REPUBLIC OF KENYA

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COUNTY GOVERNMENT OF KAKAMEGA

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HEALTH SERVICES

SECTOR PLAN (2023 – 2032)

Quality Health Services for all.

Sector Plan (2023 – 2032)

Health Services

Prepared by:

Ministry of Health Services

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Vision

Quality health services for all.

Mission

Committed to delivering accessible, equitable, efficient and respectful, Promotive, preventive, curative and rehabilitative health services for all.

STATEMENT FROM THE COUNTY EXECUTIVE COMMITTEE MEMBER OF FINANCE, ECONOMIC PLANNING AND ICT.

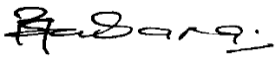
The Kenyan Government adopted Kenya vision 2030 as the long-term development blue print in 2008 which is being implemented through a Five-year Medium-Term Plans (MTPs). With the inception of the two-tier governments under the constitution of Kenya 2010, the development framework for the county government required the implementation of the projects and programmes through the County Integrated Development Plans (CIDPs) implemented through the Annual Development Plans (ADPs). The County Government of Kakamega has so far implemented the First- and Second-generation County Integrated Development Plans with the Third generation being implemented between 2023-2027.Equally the County Government Act, 2012 Section 109 requires the development of a ten-year County Sectoral Plan as component part of the County Integrated Development Plan which shall be revised every five years but updated annually. The County Government developed Ten Sector plans by the established Ten Sector Working Groups which provide the background information for the third generation CIDP.

The Sector Plans provide in greater detail the outline of specific plans to be implemented in each sector during the 2023-2032 Plan period with provision for revision every Five years as provided by Section 109 of the County Government Act, 2012.The Sector Plans have been prepared through a participatory and inclusive process which involved representatives from both the National as well as the County Government Departments, Private Sector, NGOs, Civil Society Organizations, Faith Based Organizations, Academia and Research Organizations, Professional Organizations as well as the Organizations representing Women, Youth and Differently Abled Persons among other stakeholders. All the sector priorities have incorporated views from the Community areas, Ward, Sub-County and County forums which captured the views and priorities of the residents of Kakamega in different levels. The Sector Plans have also taken into consideration the broad priorities outlined in the National and County policies including the Governors Manifesto.

The Third generation CIDP, the Spatial Plans, Departmental and Agencies Strategic Plans 2023-2027 as well as future plans will be aligned to the Sector Plans. In addition, the implementation

of the plans will be linked to the Result Based Management Framework through the Performance Contract, Staff Performance Appraisal System and other performance management tools for effective service delivery. To ensure tracking of progress, my department will put in place a robust Monitoring, Evaluation and Reporting Framework constituting the County Integrated Monitoring and Evaluation System (CIMES) and the electronic Project Monitoring Information System (e-CIPMIS). These will be fully integrated in the County Government Financial System that will boost public investment and confidence.

Finally, I take this opportunity to sincerely thank H. E the Governor and Deputy Governor for their visionary leadership, guidance and direction that enabled this process to be undertaken. I also appreciate the County staff who formed part of the Ten Sector Working Groups for their valuable inputs. In addition, I commend the Department of Economic Planning and Investments staff led by the Chief Officer Planning for the effective co-ordination of the Sector plan preparation process.



Dr. Beatrice A. Sabana, Ph.D.
County Executive Committee Member,
Finance, Economic Planning and ICT.

FOREWORD

The sector plan is one of the frameworks for the health sector's key priority Programme areas. The health sector is charged with the mandate of providing quality health services to the citizens by addressing issues of equity and social accountability. It is one of the major contributors to the County Gross Domestic Product hence the provisions herein will be the basis for subsequent sector programming where priorities will be focused on programmes listed in the sector specific Plans.

Kenya Vision 2030 goals would be a delusion if the health sector does not institute and implement measures to generate a healthy productive population. The priorities captured are enshrined within Article 43 of the Constitution of Kenya, 2010 which provides for the right to the highest attainable standard of health, including sexual reproductive health.

While taking into account the evolving socio-political environment, this Sector Plan builds upon the achievements and shortfalls of other existing plans. It explores the problems and challenges that would likely emerge over the plan period, including the stagnating health outcome indicators, changing epidemiological patterns and inadequate coverage of services. Special consideration is given to those health problems that affect the majority of the population. Flagship programmes have been designed to have the farthest reach by reducing inequalities, mitigating priority health problems and implementation of cost-effective interventions.

This Plan identifies 7 (seven) strategic priorities namely; Finance, Leadership & Governance, Health Products and Technologies, Service delivery, Health Information and Technology, Infrastructure and health workforce where flagship projects are drawn from. These areas primarily focus on improving the physical and financial accessibility of health services to the general population, and using the most proven interventions while addressing key problems such as high maternal mortality during pregnancy and childbirth among others. Public-Private Partnership (PPP) programmes are also included as mechanisms for additional investment to the health sector for areas that public resources are limited, such as medical tourism and locally derived natural medicinal products.

The successful implementation of this Plan will fast-track achievement of the anticipated health outcomes. The expanded coverage and improved access to quality and effective health care will result in a better performing health care system. It is therefore incumbent upon the various actors to play their respective roles in implementation of this Plan, and particularly for the Ministry of Health Services to provide stewardship and leadership in subsequent programming.

Dr. Collins Matemba
County Executive Committee Member (CECM), Health Services.

PREFACE

The commitment to optimal utilization of scarce resources is necessary to achieve the desired county transformation and comprehensive development planning. The County Government Act, 2012 requires that counties prepare 10-year County Sectoral plans as component parts of the County Integrated Development Plan, that shall be Programme based and form the basis for budgeting and performance management.

The Sector plan contains detailed analysis of the sector covering: the various challenges experienced; the emerging issues affecting the performance of the sector; the environment through which the plans will be implemented and key developmental issues within the county with the relevant interventions that inform the formulation of the programmes. The plan shall mainstream various cross cutting issues and clearly outline the implementation framework as well as the monitoring, evaluation and reporting mechanism.

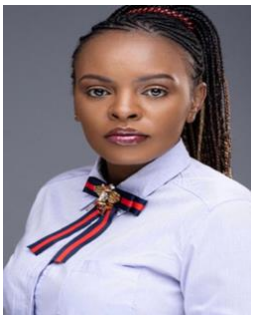
The Plan sets the county strategic priorities for the health sector during the plan period (2023-2032) and identifies health programmes that are likely to make the highest impact towards improving health. The plan will be operationalized through the five-year County Integrated Development Plan (CIDP) and the Annual Development Plans (ADP). The Plan will be evaluated annually, after five years and at the end of the plan period. The reports prepared will outline the achievements in comparison to targets, facilitating factors, challenges faced and lessons learnt and reports produced and disseminated.

We therefore call for collaboration from all players in the health sector to ensure the realization of Kenya's Vision 2030 Development Agenda and the Sustainable Development Goals (SDGs).

Dan Borter

Chief Officer, Economic Planning and Investment.

ACKNOWLEDGEMENT



The Department of Health Services would like to express sincere gratitude to H.E the Governor and the Deputy Governor for their support in the process of development of this Sector Plan. I acknowledge the County Executive Committee Member Dr. Collins Matemba and Directors for their overall support throughout the process of developing this plan.

I wish to also appreciate all those who participated in the development of this Plan. The technical support received from County Health Management Team (CHMT), development partners and other stakeholders including National and County line departments and ministries, all of whom were very instrumental in putting together the document. Further, special recognition goes to the Planning department under the guidance of the Chief Officer Economic Planning and Investment Dan Borter, Chief Officer Finance, CPA Samson Otieno, the director Ondari Cyrus and the sector planning Officer Loreen Omwakwe for coordinating the Sector Plan preparation process.

We call on the continued support of the entire department to make this plan a success.

Dr. Felista Moraa Mose
Chief Officer, Health Services.

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Abbreviations and Acronyms

ADP	Annual Development Plan
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Care
ARV	Ante Retro Viral
ART	Anti-Retro Viral Therapy
AWP	Annual Work Plan
BSN	Bachelor of Science in Nursing
CCC	Comprehensive Care Clinics (for HIV)
CHA	Community Health Assistant
CHEWs	Community Health Extension Workers
CGH	County Government Hospital
CGK	County Government of Kakamega
CHMT	County Health Management Team
CHSSIP	County Health Sector Strategic and Investment Plan
CHVs	Community Health Volunteers
CIDP	County Integrated Development Plan
CPR	Contraceptive Prevalence Rate
CT Scan	Computed Tomography Scan
DHIS	District Heath Information System
EPI	Expanded Programme on Immunization
FBO	Faith Based Organization
GBV	Gender Based Violence
HPT	Health Products and Technologies
HRH	Human Resources for Health
ICU	Intensive Care Unit
IMR	Infant Mortality Rate

KCTRH	Kakamega County Teaching and Referral Hospital
KECHN	Kenya Enrolled Community Health Nurse
KEMSA	Kenya Medical Supplies Authority
KERRA	Kenya Rural Roads Authority
KHFA	Kenya Harmonized Health Facility Assessment
KMTC	Kenya Medical Training College
KRCHN	Kenya Registered Community Health Nurse
LLIN	Long Lasting Insecticide Treated Net
M&E	Monitoring & Evaluation
mCPR	Modern Contraceptive Prevalence Rate
MEDS	Mission for Essential Drugs and Supplies
MHM	Menstrual Hygiene Management
MMR	Maternal Mortality Ratio
MNCH	Maternal Nutrition and Child Health
MOH	Ministry of Health
MTP	Medium Term Plan
NASCOP	National AIDS and STI Control Program
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHIF	National Hospital Insurance Fund
NTD	Neglected Tropical Diseases
OPD	Out Patient Department
OSR	Own Source Revenue
PHC	Primary Health Care
PLHIV	People Living with HIV/AIDS
PREP	Pre-Exposure Prophylaxis
PWD	Persons with Disability
RMNCH	Reproductive, Maternal, Newborn and Child Health
THS	Transforming Health Services
WASH	Water Sanitation and Hygiene
WRA	Women of Reproductive Age

Basic Concepts and Terminologies

Activities: Actions taken or work performed during which inputs are used to produce outputs;

Advocacy: The process of informing and/or influencing decision makers in order to change policies and/or financial allocations, and to ensure their effective implementation.

Capital Projects: A group of related activities that are implemented to achieve a specific output and to address certain public needs. The amounts involved are over KES 5 million.

Community Health Strategy: Recognition and introduction of level 1 services, which are aimed at empowering Kenyan households and communities to take charge of improving their own health.

Contraception Prevalence Rate: Percentage of currently married women and sexually active unmarried women who are currently using a method of contraception or whose sexual partners are practicing any form of contraception.

County Executive Committee: A County Executive Committee of the County Government of Kakamega established in accordance with Article 176 of the Constitution;

Doctor's Plaza: A multi-specialty medical Centre consisting of all specialized services at consultancy level.

Evaluation: Planned and periodic assessment of program or project to assess the relevance, effectiveness, efficiency and impacts it has had on the intended population;

Flagship/Transformative Projects: These are projects with high impact in terms of employment creation, increasing county competitiveness, revenue generation etc;

Impacts: The long-term consequences of the program or project, may be positive or negative**.**

Inputs: All the financial, human and material resources used for the development intervention;

Linkage: A relationship between different parties such as, between community to health facility, Sub- County and County hospitals or between two departments within a facility.

Monitoring: The continuous and systematic collection and analysis of information in relation to a program or project that provides an indication as to the extent of progress against stated objectives;

Objectives: A measurable statement about the end result that an intervention is expected to accomplish within a given time period;

Outcome Indicators: Outcome indicators measure the quantity and quality of the results (change) achieved through the provision of services;

Outcomes: The medium-term results for specific beneficiaries which are the consequence of achieving specific outputs. Outcomes are often further categorized into immediate/direct outcomes and intermediate outcomes;

Outputs: These are the final products, goods or services produced as a result of a project activities;

Performance indicator: A measurement that evaluate the success of an organization or of a particular activity (such as projects, programs, products and other initiatives) in which it engages;

Programme: A grouping of similar projects and/or services performed by a Ministry or Department to achieve a specific objective;

Project: A set of coordinated activities implemented to meet specific objectives within defined time, cost and performance parameters. Projects aimed at achieving a common goal form a Programme;

Sector: A composition of departments, agencies and organizations that are grouped together according to services and products they provide. They produce or offer similar or related products and services and share common operating characteristics.

Stakeholders – A group of people, organizations and institutions who have a direct or indirect interest, or a role, in the project, or who affect or are affected by it.

Sub-sector: An individual department, agency or organization that provide specific service/product.

Sustainable Development Goals (SDGs) – The Sustainable Development Goals (SDGs) agenda is a plan of action for people, planet, peace, prosperity and partnership that was adopted by the UN member countries as the 2030 Agenda for Sustainable Development.

Total Fertility Rate: Ratio of live births in an area to the population of that area; expressed per 1000 population per year.

Maternal mortality: Deaths due to complications from pregnancy or childbirth

Neonatal mortality: Number of deaths during the first 28 completed days of life per 1000 live births in a given year or other period.

Perinatal mortality: The number of fetal deaths past 22 (or 28) completed weeks of pregnancy plus the number of deaths among live-born children up to 7 completed days of life, per 1000 total births (live births and stillbirths).

Executive Summary

This Health Sector plan provides a framework for implementation of strategies aimed at improving the health status of the Kenyan people. The Sector Plan is aligned with the Kenya Vision 2030 blueprint, the Kenya Health Policy (2014-2030) and SDGs). The Constitution of Kenya places a greater emphasis on the right to health. Article 43 of the Constitution states that, "every person has a right to the highest attainable standard of health, including sexual reproductive health" thus raising expectations from the citizens regarding healthcare. With the devolution of the health service delivery to the Counties, it is envisaged that service delivery for the poor, under-served populations and accountability will improve.

The Health sector is one of the departments in Kakamega County aimed at improving the quality of health services. The background information is key and is well outlined in this plan enumerating the composition and mandate of the Health Sector. The preparation of the plan is well anchored on several policy documents which also provide the procedure to be followed in the preparation process.

Performance review is key in promoting communication and providing useful feedback about sector performance. It facilitates strengthening human resource capacity, to provide an historical record of performance and to contribute to professional development. This document analyzes the Sector's situation under Service delivery, leadership and Governance, Health Financing, Infrastructure, Human Resource and Key indicators. It further provides the achievements, challenges and lessons learnt since the inception of devolution. Communicable diseases including those that can be prevented still constitute the highest proportion of disease burden and further confounded by the emergence of drug resistant strains of TB and co-infection with HIV/ AIDS. Underfunding and inadequate staff are the major hindrance to accessibility to health services. Currently the Government health expenditure as a percent of Total government expenditure range between 25% and 29%. The sector's development issues, causes and opportunities are also analyzed, in addition to the cross cutting & emerging issues and stakeholder analysis. From this comprehensive analysis, it is evident that the sector has made tremendous stride in ensuring a healthy population despite the setbacks. Major infrastructural development has been recorded especially for construction, upgrading and equipping of the health facilities which has reduced the distance travelled, improved quality of services offered and sanitation. Under the Human Resources Strategy, established 425 community units under Community Strategy in order to increase access to equitable and quality health care.

Improvement of infrastructure, human resource strengthening, digitization of health services, reducing morbidity and mortality and improving sanitation and hygiene coverage are the major objectives of the sector for this planned period. With these areas well addressed, the outcome will be increased access to quality health services and proper sanitation and hygiene which

translates to reduced mortality due to preventable causes. All these interventions cannot be realized without a budgetary allocation which is well provided in this same chapter.

The objectives and strategies provided in this plan have been well backed up with the implementation mechanisms. The success of the Plan is attributed to the institutional arrangement, coordination framework, sources of funds and the management of risks. It is important to note that the areas listed depend on each other.

Monitoring and Evaluation aspect is key in ensuring that the strategies proposed are on track. The plan outlines the reporting structures, data sources and collection method, types of reports to be produced, dissemination and feedback mechanism and how to review and update the sector Plan. The Plan will be evaluated annually, after five years and at the end of the plan period. The reports prepared will outline the achievements in comparison to targets, facilitating factors, challenges faced and lessons learnt.

In moving forward, the Ministry remains steadfast to deliberately build progressive, responsive and sustainable technologically-driven, evidence-based and client-centered health system for accelerated attainment of the highest standard of health to citizens. The focus still remains access to quality health care services through Universal Health coverage under sustainable mechanisms. The policies, legal and institution frameworks necessary for the successful implementation of this plan will be fast-tracked and a concerted effort from all stakeholders and cross linkages from other sectors will be key during the implementation period.

CHAPTER ONE: INTRODUCTION

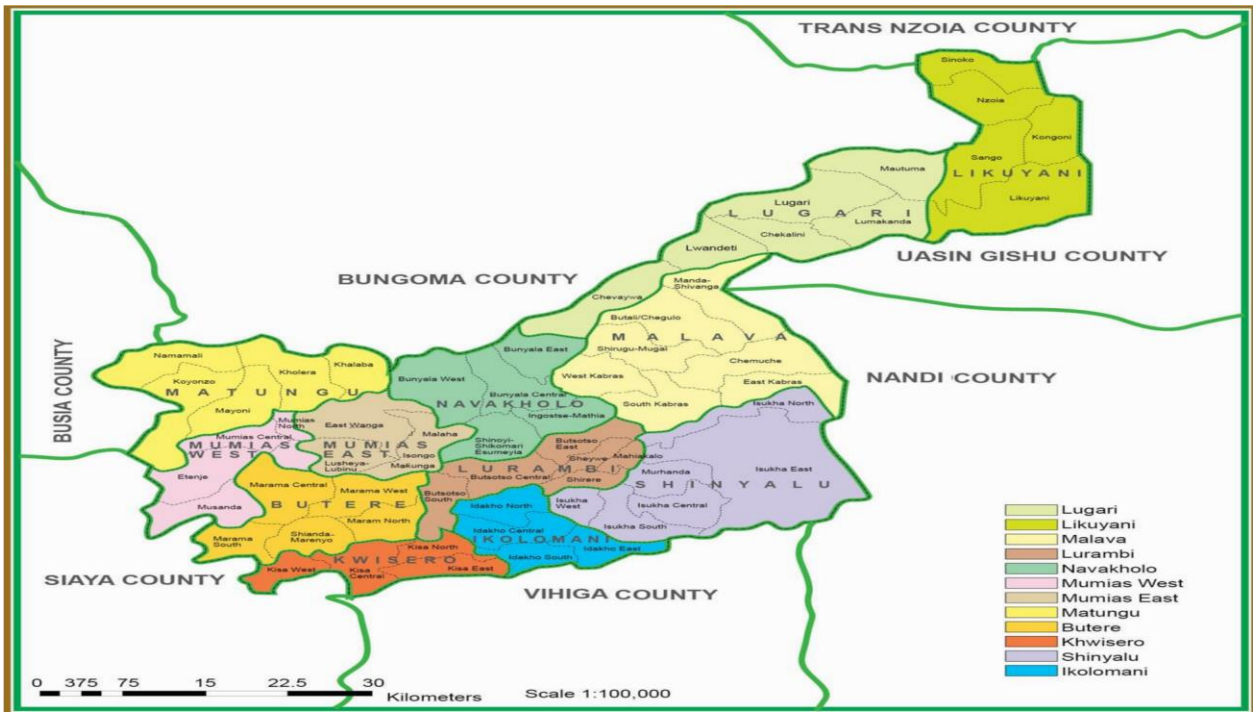
1.1 Overview of the County

1.1.1 Location and Size

The Constitution of Kenya, 2010 created a decentralized system of government; the national government and forty-seven (47) county governments, as provided for under Article 6 and specified in the First Schedule,[1]. Kakamega County is located in the Western part of Kenya bordering Vihiga County to the South, Siaya County to the West, Bungoma and Trans Nzoia Counties to the North and Nandi and Uasin Gishu Counties to the East.

The County covers an area of 3,051.3 Km^2 and is the fourth populous county after Nairobi, Kiambu and Nakuru with the largest rural population. Map 1 below shows the County administrative units and their boundaries.

Map 1: Map of Kakamega County showing administrative units



Source: Kakamega County Integrated Development Plan, 2018 – 2022

[1] http://kenyalaw.org/kl/index.php?id=3979

1.1.2 Administrative Units

The County administrative units comprise 12 Sub-counties, 60 wards, 187 Village Units and 400 Community Areas. This information is provided in table 1.

Table 1: Administrative Units in the County

Sub-county	No. of Wards	No. of Village Units	No. of Community Areas
Likuyani	5	14	31
Lugari	6	20	43
Malava	7	23	49
Navakholo	5	14	32
Lurambi	6	17	35
Ikolomani	4	12	26
Shinyalu	6	19	38
Khwisero	4	11	25
Butere	5	17	38
Mumias West	4	13	26
Mumias East	3	11	23
Matungu	5	16	34
Total	**60**	**187**	**400**

Source: Kakamega County Integrated Development Plan, 2018 – 2022

1.1.3 Physiographic Conditions

The altitude of the County ranges from 1,240 metres to 2,000 metres above sea level. The southern part of the County is made up of rugged granites rising in places to 1,950 metres above sea level. The Nandi Escarpment forms a prominent feature on the County's eastern border, with its main scarp rising from the general elevation of 1,700 metres to 2,000 metres. There are also several hills in the County such as Misango, Imanga, Eregi, Butieri, Sikhokhochole, MaweTatu, Lirhanda, Kiming'ini among others. There are ten main rivers in the County namely; Nzoia, Yala, Lusumu, Isiukhu, Sasala, Viratsi, Kipkaren, Kamehero, Lukusitsi and Sivilie.

1.1.4 Ecological Conditions

There are two main ecological zones in the County; the Upper Medium (UM) and the Lower Medium (LM). The Upper Medium covers the Central and Northern parts of the County such as

Ikolomani, Lurambi, Malava, Navakholo and Shinyalu that practice intensive maize, tea, beans and horticultural production mainly on small scale; and Lugari and Likuyani where maize and dairy farming is done on large scale. The Lower Medium (LM) zone covers a major portion of the southern part of the County which includes Butere, Khwisero, Mumias East, Mumias West and Matungu where the main economic activity is sugarcane production with some farmers practising maize, sweet potatoes, tea, ground nuts and cassava production.

1.1.5 Climatic Conditions

The annual rainfall in the county ranges from 1,280.1mm to 2,214.1mm per year. The rainfall pattern is evenly distributed all year round with March and October receiving heavy rains while December and February receiving light rains. The temperatures range from 18^0 C to 29^0 C with an average humidity of 67 percent.

1.1.6 Population Size and Composition

Knowledge of the population and its distinct features is an important aspect while planning. According to the 2019 Population and Housing Census, the County population was 1,867,579 consisting of 897,133 males and 970,406 females giving a population distribution of 48.04% and 51.96% for male and female respectively. The County population is growing at a rate of 2.1% and is projected to increase to 2,107,751 by the end of the year 2032.

The youthful population aged between 15 and 34 years comprises 33.16% of the total population. The rapid increase of the youth population calls for quick government intervention in terms of job creation to minimize unemployment, increased establishment of training institutions such as youth polytechnics to equip the youth with necessary life skills and help reduce dependency ratio and vices such as drug use, alcoholism and crime. The labor force, aged between 15 and 64 years comprises of 53.28% of the total population. The high labor force implies that the government should put appropriate policies in place to create employment and encourage setting up of private enterprises to absorb this labor force. The analysis of County population by age group is presented in table 2.

Table 2: County Population by Age Group

Age Group	2019 Census			2022			2027			2032		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Total	**897,133**	**970,406**	**1,867,539**	**927,232**	**1,002,964**	**1,930,196**	**968,941**	**1,048,080**	**2,017,021**	**1,012,526**	**1,095,225**	**2,107,751**
0 - 4	112,360	113,559	225,919	116,130	117,369	233,499	121,354	122,649	244,002	126,813	128,166	254,978
05-09	134,230	134,555	268,785	138,733	139,069	277,803	144,974	145,325	290,299	151,495	151,862	303,358
10-14	144,975	147,002	291,977	149,839	151,934	301,773	156579	158768	315347	163622	165910	329533
15-19	120,265	118,406	238,671	124,300	122,379	246,679	129,891	127,884	257,775	135,734	133,636	269,371
20-24	70,440	79,144	149,584	72,803	81,799	154,603	76,078	85,479	161,557	79,500	89,324	168,825
25-29	50,363	63,950	114,313	52,053	66,096	118,148	54,394	69,069	123,463	56,841	72,176	129,016
30-34	50,695	66,096	116,791	52,396	68,314	120,709	54,753	71,387	126,139	57,216	74,598	131,813
35-39	41,408	43,063	84,471	42,797	44,508	87,305	44,722	46,510	91,232	46,734	48,602	95,336
40-44	38,070	42,651	80,721	39,347	44,082	83,429	41,117	46,065	87,182	42,966	48,137	91,103
45-49	30,545	33,453	63,998	31,570	34,575	66,145	32,990	36,130	69,120	34,474	37,755	72,230
50-54	24,415	29,797	54,212	25,234	30,797	56,031	26,369	32,182	58,551	27,555	33,630	61,185
55-59	22,399	27,417	49,816	23,150	28,337	51,487	24,191	29,612	53,803	25,280	30,944	56,223
60-64	19,330	23,048	42,378	19,979	23,821	43,800	20,878	24,893	45,770	21,817	26,012	47,829
65-69	14,387	17,267	31,654	14,870	17,846	32,716	15,539	18,649	34,188	16,238	19,488	35,725
70-74	10,503	12,321	22,824	10,855	12.734	23,590	11,343	13,307	24,651	11,854	13,905	25,760
75-79	5,649	8,419	14,068	5,839	8,701	14,540	6,102	9,092	15,194	6,376	9,501	15,878
80-84	3,879	5,278	9,157	4,009	5,455	9,464	4,189	5,700	9,890	4,378	5,957	10335
85-89	2,105	3,276	5,381	2,176	3,386	5,562	2274	3,538	5,812	2,376	3,697	6074
90-94	746	979	1,725	771	1,012	1,783	806	1,058	1,863	842	1,105	1,947
95-99	306	554	860	316	573	889	330	599	929	345	626	971
100+	47	156	203	49	161	210	51	168	219	54	176	229

Source: KNBS National Population and Housing Census Report, 2019

1.1.7 Population Density and Distribution

According to the 2019 Population and Housing Census, the County has a population density of 612 persons per square kilometre, which is projected to increase to 626 persons per square kilometre by the year 2022. The population distribution per administrative unit is indicated in table 2. The table indicates that Lurambi Sub- County is the most densely populated with a population density of 1,164 people per square kilometre. This high population density can be attributed to urbanization and several higher learning institutions within Lurambi which hosts Kakamega town.

On the other hand, Shinyalu Sub- County has the lowest population density of 376 people per square kilometre. The low population density can be attributed to the presence of Kakamega Forest that covers a large part of the Sub- County. Population density is an important parameter while planning for services to be provided in different localities. The high population density in Lurambi and other urban areas like Mumias, Malava, Butere, Lumakanda, Moi's Bridge and Matunda has led to sub-division of parcels of land into uneconomical sizes that have reduced agricultural productivity, leading to high levels of unemployment and pressure on the available infrastructural and social facilities. This calls for strategies to address these shortcomings.

Table 3: Population Distribution by Sub-County

Sub-County	(Km^2)	2019 (Census)	
		Population	Population Density (Km^2)
Lurambi	161.7	188,206	1,164
Navakholo	258	153,970	597
Ikolomani	143.6	111,743	778
Shinyalu	445.5	167,637	376
Malava	427.2	238,325	558
Butere	210.4	154,097	732
Khwisero	145.6	113,473	779
Mumias West	165.3	115,353	698
Mumias East	149.2	116,848	783
Matungu	275.8	166,936	605
Likuyani	302	152,051	503
Lugari	367	188,900	515
Total	**3,051.30**	**1,867,539**	**612**

Source: KNBS National Population and Housing Census Report, 2019

1.2 Sector Background Information

Kenya adopted a new constitution in 2010 whose major milestone was the changing of the governance structure adopted at independence from a centralized system to a decentralized system of government comprising of the national government and forty-seven (47) county governments each with specific delegated functions and powers. Kakamega County is one of the 47 counties established. As per the fourth schedule of the Constitution of Kenya, 2010, decentralized units were delegated fourteen (14) functions while the national government delegated thirty-five (35) functions.

The sector comprises of two directorates: Public Health and Medical Services. As of June 2022, data from the master facility list (MFL) shows that the county has a total of 356 health facilities and 425 community units. Public health facilities comprise of; one (1) level V hospital (CGH), fourteen (14) level-IV hospitals, fifty-six (56) level III facilities, and one hundred and nineteen (119) level II facilities; it also has 138 private facilities, 24 faith-based facilities, five (5) NGO facilities and two (2) affiliated to academic institutions.

The Department is responsible for the following Functions:

(i) County health facilities and pharmacies;

(ii) Ambulance service;

(iii) Promotion of primary health care;

(iv) Licensing and control of undertakings that sell food to the public;

(v) Disease surveillance & response;

(vi) Cemeteries, funeral parlor, and crematoria;

(vii) Veterinary services (excluding regulation of the profession);

(viii) Refuse removal, refuse dumps and solid waste disposal.

Strategic Objectives

(i) To increase the awareness on healthcare services by equipping the community with health information in order to enhance health seeking behavior.

(ii) To renovate, construct, upgrade, equip and network health facilities to ensure equitable access to quality health services.

(iii) To ensure adequate number of skilled, motivated, knowledgeable health workers with positive attitude through effective hiring, training and updating, upgrading, promotion, deployment, support supervision and exchange learning programs.

(iv) To improve the maternal and child health through increased service uptake of high impact interventions at the community and health facilities.

(v) To ensure availability and access to essential health products and technologies and effective management system in all health facilities through capacity building of staff, procurement and distribution, adequate ware housing and promotion of appropriate use of the products.

(vi) To reduce the risks and impact of non-communicable diseases (NCDs) by ensuring availability of the right and adequate equipment/ technologies and skilled staff for early detection and treatment of NCDs and provision of health education and health promotion.

1.2.1 Directorate of Medical Services

The Directorate of Medical Services comprises of the following units: Health Products and Technology (HPT), Administration, M & E, Health Information System (HIS) and various programs (TB, HIV, Reproductive Health, Malaria, Nutrition and child survival). Its functions include:

i. Coordinate provision of preventive, promotive, curative, rehabilitative and palliative health services.
ii. Develop county health policies, strategies, laws, and programs and coordinate their implementation.
iii. Liaise with regulatory bodies in the enforcement of norms, standards, and best health practices
iv. Coordinate implementation of national health policies and laws at the county level
v. Promote public private partnership and coordinate public and private sector health programs and systems at the county level
vi. Procure and manage medical supplies and commodities.
vii. Oversee the management and governance of county health facilities and facilitate their infrastructure development
viii. Develop and manage the county health referral system including ambulance services
ix. Facilitate capacity building and professional development for health service personnel
x. Coordination of projects and programs (under medical services)
xi. Provide for the development and management of health information systems
xii. Facilitate registration, licensing and accreditation of health service providers and health facilities respectively according to standards set by the national ministry responsible for health and relevant regulatory bodies
xiii. Coordinate, oversee and/or conduct high quality and ethical research and ensure dissemination of research findings.
xiv. Health planning, administration, monitoring, and evaluation and management of human resources for health under the department.
xv. Health promotion and education
xvi. Implement quality improvement standards, including infection prevention and patient safety.

1.2.2 Directorate of Public Health

Public health mandate is derived from the constitution of Kenya, Public Health Act Cap 242 L.O.K, Food, Drugs and Chemical Substances Act Cap 254 L.O.K and other Public Health related laws and policies. Public Health Section envisions being a responsive authority in matters of preventive health services from community level: Community Administrative Unit, Village Level, Ward Level, Sub- County level and County level. The Directorate comprises of the following units: Disease surveillance, Water and Sanitation Hygiene (WASH), Community Health Strategy (CHS), Vector Borne & Neglected Tropical Diseases (VB & NTDs), Non-Communicable Diseases (NCDs), Food Safety, Occupational Health & Safety, Universal Health Care (UHC), Public Health Standards and Primary Health Care (PHC). Its functions include:

i. Provision of preventive and promotive health services to the communities
ii. Develop county public health policies, strategies, laws, and programs and coordinate their implementation.
iii. Liaise with public health regulatory bodies in the enforcement of norms, standards, and best preventive and promotive practices
iv. Coordinate implementation of national public health policies and laws at the county level
v. License and control undertakings that sell food to the public
vi. Coordinate environmental health and public health sanitation services
vii. Water, food safety quality control
viii. Health inspection and other public health services
ix. Administration of Quarantine for infectious diseases
x. Preventive health programs including vector control
xi. Undertake public health research and innovations
xii. Responding to national public health commitments e,g Mass campaigns
xiii. Disease surveillance and epidemic response.
xiv. Emergency preparedness and public health response to disasters
xv. Facilitate community diagnosis, management, and referral.
xvi. Control the management of cemeteries, funeral homes, and crematoria
xvii. Communication and social mobilization to promote community health

1.3 Rationale

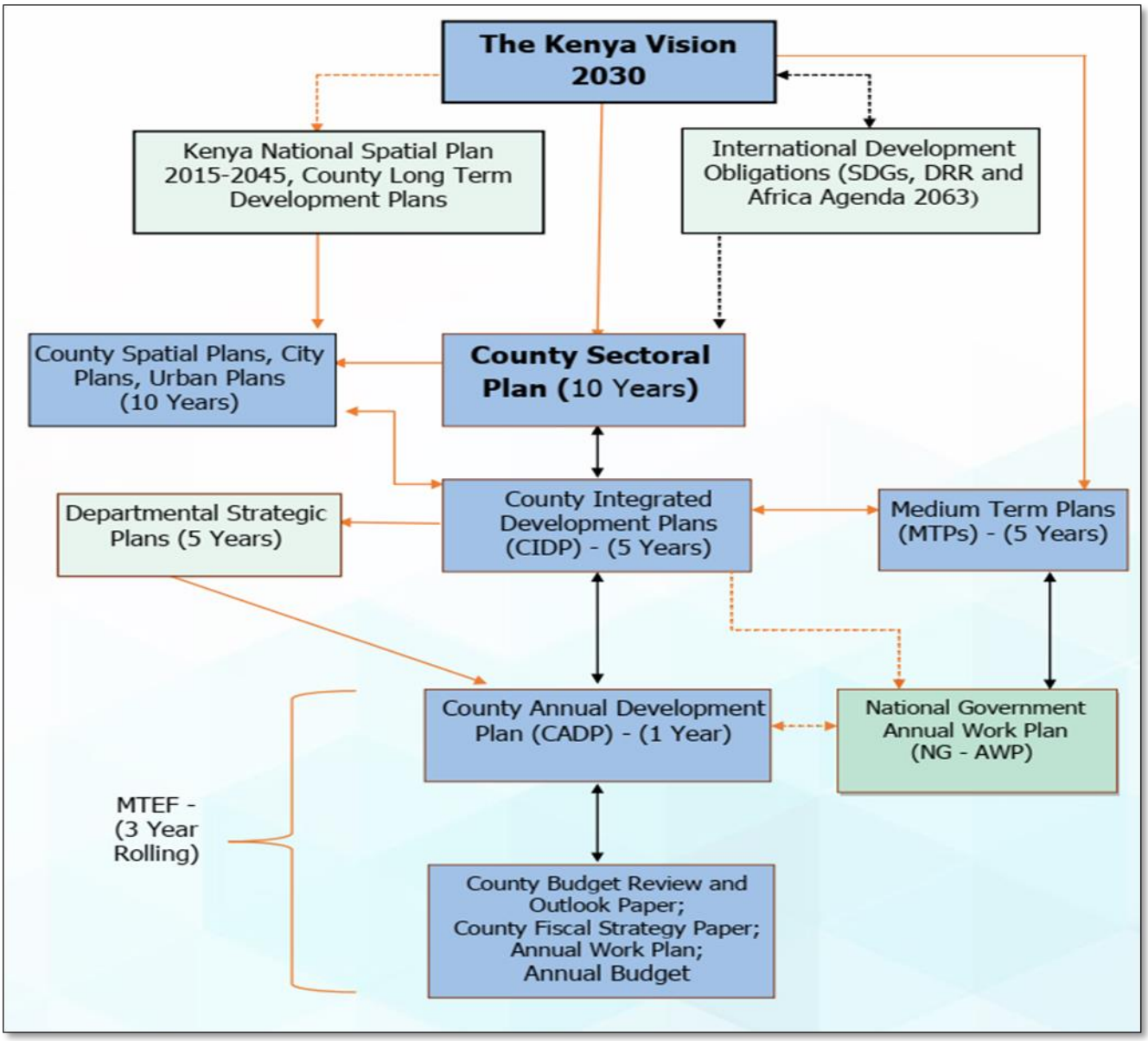
The Constitution of Kenya, 2010 is the basis for the process of devolution in Kenya. To implement devolution and realize its objectives, the National Assembly enacted the County Government Act, 2012 and the Public Finance Management Act, 2012. Part XI of the County Governments Act, 2012 requires County governments to prepare development plans which include County Spatial Plans, Sector Plans, County Integrated Development Plan (CIDP), and Cities and urban areas plans. These plans form the basis for all budgeting and spending in the County. This plan therefore set priorities and define indicators that measure progress in line with its mandate and is developed to align to new emerging issues, the CIDP 2023-2027, Manifesto and the Big four Agenda.

1.4 Linkage between the Sector Plan and other development Plans

The plan is linked to other development plans to ensure that efforts by the County Government, National Government and other relevant stakeholder are coordinated and integrated to achieve all-inclusive and desired development and efficient, timely and quality service delivery. The Kenya Vision 2030 is the national blueprint that forms the national development agenda that is being implemented through a series of 5-year Medium Term Plans (MTPs) at the National level. At the County level, the Kenya Vision 2030 is implemented through 10-year long-term plans (Sector Plan). The Sector Plan identifies programmes for implementation over the ten-year period which are which are then presented in the CIDP for a 5-year period and then an annual development plan prepared to implement projects and programmes identified in the CIDP.

Figure 1 provides a diagrammatic presentation of the link between the Sector plan, Kenya Vision 2030, the CIDP, the ADP, the budget and other plans.

Figure 1: Linkage of the Sector Plan with other Plans



1.5 Methodology

Sector Planning has become an indispensable and standard feature of management in Government offices and marks a major paradigm shift for operations in the Public Service. Some of the hallmarks of such a plan include clearly measurable interventions (inputs) and results (output) over a specified period of time.

This Sector Plan is a product of extensive consultation and participatory preparation. The process of preparing this Sector Plan began in March 2022 with a meeting with the County Planning which gave birth to a concept note which provided a road map for the plan. The next meeting was held with County Health Management Team (CHMT) to help them familiarize with the structure of the sector plan.

The first public participation forum was held in the sub-counties being attended by the chairs of the Community councils. The meeting came up with various resolutions on the objectives and specific programmes that should be included in the plan. Further, a consultative meeting with the health sector stakeholders was held and their inputs incorporated into the plan.

A draft document was prepared, shared and validated by the relevant stakeholders. This gave rise to Draft One which was exposed to a County Forum for further validation after analyzing and making additional comments. A final document is prepared after making the changes captured during validation. The document is then forwarded to the cabinet and later to the county assembly for approval.

CHAPTER TWO: SITUATION ANALYSIS

2.1 Sector Context Analysis

This section provides analysis of the sector's performance by policy objective and investment area. The health sector has undertaken several detailed and exhaustive reviews to assess progress and provide evidence that can inform the direction of and priorities within the sector Plan. Significant progress was made on many indicators while a number of indicators either stagnated or declined within the implementation period. Although impact and health outcome indicators relied on modeled data, progress was generally slow for most of these indictors, which comprise mostly of mortality estimates. It analyzes the performance of the sector in terms of seven pillars: service delivery, leadership and governance, human resource, HPT, Financing, Infrastructure and key health indicators.

2.1.1 Service Delivery

Several initiatives and programmes have led to general improvement in health service delivery in the county since inception of devolution. Access to basic primary health care (PHC) and referral services has significantly improved due to the ongoing investments. 52% of Kenya's population has access to basic health services within 5km. 80% of public primary healthcare facilities are understaffed; infrastructure and equipment are of standards in many dispensaries and hospitals; availability of essential medicines and medical supplies is consistent; and access to quality referral services and emergency transportation is equally improved. Continuous support from development partners has further improved the quality of services provided to the citizens.

2.1.2 Leadership and Governance

Intergovernmental coordination structures have been established and are functioning fairly well. Achievements of the period covered include: enactment of legislation; development and dissemination of norms & standards, policies, guidelines and manuals; development and implementation of health service management structures; capacity-building; establishment

of social accountability mechanisms; development and implementation of partnership coordination frameworks and the conduct of annual performance reviews. However, some leadership and governance challenges were experienced, most attributable to teething problems in implementing the devolved system of governance provided for in the Constitution. Some of the issues that need to be addressed are: constrained budgetary allocations, weak social accountability at all levels, inadequate public–private partnership framework and alignment and harmonization of policy and strategic documents.

2.1.3 Human Resource

The human resource for health establishment in the county for the core health workforce is 9.9 per 10,000 population, which is less than half of what is required, (23), (KHFA 2018/19), creating the need to lobby for employment of more healthcare workforce and establish more medical training institutions. Similarly, the county has a total of 4,250 Community Health Volunteers (CHVs) and 94 Community Health Extension Workers (CHEWs). Even though the low ratio can be attributed to lack of trained skilled personnel, it is noted that there exists a large number of unemployed health personnel in the county.

Some of the key issues that need to be addressed include: gaps in policy guiding the management of health workers, industrial action by health workers, inadequate management and leadership capacity in relation to human resources, inadequate numbers and inequitable distribution of health workers, low absorption of skilled health professionals into the health system and inadequate numbers of trained specialists and sub-specialists and high staff turnover.

Table 4: Number of Healthcare Workers

S/No.	Staff cadres	No.
1	Consultants	24
2	Medical officers	85
3	Dentists	3
4	Dental Technologists	4
5	Public Health Officers	121
6	Public Health Technicians (PHTs)	36

S/No.	Staff cadres	No.
7	Community Health Extension (CHAs)	94
8	Pharmacists	28
9	Pharm. Technologist	39
10	Med Lab. Technologist	86
11	Med Lab Technicians	10
	Orthopedic technologists	18
13	Orthopedic Trauma/technologist	2
14	Orthopedic Trauma/Technicians	14
15	Nutritionists Officers	4
16	Nutrition Technologist	19
17	Nutrition Technicians	3
18	Radiographers	0
19	Physiotherapists	17
20	Occupational Therapists	10
21	Health Promotions Officer	1
22	Health Records & Information Managers	47
23	Medical engineering technologist	16
24	Medical engineering technicians	1
25	Mortuary Attendants	6
26	Health Administrators Officers	15
27	Clinical Officers (Specialists)	21
28	Clinical Officers (General)	148
29	Nursing Officers (BSN)	40
30	Nurses Specialist	34
31	Nursing staff (KRCHNs)	772
32	Nursing staff (KECHN)	251
33	Support Staff	65
34	Medical Social Workers	21
35	Community Health Volunteers (CHVs)	425
	Total	**2,480**

Source: County Human Resource

2.1.4 Health Products and Technologies

One of the eight orientations in the Kenya health Policy 2014 – 2030 is Health Products and Technologies. The HPT investment area seeks to ensure that effective, safe, and affordable health products and technologies are available and rationally used, while maintaining a strategic County health products and technologies (HPT) reserve. The products offered by the sector fall under different units; medical drugs, non-pharmaceuticals, laboratory, radiology, nutrition, occupational therapy, mental health, oncology, renal, eye clinic,

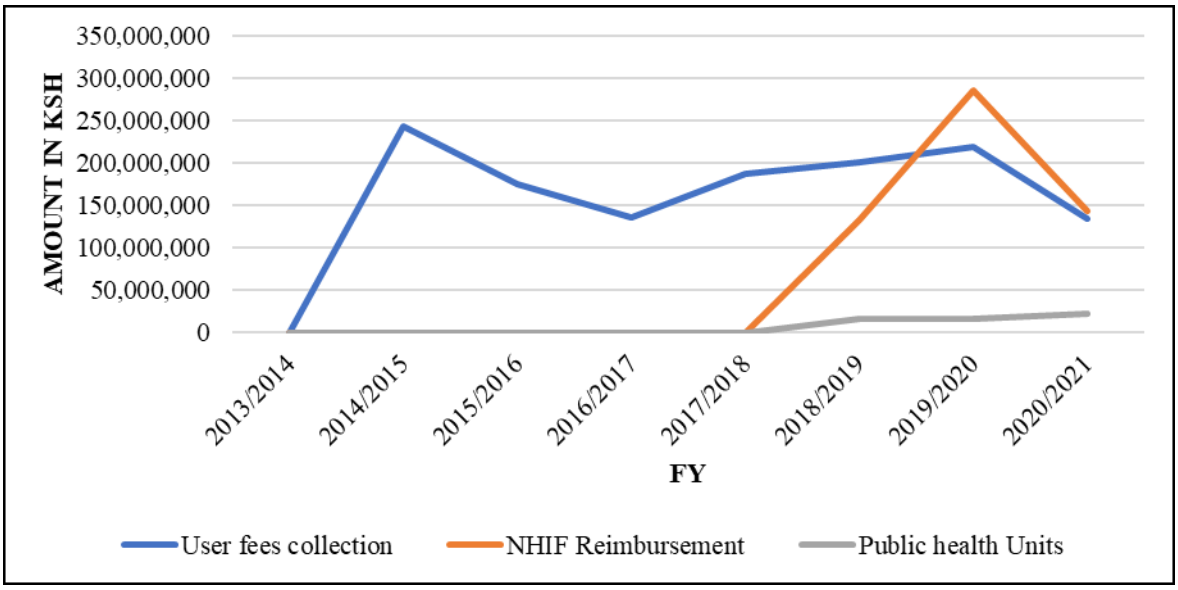
mortuary among others. The supply of health products and technologies in Kakamega County is supported by both local and international pharmaceutical manufacturers. Medical drugs are supplied majorly by KEMSA and MEDS. In terms of performance in procurement of HPT, order fill rate for EMMS by KEMSA stood at 52% in FY17/18 as per the Kenya Health Facility Assessment (KHFA). KEMSA's order turnaround time for hospitals is 15 days against target of 5 days, while for rural health facilities (RHFs) was 15 days against a target of 8 days. The average availability of basic diagnostic tracer items and EMMS in PHC facilities was 45% and 41% respectively. The Kenya Health Facility Assessment (KHFA) also revealed that the Percentage of Health facilities with stock out for any of the 18 tracer medicines for 7 consecutive days in a month was 44% in FY 17/18. Poor supplier performance remains one of the highest HPT risk – thus the need to prioritize contract management as a strategy for managing this risk. There are also inadequate mechanisms for ensuring access to EMMS through non-public provides including alternating sourcing facilities in the event of stock out at KEMSA.

The key issues to be addressed include; Weak linkage between forecasting and quantification plans, procurement plans and the annual budgetary allocations to the Department, inadequate capacity for procurement, storage and distribution of HPTs, inadequate use of ICT in all aspects of Supply Chain for HPT, the shortfall in blood as a health product and parallel logistics management information systems (LMIS) that lack real time visibility at the facility level, posing a challenge for the collection of data to inform supply.

2.1.5 Health Financing

The counties' sources of revenue are from the share of national revenue received as a block grant from the national government (also known as the equitable share), own-source revenue (OSR) that includes funds that public health facilities and public health units generate from user fees and NHIF reimbursements, (approximately 30% of OSR in 2020/2021) and conditional grants from the national government and donors. According to the County Budget and Outlook Papers, revenue from health facilities is shown to have drastically declined in the FY 2019/2020 and further in 2020/2021 as compared to the FY 2018/2019.

Figure 2: Revenue generated from health facilities FY 2013/14-2020/21



Source: Authors based on Finance and Economic Planning Department 2015;2016;2017; 2018; 2019; 2020; Finance, Economic Planning, and ICT Department 2021.

As a commitment to the health sector, the county's per capita expenditure on health has increased from Kshs. 1,2772 in 2012/13 to Kshs. 2,500 in 2020/21. Even though there has been improvement it is still below the recommended World Health Organization (WHO) target of Kshs. 8,000 to meet a basic package of healthcare. Towards the implementation of universal health coverage (UHC) to ensure that the populace has equitable access to health, the county since FY 2018/2019 has committed to pay full NHIF premiums for 8,840 indigents. The national government is also paying for 42,797 indigents under the UHC program.

Kakamega has a large population without health insurance currently at 60%. NHIF playing a major role in social health protection through the implementation of the insurance subsidy Programme among the vulnerable groups. The total membership for NHIF is currently 840,987with the private sector having 57,482 and the informal sector 129,329. (NHIF, 2022).

2.1.6 Health Infrastructure

This investment area comprises four interrelated components; health facilities, medical equipment, information and communication technology (ICT) and transport.

[2] County expenditures books 2014/2015

2.1.6.1 Health Facilities

Number of health facilities increased from 174 in 2013 to 350 in 2022 with those providing basic health services from 118 to 175, a 48% increase. 425 community units were established under the community strategy.

Table 5: Number of Health facilities by category

	FBO			FBO Total	MOH				MOH Total	NGO		NGO Total	Private			Private Total	Grand Total
Levels	**II**	**III**	**IV**		**II**	**III**	**IV**	**V**		**II**	**III**		**II**	**III**	**IV**		
Butere	1			1	4	11	2		17				9	2	1	12	30
Ikolomani		3		3	10	2	2		14	1		1	7	1		8	26
Khwisero	1	2	1	4	2	12	1		15				6	3		9	28
Likuyani					8	2	2		12				12	2		14	26
Lugari	1	1		2	15	2	2		19				10			10	31
Lurambi	2	1		3	17	3		1	21	1		1	23	4		27	52
Malava	2			2	21	4	1		26				6	1		7	35
Matungu	1			1	6	5	1		12		1	1	10	2		12	26
Mumias East			1	1	7	4	1		12				10			10	23
Mumias West	2		1	3	7	3	1		11				10	1		11	25
Navakholo	2			2	9	3	1		13				5			5	20
Shinyalu		1	1	2	14	5			19		1	1	10	2		12	34
Grand Total	**12**	**8**	**4**	**24**	**120**	**56**	**14**	**1**	**191**	**2**	**2**	**4**	**118**	**18**	**1**	**137**	**356**

There has been significant improvement of the infrastructure through construction, upgrading and equipping. A total of 25 new health facilities have been constructed, seven health centers have been upgraded to level IV hospitals and all facilities have been equipped with different equipment which has improved the health outcomes. The upgraded health centers to level 4 hospitals continue to operate without requisite infrastructure and equipment compromising the quality of services provided. This weakens the referral system resulting to primary health facilities offloading basic health conditions to level V facility. In view of this, there is need to provide the upgraded health facilities with requisite infrastructure and equipment to enable them optimize their functions.

2.1.6.2 Medical Equipment

The Biomedical Engineering unit supports patient diagnosis and treatment by installing, testing, calibrating and repairing biomedical equipment, training users and maintaining safe operations. The county has made tremendous strides in ensuring proper function of medical equipment including, formation of multi-Disciplinary medical equipment task force teams, facility medical equipment assessment, Remote Monitoring Solutions (RMS-Lite) training supported by UNICEF, maintenance and strengthening coordination of medical equipment management. This has improved service delivery in all the health facilities.

Some of the major equipment funded by Managed Equipment Service (MES) Programme include; MRI, CT scan, CSSD autoclave, 6 renal dialysis equipment, 6 ICU fully equipped beds, 2 computerized radiology processors among others. Navakholo theatre and dental unit and Likuyani radiology and theatre have also been equipped. Lack of a calibration centre, inadequate preventive maintenance and human resource are some of the challenges that need to be addressed.

Health Information System

A health information system (HIS) refers to a system designed to manage healthcare data. This includes:

- Systems that collect, store, manage and transmit a patient's electronic Health record (EHR), a hospital's operational management or a system supporting healthcare policy decisions.
- Integrated efforts to improve patient outcomes, inform research and influence decision-making
- It brings together data from different sources, routine (service delivery) & non-routine (census, survey)
- These data enable decision makers at different levels to answer specific questions affecting the health of the population.

2.1.6.3 ICT

Information Communication Technology (ICT) is identified as enabler or foundation for socio economic transformation. In Kakamega County, there is an established ICT, e-Government and Communication Department charged with the responsibility of designing,

developing and implementing innovative information systems that have an impact on improved service delivery to the citizens of the county. Department of Health Services together with partners commit to digitize Health services in all health facilities in the County. In order to realize this goal, resources have been mobilized to undertake the following:

1. Hardware
2. Software solutions
3. Networking
4. Capacity building

Currently the sector has deployed both hard and software solutions (KEMR and Fun soft-CHIS) in 55 health facilities across the County. Training of health care workers on how to use solutions to manage patients/clients and cash collection is underway.

2.1.6.4 Transport

Referral Services

As at 2021, the County had 9 contracted ambulances from Kenya Red Cross and 3 County ambulances. The contracted ambulances are used in client evacuation. The county ambulances are not convenient for emergency patient evacuation and are used as utility vehicles within 2 sub-counties and one hospital- Mumias East, Shinyalu and Kakamega County General Hospital respectively. The leading causes of referral are obstetric and neonatal cases accounting for 44%, medical patients' cases account for 31% while surgical cases are at 25%.

Timely response and evacuation of patients to the next level of care is key for Kakamega county which is still reporting very high maternal and neonatal mortality rates of 316/100,000 and 22/1000 live births respectively (KDHIS, 2018) mainly as a result of delay in the decision to refer, inadequate number of ambulance vehicles and poorly prepared health facilities that lack commodities and experts. Further, key components of the referral system such as expertise movement, timely evacuation of patients, development and implementation of feedback mechanisms to the referring facility, provision of mechanisms for preparedness and response to emergencies and disaster, establishment of intercounty and county to national referral protocols, as well as transfer of patient/clients' parameters and specimens' movement have not been addressed appropriately. There is need to establish a dispatch center that is domiciled within the county instead of depending on the ones stationed in the Capital. This will improve efficiency in service delivery as well as effectively monitor and tie cost to performance.

The Department has a total of 66 utility vehicles of which 42 vehicles are currently operational. Out of the 42 operational vehicles, 26 are distributed in the various MOH facilities across the county with 16 vehicles at the headquarters operations. The county

received a total of 3 vehicles (land cruisers) as a donation from the Afya Halisi for RMNCH activities during the FY2020/2021 and 1 double cabin from the National Government (UNICEF for the vaccination Programme during FY2021/2022. The THS Programme also purchased 2 double cabins for the department.

The major challenge affecting transport section in health is under-budgeting for repairs, maintenance and fueling. The number of vehicles attached to the department has been growing with time while the budget is always reducing. The department has also motorbikes attached to the department of public health. However, motorbikes are not funded in terms of fueling and maintenance.

2.2 Review of Sector Financing

Regular financial review is an essential component of financial management aimed at identifying errors, anomalies, potential compliance issues, and significant budget variances. Financial reviews provide an important check that funds are used appropriately to achieve the sector objectives, that funds governed by external restrictions are appropriately utilized, and that amounts allocated are reasonable to expectations.

County allocation to health is mainly from the equitable share, own-source revenue, and conditional grants i.e., THS-UCP grant; reimbursement for user fees foregone; level 5 grant for level 5 facilities and Danish International Development Agency (DANIDA) for level 2 and level 3 facilities. Grants to health facilities has increased over time from Kshs, 311,303,177 to Kshs. 543,448,792 with a sharp increase in 2019/2020 due to the COVID 19 grant received from the national government towards management of the covid 19 pandemic. Level 5 grant and user fee forgone for the Level 2& 3 facilities remained constant with DANIDA decreasing over time due to the phase out of the grant. The department has received a total of Kshs. 23,859,952,309 between financial years 2013/14 and 2021/22 (third quarter). Of the total budget allocation, Kshs. 18,993,817,936 was actually spent translating to 79.61% absorption rate. Table 6 provides sources of funding for the health sector for the financial years 2013/14 to 2021/22.

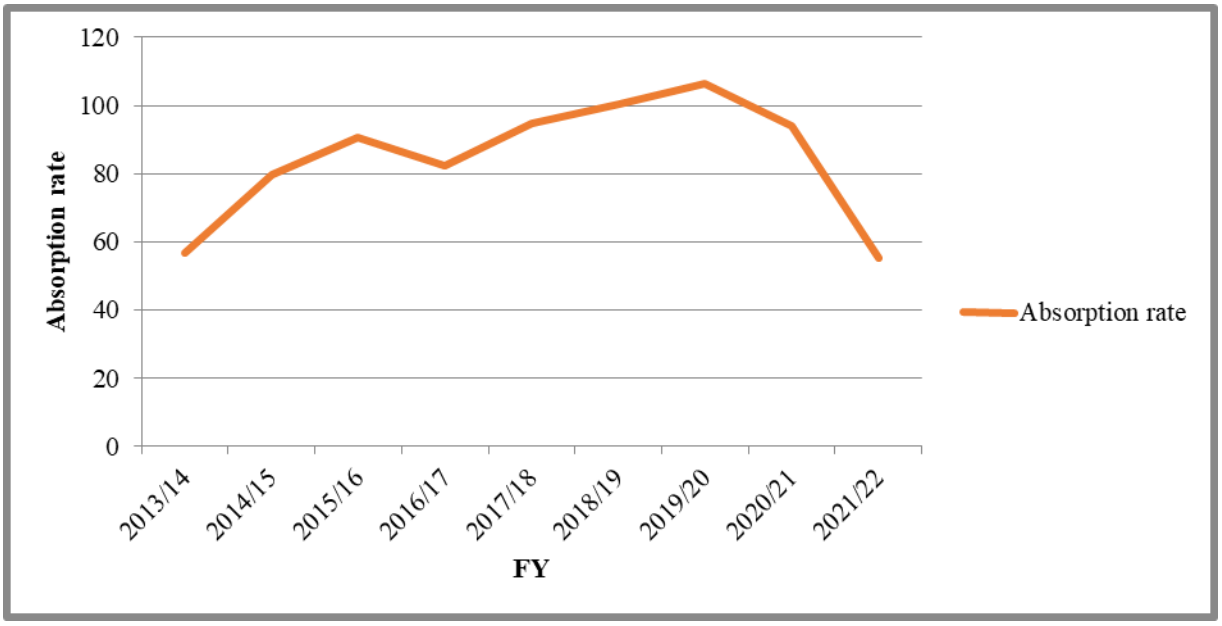
Table 6: Source of Sector Budget Financing

Source of Financing	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
County Government (equitable share, and own source revenue)	3,312,049,208	2,366,322,277	3,085,367,650	3,167,513,256	1,638,523,681	1,289,663,993	1,382,942,215	1,641,002,807	2,181,943,072
National Govern			204,654,7	836,092,5	465,900,3	465,072,5	806,175,5	465,072,5	

ment (conditional grants)			16	64	83	28	24	27	
Development Partners (conditional grants)	21,120,000	11,750,000	11,750,000	89,865,919	100,329,854	104,153,348	212,686,787	-	
Total Sector Financing	**3,333,169,208**	**2,378,072,277**	**3,301,772,366**	**4,093,471,739**	**2,204,753,918**	**1,858,889,869**	**2,401,804,526**	**2,106,075,334**	**2,181,943,072**
Actual Expenditure	**1,893,857,840**	**1,899,744,311**	**2,987,056,025**	**3,368,075,011**	**2,093,078,374**	**1,864,818,087**	**2,555,779,761**	**1,878,896,114**	**1,207,512,413**
Total county Financing	**7,156,086,781**	**8,532,742,034**	**10,095,720,459**	**11,347,358,859**	**11,640,760,649**	**12,963,808,740**	**12,416,574,234**	**14,018,883,280**	**4,402,210,514.00**

The absorption rate for the sector is at an average of 79%. The rate has been increasing gradually since 2013/14 with a decline in the FY 2016/17. FY 2019/20 recorded the highest expenditure attributed to the Covid grants.

Figure 3: Absorption rate trend



2.3 Sector Performance Trends and Achievements

The section provides an analysis of the sector performance trends based on the key sector statistics (outcomes). It also highlights the key achievements of the sector within the last ten-year period as well as lessons learnt.

2.3.1 Key Health Indicators Performance trends

The burden of under nutrition is unacceptably high. 28% of children under five are stunted, 1.8% are wasted and 10.6% underweight. Suboptimal diets are a major risk factor of malnutrition, disease, disability and death. Among infants, only 30.1% were initiated early on breastfeeding while 34.7% were exclusively breastfed. Among children 6-8 months 91.8% were introduced on complementary feeding, 68.9% received solid, semi-solid or soft foods, 38.6% received foods from 4 or more food groups, 22.9% had at least the minimum dietary diversity and the minimum meal frequency. Beyond early exposure to adverse conditions such as illness and/or inappropriate diets and poor feeding practices as the immediate causes of malnutrition, underlies the socio- cultural, political and economic factors contributing to malnutrition.

While the department aims to reduce the incidence rate of hypertension and Diabetes, the high numbers may be an indication that there are many patients who have not been diagnosed yet. Efforts to identify these clients are required at all levels of care (I-V). While an indicator around cancer incidence may be more representative of the cancer status of the county, data is not readily available. For Mental health data documentation has been a challenge resulting from no prioritization, no budget line and no focal person.

The TB unit is mandated to carry out screening, diagnosis and treatment. The TB cases notified as at 2021 was 1,901 with a notification rate of 127cases per 100,000. Screening for TB is done in facilities and communities. TB screening success rate stood at 87% as at 2020 with a death rate of 11%.

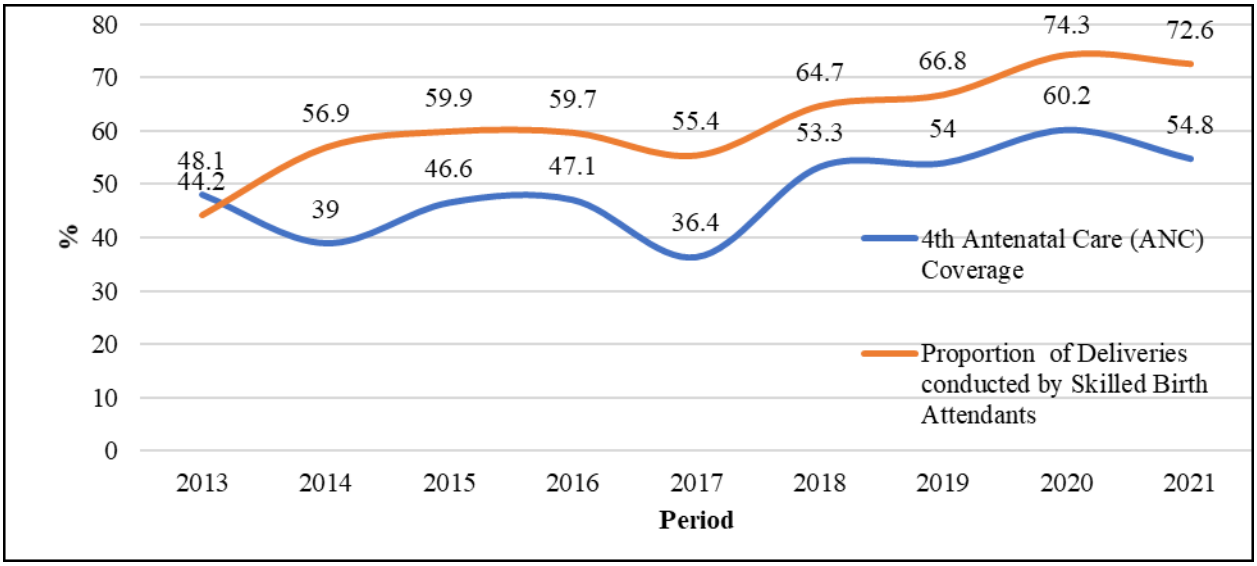
The most prevalent diseases in the county include respiratory diseases, malaria, diarrhea, skin diseases and urinary tract infections, in order from the most prevalent. Respiratory diseases at 31% prevalence rate were noted to overtake Malaria (24%), which had been the most prevalent disease over the years, owing to the COVID-19 pandemic. This calls for the need to emphasize on infection prevention control measures, and enhance the county's disaster preparedness to handle emerging

A total of 286 health facilities out of 350 offer family planning services. 143 health facilities are conducting deliveries as at 2022. Skilled deliveries increased from 36.1% in 2012 to 72.6% in 2021. This majorly attributed to the Linda mama and *Imarisha Afya ya Mama na*

Mtoto programmes among other initiatives. Maternal mortality reduced from 47 to 38 per 100,000 live births. Family planning coverage has been ranging from 38% to 48%. Modern Contraceptive prevalence rate ranges from 62% to 67%. Total Fertility Rate (TFR) stands at 4.4%.

Skilled delivery and forth Antenatal Care have been steadily improving from 44% and 48% in 2013 to a high of 73% and 55% in 2021 respectively as illustrated in figure 4. These can be attributed to increased support of maternal program since devolution by different players like *Imarisha Afya ya Mama na Mtoto* and *Linda Mama* programs, and support from different partners.

Figure 4: 4th ANC and Skilled birth attendance



The objective of immunization is to ensure that children are protected against childhood diseases such as tuberculosis, polio, tetanus, Diphtheria, hepatitis B and diarrhea, pneumonia, meningococcal meningitis and measles. Immunization is carried out among children less than 5 years old. By December 2021(KHIS) the proportion of children under one year who were fully immunized was 82.3% against a target of 90%. In addition, the proportion of under two years receiving vaccine against measles and rubella2 was at 56.6%. Therefore, strategic interventions need to be implemented to ensure that the set targets are met.

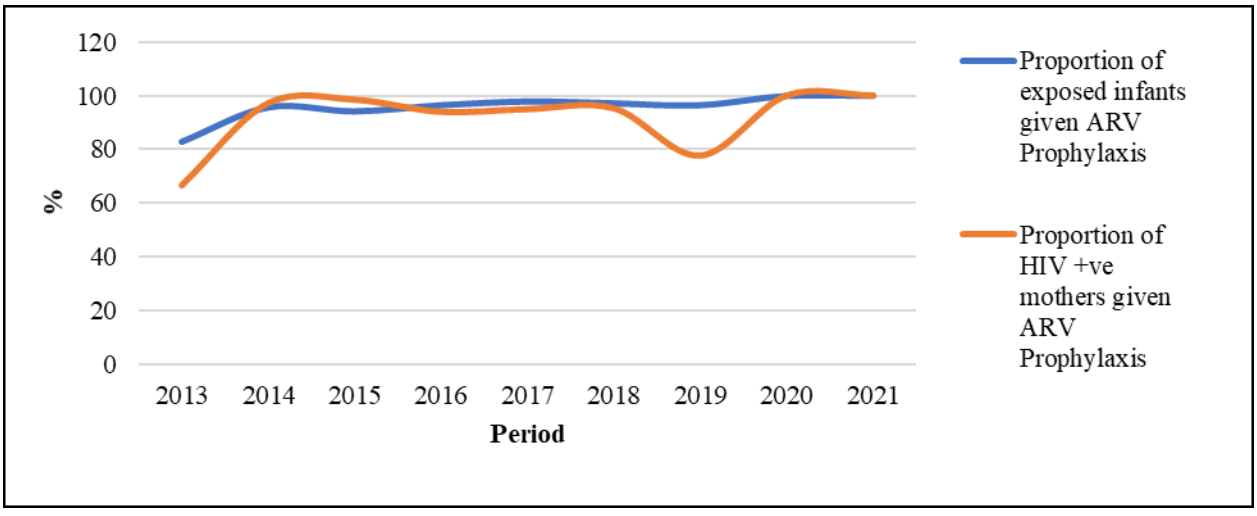
Malaria remains a public health and socioeconomic problem in the county, with the whole of the county's population at risk of the disease. Though the county's prevalence rate has dropped from 27% in 2015 to 15.2% in 2020 it is still a threat accounting for 37% of OPD cases in the year 2021. The county has committed to reduce malaria prevalence rate from 15.2% to 14% in the next five years through various interventions including vector control,

case management, malaria surveillance and Malaria Social and Behaviour Change among others. Mortality rate stands at 0.04%.

Kakamega County has made considerable strides in HIV, AIDS and STI control. Services provided include preventive, treatment of STIs, opportunistic infections and other conditions and management of HIV. In Kakamega County, HIV prevalence stands at 3.9% which is slightly lower than the National prevalence of 4.9% (NACC, 2018). Among adult males aged 15-49 years prevalence stands at 3.4% while that of females is 5.6% with an incidence rate of 1.8/1,000 persons. It is estimated that of the 51,549 PLHIV 45,493are currently on ART (KHIS, 2021). Of the PLHIV, more than 90% are aged 15 years and above, 8% are adolescents aged 10 to 19 years, while 13% are young adults aged 15 to 24 years (NACC, 2018). HIV and AIDS remains one of the leading causes of death in Kakamega County. As at 2018, the mortality rate was at 14.2% compared to the national average of 10.5% (MOH, 2018).

Currently the use of ARV Prophylaxis among HIV positive Mothers and HIV exposed Infants is at 100%. The trend has been over 95% from 2014 to date, however, in 2019 the use of ARV among mothers dropped to 80% as shown in figure 5. While HIV positive clients on ART dropped from 94% in 2013 to 76% in 2018, and it has gradually increased to 85% in 2021 as illustrated.

Figure 5: % Mothers and Infants given ARV Prophylaxis



According to Kenya Population Housing Census 2019, the status of household access to various sanitation facilities and services in the County were; main sewer (0.8%), septic tank (2.4%), cess pool (0.1%), ventilated pit latrine (12.3%), pit latrine covered (73.4%), bucket latrine (0.4%) and open/bush (1.1%). Access to bio-septic/bio digester was below 1 per cent.

(KNBS 2019). The main sewerage systems are found in the urban areas of Lurambi and Mumias West sub-counties.

The current waste generation in the county is estimated to be 2400 tons per day, of which 68 % is from Kakamega town. Daily collection is currently between 1100-1500 tons per day. Recycling is at the moment very low or negligible. There are three main factors involved in waste collection, transportation and disposal. These include the County staff, private contracted companies through Private Public Partnership and a few youth groups involved estate waste collection.

The County, in support of the principle of Reduce – Reuse- Recycle has initiated installation of separation at source elevated litter bins in selected market areas of the County. So far, the County has installed 106 three in one such bins on diverse and selected markets and streets. In line with EMCA, 1999 the County has put in place 9 refuse chambers in the following markets; Kakamega, Butere, Khwisero, Sabatia, Mumias, Malava, Kipkaren and Matunda;

2.3. 2 Key Achievements

Since the inception of devolution, the county has recorded major milestones which have improved service delivery in the county.

- Installed 11 No. 50 KV stand-by generators in various hospitals that have reduced service interruptions;
- Construction of Kakamega County Teaching and Referral Hospital (Phase I – 93%, Phase II – 0% and phase III – 0%) and currently in the process of being handed over to the National Government for completion and operationalization;
- Constructed and equipped Mumias level IV hospital geared towards offering quality health services;
- Ongoing construction of Shamakhubu (85%) and Butere (50%) Hospitals;
- Constructed seven (7) general wards (Malava, Matunda, Shibwe, Iguhu, Matungu, Khwisero and Lumakanda hospitals) and four (4) laundry blocks (Khwisero, Matunda, Malava, Likuyani hospitals) which has improved inpatient services;
- Constructed twelve (12) maternity blocks and two (2) pediatric wards (Butere and Likuyani hospitals) which have improved access to maternal and child health care services.

- Constructed fifteen (15) Out-Patient Departments (OPD) blocks, renovated and operationalized dilapidated facilities taken over by the county government which has improved access to out-patient services;
- In order to ease pressure at the County General Hospital, constructed a theatre at Navakholo hospital, an administration block at Iguhu hospital; pharmacy stores at Khwisero and Likuyani, a laboratory at Khwisero hospital, three (3) burning chambers at Shibwe, Kongoni and Iguhu hospitals, two (2) central stores at Matungu and Malava hospitals, staff houses at Lumani, Mundoberwa and Shiraha dispensaries, toilets, gates and placenta pits to improve service delivery in health facilities;
- Purchased three ambulances and contracted nine (9) ambulances from The Kenya Red Cross which has improved referral services;
- Improved infrastructure at the County General Hospital (CGH) through construction of Eye Clinic, Bio-Medical Waste Management Plant, installation of CCTV cameras, renovation of parking, outpatient and inpatient wing, kitchen and amenity blocks;
- Constructed and equipped a Modern funeral parlor and renovated the old mortuary at County General Hospital (CGH) and ongoing construction of two (2) mortuaries at Butere County Hospital and Likuyani County Hospital to ensure preservation of bodies, reduce distance between mortuaries, requirement to upgrade facilities to level IV hospitals;
- Enrolled over 66,000 needy and vulnerable mothers to *Imarisha Afya ya Mama na Mtoto* Programme which has increased access to skilled delivery;
- Sponsored 8,840 vulnerable households to the Universal Health Care (UHC) Programme which has increased access to healthcare;
- Purchased and installed medical equipment including CT scan machine, MRI machine, oxygen plant, X-ray machine, ultrasound machines, 10 ICU beds, 12 oxygen concentrators and delivery beds in various health facilities;
- Renovated and equipped Kakamega Blood Transfusion Centre serving the county and neighbouring counties;
- Establishment of Oncology department and ward to handle cancer patients. This has reduced referrals to other facilities and increased own source revenue;

- Established covid-19 isolation centres in Mumias Level IV hospital and County General Hospital which were well equipped with the necessary equipment including electric ICU beds, ventilator machines, oxygen concentrators, suction machines, PPE kits among others.
- Established liaison office for partners and stakeholders thus improving service delivery in all levels.

Photo 1: The new Teaching and Referral Hospital under construction in Lurambi Sub-County

Photo 2: H.E The Governor with Beneficiaries of Imarisha Afya ya Mama na Mtoto Programme

Photo 3: The Newly Constructed Kakamega Funeral Parlor

Photo 4: CT scan installed at the County General Hospital

2.3.4 Challenges

- Pressure on the health system as a result of an increase in NCDs such as hypertension, heart disease, diabetes and cancer;
- Inadequate interventions at primary care and community level targeting NCD related conditions;
- Delayed and erratic disbursement of funds;
- Slow procurement process;
- Inadequate budgetary allocation;
- Industrial strikes by the health care workers;
- Over reliance on support from development partners;
- Inadequate skilled and specialized staff.

2.3.3 Lessons learnt

- A multi-sectoral approach is essential for successful implementation of the health sector projects and programmes;
- Training and proper motivation of staff to retain them;
- Need to enhance domestic and external resource mobilization.

2.4 Sectoral Development Issues

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

Table 7: Sectoral Development Issues, Causes and Opportunities

Sub-Sector	Development issues	Causes	Opportunities
Medical Services	Inadequate access to quality health services	Stalled health infrastructure	• Support from development partners.
		Inadequate land for constructing new health facilities	Land donation from community
		Non-operationalized health infrastructure.	
		Level IV hospitals do not	

Sub-Sector	Development issues	Causes	Opportunities
		meet the standards of care.	
		Inadequate medical equipment	Donations
		Inadequate staff as per the HRH norms and standards	• Availability of medical practitioners who are not absorbed • Medical training schools available
		Inadequate skill mix and specialization	Short term training courses
		High turnover rate of healthcare workers	
		Inaccessible roads in some areas	Dedicated Roads department Support from KERRA
		Inadequate Health Products and Technology (HPT)	Established HPTU setting in the county County engaging local manufacturers Establishment of research entities to produce HPTs
		Inadequate maintenance of equipment	
		Low uptake of social insurance	Implementation of UHC Programme
	Inadequate digitization of health services	• Low internet connectivity • Ineffective soft wares solutions • Inadequate hardware • Knowledge gap	Availability of KHIS Dedicated ICT department
	Health financing constraints	• Delayed and erratic disbursement of funds • Inadequate Budgetary Ceilings placed on the sector • Sub-optimal resource mobilization • Fixed facility allocations.	Unexplored revenue streams
Public Health	Low sanitation and hygiene services	• Low latrine coverage. • Inadequate coverage of sewerage treatment services in urban centres. • Irregular waste collection and disposal. • Inadequate waste receptacles. • Population increases in urban areas. • High poverty levels. • Limited access to clean and	• Developmental partner's involvement in sanitation marketing. • Private Waste collection firms. • Adequate hand washing facilities provided by CGK &Partners • Continuous hygiene education of the public.

Sub-Sector	Development issues	Causes	Opportunities
		safe water.	
	Non -Compliance to Public Health standards	• Inadequate technical capacity. • Weak surveillance system. • Weak enforcement	• Public Health standards community awareness programmes • Continuous food and water quality assurance • Routine inspection of food premises and buildings. • Testing and vaccination of food handlers
	Increased morbidity and mortality due to preventable causes	• Sedentary lifestyles • Poor nutrition. • Knowledge gaps • Drug and substance abuse. • High poverty level. • Meagre funding for BCC • Inadequate healthcare workers • Weak referral system	• Advanced diagnostic services. • Inter- sectoral collaboration. • Variety of communication channels for behavior change communication • Presence of developmental partners supporting the programmes.
	Poor prevention and control of infections	• Poor management of health care waste. •	•
	Inadequate Advocacy, Communication and Social Mobilization	• Acute shortage of staff • Inadequate funding • Insufficient equipment	Partner support

2.5 Cross cutting Issues

Cross-cutting issues refer to aspects that impact the Health Sector to achieve its objectives and cuts across many sectors.

Table 8: Analysis of Sector Crosscutting Issues

Cross- cutting Issue	Current Situation	Effects of the Issue on the sector	Gaps (policy, legal and institutional)	Measures for addressing the gaps
HIV & AIDS	Prevalence rate is 3.9%. High prevalence among youth	High cost of prevention and management.	High dependency on donors	Gradual increase of investment by county in response to the journey of self-reliance. Implementation of county HIV policy.
GBV	-Development of GBV policy -Constructed a GBV centre	High burden of cost on management of STDs and teenage pregnancy	Non-operational GBV centre Lack of policy documents	Operationalization of GBV centre -Implementation of policy documents

	-Sensitization of community and healthcare workers.		Lack of youth friendly facilities	-Provision of youth friendly facilities
Disability mainstreaming	Most of the buildings are PWD friendly, health care workers trained on sign languages Sensitized health care workers on disability mainstreaming. Evaluation of facilities for disability, usability and accessibility environment. Assessment for PWDs for registration and assistive devices.	PWDs are able to access services	Lack of braille inclusion	Need to include braille
Mental Health	Established mental health unit serving the entire region hence putting a strain on the existing resources.	High cost of managing health cases since they are exempted.	No budgetary allocation. Lack of partners supporting mental health. No guidelines and framework for management of mental health in the county.	Develop guidelines and framework for management of mental health in the county level. Training of mental health practitioners. Budget allocation. Domestication and implementation of national mental health policy.
Disaster risk Management	Major disasters include road accidents from trailers and boda boda, collapse of mines and quarries, lightning, fires, floods along major rivers and landslides	Diversion of budgetary allocation to mitigate the effects of the disaster	Inadequate funding of mitigation strategies; Lack of early warning systems; Lack of disaster risk, reduction preparedness plans.	Develop and implement disaster risk reduction preparedness plan
Climate change	Occurrence of disasters; Erratic weather patterns	Diversion of budgetary allocation	Lack of a climate change mitigation and adaptation plan	Develop a climate change mitigation and adaptation plan

2.6 Emerging issues

This section provides emerging issues and how they are affecting the performance of the sector. It also gives the interventions in place or proposals to mitigate the negative effects or harness the positive effects.

Table 9: Emerging issues

Emerging issues	Proposed Measures to Mitigate the Negative Effects

	or Harness the Positive Effects
Pandemics (Covid-19)	Strengthen Risk Communication and Community Engagement
Climate change	Setting aside 2% of the development budget to mitigate climate change
High prevalence rate of NCDs	Sensitization of the community.

2.7 Stakeholder Analysis

Timing is an important factor in the identification of Stakeholders to ensure the usefulness of the results for policy formulation. Stakeholder Analysis remains an ongoing process allowing for policy design to adjust. The recognition of the key role played by stakeholders in the determination of policy, its implementation, and outcomes has made stakeholder analysis a vital tool for strategic managers.

Table 10: Stakeholders Analysis

Stakeholder	Role	Possible areas of Collaboration
MOH (National Government)	Policy formulation, standards and coordination.	Formulation of policies
Ministry of Education		Mass Drug Administration, training
County Assembly	Legislation, budget allocation and oversight	Preparation of budget estimates
Regulatory Boards and Councils	Regulate professional human resource and facilities	Public health
Community	Public participation	Public participation
KEMSA and MEDS	Provision of medical supplies	Medical drugs and non-pharmaceuticals
AMREF AFRICA, WORKING WITH LOCAL SRs	Deliver mobile health services and to provide mission hospitals with surgical support.	PR-GF TB, Malaria, NTDs
World Bank	Provides financing, policy advice, and technical assistance to government.	Risk Communication and Community Engagement (RCCE), UHC, MNH/FP, GBV, EPI, M&E
PATH	Tackle complex health challenges, strengthen health systems, and improve outcomes.	GBV, ASRH, HIV care & Treatment, Malaria, MNCH, TB. Risk Communication and Community Engagement (RCCE)
Jacaranda Health	Cross sectoral support to improve MNH indicators	Emoc PROMPTS, Human Centered Designs, Access to emergency care and health financing.
KANCO (Kenya AIDS NGO Consortium)	Key populations, HIV prevention care and treatment cascades.	HIV and malaria
KARP (Kenya AIDS response program)	Technical support and capacity building of healthcare workers	HIV and TB in Faith-Based facilities
National Aids Control Council (NACC)	Technical support, advocacy and resource mobilization	HIV Control
KENYA RED CROSS	Technical support, Key populations,	HIV and Mental Health

	HIV prevention care and treatment cascades.	
FASI (Family AIDS Support Institute)- Red Cross GF SR	Increased demand access by PLHIV, HIV at the community level.	HIV control, community house hold visits for treatment adherence; HTS. BCC, stigma reduction campaigns, OVC
NEPHAK-(Network of People living with HIV AIDS in Kenya) RED CROSS GF SR	Increased demand access by PLHIV, HIV at the community level.	HIV control, community house hold visits for treatment adherence; HTS. BCC, stigma reduction campaigns, OVC
Civil Registration Department (CRD)	Birth & Death Notifications	Birth & Death Notifications
CSO'S / CBO's - VOKA BUMULUSI	Community sensitization/mobilization and referrals	MNH/FP
KMTC	Training in medical courses	Training & capacity building
MARIE STOPES	Service delivery in FP and safe motherhood.	FP and safe motherhood
NHIF	Provision of insurance cover	Insurance cover for MNH/FP
UNICEF	Remote monitoring of medical equipment and EPI	Medical Equipment, Immunization, RMNCH.
PHILIPS - UNICEF	Medical equipment	Medical Equipment management
K-MET	Technical support and capacity building of healthcare workers	Leveraging on the LREB platform to strengthen aspects of nurturing care planning, coordination, financing and budgeting.
WORLD VISION	Livelihood Support of Vulnerable Households	WASH, MNCH, malnutrition and recovery, nutrition sensitive agriculture
CABDA	Community TB, OVC and HIV intervention.	Support to OVCs, TB and HIV.
PHARM ACCESS- IPUSH	Technical assistance, financial and assets	RMNCH, HIS, UHC, research, policy influence and advocacy.
AFYA UGAVI	Logistic and technical support.	Supply chain for HIV, Malaria and RMNCH
USAID Advancing Nutrition	Strengthen the value chains of high-impact commodities—those that are in demand locally or regionally.	Nutrition
USAID Boresha Jamii	Direct service delivery, offer technical support and health system strengthening.	HIV, RMNCH, Nutrition and WASH.
Centre for Behaviour Change	Transformation of communities by providing comprehensive Social and Behaviour Change (SBC) solutions for the public and private sectors.	Behaviour Change Communication (BCC)
CIHEB (Centre for International Health, Education and Biosecurity)	Technical support, capacity building in covid-19 vaccination and HIS	Covid-19
Break Through Action	Ignites collective action and encourages people to adopt healthier behaviors	Behaviour Change Communication (BCC)
KCCB- KARP (Kenya AIDS response program). Funded by PEPFAR CDC	Capacity building, commodity-buffer stocks, support supervision, outreaches, service delivery, lab	HSS, HIV care & treatment HTS, OVC

	networking.	
LVCT HEALTH	Technical support to Kenya prison services through AIDs control unit.	HIV, TB.
Anglican Development Services (ADS)	Identification of children in facilities and linkage from community to facilities.	HIV, Nutrition.
IFAD International Fund for Agriculture Development (FISH PROJECT)	Capacity building of farmers, outreaches in communities, education for school going children	Nutrition- Fish consumption
HELLEN KELLER / SETH	Support Vitamin A supplementation and Malezi Bora initiative.	Nutrition.
IPAS	Capacity building, equipment and commodity supply and stigma reduction for SRH services.	MNH, FP safe abortion care, FP,
MARIE STOPES	Post abortion care, family planning services, RH outreaches, youth group formation, sensitization and referrals	FP/ASRH/PAC
Measure Malaria	Technical support and malaria surveillance.	Malaria surveillance, M& E
BREAKTHROUGH ACTION KENYA	Capacity strengthening	Social and BCC in malaria.
IMPACT MALARIA	Capacity building, mentorship and technical support.	Malaria M & E
WORLD VISION	Child development and protection	Child survival
Afya Ugavi	Logistic and technical support	Supply chain for HIV, Malaria and RMNCH.
KOMESHA TB	Promoting care seeking and prevention of TB.	TB
TB ARC-II	TB control and prevention	Improve case finding
COMMUNITY SUPPORT PLATFORM (CSP)	Identification of missing cases in school and the community contacts	TB control and prevention
CHRISTIAN ASSOCIATION OF KENYA (CHAK)	Community based education and awareness, CHVs and CHEWs training, screening camps using link facilities and support facilities with glucose strips, referrals of patients.	NCDs: Diabetes and Hypertension
MEDTRONIX (CONSORTIUM NOVATIS AND Management Science Health)	Full management of Diabetes and Hypertension. End to end care	NCDs: Management of Diabetes and Hypertension
Kakamega Health private sector organization	Delivery of health services	Partnerships for improved health services.

CHAPTER THREE: SECTOR DEVELOPMENT STRATEGIES AND PROGRAMMES

3.0 Introduction

This chapter discusses the strategic objectives that the Health Sector has identified, and on which it will focus on, in order to achieve its mission and vision. The strategic objectives and the strategies to be pursued will be at the core of the sector's daily functions over the next ten years. The success of this strategic plan will depend on the strategic areas that are key variables or conditions which have a tremendous impact on how effectively the department meets its mission and goals.

The strategic objectives are developed to:

(i) Improve capacity of the sector to undertake its functions;
(ii) Establish and maintain good stakeholder relationships;
(iii) Establish good corporate governance and management practices;
(iv) Enhance the quality of services; and
(v) Promote inclusivity.

3.1 Sector Vision, Mission and Goal

3.1.1 Vision

Quality health services for all.

3.1.2 Mission

Kakamega County is dedicated to delivering accessible, equitable, efficient and respectful, Promotive, preventive, curative and rehabilitative health services to all.

3.1.3 Goal

The sector`s goal is to ensure improved access to quality and affordable health services to all.

3.2 Sector Development Objectives and Strategies

This section presents the sector objectives and strategies in relation to development issues identified in the previous chapter.

Table 11: Sector Developmental Issues, Objectives and Strategies

Sub-sector	Development Issue	Development Objectives	Strategies
Medical Services	Inadequate access to quality medical services	To strengthen the human resource capacity	Strengthen the Human resource
		To improve the health infrastructure	Improve Infrastructural development
		To increase access to referral services	Upgrade the referral services
		To strengthen blood transfusion services	Upgrade blood transfusion services
		To increase resource base	Enhance resource mobilization
		To Digitize health services	Promote digitization of health services
Public Health	Increased morbidity and mortality due to preventable causes	To reduce morbidity and mortality due to preventable causes	Enhance community health strategy
			Strengthen primary health care
			Promote HIV & AIDS prevention and control
			Promote malaria control and management
			Strengthen community health program
		To promote maternal and child health	Improve maternal and Neonatal Health
			Increase the uptake of family planning services
			Strengthen Behaviour change communication
			Enhance nutrition services
	Low sanitation and hygiene coverage	To improve sanitation and hygiene coverage	Enforce public health laws
			Promote community engagement and empowerment
	Poor prevention and control of infections	To promote infection prevention and control	Promote proper management of medical waste.
			Improve IPC practices among healthcare workers
			Enhance community health programmes

3.3 Sector Programmes and Interventions

This section provides the programmes, their objectives and the key interventions. The programmes are in line with the strategies identified in table 12.

Table 12: Implementation Matrix

Programme	Objectives	Strategies/ Interventions	Implementing Agency(s)	Time Frame	Funding	
					Total Budget (Ksh in millions)	Source(s)
Promotion of Curative health services	To improve access to health services	Strengthen Human resource	MOH - CGK	2023 - 2030	30,000	CGK
		Enhance Infrastructural development	MOH - CGK	2023 - 2032	12,000	CGK
		Upgrade the referral services	MOH - CGK	2023 - 2032	1,000	CGK
		Upgrade blood transfusion services	MOH - CGK	2023 - 2032	200	CGK
		Enhance resource mobilization	MOH - CGK	2023 - 2032	2,000	CGK
		Promote digitization of health services	MOH - CGK	2023 - 2032	300	CGK
Sub-total					**45,500**	
Preventive and Promotive Health care services	To reduce morbidity and mortality	Enhance community health strategy	MOH-CGK	2023 - 2032	2,000	CGK, Implementing partners
		Promote HIV & AIDS prevention and control	CGK, NASCOP, implementing partners	2023 - 2032	1,000	CGK/NASCOP, NACC, Implementing partners
		Promote malaria control and management	MOH-CGK, National Govt	2023 - 2032	1,000	CGK/USAID partners
		Promotion of Behavior Change Communication	MOH-CGK, USAID Partners	2023 - 2032	1,000	CGK/USAID partners
	To promote maternal and child health	Improve maternal and Neonatal Health	MOH-CGK, implementing partners	2023 - 2032	3,000	CGK, implementing partners
		Increase the uptake of family	MOH-CGK, National	2023 - 2032	600	MOH-CGK, National Govt,

Programme	Objectives	Strategies/ Interventions	Implementing Agency(s)	Time Frame	Funding	
					Total Budget (Ksh in millions)	Source(s)
		planning services	Govt, implementing partners			implementing partners
		Strengthen Behaviour change communication	MOH-CGK, National Govt, implementing partners	2023 - 2032	500	MOH-CGK, National Govt, implementing partners
		Enhance nutrition services	MOH-CGK, National Govt, implementing partners	2023 - 2032	500	MOH-CGK, National Govt, implementing partners
	To improve sanitation and hygiene coverage	Enforce public health laws	MOH-CGK	2023 - 2032	800	CGK
		Promote community engagement and empowerment	MOH-CGK	2023 - 2032	1,000	CGK
		Water and food sampling	MOH-CGK	2023 - 2032	50	CGK
	To improve Health Promotion activities	Enhance Advocacy Communication and Social Mobilization activities.	MOH - CGK	2023 - 2032	100	CGK
Sub-total					**11,550**	
TOTAL					**86,050**	

3.4 Sector Flagship Projects

This section captures major projects/large scale initiatives with high socio-economic impact in terms of creating employment, enhancing competitiveness, revenue generation, and ability to deliver services including promoting peace and co-existence across the county.

The impact generates rapid and widely shared growth that is felt beyond the locality where it is being implemented. Table 13 shows the flagship projects to be implemented by the health sector.

Table 13: Sectoral flagship projects

Project Name: (Location)	Outcome	Description of Key Activities	Time Frame	Beneficiaries (No.)	Estimated Cost (In millions)	Source of Funds	Implementing Agency
KCTRH	Increased access to quality health services	Completion of KCTRH	2023-2025	Kakamega county and its neighbours	6,200	National Govt	MOH– CGK NG
Cancer Centre	Improved access to cancer services	Construction	2024-2026	Kakamega county and its neighbours	2,000	CGK	MOH - CGK
Doctor's Plaza		Establishment	2025 - 2027	Kakamega	500		MOH - CGK
Imarisha Afya Ya Mama na Mtoto Programme	Increased access to skilled delivery	Provision of stipends to vulnerable mothers who deliver in health facilities	Continuous	Vulnerable mothers	1,500	CGK	Imarisha Afya ya Mama na Mtoto directorate
Universal Health Coverage	Equitable access to quality health services	Financial protection Identification of indigents	2023 - 2032	Indigents	2,000	CGK	CGK, National Govt and partners
Total					**11,900**		

3.5 Cross-Sectoral Linkages

This section provides mechanisms/actions on how sectors will build synergies and address

adverse effects that may arise from the implementation of the programmes. For each Programme, the considerations that should be made in respect to harnessing cross-sector synergies arising from programmes, and mitigation measures are adopted to avoid or manage potential adverse cross-sector effects are indicated.

Table 14: Cross-Sectoral linkages

Programme Name	Linked Sector	Cross-sector Linkages		Measures to Harness or Mitigate the Effects
		Synergies	Adverse Effects	
Promotive and preventive health services	Education	Improved nutrition due to deworming and vitamin A. supplements	Due to lack of record, there his toxicity in the body system.	Advocacy to school health clubs. Strong co-ordination mechanisms
		Compliance to public health regulations	Demolition of the school structures. Reduction of school population	Proper guidelines on building approvals.
	Water	Ensure clean safe drinking water		Provision of chlorine
	Agriculture	Create awareness on agri-nutrition	–	
		Establishment of kitchen-gardens		
		Ensure distribution of safe and quality agricultural, livestock and fishery products	Accumulation of organophosphate in the environment	Adoption of Natural methods
			Usage of strong Antibiotics for treatment of livestock	
			Usage of strong preservatives on agricultural, livestock and fishery products	
		Food fortification		
		Treatment of zoonotic diseases. Joint health and Agriculture surveillance campaigns		Increase surveillance for zoonotic diseases
	Social Services	Gender mainstreaming	Men being neglected in gender mainstreaming	Principle of equity needs to be applied and boy child advocacy conducted
		Adoption of		

Programme	Linked	Cross-sector Linkages		Measures to Harness or
		abandoned children		
		Hospital waivers for needy cases	Loss of revenue to the county	Social services investigating
		Disability mainstreaming within health facilities		Buildings should be user friendly. Provision of sign language and braille.
	Media	Communication for change		Radio and TV talk shows, media briefs, documentaries
		Judiciary Interior and National Coordination	Law enforcement Revenue generation	

CHAPTER FOUR: IMPLEMENTATION MECHANISMS

4.0 Introduction

This chapter provides a detailed discussion on the implementation framework which includes institutions responsible for the actualization of the plan, resource requirement and mobilization.

Critical Success Factors

In order to realize the vision and mission of the office, successful implementation period should be considered relying on several factors among them;

a) Timely disbursement of funds;
b) Building capacities at all levels;
c) Total commitment of staff;
d) Increased development partners support and participation;
e) Expansion of physical infrastructure; and
f) Political and macroeconomic stability.

4.1 Institutional and Coordination Framework

4.1.1 Institutional Arrangement

The institutional arrangement complements the legal framework by improving it and addressing current constraints. The institutions outlined enable the health sector to manage its activities efficiently and to effectively coordinate in fulfilling its mandate.

Table 15: Sector Institutions and their Role

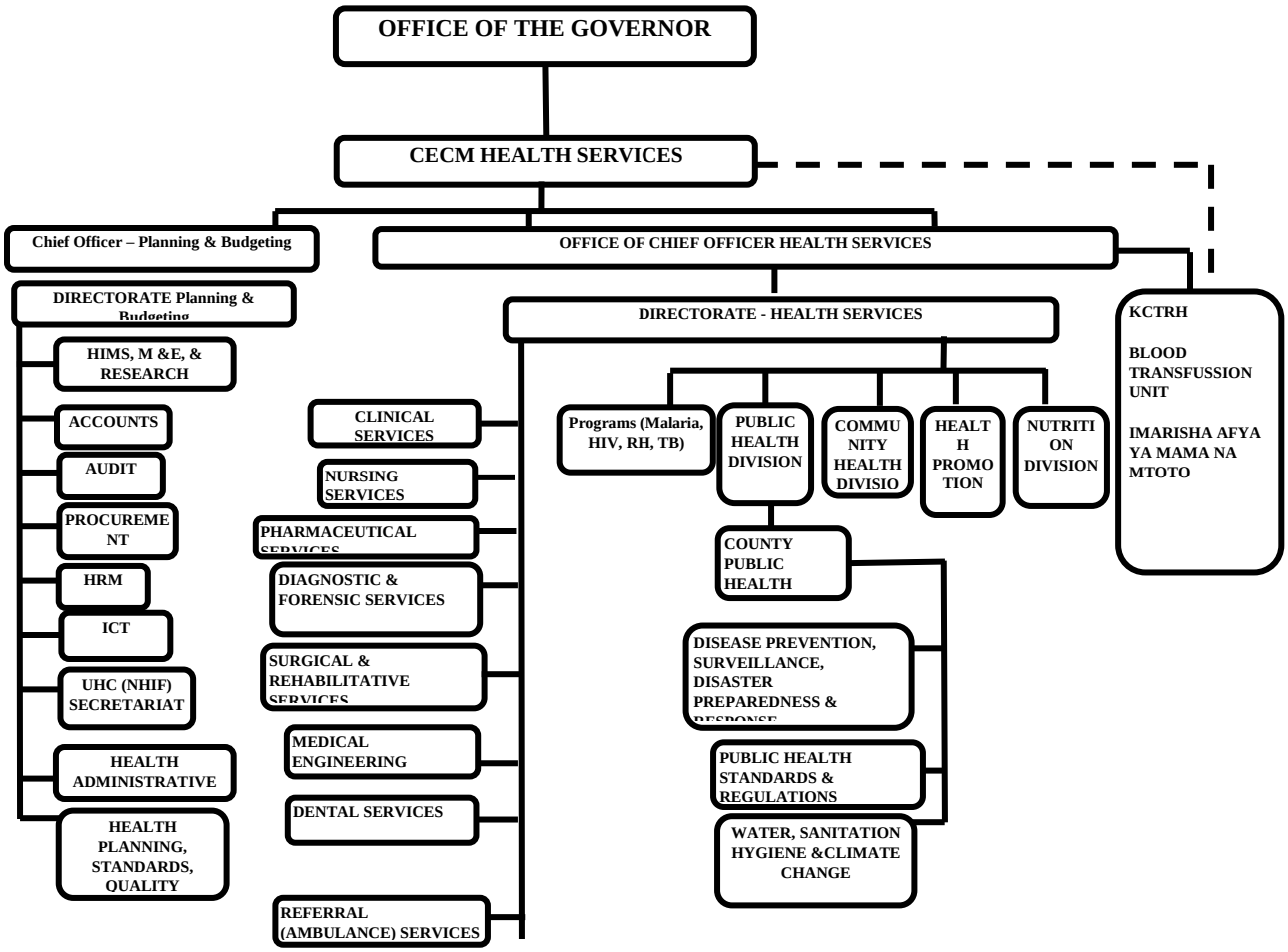
Name of Institution	Role
County Assembly	Legislation, budget allocation and oversight
Ministry of Health (National Government)	Policy formulation, standards and planning
Development Partners	Funding and technical support
County Planning Unit	Preparation of plans and budget
Training institutions	Offer training services
Research institutions	Health research and development
Professional Organizations	Maintaining professional standards, providing welfare

Lake Region Economic Bloc	Developing and implementing plans for the region
KEMSA and MEDS	Provision of medical supplies
Regulatory Boards and Councils	Regulate professional human resource and facilities
Ministry of Education	
Judiciary and Ministry of Interior	Law enforcement and community mobilization
Department of water	Water analysis and testing, springs protection and capacity building.
National public health laboratory and government chemist	Food and water analysis and testing.

4.1.1 Coordination Framework

The Health Sector is mandated with the overall function of providing quality health services for all. This calls for a coherent institutional structure that facilitates delivery of world class services in an efficient manner. The structure of the sector determines hierarchy and provides leadership in the management of the affairs of the county collaboratively to achieve a common vision. All aspects of the sector, from the formation of directorates to the reporting lines, should be clearly designed while keeping the strategic focus in mind. The implementation of this sector plan will be executed by the health sector supported by relevant County and National Government departments/agencies. Such support may include supervision on project implementation, sourcing of goods and services and provide sector policy direction and technical knowledge.

Figure 6: Organization Structure



4.2 Financing Mechanism

This section indicates the total cost of funding the sector plan disaggregated by funding sources. It also indicates the estimated total cost of implementing the specific programmes, as well as the potential financing sources. Further, it highlights the collaboration arrangements between the various agencies within the sector and other implementing agencies. The funding sources include county government budgets, national budgets, Public-Private Partnerships, development partners, private sector, among others.

Table 16: Sector Financing Mechanisms

Sub-sector	Budget (KES Millions)	Source of Funds	
		CGK	Others (Explain)
Medical Services	45,500	CGK	National Government, Development Partners
Public Health	11,550		
Flagship projects	11,900		
Total	**68,950**		

4.3 Capacity Development

This section provides measures to address capacity gaps that may hinder efficient and effective implementation of the initiatives in the sectoral plan. The capacity gaps to be addressed will include those related to: skills and knowledge; systems and processes as well as tools and equipment.

Table 17: Sector Capacity Gaps

Capacity Gap	Measures to address the gap
Inadequate budgetary allocation	Increase domestic and external resource mobilization
Inadequate human resource	Recruitment, promotion and motivation of staff
Inadequate equipment	Provision of equipment Proper maintenance of existing equipment
Delayed and erratic disbursement of funds	Timely disbursement of funds
Inadequate legal framework	Development of policies and guidelines
Slow procurement process	Fast tracking of the procurement process

4.4 Risk Management

The risk analysis highlights key areas that can affect the implementation of the Sector Plan. The contributing factors and mitigating actions form a basis of developing and implementing the broader risk management framework during the plan's period.

Table 18: Risks, Levels, Owners and Mitigation Measures

Risk	Risk Level (High, Moderate, Low)	Risk Owner(s)	Mitigation Measures
Over reliance on Exchequer for budgetary support	High	County Treasury	Widen scope of revenue streams. Strengthen accountability and transparency.
Limited donor pool for additional funding	Moderate	Health Sector	Utilize and coordinate a wider range of lending/financing instruments from development assistance.
Low absorption of funds	Moderate	Health Sector	Optimal use of resources through cost reduction and optimization.
Poor transition management	High	Health Sector	• Strengthen knowledge management • Clear job descriptions for management positions • Strengthen handing/taking over mechanisms • Succession management.
Inadequate skilled personnel in some specialized areas	High		Training Recruitment Promotion
Inadequate IT infrastructure	Moderate	Health Sector	• Prioritize and procure IT systems • Put in place a data security plan

CHAPTER FIVE: MONITORING AND EVALUATION FRAMEWORK

5.1 Monitoring, Evaluation, Reporting and Learning

The chapter outlines the mechanisms that will be used to monitor and evaluate the implementation of the strategic issues raised and reporting of the same. Monitoring and evaluation process highlights areas of the plan which requires reviewing and gives an indication as to whether the plan is achieving its aims and also helps keep the planned activities in check, reduce wastages, allow for remedial measures to be taken and ensure timely implementation.

5.2 M & E Reporting Structures

The Department has progressed in establishing an M&E Unit in line with KHSSIP 2018 - 2023. Important milestones being appointment of the County M&E Coordinator and development of costed M&E Plan. The M&E Unit is mandated with overall oversight of M&E activities in the Department. Functional linkage of the M&E Unit with the County M&E Committee and the M&E Unit in the County Department of Planning will be through the CECM for Health Services.

5.3 Data Sources and Collection Method

Data collection is coordinated by the Health Information System (HIS) Unit. The data collection strategy for the County's routine service statistics (indicators and data elements) at the community and facility levels has already been developed and rolled out through the District Health Information Software (DHIS).

At the household level, data will be collected by the Community Health Volunteers (CHVs)—guided by the household register, which lists all the households in the community unit. The CHV fills in the service delivery data on a community log/diary. This log is presented to a Community Health Extension Workers (CHEW) at the facility to which the Community Unit is attached. The CHEW aggregates all the community logs received into the CHEW summary. For those facilities that have ICT infrastructure and connectivity, the CHEW summary for the facility can be posted on DHIS2 at the facility. While for those without, the CHEW summary is posted on DHIS2 at the Sub-County.

• At the facility level, all public and private facilities will collect routine service delivery data using standard tools and registers. These will then be collated into standardized reporting forms and entered every month in DHIS2. For those facilities that have ICT infrastructure and connectivity, the reports can be posted on DHIS2 at the facility. While for those without, they are posted on DHIS2 at the Sub-County.

5.4 Types of Reports to be Produced and their Frequency and Consumers

Reporting is important as it provides feedback to establish the challenges, successes and weaknesses in the implementation of various projects and programmes, and whether the set objectives have been met or are on course. The Plan will be evaluated annually, after five years and at the end of the plan period. The reports prepared will outline the achievements in comparison to targets, facilitating factors, challenges faced and lessons learnt. The reports will be submitted to the Governor's office for information, use and dissemination to stakeholders including the County Assembly, Development partners, Beneficiaries and the Public. Issues requiring policy interventions will be submitted to the County Executive Committee for action. The reports shall be stored manually in the manual files, also electronically and will be posted on the official County website.

The following reports will be prepared and disseminated;

i) **Annual Review Report (ARR)** – The report will evaluate all the activities undertaken during the year, clearly showing the milestones, challenges and outlining plans for the next year.

ii) **Mid-term Review Report (MTER)** – The report will be undertaken midway in the implementation of the sector plan to assess the extent to which the implementation is meeting plan objectives and timelines.

iii) **End-term Review Report (ERR)** – At the end of the Plan period, there will be an external evaluation carried out by an external evaluator. The task will lead to identification of achievements against performance indicators; constraints encountered

during the plan period and make recommendations towards the development of the next plan.

5.5 Dissemination and Feedback Mechanisms and Citizens Engagement

All the stakeholders will meet routinely to review their data, identify and address data quality issues, and discuss ways in which data had been used in the period preceding the meeting to aid in decision-making. Data and information generated at all levels of the sector and from different sources will be shared, translated and applied for decision-making. The reports will be disseminated to stakeholders including the County Assembly and shared on County digital platforms where citizens will be given an opportunity to provide feedback.

5.6 Mechanism for Reviewing and Updating the Sector Plan

Assessing progress towards Programme results will entail quantitative and qualitative analyses using outcome measures. This will be complemented with brief analyses policies, strategies or programs. Performance monitoring will also assess equity, efficiency, contextual factors, and benchmarks. Equity pertains to differences in results between Sub-Counties based on urbanization, security, income, school enrolment, physical access, and gender. Efficiency relates the level of attainment of the objectives to the inputs used to achieve them.

To effectively monitor the progress of implementation of programmes in the plan and eventually evaluate them, CSP should include a Monitoring and Evaluation Matrix indicating the programmes to be implemented, their envisaged outcomes, mid-term and end-term targets and performance indicators as shown in Table 19.

Table 19: Monitoring and Evaluation Matrix

Programme	Outcome	Key Performance Indicator(s)	Baseline (2022)	Targets	
			Value	Five Year Target (s)	Ten Year Target (s)
bbPromotion of Curative services	Improved infrastructure	% Completion level for KCTRH	50	100	
		No. of health facilities constructed	12	17	23
		No. of health facilities operationalized	4	8	12
		No of stalled health facilities completed	8	15	25
		No. of health facilities upgraded	4	6	10
		No. of health facilities fully equipped	0	20	50
		% of population living within 5 km of a health facility	51.1	65	80
		Bed occupancy rate	62.9	72	85
	Improved referral system	No. of ambulances purchased and equipped	0	6	12
		No. of emergency medical teams trained	0	4	8
		Established referral unit	0	1	
		County referral strategy	0	1	
		No. of blood satellites established	0	2	4
Prevention and Promotive services	Improved immunization services	% of fully immunized children	82.6	85	90
		% of <5 vitamin A supplementation	88	90	95
		% of facilities providing Immunization	63	80	100
	Reduced TB prevalence	% of TB patients completing treatment	89	95	100
		Number of TB cases detected	329	500	700
		Proportion of eligible TB patients screened for MDR	70	85	100
	Reduced malaria transmission and incidences	Malaria testing rate	51.7	80	100
		% of targeted under 1's provided with LLITN's	86	94	100
		% of targeted pregnant women provided with LLITN's	91.4	95	100
		Proportion of pregnant women attending ANC provided with LLITNs	93.7	96	100
		Per capita outpatient utilization rate (M/F)	2.2	3.5	5
	Reduced HIV Incidence rate	Proportion of estimated HIV positive people identified	89	95	95

Programme	Outcome	Key Performance Indicator(s)	Baseline (2022)	Targets	
			Value	Five Year Target (s)	Ten Year Target (s)
		Proportion of identified PLHIV on ART	100	95	95
		Proportion of PLHIV on care who are virally suppressed	93	95	95
		Proportion of exposed infants receiving timely PCR (6 weeks)	96.7	98	100
		MTCT Rate	8.2	<5	<5
		Proportion of estimated eligible population receiving Prevention interventions-PREP	ND	50	95
	Reduced prevalence of NCDs	Number of new outpatients with mental health conditions per 100,000 population	175	228	297
		Number of new outpatients diagnosed with Diabetes per 100,000 population	605	786	1022
		No of new outpatients diagnosed with high blood pressure per 100,000 population	2159	2806	3647
		Cancer incidences	822	790	700
		% of facility-based FSB	8.8	9.2	9.5
	Improved skilled delivery	Infant mortality rate per 1000 live births			
		Under five mortality rate per 1000 live births			
		Maternal mortality rate per 100,000 live births.	59.5	55	50
		% of skilled deliveries	72.6	75	80
		% of first ANC visits	95	98	100
		%of 4th ANC visits	55	60	65
		% of ANC mothers issued with IFAS	85.5	90	95
		Number of ANC mothers referred by CHVs	39.2	45	55
		% of newborns with low birth weight	5.3	5	4.5
		% of WRA screened for cervical cancer	2	8	14
	Improved nutrition	% of infants under 6 months on exclusive breastfeeding	78.9	83	90
		% of under 5's stunted	28	23	17
		% of under 5 underweight	2.1	1.8	1.3
		% of under 5's with diarrhea treated with ORS and Zinc	78.8	83	88

Programme	Outcome	Key Performance Indicator(s)	Baseline (2022)	Targets	
			Value	Five Year Target (s)	Ten Year Target (s)
	Improved family planning uptake	Family Planning uptake.	45	48	50
		% of WRA receiving FP	42	48	55
	Improved sanitation	% of households with latrines	85	90	95
		NTDs prevalence rate			
		% of population with access to treated water	75.9	80	85
		No. of villages declared ODF	766	700	650
		% of school age children dewormed	98	100	100
		MHM guidelines and Strategy	0	1	1
	Strengthened human resource	Increase in doctors (No.) per 10,000 population	0.6	3	6
		Increase in nurses (No.) per 10,000 population	5.75	8	12
	Increased resource base	No. of PPP engagement	1	3	5

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