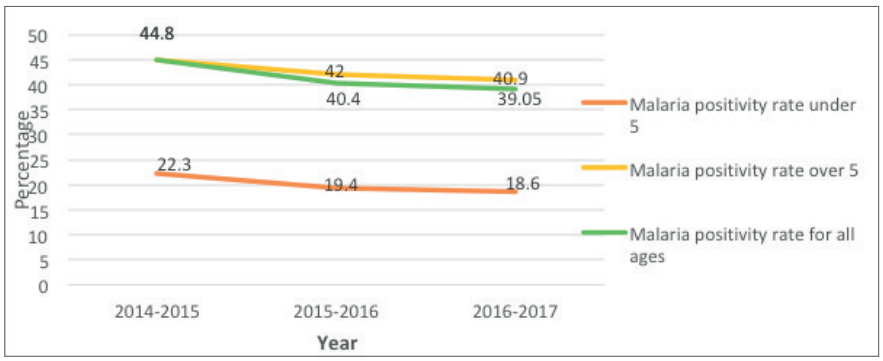
The end term review confirmed that there were missed opportunities in identification and/or enrollment of HIV positive pregnant mothers and other HIV positive clients and poor adherence among some of the enrolled clients. Some of the contributing factors include: fear, denial and non-disclosure of HIV status due to stigma and discrimination, feeling of wellness after taking ARVs for some time, patient's decision not to take ARVs, religious beliefs in divine healing, ignorance and long distances to facilities in some places.

Malaria positivity

As one of the malaria-endemic Counties, Kakamega residents remain at a higher risk of contracting malaria. Worth noting though, is that the County's prevalence rates reduced from 38% in 2010 to 27% in 2015. Among the at-risk population, 16.7% live in the two epidemic and seasonal malaria transmission Sub Counties: Lugari and Likuyani, where P. falciparum parasite prevalence is less than 10%. However, an estimated 1.6 million people live in the ten endemic sub counties with estimated prevalence rate less than 50%. There has been a decline in the positivity rate from 44.8% in FY 2014/15

to 39% in FY 2016/17 for all ages with the over five-positivity rate declining from 44.8% to 40.9% and the under-fives rate from 22.3% to 18.6%.

Figure 6: Malaria Positivity Rate, FY 2014/15 – 2016/17

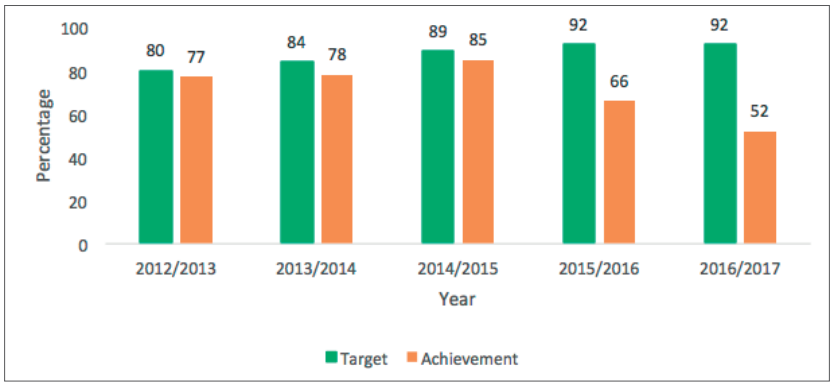


Source: Kakamega CHSSIP End Term Review Report, 2018

Proportion of children under-1 given LLINs

Figure 7 outlines the proportion of children under-1 given LLINs verses the targets over the review period. The findings indicate that the proportion of children under-1 who were issued with LLINs increased from 77% in FY 2012/13 to 85% in FY 2014/15, then suddenly dropped to 66% in FY 2015/16. Across the four years, the proportions of those provided with LLINs were below the set targets.

Figure 7: Proportion of under-1 Issued with LLINs FY 2012-2017



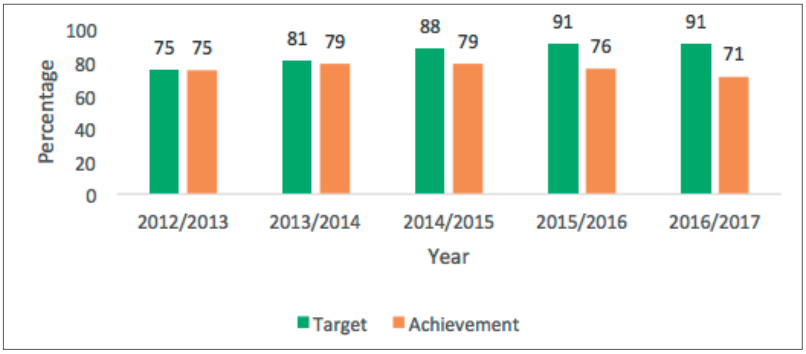
Source: Kakamega CHSSIP End Term Review Report, 2018

Proportion of pregnant women given LLINs

In malaria-endemic areas, adults usually have acquired some degree of immunity to severe, life threatening malaria. However, pregnancy leads to suppression of the immune system, thus leaving pregnant women, especially those in their first pregnancy, at a higher risk of malaria. Moreover, these infections may be asymptomatic, may lead to malaria-induced anaemia, and may interfere with the mother-foetus exchange, resulting in newborns with low birth weight. During pregnancy, women can

reduce their risk of adverse malaria effects by sleeping under insecticide-treated mosquito nets. The proportion of pregnant women who were issued with LLINs versus the set target is presented in figure 8.

Figure 8: Proportion of Pregnant Women Issued with LLINs



Source: Kakamega County CHSSIP End Term Review

Similarly, the proportion of pregnant women issued with LLINs fluctuated during the four years. In FY 2013/14 and 2014/2015, the County reported the highest proportion at 79% with the lowest performance (71%) being reported in FY 2016/17. However, according to the KMIS 2015, the number of pregnant women sleeping under an insecticide-treated net (ITN) in the County increased from 49% in 2009 to 72.6% in 2015. These findings indicate that most mothers were provided with LLIN during their first ANC visit and children under-1 at birth or during first immunization. For the missed opportunities, the following factors were cited as possible barriers to access and/or use: home deliveries, ignorance, sale of distributed nets, and absence during mass net distribution.

Neglected Tropical Diseases (NTDs)

Neglected Tropical Diseases (NTDs) are a group of infectious diseases that affect poor people in the tropics. They are disabling and cause severe morbidity and suffering among the poorest communities in the country. They present one of the largest economic, health burdens on the population due to their debilitating nature, and they perpetuate poverty (WHO). NTDs in the County include soil helminths and jiggers. NTDs control faces challenges that include inefficiencies in coordination of prevention, management and control, inadequate trained health care workers to handle NTDs, inadequate data on prevalence and incidence of NTDs and inadequate funding.

2.3.2 Policy Objective: Halt, and Reverse the Rising Burden of Non-Communicable Diseases

This policy objective was to be achieved by implementing strategies that would address all the identified non-communicable Diseases (NCDs). Reduction of the proportion of overweight and obese adults, as well as increasing cancer screening for women of reproductive age were among the priority interventions put in place.

Table 7: Priority Indicators Under Non Communicable Conditions

OBJECTIVE	INDICATOR	BASELINE	PERFORMANCE FOR 2016/2017	
			TARGET	ACHIEVEMENT
Halt, and reverse the rising burden of non-communicable conditions				
	% of adult population with BMI ≥ 25	20	12	No data
	% of women of reproductive age screened for cervical cancers	8	57	No data
	% of new outpatients with mental health conditions	2	1	0.2
	% of new outpatients cases with high blood pressure	2	1	1.1
	% of patients admitted with cancer	1	1	No data

Key challenges in the management and control of NCDs include: uncoordinated multidisciplinary approach in control of NCDs, inadequate HRH and funding for NCDs prevention and control, low level of population awareness on NCDs and lack of a communication strategy on NCDs. Similarly, inadequate NCDs diagnostic capacities at various levels of health care and erratic supply of NCDs medicines and medical supplies continue to hamper efforts towards eradication of these conditions.

2.3.3 Policy Objective: Reduce the Burden of Violence and Injuries

The major types of violence and injuries targeted were gender-based violence (including sexual violence) and injuries due to road traffic accidents. Table 9 below shows the summary of the indicators.

Table 8: Priority Indicators Under Violence and Injuries

OBJECTIVE	INDICATOR	BASELINE	PERFORMANCE FOR 2016/2017	
			TARGET	ACHIEVEMENT
Reduce the burden of violence and injuries	% of new outpatient cases attributed to gender based violence	5	1	1
	% of new outpatient cases attributed to road traffic injuries	25	10	2.39
	% of new outpatient cases attributed to other injuries	15	4	1.4
	% of deaths due to injuries	20	10	1

Gender-Based Violence (GBV)

According to the 2014 KDHS Report, 47.4% of women aged 15-49, and 45.5% of men aged 15-49 had experienced either physical or sexual violence. GBV is a major human rights violation which disproportionally affects women. The Department of Health Services has been working with stakeholders and other County Government Departments, namely; Police Service and Judiciary to strengthen legislative and policy frameworks on GBV. The department has further trained health care workers and community health volunteers to detect, respond and manage victims of GBV. Kakamega County is among the top ten Counties that account for SGBV cases reported in a health facility in Kenya. In the period 2016-2018, Lurambi, Shinyalu Ikholomani, Likuyani and Malava accounted for the

highest cases. The National Crime Research Centre 2014 revealed that Kakamega County accounts for 21% of defilement cases as compared to national level of 17 %. Table 9 summarizes performance for this policy objective.

Table 9: SGBV Rape Survivors Cases Reported in Kakamega 2016-2018

YEAR	SGBV RAPE SURVIVORS SEEN 0-9 YRS	SGBV RAPE SURVIVORS SEEN 10-17 YRS	SGBV RAPE SURVIVORS SEEN 18-49YRS	SGBV RAPE SURVIVORS SEEN 50 YRS AND ABOVE	TOTAL SGBV RAPE SURVIVORS SEEN ALL AGES
2016	12	61	20	0	93
2017	14	69	363	5	451
2018	76	183	99	9	367
Total	102	313	482	14	911

Factors attributed to the high prevalence of GBV include poverty and economic issues, domestic issues including unfaithful partners and extramarital affairs, cultural beliefs that women need to be disciplined, deteriorating morals in the society, alcohol abuse among perpetrators and even victims, vulnerability of orphans, dissatisfaction in marriage and inadequate legal enforcement for reported cases.

Road traffic injuries

Road traffic injuries due to boda boda accidents are on the rise in the County. This was attributed to recklessness and carelessness of drivers and boda riders, speeding, overloading of vehicles, poor road maintenance, ignorance, lack of protective gear for riders, and inadequately marked roads with no warning signs.

2.3.4 Policy Objective: Provide Essential Health Services

The CHSSIP 2013-2017 was geared towards providing affordable, equitable, accessible and quality healthcare that is responsive to clients' needs. This was expected to be achieved by strengthening the County planning and monitoring processes relating to health care to ensure efficiencies and effectiveness in delivery of demand driven priority interventions. Table 11 provides a summary of the performance of the indicators in 20162017.

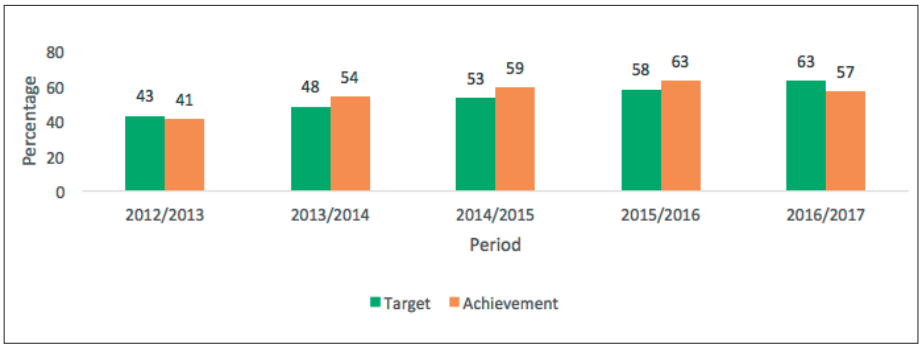
Table 10: Priority Indicators Under Essential Health Services Indicator Analysis

OBJECTIVE	INDICATOR	BASELINE	PERFORMANCE FOR 2016/2017	
			Target	Achievement
Provide essential health services	% deliveries conducted by skilled attendant-	34	63	57
	% of WRA receiving family planning	70	95	37
	facility based maternal deaths per	166	0	110
	100,000 live birth			
	facility based under-five deaths per1000 live birth	0	0	6.1
	% of newborns with low birth weight	8	2	3.3
	% of facility based fresh still births	1	0	1
	Surgical rate for cold cases	33	50	No data
	% of pregnant women attending 4ANC visits	37	63	44

Deliveries by skilled birth attendants

All women should have access to skilled care during pregnancy and childbirth to ensure prevention, detection and management of complications. Assistance by trained health personnel with adequate equipment is paramount in lowering both infant and maternal deaths. The performance of the County on this indicator is presented in figure 9.

Figure 9: Percentage of Deliveries By Skilled Birth Attendant



Source: Kakamega CHSSIP End Term Review Report, 2018

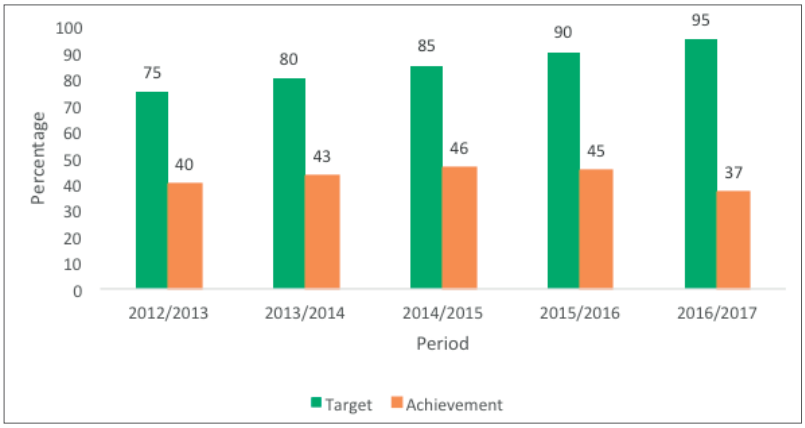
The proportion of deliveries by skilled birth attendants increased annually during the plan period. All the annual set targets were surpassed except in 2016/2017. This performance is well above the estimate from the 2014 KDHS of 49 percent for Kakamega County.

Family planning uptake

Uptake of family planning methods stood at an average of 42% against the average target of 83% during the period. The performance reported was far below the estimated contraception prevalence rate of 60% for Kakamega according to KDHS 2014. Despite the efforts in promoting family planning services, not all women of reproductive age in Kakamega County use family planning methods. Various factors have been attributed to the low uptake of family planning methods. These include preference

for natural methods of family planning which cannot be tracked or documented at the health facility, myths and misconceptions about family planning, lack of male involvement, associated side effects of family planning methods, poor attitudes of staff offering services and inadequate capacity by staff to offer various FP services.

Figure 10: Percentage of WRA Receiving Family Planning

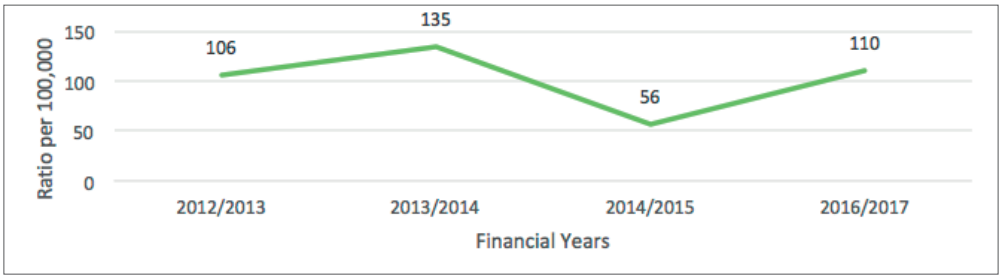


Source: Kakamega CHSSIP End Term Review Report, 2018

Maternal deaths

The CHSSIP 2013-2017 estimated maternal deaths at 880 deaths per 100,000 live births. This was comparatively higher than the national estimate of 362 per 100,000 live births as reported by the 2014 KDHS. During the plan period, the number of facility maternal deaths per 100,000 live births in the County reduced to 56 in FY 2015/16 and 110 in FY 2016/17 respectively as shown in figure 11. Factors contributing to maternal deaths in the County include home deliveries and deliveries by unskilled personnel, unsafe abortions by teenagers due to unplanned pregnancies, cultural beliefs in hegemonic femininity (when one is in labour they should not tell anybody), the first delay in decision making to seek health care during labour, poor road network, prolonged labour, poor ANC attendance, delays in referral from lower level facilities and lack of medical supplies, commodities and equipment needed to manage various complications.

Figure 11: Maternal Mortality Ratio, 2013-2016

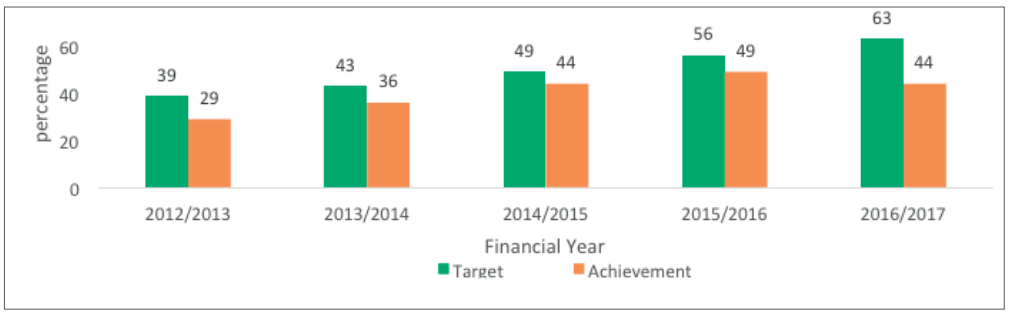


Source: Kakamega CHSSIP End Term Review Report

Antenatal care

The indicator on antenatal care provides insight on access and uptake of the recommended package of services by pregnant women in line with the WHO recommendation of a minimum of four ANC visits. Safe motherhood aims to assisting every woman through pregnancy and childbirth in order to achieve the desired outcome of a live and health baby and mother (MOH, 2017). The County's performance on this indicator is presented in the figure 12.

Figure 12: Percentage of Pregnant Women Attending at Least 4 ANC Visits



Source: Kakamega CHSSIP End Term Review Report, 2018

The findings above point to a gradual increase in the proportion of women attending at least four ANC visits from 29% in FY 2012/13 to 44% in FY 2016/17. The performance was however below the set target. This was attributed to the following factors: late first ANC attendance, inadequate knowledge on importance of ANC visits, distance and associated transport costs, peer pressure and cultural beliefs, Inadequate partner support and shame associated with pregnancies in older women and underage girls. Health system challenges include health workers strikes affecting scheduled appointments and long queues in health facilities due to staff shortages.

2.3.5 Policy Objective: Minimize Exposure to Health Risk Factors

This policy objective seeks to strengthen promotion of health interventions, which address risk factors to health, and facilitating use of products, and services that lead to healthy behaviors in the population. The policy objective had six indicators identified in KCHSSIP I. The ETR findings revealed gaps in tracking indicators under this policy objective. Of the six indicators, quantitative data was only available for one indicator - percentage of infants under 6 months on exclusive breastfeeding as shown in Table 11.

Table 11: Priority Indicators Under Minimizing Exposure to Health Risk Factors

OBJECTIVE	INDICATOR	BASELINE	PERFORMANCE FOR 2016/2017	
			Target	2016-2017
Minimize exposure to health risk factors	% of population who smoke	10	2	No data
	% of population consuming alcohol regularly	8	3	No data
	% of infants under 6 months on exclusive breastfeeding	28	54	39
	% of population aware of risk factors to health	0	28	No data
	% of salt brands adequately iodized	80	100	No data
	% of couple year protection due to condom use	17	25	No data

*** 0.3% of the women of age 15-49 years as per the KDHS 2014, are reported to smoke cigarettes, while 8.4% men smoke cigarette with 1.5% documented to sniff tobacco. Moreover, 5.5% of women are documented to be consuming alcohol regularly as compared to 25.7% of the men in western province.*

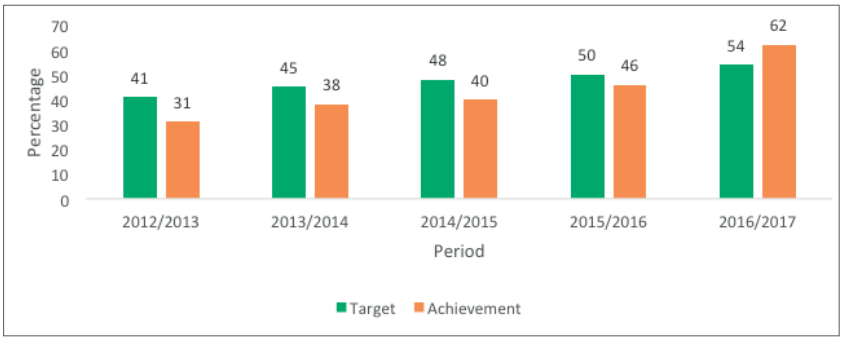
Awareness of health risk factors

Majority of the population in Kakamega are aware of risk factors of health such as smoking, drinking, risky sexual behaviors and alcoholism. A few reported that they had witnessed a reduction in such cases due to increased levels of awareness. This was achieved through routine health talks in health facilities, community dialogue days, action days as well as outreaches. Various media such as posters, social media, radio and television have also been used to relay this information.

Exclusive breastfeeding for infants under 6 months

To enhance child health, the CHSSIP 2013-2017 emphasized that all infants under 6 months be exclusively breastfed. Findings of the review however highlight that not all mothers in Kakamega County practice exclusive breastfeeding (EBF) despite the efforts put in place. Figure 25 presents the proportion of infants under 6 months who were exclusively breastfed.

Figure 13: Percentage of Infants Under 6 Months On EBF



Source: Kakamega CHSSIP 2018 – 2023

However, a progressive increase in the proportion of infants under 6 months who were exclusively breastfed (31% in FY 2012/13 to 62% in FY 2016/17) was observed. Despite strides made towards achieving set targets for this indicator, a number of factors that hinder exclusive breastfeeding were

highlighted as follows; Inadequate knowledge on importance of breastfeeding, HIV-Exposed Infants (HEIs) feeding and feeding for lactating mothers. This is aggravated by community perception on EBF, which is associated with HIV infection resulting in stigma.

Prevention of alcohol and drug abuse

Kakamega does not have referral rehabilitation centers. Therefore, patients are either treated with the general patients or referred to other Counties for specialized care. Lack of trained staff on substance abuse management was noted as a gap in service delivery.

2.3.6 Policy Objective: Strengthen Collaboration with Health-Related Sectors

The Kenya Health Sector Strategic Investment Plan (2013-2017) aims to adopt a 'Health in all Policies' approach, which ensures that the health sector interacts with and influences design, implementation and monitoring processes in all other health-related sector actions. The CHSSIP 2013-2017 therefore purposed to strengthen collaboration with three major health-related sectors: water and sanitation, education, and transport. During the review, the County Department of Health Services evaluated progress in two out of the eight indicators due to lack of data i.e. children under-5 who are stunted and those underweight.

Table 12: Priority Indicators on Strengthening Collaboration with Health-Related Sectors

OBJECTIVE	INDICATOR	BASELINE	PERFORMANCE FOR 2016/2017	
			Target	Achievement
Strengthen collaboration with health-related sectors	% population with access to safe water	32	73	No data
	% of under-5s stunted	NR	0	1.0
	% of under-5s underweight	35	15	6.7
	% of school enrollment rate	21	60	No data
	% of households with latrines	46	88	No data
	% of houses with adequate ventilation	26	79	No data
	% of classified road network in good	NR	5	No data
	Condition			
	% of schools providing complete school	14	44	No data
	Health package			

NB: The targets and achievements of these indicators refer to the children who accessed health care services in health facilities and not all children under five in the population.

Percentage of children under-five stunted

A child's size at birth is an important indicator of the child's vulnerability to the risk of childhood illnesses and chances of survival. According to KDHS 2014, 26% of children under 5 are stunted in Kenya. Data from routine information system was however not available for the performance period.

Percentage of children under-five underweight

The KDHS 2014 estimates that 10% of children in Kakamega were underweight. This was attributed to high poverty levels in the County hindering access to a balanced diet in some households, low knowledge on balanced diet and on available nutritional services, high teenage pregnancies, low uptake of MNCH services and poor breastfeeding practices resulting in increased vulnerability of children.

Access to safe water

The evaluation revealed that not all households in Kakamega County have access to safe water and for those who access safe water; it is through piped water and protected springs. Lack of access to an improved water source therefore limits the number of households accessing safe water suitable for drinking therefore increasing the risk of illness. Barriers identified as hindering access to safe water include: low coverage of piped water, long distances to safe water sources, poor maintenance of boreholes, human activities leading to water pollution and unprotected springs.

Households with latrines

Unsafe disposal of human waste spreads disease, either by direct contact or through indirect transmission. Hence, proper disposal of human waste, especially of children's stool, is extremely important in preventing the spread of diseases. Findings of the CHSSIP 2013-2017 review revealed that a large proportion of communities have pit latrines. This was attributed to increased public health awareness on the importance of pit latrines and proper waste management as a measure for curbing morbidity and mortality due to diarrhea. Despite efforts to ensure all households in the County have pit latrines, some families still lack these facilities and rely on shared pit latrines. The implementation of the community health strategy (CHS) at County reveals some of the barriers towards this achievement namely extreme poverty levels, persistence open defecation especially among people living near forests and sugarcane plantations, limited knowledge on the importance of pit latrines, poor planning particularly in the urban areas (low settlement area) such Jua kali and in swampy settlement areas. To ensure all households own pit latrines, the department continues to provide health education to communities on the need for latrines, enforcing Public health law, conducting inspections to identify homesteads lacking latrines and offering financial support to underprivileged families for construction of pit latrines and building adequate toilets in public places.

2.3.7 Health Systems Investments

Strategy implementation was structured in two key areas namely: service delivery and support services with selected indicators for each component. The support services indicators were designed to address systemic issues that affected health service delivery and they included; service delivery systems, health workforce, health products, health financing, health leadership, health information, partnership and coordination. To assess their performance, qualitative data was collected through key informant's interviews and Focused Group Discussions (FGDs) with different interest groups which

included health leadership – County Executive Committee (CEC), Chief Officer of Health (COH), County Director of Health (CDH), County Health Management Team (CHMT) and Hospital Management Teams (HMT) members, service providers, women groups and selected stakeholders. Overall, the evaluation established majority of the set targets for the priority indicators were achieved and effectively supported service delivery mechanisms.

Service delivery system

Community Units

In line with the Community Health Strategy (CHS) guidelines, the evaluation sought to establish the extent of implementation of the strategy. Findings established that despite having 100% community unit coverage (422 CUs), some key components of the strategy were not fully implemented. Further, majority of the 422 CUs had not attained the functionality threshold. Some of the proposed strategies for addressing these gaps include capacity building for CUs through trainings, strengthening monthly reporting, conducting quarterly dialogue days and development of monthly action plans.

Table 13: Distribution of Community Health Volunteers Per Sub County

No.	SUB COUNTY	NO.OF CUs	NO.OF CHVs
1.	Lurambi	40	400
2.	Shinyalu	41	410
3.	Ikolomani	26	260
4.	Khwisero	25	250
5.	Butere	43	430
6.	Mumias West	33	330
7.	Matungu	36	360
8.	Mumias East	29	290
9.	Navakholo	31	310
10.	Malava	51	510
11.	Lugari	39	390
12.	Likuyani	28	280
	TOTAL	**422**	**4,220**

The review identified the following as factors that have affected effectiveness of community health service implementation:

- Inadequate supervision of CHVs due to shortage of community health extension workers (CHEWs).
- Overreliance on Community Health Volunteers (CHVs) who are not trained.
- Inadequate logistics supports from the County.
- Lack of motivation for CHV's.
- Inadequate reporting tools.

County Referral Services Strategy

The CHSSIP End Term review confirmed that the County adopted the Kenya Health Sector Referral Strategy 2014-2018 for use in coordinating referral services. However, implementation was skewed towards client movement with minimal input to other strategy components namely; expertise, specimen and movement of clients parameters. Further, it was also noted that health workers had very limited awareness of the strategy yet they were expected to comply with the guidelines.

During the CHSSIP implementation period, the County Government procured four new ambulances which are being managed by the department. Further, nine ambulances were leased and managed by Kenya Red Cross.

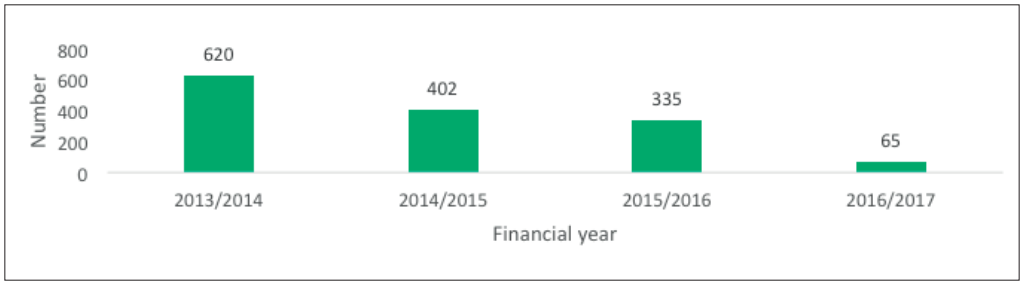
Health workforce

Human Resources for Health (HRH) remain a critical pillar of any functional healthcare system. The County Department of Health Services in the last five-year period (2013-2017) invested in recruitment of additional 629 health workers across different cadres. These included 35 Doctors, 452 Nurses, 50 General Clinical Officers, 5 RCO Anesthetists, 20 Pharmaceutical Technologists, 20 Lab Technologists, 5 Radiographers, 5 Health Administrators, 11 Orthopedic Technologists, 7 Orthopedic Trauma Technicians, 4 Physiotherapists, 6 Nutritionists, 3 Occupational Therapists and 6 Mortuary Attendants, to address the inadequate health workforce.

In 2017, the department had a workforce of 2574 up from 1,844 in FY 2013/14. However, due to inter-county transfers, resignations, lucrative opportunities in the Private Sector, ageing workforce and natural attrition; the department has continued to suffer staff shortage against the backdrop of increasing demand for quality health care construction of new health facilities, upgrading of existing facilities and construction of the new Teaching and Referral Hospital (level 6 facility). All this changes demand more human resources to operationalize these facilities. As at June 2017, health workforce comprised of 2525 regular health workers and 4220 community health volunteers as per the HRH records. Some of the notable gaps within the County HRH component were as follows:

- HRH Strategic Plan not revised with no operational guidelines.
- Industrial unrest by healthcare workers on the implementation of their Collective Bargaining Agreement (CBAs).
- Lack of a HRH policy (Human Resources for Health, Training and Development Policy).
- Poor working environment.
- Inadequate financial support for HRH activities implementation.

Figure 14: Number of Healthcare Workers Employed By Financial Year

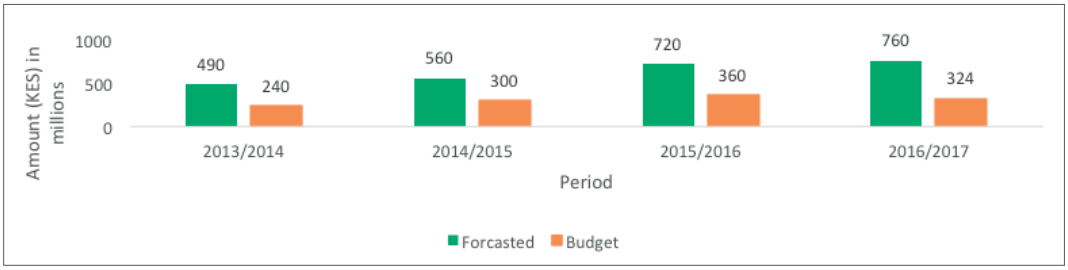


Source: Kakamega CHSSIP End Term Review, 2018

Health Products and Technologies

The ETR findings highlighted significant investment by the County towards health products. Although the County made some strides in this investment area, allocation of resources has been inadequate as demonstrated by the figure below. To ensure efficient procurement and supply of health commodities, the County with support of partners conducted forecasting and quantification (F&Q). The County Government also pre-qualified KEMSA and MEDS as the main source to supply essential medicines and medical supplies.

Figure 16: Budget Analysis for Essential Medicines and Supplies - Allocation Vs Forecast



In FY 2017/18, the County procured commodities as shown in table 14.

Table 14: FY 2017/18 Annual Medical Supplies Expenditure for County Government Health Facilities

	ITEM	LEVEL 5 AND 4	LEVEL 2	LEVEL 3	EXPENDITURE
1	Medical Drugs	130,850,000	1,530,080	860,000	133,240,080
2	Non Pharms	120,352,310	1,568,800	789,500	122,710,610
3	Lab materials	24,225,500	1,516,700	666,500	26,408,700
	TOTAL	**275,427,810**	**4,615,580**	**2,316,000**	**282,359,390**

Challenges noted in supply chain management included the following:

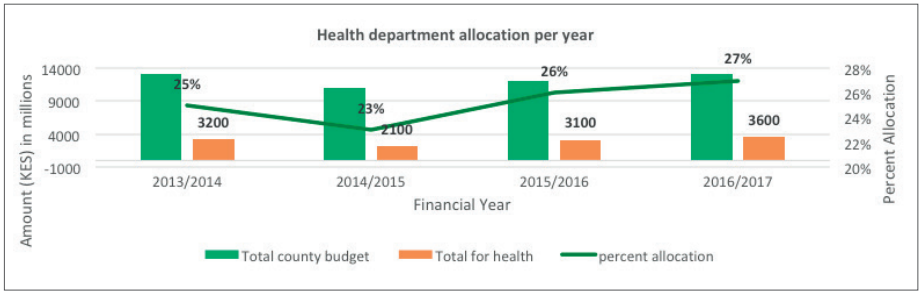
- Weak coordination mechanisms and accountability.
- Poor quality data in the supply chain.
- Lack of integration of the logistics information system (for example, ART, EMSS nutrition, vaccines and so on

- Implementation of electronic Logistics Management Information System (LMIS) on a small scaler.
- Limited specialized human resource capacity in supply chain management and regulation.
- Limited storage and distribution capacity at County, Sub County and health facility levels.
- Limited supervision and mentorship of staff on the supply chain.
- Dormant Medicines and therapeutic Committees (MTCs) at all levels.

Health financing

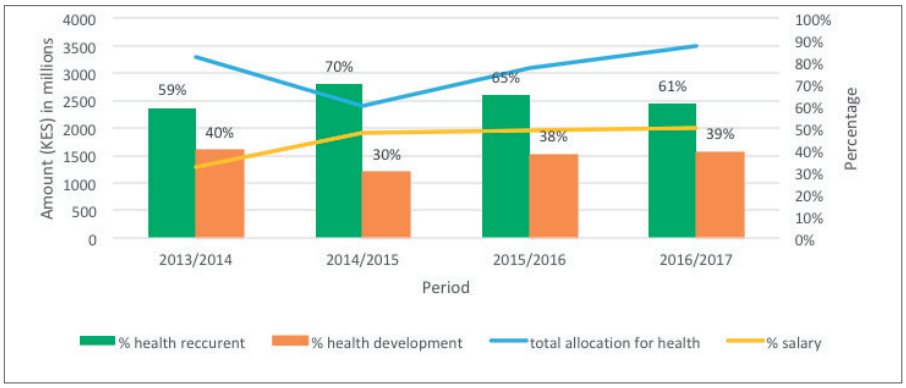
With devolution, the National government disburses funds to the Counties for implementation of devolved functions. The County Government further allocates resources to the County departments based on prescribed criteria as set out in the Public Finance Management Act, 2012. The evaluation highlighted that the County Government has over the last four years allocated approximately 25% of its revenue to the Department of Health Services as shown in figure 17.

Figure 17: Health Department Allocation per Year



The Department of health has consistently seen receiving an increment in budget allocation across all the financial years. However, majority of the resource allocation (48%) goes to staff re-numeration leaving inadequate resources for implementation of health priorities. Figure 18 shows the health expenditure by programme over the CHSSIP I implementation period.

Figure 18: Health Expenditure per Year



Although partners working with the department invested financial resources for implementation of planned activities, the Department of Health lacked a system to track the partners' investment. It was noted that partners undertake joint planning and implementation with the department including direct funding for some activities but majority do not disclose their resource envelope to the County. It is therefore important for the County to develop a system to track partner investment for accountability purposes. To address out of pocket expenditure there is need to equip health facilities with essential and specialized medicines and equipment to address unmet service delivery needs. Further, scaling-up of National Hospital Insurance Fund (NHIF) uptake to provide social safety nets to access of healthcare should be prioritized.

Table 15 gives a summary of the allocation in both recurrent, development and absorption rate for the last five years.

Table 15: Kakamega County Department of Health Development Budget

	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17	FY 2017/18
Allocation	1,273,500,000	624,336,246	1,139,425,357	1,273,251,179	1,709,568,672
Expenditure	434,765,251	284,619,232	805,197,728	1,336,581,902	1,184,832,977
Absorption (%)	34.1	45.6	70.7	105.0	69.3

Source: County Treasury 2018

Table 16: Kakamega County Department of Health Recurrent Budget Allocation, Expenditure and Absorption Rates

	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17	FY 2017/18
Allocation	3,333,169,208	2,284,548,523	3,301,772,366	1,805,043,399	2,204,753,918
Expenditure	593,857,839	1,744,453,345	2,737,056,025	1,853,700,917	1,673,577,719
Absorption (%)	17.82	76.36	82.90	102.70 *	75.91

Source: County Treasury 2018

Health leadership and governance

With devolution of health services, Counties were mandated to establish governance structure to coordinate of health services. The County enlisted a consultant to develop and operationalize governance structures for the different departments. However, the organogram presently being implemented is different from the one expressed in the CHSSIP.

It was established that facilities were inspected before they are opened to ascertain whether they met the KEPH regulations. However, lack of clarity on who was expected to undertake inspection was observed with some respondents proposing CHMT members while others felt it was being done quarterly basis by SCHMT. There is therefore need to provide clarity to health workers on the type of inspection, purpose, frequency and the inspecting authority.

Similarly, the county health sector steering committee through the CHMT and SCHMT is expected to hold periodic meetings to review progress in implementation of health sector plans. However, the quarterly meetings held were irregular and poorly coordinated. In regard to coordination mechanisms,

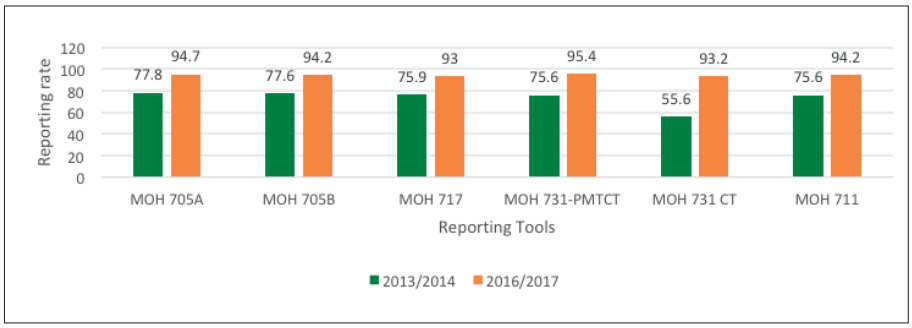
the evaluation established coordination structures were in place and functional. These structures included thematic CHMT, SCHMT, technical working groups (TWGs) and stakeholder's forums tasked with monitoring progress on implementation of the planned activities. However, coordination of stakeholder forums was identified as a challenge due to political interference.

The County has 275health facilities as per data - DHIS2. The CHMT and SCHMT is expected to undertake periodic supervision on quarterly basis. It was observed that in most cases this is not done due to other competing activities and limited resources. In most cases, the supervision is integrated and not focused which has greatly affected the quality. A proposal to have strengthen scheduling and enforcement of supportive supervision was recommended.

Health information

Quality, accurate and timely health information to inform decision-making is critical to planning for health services. The review established that majority of health facilities submit periodic reports as per the agreed timeline of fifth of every subsequent month, but the accuracy and quality of the reports requires improvement. Figure 33 below shows the trends in reporting for select reporting tools during the CHSSIP implementation period.

Figure 19: Reporting Rate for Select Reporting Tool During the CHSSIP Implementation



Source: DHIS2, 2018

Both County and stakeholders have invested heavily to support production of tools, hiring Health Records and Information Officers (HRIOs), and conducting data review meetings to ensure data collected, analyzed and shared is of good quality. Communication barriers between HRIOs and reporting authorities due to poor network, delayed submission by some facilities and inadequate reporting tools were identified as some of the challenges hampering completeness of the reports. Recruitment of additional HRIOs to support facilities, data review meetings at facility level, provision of adequate data collection tools and on time and regular Data Quality Assessments (DQAs) were proposed as interventions to improve data quality, accuracy and completeness. On whether communities had access to health information, it was established that communities were receiving health information during community dialogue and action days but it was not adequate to stimulate behaviour change. More information is needed if behaviour change communication is to yield results.

The Department of Health Services does not have a fully functional M&E unit but has a dedicated M&E officer. The unit is supposed to coordinate M&E activities in the department which include performance monitoring and review, development and monitoring implementation of M&E policies/standards and synthesis of data for use by decision makers. However, support supervision and RDQA, which are critical for improving data quality for decision making remain adhoc. These are also dependent on donor priorities, timetables and resources. A number of strategic documents developed at the department have not been adequately disseminated resulting in non-use.

Health infrastructure

Equipping of health facilities is critical for delivery of quality health services. The County Government in collaboration with the Ministry of Health (MOH) equipped two facilities, Kakamega County General Hospital and Malava County Hospital through the National Managed Equipment Scheme (MES) that provided them with key diagnostics equipment for radiology and theatre. The investment towards infrastructure renovation and development over the CHSSIP period was estimated to be KES 1.3 billion and the breakdown of the projects undertaken. The evaluation also highlighted that the department renovated a number of health facilities but lacks a master plan for routine maintenance.

Investments by key stakeholders in health have also led to growth in the number of health facilities in the County. Kakamega County has 275 health facilities including 1 County General hospital, 4 County hospitals, 7 Sub County hospitals, 3 mission hospitals, 1 private hospital, 8 nursing homes, 44 public health centers, 7 private health center, 118 public dispensaries, 5 private dispensaries, 14 mission dispensaries and 66 private clinics. The total bed capacity in the County for all the public and private facilities is 3,949 with the public sector having 2,338 beds while the private hospitals have 197 beds. The bed capacity in the mission/NGO health facilities is 1,414. There has been construction of new County-funded health facilities and units to increase access to services in underserved parts of the County.

The department also installed 12 generators in the County General Hospital and all other Sub-County Hospitals. The availability and functionality of diagnostic medical equipment is critical in care of patient as there is a rising demand for standard therapeutic and diagnostic equipment yet the majority of health facilities do not have adequate modern equipment and where available are broken down and not in use due to lack of maintenance.

2.3.7 Partnership and Coordination

The strategic plan provided for a County inter-agency forum coordination framework. The framework provided a basis for routine performance review of the health sector. Majority of the respondents were not sure whether the inter-agency forum was in place, frequency of their meetings and could not distinguish the difference between inter-agency and health stakeholder's forum.

The CHMT felt that the level of quarterly stakeholder's engagement was adequate. In regard to the roles of partners in support of strategy implementation, it was highlighted that more mentorship, focused supervision, capacity building, technical and financial support is still required. Joint planning and monitoring of the strategic plan were also identified as areas requiring improvement.

Health research and development (R&D)

Investing in Research and Development (R&D) is key to informing health policy and improving access to quality healthcare with the aim of achieving universal health coverage. The Department of Health Services lacks an independent research and development unit to plan and coordinate research activities in the County, despite presence of several training institutions in the County involved in health research. To advance the use of data for evidence-based decision making there is need for coordinated research efforts approaches and establishment of a data repository for all health research findings conducted in the County.

2.4 Pestel Analysis

Table 17: Kakamega Health Sector PESTEL Analysis

ISSUES	STRENGTHS	WEAKNESSES
Political issues	• Political good will from national government and County government as demonstrated through provision of financial resources and policy guidelines • The County Assembly through the health and budget committees approves health budgets • Development and operationalization of Imarisha Afya ya mama na Mtoto programme by the governor aimed at addressing maternal and child health challenges bridging service gaps identified within the broader MCH program • Operationalization of Beyond Zero programme that has enhanced access of integrated health services.	• Delays in instituting key policies to support implementation of some programs, e.g. RH, Nutrition and EPI. • Political influence, which resulted to mass establishment and opening of health facilities leading mismatched resources, i.e. personnel, equipment, hence affecting the quality of services
Economic issues	• Increased County budgets to the department of health to 28% of County revenue. • Significant financial support from partners through various health programs	• Inadequate funding from County Government to address health priorities. • Minimal financial contributions from the private sector due to inadequate engagement hence limited opportunities to mobilize resources
Social issues	• Collaboration by communities during implementation of health interventions as evidence through community units • Knowledgeable community members on health issues resulting to high uptake of health services	• Low perceptions of health workers in HIV, TB and MCH areas of work affecting uptake of services in those affected areas. • Poverty in the community leading to poor health access

ISSUES	STRENGTHS	WEAKNESSES
Technological issues	• Computerization of health records through EMR programme in selected health facilities resulting to improved documentation • DHIS II rolled out and functional • LMIS system being utilized for procurement planning • Specialized X-ray machines and equipment procured for high volume facilities in collaboration with the National Government.	• Lack of a structure-training programme on equipment repairs and maintenance and as a result, there are inadequate skills to operate specialized equipment. • Inadequate funding to support automation in all health facilities e.g EHMR
Ecological issues	• Consistent inter-departmental meetings through CHMT that regularly reviews management and operational issues arising from the department • Effective coordination with other departments relevant to the health sector through which coordination of health services is enhanced. • Coordination with other arms of government at national and County level through quarterly inter-sectoral meetings • Existence of Inter-country coordination forums by CEC Health through the CoG. • Existence of Health policies, strategies, guidelines and protocols that guide services delivery	• Minimal collaboration with other arms of government including joint planning and monitoring. • Weak coordination between health and other government departments and as a result service delivery is affected since there is no joint ownership of planned interventions in some cases. • Natural disasters including landslides and floods in some Sub-counties • Inadequate mechanisms for waste disposal including e-Waste
Legal issues	Policies available Two Bills have passed: • Health Bill • Parastatalization of the County Teaching and Referral Hospital Development, publishing, and enactment of "Maternal and Newborn Health" Act commonly known as the Oparanya Care that is currently awaiting approval by the County Assembly Health Committee.	• Unclear policy agenda leading to unidentified gaps with no framework to monitor progress on policy implementation.

3 HEALTH PRIORITIES, OBJECTIVES AND TARGETS

The department intends to scale up services offered at the primary and secondary care levels in line with Kenya Essential Package of Health over the five years. This Plan therefore provides details on the sector inputs and processes in line with the eight investment areas to enable achievement of the targets as described below. It further outlines the sector targets and outcomes, with interventions and milestones for achievement in the five-year period.

3.1 Health Access

3.1.1 Universal Health Coverage

Like the National Government, the County Department of Health services aims to attain equitable, affordable, accessible and quality health care for all. One way of achieving this is through interventions targeting UHC for all. To realize this goal, the National Government has initiated reforms and programs towards UHC which include: free maternity and primary health care in all public primary health facilities, programme to equip major facilities in the country with modern diagnostic equipment and provision of health insurance subsidies through NHIF targeting disadvantaged and vulnerable groups. The goal of UHC is to ensure that the County is able to:

- Identify and plan to make available the full range of essential health and related services that the County residents require.
- Progressively increase coverage of these essential health and related services by addressing access and quality of care barriers.
- Progressively reduce catastrophic household expenditure on essential health services.
- Increasing the number of facilities accredited by NHIF to enhance access to care for citizens.
- Increasing the quality of health services using the KQMH model.
- Rational distribution and strengthened capacity of facilities to KEPH levels.
- Strengthened referral strategy across the various levels of care within the County.

In rolling out the UHC, the County will ensure inclusivity of the vulnerable populations. During this County Health Sector Strategic Plan 2018-23-implementation period, attainment of Universal Health Coverage will be the main priority. The sector will primarily focus on expansion of the programme to the underserved populations.

The County will use various strategies to enhance UHC including:

- Mobilize enrollment of the residents to insurance schemes such as NHIF to ensure that at least 60% of the population is covered under these schemes by the second year of the plan and 100% by the fifth year of implementation of the plan.
- Implementation of 'Imarisha Afya ya Mama na Mtoto Program' that aims to increase utilization of health services with a focus on maternal health. The programme targets the most vulnerable.
- Implementation of the community health strategy through strengthening the capacities of the CHVs and functionality of community units.
- Completion of the Kakamega Teaching and Referral Hospital to enhance access to specialized care.
- Increase health advocacy, communication and social mobilization interventions on preventive health with a focus on health education and promotion.

3.1.2 Physical Accessibility

To improve accessibility to health services for all Kakamega County residents, this plan prioritizes the following:

- Every Sub County to have a fully operational level 4 facility as per KEPH levels through construction/upgrading of existing facilities to the required standards, equipping and staffing.
- Every ward to have a level III facility as per KEPH levels by upgrading and improving the existing level II facilities.
- Operationalize the Eye Hospital for specialized eye care.

3.1.3 Acceptability

To ensure optimal utilization of health services, the county will address the following:

- Socio cultural barriers:- The department will carry out targeted interventions to cater for vulnerable and special interest groups.
- Demand for services:- Improvement in increasing demand for services will focus on improving the awareness of individuals, households and communities of the health problems they are facing and the available services.
- Quality of Care:- This is critical to improving client experiences with care, ensuring patient safety and ensuring effectiveness of care. The KQMH will serve as the vehicle for achieving this objective.

3.2 Service Delivery

The sector will in the next five years scale up services provided at the various levels of health care from community (level one) to level five in line with the policy objectives, standards and norms. The priorities have been organized along the six policy objectives.

3.2.1 Policy Objective: Eliminate Communicable Conditions

Communicable diseases are the leading cause of morbidity and mortality in the County. This Strategic Plan sets priorities to prevent, control and reduce the high burden of these diseases. Reduction in the prevalence and the incidence of these diseases will contribute to attainment of the health-related Sustainable Development Goals (SDGs) and the County's health sector goal. This section provides details on the targets and priorities for the prevention and control of each disease.

Immunization services

The Department of Health Services plans to increase the percentage of fully immunized children. The following interventions will be undertaken to enhance immunization services:

- Accelerated immunization services (RRI) in all the sub-counties.
- Expanded programme for Immunization (EPI) operational level training.
- Focused support supervision and EPI Performance review.
- Target setting meetings and strengthening the supply chain for EPI.
- Lobbying for funds to support EPI programme.
- Improve staffing at health facilities.
- Regular outreaches in hard-to-reach areas.
- Door-to-door follow up for mothers with under 5 children.
- Putting in place effective defaulter tracing mechanisms.
- Designing an integrated school health programme for children.
- Streamlining supply of antigens and other immunization supplies.

TB/leprosy/lung health treatment prevention and control

The burden of TB is still high in the County with the rising number of MDR cases being reported. Leprosy is a re-emerging condition in the County. The sector will in the next five years work to reduce this burden by implementing the following:

- Follow-up for MDR TB patients, quarterly TB data review meetings/monthly meetings on progress on Active case finding (ACF).
- Refresher trainings targeting lab technologists on acid-fast bacteria (AFB) microscopy/ gene-expert.

- Training of HCWs and CHVs on integrated TB curriculum, defaulter tracing/contact tracing by CHVs, targeted outreaches using digital x-ray machines and World TB day commemoration.
- Training of HCWs and CHVs on identification, management and prevention of disability due to leprosy.
- Establishment of leprosy camps for clients.
- Conduct outreaches on leprosy.
- Health promotion focusing on importance of adherence.
- Increased allocation of funds for defaulter tracing and awareness creation programs.
- Increased specialized staffing on the area of TB treatment and education on importance of family support in TB treatment.
- Health education through school health programmes.
- Strengthen referral systems from community to facilities.

HIV/AIDS services

To control transmission of HIV/AIDS, the sector will invest in preventive interventions including; screening to identify infected clients, ensure linkage and retention in treatment and achieve viral suppression for all those on treatment. This can scan be achieved through scaling up 90:90:90 strategy. The County HIV STI control programme objectives are as follows.

- Identify PLHIV who do not know their HIV status.
- Provision of care and treatment to identified PLHIV to support their quality of life, and prevent transmission to uninfected people through viral load suppression.
- Stakeholder coordination.
- HIV STI prevention.

The above objectives will be achieved through implementation of the following priority services:

- HIV care and treatment.
- PMTCT services.
- HIV Key Populations prevention programs.
- Home and Community-Based Care (HCBC).
- HIV/STI Monitoring and Evaluation.
- HIV stakeholder coordination.
- Adolescents and young person's HIV programme.
- HIV STI commodities.
- HIV testing services (HTS).
- Combination prevention.

Malaria prevention and control services

In order to reduce the prevalence of malaria, the health sector has prioritized the following strategies:

- Improvement in environmental control measures for malaria prevention.
- Epidemic preparedness and response for Lugari and Likuyani sub counties.
- Increase access to ITNs and IPTp during the ANC visits for pregnant women.
- Timely procurement and distribution of malaria commodities at all levels.
- Strengthen implementation of the three T strategy (test, treat and track) at all levels of healthcare by ensuring availability of diagnostic services.
- Intensify community malaria case management with addition of the MIP component.
- Routine malaria vector surveillance using CHVs.
- Strengthen operational research and M&E systems.
- Monitor trends in disease burden and measure the impact of interventions.

Neglected tropical diseases (NTDs)

In order to address NTDs, the County Department of Health Services will implement interventions to prevent, manage and control the NTDs. These include:

- Strengthening school deworming campaigns.
- Enhance surveillance of NTDs and improve management so that all cases are promptly treated.
- Strengthen sanitation and hygiene promotion programmes that are aimed at preventing and reducing NTDs.
- Implement treatment guidelines and protocols for all NTDs in line with WHO.
- Advocacy for resource allocation for NTD control programme.
- Produce data capturing tools for NTDs to be incorporated in the existing HMIS.

Community health services

Successful Community Health Services (CHS) will encompass various activities and interventions aimed at promoting health promotion and strengthening disease prevention. In addressing community health challenges, the County Government and Community Health Services Implementing Partners (IPs) will therefore prioritize the following initiatives to strengthen service delivery at level one:

- Community Health Volunteers (CHV) motivation through payment of stipends.
- Training of 4220 CHVs on the Kenya Quality Model for Health (KQMH).
- Recruitment and training of 3500 community health committee members on leadership and governance of Community Health Units (CHUs).
- Conducting bi-annual household mapping and registration.

- Defaulter tracing of ANC, immunization, TB and ART by CHVs.
- Conducting community-integrated outreaches.
- Conduct advocacy and community mobilization.
- Convene and conduct community dialogue days and action days.
- Training 500 newly recruited and replacement CHVs on CHS basic module.
- Conducting Community health unit link facility/CHU support supervision.
- Conducting quarterly CHU data review meetings.
- Printing of community health services tools.
- Supporting community/facility referrals and follow-ups.
- Procurement of 4220 bicycles for CHVs and 60 Motorbikes for Community Health Assistants (CHAs).

Health promotion

The Department of Health Services will work to create and sustain demand for and uptake of improved preventive and promotive healthcare services by implementing targeted interventions that will ensure:

- Reduction in unsafe sexual practices, particularly among targeted groups.
- Mitigation the negative health, social and economic impacts of excessive consumption of alcoholic products.
- Reduction of the consumption of tobacco and exposure to tobacco smoke and other harmful addictive substances.
- Institution of population-based, multi-sectoral, multidisciplinary and culturally relevant approaches to promoting physical activity and healthy diets.
- Strengthened mechanisms for screening and management of conditions arising from health risk factors at all levels.
- Increased collaboration with research-based organizations and institutions.

To achieve the above, the department has prioritized the following initiatives:

- Health education and promotion through media houses to increase uptake of health services and health days.
- Community and patient sensitization on various health risky behaviors.
- Communication on harmful effects of tobacco use.
- Development of facility-based health messages on benefits and approaches to improving physical activities.
- Assessment of school health promotion programmmes.
- Conducting of school-based disease prevention programme.

- Capacity building on effective communication.
- Advocate for recruitment of additional health promotion officers.
- Establish an inter-county ICT health communication platform.
- Establish a physical activity centre for staff in 12 hospitals.
- Dissemination of health promotion policies, standards, strategies and Information, Educations and Communication (IEC) materials.
- Develop and launch the County Communication Strategy.

3.2.2 Policy Objective: Halting and Reversing the Rising Burden of Non-Communicable Diseases

The health sector targets to reduce morbidity and mortality attributed to NCDs through appropriate intervention including the following:

- Allocation of the required resources for effective interventions.
- Risk factor stratification at the community level to inform the basis of incidence and prevalence data, which are currently inadequate.
- Diagnosis and case management of NCDs to reduce the disease burden.
- Advocacy for revision of tools to allow for collection of data on morbidity and segregated into uncomplicated and complicated NCDs.
- Undertake routine assessment of prevalence and incidence of NCDs.
- Develop policies to guide interventions for NCDs.
- Enhance community education and awareness, prevention, early diagnosis and treatment.
- Revise protocols to aid healthcare workers in prevention, diagnosis, treatment, equipment, drugs and case management of NCDs.
- Train CHVs to offer basic advice and care on NCDs and refer people to health facilities, where necessary Integrate nutrition interventions in the NCDs prevention programs.
- Scale up health promotion and education on the risk factors and prevention of NCDs at all levels, using a multi-sectoral approach.
- Scale up promotion and support of physical activity among the population, including in schools, workplaces, and communities through wellness centers in the County.

3.2.3 Policy Objective: Reduce the Burden of Violence and Injuries

The Department of Health Services will play a crucial role in addressing violence and injury prevention and control through:

- Developing surveillance systems to capture incidence and prevalence of injuries.
- Provide pre-hospital emergency care in coordination with other emergency services.
- Provide rehabilitation services for those who have been injured.
- Contribute to policy and legislative development and review on violence and injury prevention.

Road traffic accidents

In this strategic planning period, the sector will prioritize to improve prevention and management of injuries and violence through:

- Collaborate with other sectors to sensitize the communities on safety practices.
- Train CHVs on management of injuries and first aid.
- Strengthen the referral system.
- Equipping all health facilities to better manage injuries.
- Capacity building of health workers on management of injuries.
- Strengthen reporting for injuries and violence.

Gender based violence

Gender-based violence (GBV) is a major human rights violation, which tends to disproportionally affect women. In order to effectively respond and manage gender-based violence, the department's priority interventions are:

- Develop and disseminate SGBV policy.
- Develop county sexual harassment prevention guidelines at the workplace.
- Facilitate the establishment/ strengthening of existing Recovery Centre/safe houses/ shelters.
- Conduct school health visits to address teenage pregnancy through health education on adolescent and youth sexual reproductive health (AYSRH) and sexual abuse in secondary schools.
- Procure and distribute Post-Rape Care Kits to high volume health facilities.
- Develop, print and disseminate SOPs on response and management of GBV.
- Conduct targeted community dialogues on gender-related determinants that hinder access and utilization of RMNCAH services.

- Observe the 16 days' activism against GBV.
- Train and mentor service providers and community on management of gender violence cases.
- Advocate for budgetary allocation for GBV.
- Improve collection, analysis and use of data and research to enhance SGBV prevention and response efforts.
- Conduct continuous education for women on dangers of GBV and support them to start income generating activities.
- Enforce strict punishment for the perpetrators of GBV, offer health education on short and long-term effects of GBV.
- Review of socialization processes within family units, encourage and recommend marital counseling for married couples to address marital issues affecting them before they escalate to violence.
- Work with stakeholders such as ministry of internal coordination to mitigate alcohol and drugs abuse and ensure gender-based violence cases in courts are well concluded in line with human rights as per the constitution of Kenya, 2010.

3.2.4 Policy Objective: Provide Essential Health Services

The health sector is committed to providing affordable, equitable, accessible and quality healthcare that is responsive to population needs. Investment in health systems strengthening is required for ensuring provision of health services. To do so, the following interventions will be undertaken:

- Implementing standard treatment protocols/guidelines.
- Implementing infection prevention activities.
- Conducting regular clinical audits and quality assurance/quality improvement (QA/QI) interventions.
- Capacity building of service providers through On Job Training (OJT), mentorship, continuous professional development and long-term training.
- Enhancing ICT in healthcare through digitization.
- Strengthening referral system and feedback mechanism by developing a County Referral Strategy and formulating guidelines and policies.
- Extending outreach services to hard-to-reach areas.
- Strengthening blood transfusion services by setting up two more blood satellite centers.
- Strengthening provision of essential and emergency care at the level 4 facilities.

Child health services

To reduce the under-five mortality rate the department is committed to scaling up high-impact child survival interventions and improve coordination and health systems to support delivery of child health services at all levels of the healthcare system. The following interventions will be undertaken:

- Strengthening care for the sick child; and emergency triage assessment and treatment.
- Expand, strengthen and enforce the use of all components of Integrated Management of Childhood Illness strategy.
- Scale up integrated community case management (ICCM).
- Empower communities to improve community newborn and child health care practices and support continuum of care.
- Increase availability, access, and utilization of quality newborn and perinatal health care at all levels.
- Strengthen promotion of breastfeeding (early initiation and exclusive breastfeeding).
- Scale up infant and young child feeding services, including promotion of breastfeeding and complementary feeding after six months up to two years.
- Integrate and strengthen outreach services particularly for hard-to-reach areas.
- Support research and development of innovations and technologies for newborn, child health, and nutrition interventions.

Reproductive, maternal and new born health services

The health sector will implement strategies to improve the quality of reproductive services by:

- Scaling up Imarisha Afya ya Mama na Mtoto programme from 25 to 30 facilities.
- Building Capacity of health workers to provide quality services through training and mentorship in key skills in Kenya Quality Model for Health, Family Planning, Post Natal Care, Emergency Obstetric and New Born Care among others.
- Creating awareness at community level in reproductive health services utilization.
- Increasing number of health facilities offering laboratory services.
- Advocating for Family Planning (FP) services.
- Sensitizing the community on reproductive related cancers.
- Procuring assorted RMNCAH equipment.
- Providing adolescent sexual and reproductive health education and services.
- Strengthen inter-sectoral coordination and networking, partnership and community participation in adolescent Sexual Reproductive Health.
- Strengthen ANC attendance and monitoring as per the national guidelines.
- Strengthen referral services including linkage from Basic Emergency Obstetric and New

Born Care facilities to Comprehensive Emergency Obstetric Care facilities.

- Ensure availability of blood and blood products.
- Partnering with community resource persons such as CHVs and Traditional Birth Attendants to promote use of skilled care during pregnancy and delivery.
- Improve health infrastructure and human resources for health.

Reduce maternal and perinatal mortality

This strategic plan lays emphasis on elimination of preventable maternal and perinatal deaths. Key interventions will focus on:

- Strengthening documentation of maternal and perinatal deaths.
- To gain understanding of the health system failures that led to the maternal/ perinatal death complication.
- To raise awareness among health professionals, administrators, programme managers, policy makers and community members about those factors in the facilities and the communities which, if avoided, the death may not have occurred (the avoidable factors).
- To stimulate action to address the avoidable factors thereby prevent future maternal and perinatal deaths.

Nutrition services

In this second County Health Strategic Plan, focus will be placed on improving nutrition in the all the lifecycle. Key interventions will focus on promotion of appropriate nutrition practices through:

- Creation of awareness and empowering communities to adopt and sustain recommended nutrition practices.
- Strengthen multi-sectoral collaboration; and mainstreaming and integrating nutrition programme into other health programme.
- Build capacity of healthcare workers in nutrition service provision at all levels.
- Provide nutritional products.
- Strengthen provision of maternal, infant adolescent and young child nutrition.
- Integrate management of acute malnutrition (IMAM).
- Growth monitoring.
- Micronutrients supplementation.
- Strengthen integration of nutrition in other key health sector interventions, such as maternal and adolescent health, HIV, TB, IMCI and NCD.
- Strengthen SBCC for effective adoption and practice of good nutrition.
- Advocate for increased funding for nutrition care services in health facilities.

3.2.5 Policy Objective: Minimize Exposure to Health Risk Factors

The Department of Health Services will strengthen Social behaviour Change and Communication interventions at all levels and facilitate the use of products and services that promote healthy lifestyles by the communities to promote a healthier environment and intensify primary prevention of environmental threats to health.

- Conduct health education in community barazas, schools, dialogue days and at household level.
- Procure and distribute protective clothing: aprons, gumboots and heavy duty gloves, for health care workers.
- Implementation of Infection Prevention and Control (IPC) guidelines.
- Disseminate IPC SOPs and train/sensitize HCWs on IPC.
- Use of enzymatic detergents for IPC instead of chlorine.
- Revitalize the departmental disaster preparedness and response committee.
- Advocate for water storage facilities at schools, health facilities and communities.
- Scaling up Community-Led Total Sanitation (CLTS) activities.
- Enforce sanitation laws and regulations.
- Enforce food regulations.
- Allocating resources for health promotion activities.
- Encouraging health workers to undertake trainings on health promotion.
- Set up rehabilitation and facilitate rehabilitation of addicts.
- Utilize media such as radio programs, chief barazas, churches, posters, social media, mobile phone platforms and youth groups to pass information.
- Involve more men in the health awareness programme since majority don't go to the facilities.
- Enforcement of laws on drug and substance abuse.
- Continuous education on healthy living.
- Strengthen collaboration with other health-related sectors.

Exclusive breast feeding (EBF)

The proposed strategies for ensuring exclusive breastfeeding of children by all mothers include: health education for pregnant and breastfeeding mothers on importance of EBF, education to address the negative attitudes associated with EBF, Enforcing, advocacy for provision or provision of breast feeding-friendly spaces, forming support groups for breastfeeding mothers, provide food for breastfeeding mothers who are poor to encourage breastfeeding and encourage working mothers to express breast milk for their children.

Malnutrition

To reduce malnutrition cases, EBF should be encouraged and mothers should continue attending ANC and ensure their children are fully immunized and growth monitoring is conducted. Further, education on children nutrition will be conducted targeting mothers with significant focus on empowering families economically through provision of youth loans including uwezo Fund and free farm inputs such as maize and fertilizers. In partnership with the Ministry of Agriculture and Education, the department will work to educate households on choices of food crops to grow especially traditional foods in addition to providing MUAC tapes to health facilities to ensure monitoring for malnutrition. Other strategies will include provision of food and supplements for malnourished children, employment and deployment of additional health facility nutritionists and educating the community on proper nutrition, promotion of Child Welfare Clinics (CWC) attendance through CHVS for all under-fives, strengthening of referrals for malnutrition cases for follow up by CHVs and continued health education during immunizations and screening during immunization.

Safe water

To address barriers affecting access to safe water, the government will provide tapped water, improve sewage system, encourage use of innovations like harvesting of rain water, initiate a programme to protect more springs, supply of water treatment drugs, improve on handling of safe water and protection of water sources, establish water user committees and undertake periodic water sampling and testing.

Prevention of alcohol and drug abuse (ADA)

The department commits to undertake the following:

- Establish Alcohol and Drug Abuse (ADA) committee to coordinate efforts towards reduction in abuse.
- Conduct baseline survey on alcohol and drug abuse among HCWs.
- Domesticate workplace policy on alcohol and drug abuse.
- Support mechanisms for persons with substance abuse disorders.
- Strengthen referrals to rehabilitation centers.
- Sensitize the community on dangers of alcohol and drug abuse.
- Establish and enhance counselling services.
- Training of HCW on alcohol and drug abuse.
- Strengthen collaboration with stakeholders.
- Peer to peer learning on best practices on rehabilitation.
- Establish and enhance counseling services Sub Counties /CGH.
- Dissemination of alcohol and drug abuse guidelines.
- Benchmark best practice on rehabilitation alcohol and drug abuse (Mombasa County).

3.2.6 Policy Objective: Strengthen Collaboration with Health Related Sectors

The Department of Health Services recognizes the importance of stakeholder participation at all levels of planning, implementation and monitoring of health service delivery. The department will strengthen collaboration with other heath related sector to improve health outcomes. Specifically, the department will focus on advocacy for:

- Reduction of environmental pollution.
- Provision of electricity, safe water, sanitation and hygiene for all.
- School deworming and feeding programs.
- Physical planning and housing environment to promote healthy living including prevention of rickets.
- Food, micronutrients fortifications.
- Road safety/injury prevention.

3.2.7 Service Delivery Outcome and Output Targets for Achievement of County Objectives

Table 18: Services Outcomes for Realization of County Objectives

Objective	Indicator	Baseline 2016/2017	Targets (Where Applicable)				
			2018/19	2019/20	2020/21	2021/22	2022/23
HEALTH & RELATED SERVICE OUTCOMES							
Eliminate Communicable Conditions	% of Fully immunized children	70.4	72	74	76	78	80
	% of TB patients completing treatment	89	90	90.5	91	91.5	92
	% of HIV + pregnant mothers receiving preventive ARV's	92	95	96	97	98	99
	% of eligible HIV clients on ARV's	99	100	100	100	100	100
	% of malaria testing rate	69.2	76	82	88	95	100
	Proportion of ANC clients receiving at least two doses of IPT 2	51.7	53	56	58	60	63
	% of targeted under 1's provided with LLITN's	53	58	63	68	75	80
	% of targeted pregnant women provided with LLITN's	71	73	75	77	79	80
	% of under 5's with diarrhea treated with ORS and Zinc	6.7	10	13	15	17	20
	Proportion of clients on ART with a viral suppression after 12 months	80	83	86	89	92	95
	Number of TB cases detected	1801	1981	2161	2241	2420	2420

Objective	Indicator	Baseline 2016/2017	Targets (Where Applicable)				
			2018/19	2019/20	2020/21	2021/22	2022/23
	Proportion of <1yr receiving Pentavalent 1	73.4	74	76	78	80	82
	Proportion of estimated HIV positive people identified	74	80	85	90	90	95
	Proportion of population receiving HTS services	24.4	25	30	35	45	50
	Proportion of exposed infants receiving timely PCR (6 weeks)	65	90	95	100	100	100
	No. of infants infected with HIV through MTCT	121	100	75	50	25	0
	Proportion of estimated key population receiving comprehensive HIV Prevention interventions	50	60	70	80	90	95
	Proportion of eligible TB patients screened for MDR	20	25	30	35	40	45
	% of School age children dewormed	85	87	89	91	93	95
	% of <5 Vitamin A supplementation	39	50	64	66	68	70
Halt, and reverse the rising burden of non-communicable conditions	% of adults with BMI above 25	0.39	0.37	0.35	0.33	0.31	0.29
	% of WRA screened for ca cervix	0.84	0.90	1.00	1.20	1.35	1.5
	% of new outpatient cases with mental conditions	0.19	0.18	0.17	0.16	0.15	0.14
	% of new outpatient cases with high blood pressure	1.47	1.45	1.43	1.41	1.39	1.36
	% of new outpatient cases with elevated blood sugar	0.39	0.37	0.35	0.33	0.31	0.29
	Cancer incidence rate	0.07	0.06	0.05	0.04	0.03	0.02
	% of patients admitted with cancer	2	1.9	1.8	1.7	1.6	1.5
Reduce the burden of violence and injuries	% of new outpatient cases attributed to gender-based violence	0.09	0.08	0.07	0.06	0.05	0.04
	% of new outpatient cases attributed to Road traffic Injuries	2.3	2.2	2.0	1.8	1.6	1.4
	% of new outpatient cases attributed to other injuries	6.7	6.6	6.5	6.4	6.3	6.2
	% of deaths due to injuries	2.14	2.1	1.9	1.8	1.6	1.4
Provide essential health services	% of skilled deliveries	57	58.8	60.6	62.4	64.2	66
	% of facility-based FSB	1.1	0.9	0.7	0.5	0.4	0.3
	% of first ANC visits	71	73.8	76.6	79.4	82.2	85
	%of 4th ANC visits	44	50.2	56.2	62.4	68.6	74.8
	% of ANC Mothers issued with IFAS	54	60.2	66.4	72.6	78.8	85
	Number of ANC mothers referred by CHVS	32	35.6	39.2	42.8	46.4	50

Objective	Indicator	Baseline 2016/2017	Targets (Where Applicable)				
			2018/19	2019/20	2020/21	2021/22	2022/23
	% of WRA receiving FP	37	42.6	48.2	53.8	59.4	65
	% of newborns with low birth weight	3.7	3.6	3.5	3.4	3.3	3.2
	% of PNC Mothers receiving PNC within 2-3 days	10.6	15	20	30	40	50
	% of PNC Mothers receiving PNC within 6 days	15.1	20	30	40	50	60
	% of PNC Cervical Cancer screening	0.7	1	2	3	4	5
	% of facility based under five deaths	15.5	13	11	9	7	5
	% of Surgical rate for cold cases	1640% **Source** DHIS2*	1000%	500%	250%	125%	100%
Minimize exposure to health risk factors	% of infants under 6 months on exclusive breastfeeding	46	51	56	61	66	71
	Couple year protection due to condom use	205	210	215	220	225	230
	% of children 6-23 months supplemented with Multiple Micronutrient Powders	2.2	7	12			
	17	22	27				
Strengthen collaboration with health-related sectors	% of population with access to safe water	79.4	80	82	84	86	88
	% of under 5's stunted	5.95	5.35	4.75	4.15	3.55	2.95
	% of under 5 underweight	10.82	2.16	2.16	2.16	2.16	2.16
	% of households with latrines	78.00	80.20	82.4	84.6	86.8	89.00
INVESTMENT OUTPUTS							
Improving access to services	% of facilities providing Immunization	74	76	78	80	82	84
	TB Cure rate	89	89.2	89.4	89.6	89.8	90
	% of fevers tested positive for malaria	59.3	55	50	45	40	35
	% of maternal deaths audit	80	100	100	100	100	100
	Malaria inpatient case fatality	64	60	56	52	48	44
	Average length of stay (ALOS)	4.6	4.3	4.0	3.7	3.4	3.1
Improving quality of care	Per capita Outpatient utilization rate (M/F)	81	83	89	92	95	97
	% of population living within 5 km of a health facility	49	55	60	70	90	90
	% of facilities providing BEOC	96.5	96.5	95	95	94	94
	% of facilities providing CEOC	3.5	3.5	5	5	6	6
	Bed Occupancy Rate	73	77	80	82	84	85

3.3 Human Resource for Health

To ensure successful implementation of this Plan, the department will seek to ensure availability and improve distribution of qualified health workers in the County. This will be achieved through:

- Advocacy for increased resources to recruit additional health workers. The goal is to reach 4,164 in the next five years.
- Introduction of relevant health cadres to support implementation of community strategy.
- Implement Occupational Health and Safety (OSH) at the workplace.
- Advocate for additional specialist healthcare workers to provide specialized services in order to strengthen the referral system.
- Development and implementation of a County HRH Policy during the five-year period.
- Capacity building of health workers.

3.3.1 Performance Indicators and Targets

Indicator	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Number of skilled staff recruited and deployed	500	500	250	100	100
Number of staff inducted	500	500	250	100	100
OSH Act Implemented	1	1	1	1	1
County HRH Policy Developed and implemented		1	1	1	1
% of staff appraised	100%	100%	100%	100%	100%

3.4 Health Infrastructure

Health infrastructure has four main components namely; physical infrastructure–buildings, plants, utilities, energy sources and others, equipment – medical devices, hospital equipment and other technologies, information and communication technologies (ICT) and transport services – ambulances, utility motor vehicles and other transport services.

3.4.1 Physical Infrastructure

To effectively serve the growing population, the County needs to invest in construction of additional health facilities and operationalization of existing facilities in order to provide quality comprehensive healthcare in line with the KEPH. To address this the Department has prioritized to undertake:

- Construction of new health facilities.
- Renovations.
- Upgrading existing health facilities (Level 2 and 3).
- Construction and/or expansion of existing medical stores and two warehouses.

3.4.2 Equipment

The Department of Health Services is mandated to ensure availability of functional medical equipment for timely diagnosis and treatment in all health facilities. The department is also tasked to ensure routine supply and/or maintenance of equipment for uninterrupted service delivery. To realize this, the department will strengthen partnerships with private sector and development partners to enhance procurement and acquisition and maintenance and management of medical equipment through:

- Procurement of service contract for specialized equipment.
- Development and implementation of a preventive maintenance plan for equipment at all levels.
- Development and implementation of an equipment replacement plan for specialized equipment.
- Routine capacity building of medical engineers and technologists.
- Procurement and distribution of tool boxes for medical equipment.

3.4.3 Transport

To have a well-maintained transport system and ensure mobility for service delivery. The department will maintain existing ambulances and utility vehicles and procure new ones to address the gaps.

3.4.4 Performance Targets

Indicators	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
% completion of Shamkhubu level 4 hospital	80	100			
% completion of Mumias west level 4 hospital	80	100			
% completion on upgrading of Ileho Health Centre to level 4 hospital	75	80	85	90	100
% completion and equipping of Kakamega County Teaching and Referral Hospital	60	70	85	100	
% completion on upgrading of Shianda Health Centre to Level 4 Hospital	20	50	70	90	100
% completion on upgrading of Khwisiero Health Centre to Level 4 Hospital	20	50	70	90	100
Number of health centres renovated and rehabilitated	1	1	1	1	1
Number of dispensaries upgraded to health centres	1	2	0	0	0
Number of dispensaries renovated and rehabilitated	0	2	3	2	3
Number of functional ambulances	2	2	3	3	1
Number of mortuaries constructed	1	1	1	1	1

Drug storage facilities	0	1	1	1	0
Number of blood transfusion satellite sites established	0	1	0	1	
Number of utility vehicles purchases	0	5	5	5	1
Number of level 4 facilities equipped with assorted medical equipment	12	12	12	12	12
Number of incinerators constructed	4	4	4	4	4
Number of pharmacy stores constructed	2	2	2	2	2
Number of central stores constructed	0	1	1	1	0
Number of laundry blocks constructed	2	2	2	2	2
Number of intensive care units constructed	1	1			
Number of theatre blocks constructed	1	1	1	1	1
Number of laboratories constructed	3	3	3	3	2
Number of maternity wards constructed	3	3	3	3	3
Number of pediatric wards constructed	2	2	2	2	2
Number of female wards constructed	2	2	2	2	2
Number of male wards constructed	2	2	2	2	2
Number of new dispensaries constructed	5	3	3	3	3
Number of stalled projects completed	20	5	4	4	4

3.5 Health Products and Technologies

The department will advocate for increased funding for health products and technologies to match health facilities workload/requirements. The department will also:

- Strengthen health workers capacities on commodity management.
- Strengthen the County Commodity Security TWG.
- Strengthen supply chain system for Essential Medicines and Medical Supplies (EMMS) and digitization of supply chain management in high volume facilities.
- Set up centers of learning for commodity management in five facilities.
- Develop, disseminate and implement a County Supply Chain strategy.
- Strengthen procurement coordination mechanisms and procedures between KEMSA/MEDS and the County.
- Strengthen pharmacovigilance activities and promote rational medicine use.
- Strengthen Medicines and Therapeutic Committees (MTCs) at County, Sub County and level 4 hospitals.

Table 19: Medical and Pharmaceutical Supplies Requirements by County

CATEGORY	NO. OF HFS	FY 2019/2020	FY 2012/2021	FY 2021/2022	FY 2022/2023	TOTAL
Pharma	170	457,708,672	640,792,141	897,108,997	1,255,952,596	3,251,562,406
Medical Supplies	170	346,894,251	485,651,951	679,912,732	951,877,825	2,464,336,759
Laboratory	170	164,124,191	229,773,867	321,683,414	450,356,780	1,165,938,253
Nutrition	170	86,963,503	121,748,904	170,448,466	238,627,852	617,788,725
Others**	170	137,284,256	192,197,958	269,077,142	376,707,998	975,267,355
Total		**1,192,974,873**	**1,670,164,821**	**2,338,230,751**	**3,273,523,051**	**8,474,893,498**

Source: Forecasting and Quantification Report 2019

*** Others – commodities for radiology, eye unit, dental unit, renal unit*

3.6 Healthcare Financing

To achieve universal health coverage, there is need for the Department of Health Services to improve the efficiency and effectiveness of utilization of available resources. The department will therefore continue to strengthen resource mobilization, allocation and tracking. An elaborate Health Financing Strategy for the department will be developed and implemented. Currently, allocation of funds to the Sub Counties and facilities is determined by facility workload. Allocation of funds will be based on population health priorities backed by evidence and therefore the health sector budget will allocate more resources to Primary Healthcare (FP; MNCH, RH); nutrition; and community health and other public health programs. The department will further build the capacities of SCHMTs to equip them with the requisite skills to effectively prioritize and negotiate for resources based on evidence. Importantly, the department will strive to reducing the gap between approved health sector budget estimates and actual expenditures is reduced by enhancing timely disbursements. This will be realized through the formation of departmental health budget committee and operationalization of Health Sector Working Group (SWG). Financial management and accounting at the County, Sub County and facility levels will be further enhanced through programme based budgeting (PBB).

To ensure allocation of adequate resources for implementation of priorities in this Plan while ensuring equity and efficiency in resource mobilization, allocation and utilization the department will:

- Develop, disseminate, implement and monitor the Health Sector Financing Strategy.
- Strengthen public-private partnerships (PPPs).
- Develop and implement MOUs with development partners and CSOs.

3.6.1 Performance Indicators

Indicator	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Budget advocacy forums conducted with County Assembly	4	4	4	4	4
Number of public private partnerships initiated	1	1	1	1	1
Number of sector working group meetings held	4	4	4	4	4
NHIF coverage by the Kakamega Citizens	80%	80%	100%	100%	100%

3.7 Health Information Systems and M&E

A functional HIS and M&E is critical for ensuring availability of quality data and information for evidence-based decision-making. In order to achieve the overall goal for Health Information Systems (HIS) and M&E, the sector of health prioritizes to invest in the following areas:

- Procurement and distribution of HIS data tools to maintain steady supply of tools.
- Conduct regular and timely support supervision to improve quality assurance in service delivery.
- Streamline data management processes (data collection, collation, validation, analysis, visualization and use).
- Coordinate development and monitoring implementation of Annual Work Plans (AWPs).
- Coordinate mid-term and end-term evaluation of the Strategic Plan.
- Documentation and dissemination of the integrated quarterly and annual implementation reports and best practices to all stakeholders.
- Improve governance of health information systems through implementation of policies and regulations, standards for ICT and Electronics Records Management and Informatics.
- Scale up Electronic Records Management in all health facilities and implementation of unique patient identifier.
- Strengthen and streamline HIS/M&E coordination mechanisms across all levels and programmes.
- Strengthen data analytics capacities at all levels for informed decision-making.

3.7.1 Performance Indicators and Targets

Indicators	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
% of facilities that had reporting tools stock outs	0	0	0	0	0
M&E Plan developed	1				
HIS policies including EMR /EHR policies and health infrastructure implemented and monitored	1	1	1	1	1
Number of staff trained in HIS and M&E skills building in data analytic, data management	50	50	50	50	50
Number of M&E TWG held	4	4	4	4	4
Number of performance reviews conducted and reports developed	4	4	4	4	4
% of facilities with fully functional EMR	30%	40%	50%	60%	80%
Quarterly data reviews and data quality audits	4	4	4	4	4
Number of quarterly information products developed and disseminated	4	4	4	4	4

3.8 Health Research and Development (R&D)

Research and Development (R&D) plays a pivotal role in guiding the development and implementation of health systems, health promotion, environmental health, disease prevention and early diagnosis and treatment. It provides high quality knowledge that can be used to promote, restore and/or maintain health status of population. The department's focus on R&D will be centered around institutionalization of research through:

- Establishment of R&D co-ordination structures to oversee resource mobilization, capacity building, development and implementation of a County research plan.
- Enhancement of stakeholder coordination mechanisms.
- Establishment of an Institutional Review Committee (IRC) that will ensure protection of the rights and welfare of human subjects involved in research activities being conducted in the County.
- Establishment of a County research and information repository center to facilitate information sharing and use.
- Identify and conduct operation research.

3.8.1 Performance Indicators and Targets

Indicators	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Research committee established		1			
County health research plan developed		1			
Train CHMT and SCHMT on operations research			30	30	30
Establish and update a research database/ repository at the County level			1	1	1
Number of operations research	4	4	4	4	4

3.9 Leadership and Governance

To build effective and efficient health systems for quality service delivery, there is need to have strong leadership and governance mechanisms in place. The health sector will achieve this through the following:

- Enacting and adopting health policies to ensure quality in health service delivery.
- Enhancing partnerships and stakeholder coordination mechanisms.
- Capacity building for health leaders and management.
- Strengthening functionality of health governance structures at all levels.
- Policy implementation and monitoring.

- Upscale advocacy with policy makers for additional resources.
- Strengthen capacity of hospital and facility committees.
- Develop and implement a comprehensive resource mobilization strategies.
- Enhance efficiency and prudency in resource utilization and management.
- Oversight of health service provision including enhancing feedback mechanisms.

3.9.1 Performance Indicators and Targets

Indicators	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Number of staff trained in leadership and management	100	100	100	100	100
Number of leadership meeting held – LDG, CHMT, SCHMT and FHT	4	4	4	4	4
Quarterly support supervision	4	4	4	4	4
Annual work planning and performance contracting	1	1	1	1	1
Organogram developed/updated and operational	1	1	1	1	1
% of hospital management committees operational	100%	100%	100%	100%	100%

4 ORGANIZATIONAL AND COORDINATION FRAMEWORK

This section discusses the mandate and focus of the department's implementation framework including the institutions, roles and responsibilities involved in the actualization of this Strategic Plan.

4.1 Roles of the County Department Responsible for Health

- Delivering County health services.
- Licensing and accrediting Non State Health Service Providers (HSPs).
- Financing of County-level health services.
- Maintain, enhance and regulate (asset development) and HSPs (operations).
- Approve County Special Partnership Agreements (SPAs) for HSPs.
- In collaboration with national Government, gazette regulations for community managed health supplies to be implemented at County level.
- Planning, investment and asset ownership function of public health facilities.
- Develop an investment plan to enable fulfillment of the highest attainable right to health and prepare an annual progress report on this fulfillment as required by the Constitution.
- Channel public and other funds to develop health facilities.
- Stewardship/Responsibilities at the different levels of the Health Sector.

4.1.1 The County Assembly – Health Committee

- Conduct oversight on the department to ensure that the Executive is exercising fiscal prudence and good governance in health sector.
- Initiate and/or scrutinize legislative and regulatory proposals on matters touching the health sector.
- Review and recommend budget allocation to the Department of Health Services.

- Investigate, inquire and report on all matters relating to health department's management, activities, administration and operations.
- Vet and report on departmental appointments and where the Constitution or any law requires, approve.

4.1.2 Roles of the County Executive Committee Member – Health

- Implement County legislation for health.
- Coordinate all health activities by ensuring that all relevant policies are formulated and all bills to County Assembly are enacted.
- Translate and implement the Governors Health manifesto.
- Acts as a link between the County and national government on matters health.
- Lead resource mobilization efforts.
- Main link between department and partners.

4.1.3 Roles of the Chief Officers of Health

- Acts as the Accounting officer for the department.
- Development and implementation of sector plans.
- In charge of administration of the department.
- Guide development and implementation of sector plans.
- Ensure effective and efficient use of financial and human resources.

4.1.4 County Health Management Teams (CHMT)

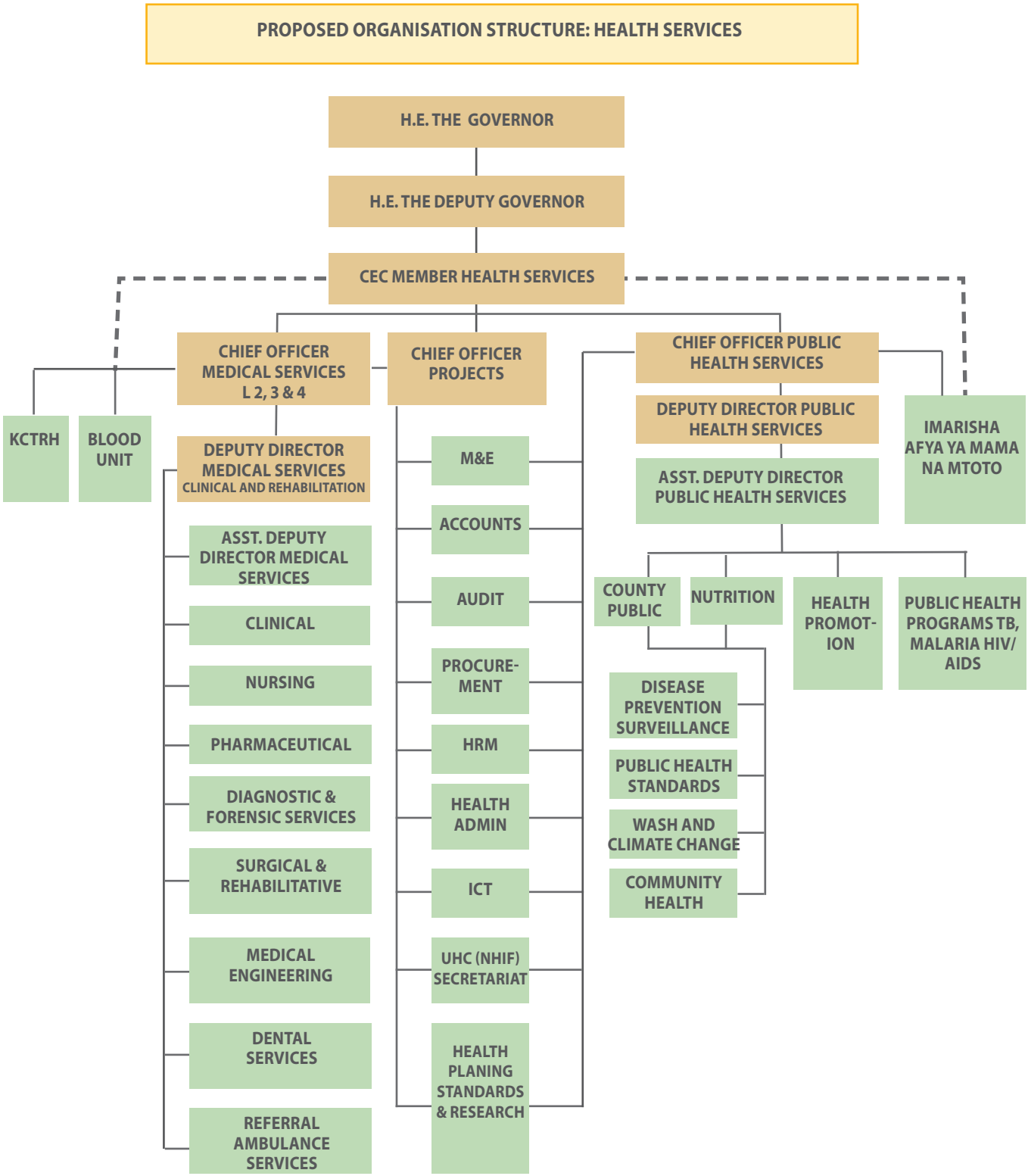
- Provide leadership and stewardship for overall health management in the County.
- Provide strategic and operational planning, monitoring and evaluation of health service delivery in the County.
- Provide a linkage with the National ministry responsible for health.
- Collaborate with state and non-state stakeholders at the County-level and between counties in health services.
- Mobilize resources for County health services.
- Establish mechanisms for the referral function within and between counties and between the different levels of the health system in line with the sector referral strategy.
- Coordinating and collaborating through County health stakeholder forums.

4.1.5 Sub-County Health Management Teams

- Delivering services in all health facilities (levels 1–3).
- Developing and implementing facility health plans (FHPs).
- Supervising and monitoring implementation of FHP.
- Coordinating and collaborating through County health stakeholder forums (FBOs, NGOs, CSOs, development partners).
- Training and developing health workers capacities (in-service).
- Maintaining quality control and adherence to guidelines.

4.1.6 Management Structure

Figure 20: Organogram for County Health Management



1. The County Health Management Team (CHMT) will comprise both the officers under the section of medical services and public health, however each will report to their respective chief officers through the deputy directors and assistant deputy directors. This is because matters pertaining to health services are cross cutting and require a joint approach to achieve the common goal of improving health services.
2. The above will also be replicated at the Sub County level, where the Sub County Health Management Team (SCHMT) will operate jointly to provide services to the residents of Kakamega County.

The Department of Health Services will also come up with actions in the areas of health systems governance, leadership and stewardship that contribute to reducing inefficiencies, wastages and corruption to ensure greater value for money through the following innovative approaches:

- A more rational use of all available resources.
- Build capacities at County and lower levels to manage and deliver County health services.
- Align and harmonize work plans for all stakeholders.
- Strengthen partnerships with the private sector care providers through PPP and sector wide approach.

4.1.7 Partnership and Coordination Structure and Actions

Implementation of this Strategic Plan will require multi-sectoral effort and approach with various health stakeholders in the County playing different roles that are complementary and synergetic at all levels of healthcare service. These responsibilities and roles are geared towards the realization of the right to health. Sectoral partnership and coordination shall be coordinated within the following frameworks:

- One planning framework.
- One budgeting framework.
- One monitoring framework.

The Kakamega County Health Stakeholders Forum (KCHSF) will provide the overarching platform for coordination and collaboration in addressing priority health needs. To avoid duplication, there will be joint planning, implementation, monitoring and evaluation of activities. The KCHSF will also play a key role in resources mobilization for health.The TWGs will be the technical arm of the partnership arrangements. In Kakamega County, there are eight TWGs. The roles of the TWG include:

- Service delivery and quality assurance.
- Leadership, governance and legal.
- Health products and technologies & blood.
- Health financing.

- Human resource for health.
- Health information and communication.
- Health infrastructure and equipment.
- M & E and research.

5 MONITORING AND EVALUATION

The Department of Health Services will ensure Monitoring and Evaluation of CHSSIP 2018-2023 is undertaken. A comprehensive M&E plan will be the basis guiding M&E activities in tracking progress in the implementation of Strategic Plan. It will provide a unified approach to monitoring progress by health sector and collaborating with other actors – Other line ministries, programs, private entities, non-state actors and community.

5.1 Data Architecture

Data architecture refers to the use of standard nomenclature for services, medicines and medical supplies, cadres of staff, etc. It also refers to the use of standard coding systems shared across all databases. It includes the use of defined standards for the exchange of patient and aggregate level data across information systems. The department will continue strengthening the consistent use and management of the available health information systems across all levels of reporting. Working with development partners, the department will also ensure interoperability of the various health information systems divided into the following functional domains:

I. Patient-centric information (EMR, ADT, Fun soft, TIBU).

II. Logistics information management system (LIMS).

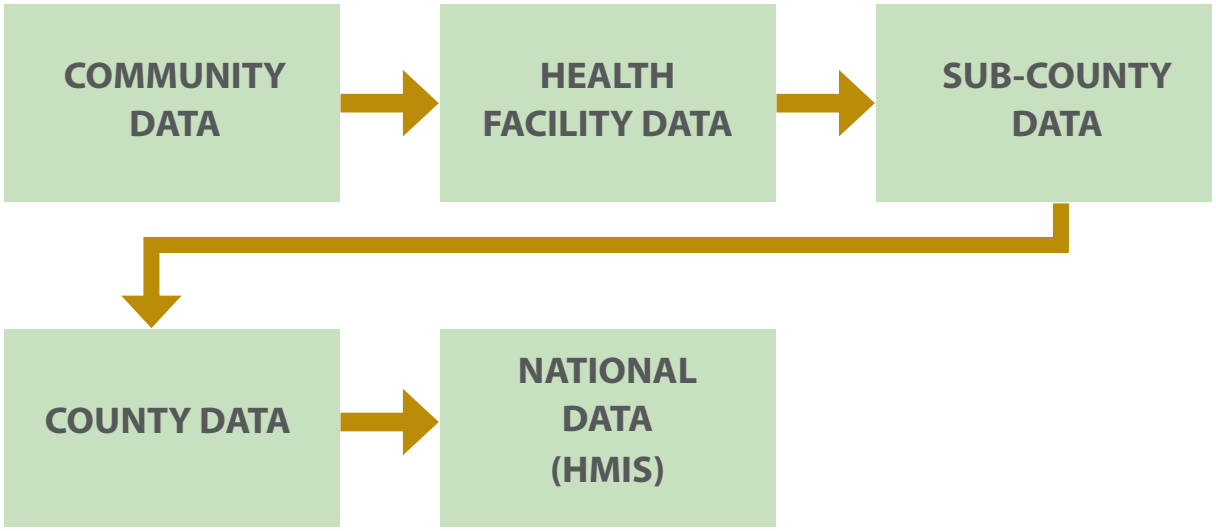
III. Integrated Financial information system (IFMIS).

IV. Integrated Human Resource Information System (IHRIS).

V. District Health Information Software (DHIS2).

Interoperability will enhance data sharing from the community, facility, and Sub County, County and National levels. Central to the achievement of this will be an ICT-driven health information management system, which responds to the healthcare needs of individuals and communities. E-Health will be an essential infrastructure and a pinning information exchange between all stakeholders in the County. Similarly, the County in collaboration with partners will undertake the development of an electronic super highway to enhance information sharing.

Figure 21: Data Architecture



5.2 Data and Statistics

This Strategic Plan will create an environment for data demand and use at all tiers. It will therefore enhance use of data and statistics for patient management, resource allocation, planning, teaching, research, monitoring and evaluation among other health-related decisions. Consistent use of health information will result in increased commitment towards data quality.

5.2.1 Data Sources for Health Sector Monitoring

The sources of M&E information will be guided by stakeholder information needs. The primary data sources for health sector M&E include the following: routine service data, vital statistics, surveys, surveillance and administrative records.

5.2.2 Data Management

Data management entails collection, collation, validation, analysis and generation of information for use in decision-making.

5.2.3 Performance Review

A performance review is a periodic assessment of activities that allows for feedback on the achievements concerning the set objectives. The diagram below illustrates the process of performance review.

The department of health will conduct various reviews at different levels not only by service providers but also through multi-sectoral and stakeholders approach.

5.2.4 Support Supervision

Various activities envisaged in this Strategic Plan will be monitored regularly through support supervision to provide mentorship for continuous improvement.

5.2.5 Performance contracting

The yearly targets will be implemented through departmental performance contracts signed by respective departmental heads and the performance secretariat. The lower level staff will participate in performance appraisal system, which will ensure everyone is given targets to enhance performance.

5.2.6 Performance Review Meetings

There will be quarterly, mid-year and annual data and performance review meetings across various thematic areas/programs.

5.3 CHSSIP 2018-2023 Evaluation

The mid-term review will be conducted after year three of implementation in 2021 July. The report will highlight gaps and challenges to give recommendations for the remaining CHSSIP years. The end-term review will be conducted at the end of implementation period. The report will focus on progress of the entire plan and will be conducted by a team of independent valuations.

6 RESOURCE MOBILIZATION AND FINANCING

6.1 Resource Requirement

This section outlines the projection of estimated financial resources required to implement all priority health interventions over the CHSSIP period. These resources will include funds for development and recurrent expenditures. The department will mobilize resources for development from National Government, County Government of Kakamega, Constituency Development Fund and health partners. The resource projection therefore takes into account the existence of development partners who support targeted health sector activities and thus bridge the capital deficit and gaps the Government may not meet on its own in the immediate term. These partners are largely available through liaison between Kenya and other Governments and they fund diverse areas e.g. infrastructure, capital intensive commodities and equipment, Capacity building, Human Resource for Health, advocacy and social mobilization, vaccines, anti-malarial commodities, HIV/AIDS commodities and TB drugs.

Cost sharing funds will be expected from level four and 5 facilities. The department, in collaboration with the County Assembly Health Committee, will draft and sponsor a Bill for enactment to ring-fence the funds for reimbursement to the collecting facilities. Proceeds from food premises, disposal of idle assets, approval of building plans and medical examination may form part of Appropriations-in- Aid (AIA). Table 20 provides a breakdown of resources required.

Table 20: Resource Distribution and Financing Gaps

INTERVENTION AREA	FY 2018/19 Y1	FY 2019/20 Y2	FY 2020/21 Y3	FY 2021/22 Y4	FY 2022/23 Y5	TOTAL
Primary health care services	263,000,000	253,000,000	263,000,000	253,000,000	263,000,000	1,295,000,000
Hospital level services	240,196,000	254,900,000	242,196,000	255,196,000	270,196,000	1,262,684,000
RMNCAH Services	65,073,650	66,073650	67,073,650	68,073,650	69,073,650	329,368,250
Immunization Services	212,829,378	224,744,578	212,829,378	224,744,578	226,029,378	1,090,777,290
Child Health services	40,826,000	42,526,000	37,426,000	36,226,000	35,126,000	266,330,000
Alcohol and Drug Abuse	24850000	20550000	20550000	16550000	16550000	24850000
Nutrition services	31,980,000	27,380,000	23,880,000	27,380,000	27,380,000	216,700,000
Disease Surveillance and Control	18,000,000	18,000,000	18,000,000	18,000,000	18,000,000	90,000,000
HIV Control Interventions	54,700,000	54,700,000	54,700,000	54,700,000	54,700,000	273,500,000

INTERVENTION AREA	FY 2018/19 Y1	FY 2019/20 Y2	FY 2020/21 Y3	FY 2021/22 Y4	FY 2022/23 Y5	TOTAL
TB/Leprosy Control Interventions	26,940,000	26,940,000	26,940,000	26,940,000	26,940,000	134,700,000
Malaria Control Interventions	141,372,000	100,280,000	106,280,000	135,634,000	149,280,000	632,846,000
Neglected Tropical Diseases Control	22,500,000	25,500,000	20,500,000	27,000,000	20,000,000	115,500,000
Non-Communicable Disease Control	85,000,000	80,000,000	80,000,000	85,000,000	90,000,000	955,000,000
Environmental Health, Water and Sanitation Interventions	46,422,000	46,536,000	47,087,000	47,200,000	46,892,000	235,000,000
School Health Interventions	101,005,602	103,267,242	105,644,007	108,021,607	110,520,009	528,458,465
Community Health – Level 1 Interventions	101,280,000	101,280,000	101,280,000	101,280,000	101,280,000	506,400,000
	199,656,000	205,656,000	140,656,000	128,656,000	128,656,000	803,280,000
Health Promotion	8,897,000	9,000,000	11,000,000	12,000,000	15,000,000	47,000,000
Human Resource for Health	3,031,000,000	3,249,042,000	3,438,042,000	3,643,542,000	3,838,042,000	1,328,668,000
Health infrastructure	1,671,283,237	1,985,283,237	3,112,283,237	3,025,283,237	687,283,237	10,471,416,185
Medical and other supplies	602,000,000	1,192,974,873	1,670,164,821	2,338,230,751	3,273,523,051	9,076,893,498
Equipment	200,000,000	2,600,000,000	2,290,000,000	2,210,000,000	130,000,000	7,450,000,000
HIS / M &E total	157,900,000	204,960,000	202,960,000	213,960,000.00	221,500,000	1,004,780,000.00
Leadership Development and Governance (LDG)	231,900,000	147,000,000	144,500,000	167,000,000	144,500,000	834,900,000
TOTALS	**7,563,710,867**	**6,130,218,110**	**7,419,908,058**	**7,954,473,988**	**9,944,571,329**	**39,012,882,352**

6.2 Strategies to Mobilize Resources from New Sources

The County health sector will devise workable strategies to will maximize resource mobilization. Potential strategies for resource mobilization will include Facility Improvement Fund (FIF), continued engagement of partners, Public-Private Partnerships, Fees, Appropriation in Aids (AIA), NHIF and other health insurance bodies, charity, donations and community engagement to explore locally available resources.

6.2.1 Strategies to Ensure Efficiency in Resource Utilization

Adequate measures will be instituted to ensure prudent utilization of resources. All expenditures will be directed towards realization of the goals and vision stated herein. Further, the department will develop a cash flow management committee to ensure proper planning, budgeting and monitoring for this strategic plan. Stakeholders' involvement at all stages will ensure efficiency and effectiveness in resource utilization.

In addition, the department will prioritize digitization (ICT) as an enabler for managerial and administrative roles to enhance efficiency in resource management and utilization. Public financial management laws, guidelines and circulars will be adhered to in the day-to-day management and execution of financial transactions. These efforts are geared towards upholding accountability, transparency and prudence in financial management processes. Similarly, continuous capacity building of staff on resource management will be prioritizes.

Table 21: Resource Requirements for Department of Health Services

KEY OUTPUT ACTIVITIES	FY 2018/19 Y1	FY 2019/20 Y2	FY 2020/21 Y3	FY 2021/22 Y4	FY 2022/23 Y5	TOTAL	SOURCE OF FUNDS
Program 1: Curative and Rehabilitative Health Services Program Outcome: Effective and efficient curative and rehabilitative health care services to the County citizens Program Objective: To provide effective and efficient curative and rehabilitative at hall health service delivery units.							
Sub-Program 1: Primary Health Facility Services							
Sub Total primary health facility services	291,000,000	291,000,000	291,000,000	291,000,000	66,000,000	1,455,000,000	CGK/Partners
Sub-Program 2: Hospital Level Services							
Sub Total hospital services	222,516,000	230,220,000	282,516,000	307,516,000	317516,000	1,360,284,000	CGK/Partners
Total curative and rehabilitative services	513,516,000	521,220,000	573,516,000	598,516,000	383,516,000	2,815,284,000	CGK/Partners
Program 2: Preventive and Promotive Health Services Program Outcome: Effective and efficient preventive and promotive health interventions within the County Program Objective: To provide effective and efficient preventive and promotive health interventions across the County							
Total preventive and promotive services	1,181,331,630	1,330,261,871	1,290,855,677	1,408,751,806	1,551,999,003	6,763,199,987	CGK, Partners
Program 3: General Administration, Planning, Management Support and Coordination Program Outcome: Effective and efficient preventive and promotive health interventions within the County Program Objective: To provide effective and efficient preventive and promotive health interventions across the County.							
Total HRH:	3,178,500,000	3,396,542,000	3,585,542,000	3,791,042,000	3,985,542,000	17,937,168,000	CGK/ Partners
Sub Total infrastructure	1,671,283,237	1,985,283,237	3,612,283,237	3,525,283,237	687,283,237	11,481,416,185	CGK/ Partners
Sub Total Medical and other supplies	602,000,000	895,000,000	1,038,000,000	1,191,000,000	1,391,000,000	5,117,000,000	CGK/ Partners
Sub programme 4: Procurement and Maintenance of Medical and Other Equipment							
Sub Total Equipment	200,000,000	2,600,000,000	2,290,000,000	2,210,000,000	130,000,000	7,430,000,000	CGK/ Partners
Sub Total programme HIS / M &E	157,900,000	199,960,000	202,960,000	213,960,000	221,500,000	838,380,000	CGK/ Partners
Sub Total LDG	231,900,000	196,500,000	154,400,000	199,400,000	154,400,000	936,600,000	CGK/ Partners
Total administrative	6,041,583,237	9,273,285,237	10,883,185,237	11,130,685,237	6,569,725,237	43,746,464,185	CGK/Partners
Grand total	**7,746,430,867**	**11,134,767,108**	**12,747,559,914**	**13,137,953,043**	**8,505,240,240**	**53,325,548172**	**CGK/Partners**

7 ANNEXES

Annex 1

Research Priorities for the Strategic Plan

PRIORITY AREAS FOR INTERVENTION	MEASURE OF SUCCESS	BASELINE	MID TERM	END TERM
1. Strengthen coordination mechanism of research for health				
Establish a research unit within the County Health Department	A functional research unit established	0	1	1
Establish a County Health Research Committee	Health research committee/TWG established	0	1	1
Develop a County health research plan	Health research plan developed	0	1	1
Identify County Research priorities	County research priorities identified	0	1	1
Establish County IRB	functional IRB	0	1	1
Train S/CHMT on Operations Research	Training Report	0	50	100
2. Strengthen data management and analysis				
Develop data management guidelines for Research	Data Management guidelines developed	0	1	1
Develop a data repository and knowledge Management System	Centralized Data repository established	0	1	1
Establish a research database/ repository at the County level.	Research Data repository exists at the County level	0	1	1
3. Conduct operational research				
3.1 Customer satisfactions survey	Customer survey report disseminated	0	2	3
3.2 Staff satisfaction survey	Staff satisfaction survey conducted and report available	0	2	3
3.3 Alcohol and drug abuse amongst staff	Survey on alcoholics in department done. Most staff most staff rehabilitated	0	2	3
3.4 Automation level and information security	Automation report disseminated and IT cascaded	0	2	3
3.5 Safety and security of healthcare workers	Safety and security report on HCWs at various departmental sections.	0	2	3
3.6 Resolution of public complaints	Report on resolution on public complaints out.	0	2	3
3.7 Corruption perception	Corruption performance index calculated	0	2	3

Annex 2
List of Stakeholders

List of Stakeholders Involved in the Development of the CHSSIP

	NAME	DESIGNATION	ORGANIZATION
1	Mrs. Rachel Okumu	CECM, Health services	County Government of Kakamega
2	Dr. Beatrice Etemesi	Chief Officer, Medical Services	County Government of Kakamega
3	Dr. Brenda Makokha	Chief Officer, Health Projects	County Government of Kakamega
4	Mrs Everlyne Mulunji	Chief Officer, Public Health and Sanitation	County Government of Kakamega
5	Dr. Ayub Misiani	Acting County Director of Medical Services	County Government of Kakamega
6	Dr. Arthur Andere	Acting County Director of Public Health	County Government of Kakamega
7	Mr. Nehemiah Muhatia	County Physiotherapist	County Government of Kakamega
8	Mr. Edward Omusotsi	CHRIO	County Government of Kakamega
9	Dr. Faustina Sakari	CMCC	County Government of Kakamega
10	Dr. John Otieno	CMEC	County Government of Kakamega
11	Mr. Kennedy Lumbe	Health Planner	County Government of Kakamega
12	Dr. Mike Ekisa	CASCO	County Government of Kakamega
13	Mrs. Sally Oronje	CRHC	County Government of Kakamega
14	Mrs Christine Bwire	CHAO	County Government of Kakamega
15	Ms. Florence Emali	CNUT	County Government of Kakamega
16	Mr. Zablon Onyango	WASH coordinator	County Government of Kakamega
17	Mr. Stephen Anjeche	Deputy CCSC	County Government of Kakamega
18	Mrs. Everlyne Etyang	County HR-Health	County Government of Kakamega
19	Mr. Husdon Malongo	Referral services coordinator	County Government of Kakamega
20	CPA David Kulova	Health Accountant	County Government of Kakamega
21	Mr. Fredrick Makokha	Epidemiologist	County Government of Kakamega
22	Mr. Fredrick Onyango	Informatics Advisor	HIGDA
23	Ms. Pauline Siror	County Planning and Learning Specialist	USAID Tupime Kaunti
24	Dr. Sam Wangila	M&E Advisor	USAID Tupime Kaunti
25	Ms. Joyce Nyaboga	Leadership and Governance Specialist	USAID Tupime Kaunti
26	Bernard Okello	Senior M&E Capacity Building Advisor	USAID Tupime Kaunti
27	Nick Oyugi	Senior M&E specialist	USAID Tupime Kaunti
28	Dr. Edwin Lutomia	Health Specialist	UNICEF Kisumu Zonal Office
29	Mr. George Gititu	Capacity Building Specialist	USAID Tupime Kaunti
30	Ms. Susan Jobando	Nutritionist	UNICEF – Kisumu Zonal Office
31	George Mutembula	M&E	PSK
32	Esther Njeri	County Coordinator	SETH
33	Melissa Wanda	Advocacy and Policy Officer	PATH

KAKAMEGA COUNTY HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN

2018– 2023