MOMBASA COUNTY

SECOND HEALTH STRATEGIC AND INVESTMENT PLAN (CHSIP II)

2018 – 2022

A Healthy and Productive Community

Abridged Version

August 2018

Department of Health Services

CONTENTS

ABBREVIATIONS

ALOS	Average Length of Stay
AMR	Adult Mortality Rate
AOP	Annual Operational Plan
ARV	Anti-Retroviral
AWP	Annual Work Plan
BEOC	Basic Emergency Obstetrics Care
CDOH	County Director of Health
CEC	County Executive Committee
CIDP	County Integrated Development Plan
CHMT	County Health Management Team
CHC	Community Health Committee
CHW	Community Health Worker
CU	Community Unit
COC	Code of Conduct
CGH	Coast Regional Hospital (CPGH)
COH	Chief Officer of Health
CPSB	County Public Service Board
DHIS	District Health Information System
DHS	Demographic and Health Survey
EMR	Electronic Medical records
FBOS	Faith-Based Organization
FMCS	Facility Management Committees
GBV	Gender-Based Violence
GFATM	Global Fund for AIDS TB and Malaria
GOK	Government of Kenya
HFC	Health Facility Committee
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management and Information System
HRH	Human Resources for Health
HRIO	Health Records and Information Officer
HSCC	Health Sector Coordinating Committee
HSS	Health System Strengthening
HSSF	Health Sector Service Fund
HW	Health Workforce
ICT	Information Communication Technology
IMR	Infant Mortality Rate
JKP	Jumuiya ya Kaunti za Pwani
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic Health Survey
KEMRI	Kenya Medical Research Institution
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package for Health
KHP	Kenya Health Policy
KHSSIP	Kenya Health Sector Strategic & Investment Plan
KMTC	Kenya Medical Training College
KNBS	Kenya National Bureau of Statistics
MCH/FP	Maternal Child Health/ Family Planning
SDG	Sustainable Development Goal

MIS	Malaria Indicator Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal and New Child Health
MOH	Ministry of Health
MTC	Medicines and Therapeutics Committee
MTEF	Medium Term Expenditure Framework
MTP	Medium Term Plan
MTPP	Medium Term Procurement Plan
NACC	National AIDS Coordinating Council
NCDS	Non-Communicable Diseases
NGOS	Non- Governmental organization
NHIF	National Hospital Insurance Fund
NTDS	Neglected Tropical Diseases
OJT	On-the-Job Training
OPD	Out Patient Department
PHO	Public Health Officer
PMTCT	Prevention of Mother to Child Transmission
PPP	Public-Private Partnership
RH	Reproductive Health Services
SCHMT	Sub County Health Management Team
SWOT	Strengths Weaknesses Opportunities and Threats Analysis
TB	Tuberculosis
TWG	Technical Working Group
U5MR	Under 5 Mortality Rate
WB	World Bank
WHO	World Health Organization

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Foreword

The mandate of the Health Services department is to coordinate and provide services that promote and protect the health of those who live, work, and play in Mombasa County. The *Second County Health Sector Strategic and Investment Plan* for 2018-22 will guide our strategic efforts in carrying out this role. The plan provides a vision and a roadmap for how we will strive to improve health in Mombasa County.

The strategic plan has been developed through consultations with county leadership, partners in health, and our staff at county, sub-county and facility level. Our new strategy has been informed by lessons learned in implementing the first generation of strategic plan under the devolved system. The strategy has been aligned to the second County Integrated Development Plan (CIDP) 2018-2022, national and global health aspirations. Implementation of the County-specific strategic priorities outlined in this strategic plan will translate into better health outcomes for the people of Mombasa and its environs.

We remain committed to achieving our vision of **"a leading County with healthy and productive community"** which will be delivered through three strategic pillars that focus on preventive and promotive health; curative and rehabilitative health, and enabler pillar. This plan highlights some of the great work that is already happening through our various programs, including some of our more recent quality improvement efforts. It also outlines some exciting new activities that we will undertake to expand upon our successes in optimizing the health of all.

The County government is committed to improving access to quality health services in the County. The achievement of our strategic plan will require that we are responsive to the health needs and expectations of our citizens, partners, and staff. We will, therefore, embrace partnerships with state and non-state actors to enable us to deliver our vision. I, therefore, urge all health stakeholders to commit resources and time into achieving these goals by participating in the implementation of the new strategic plan.

Finally, I would like to express my gratitude to all parties that provided valuable input and time into the development of the second Mombasa County Health Strategic and Investment Plan (CHSIP II).

Hon. Hazel Koitaba

County Executive for Health
Mombasa County

Acknowledgment

The Department of Health and its partners strive to provide better health outcomes for all Mombasa residents through continuous improvement and innovation, to deliver the greatest health benefit with the available resources. During the strategic planning process, the departments and its partners collaborated to identify opportunities for aligning our efforts with those in the community to maximize the use of resources to optimize health in Mombasa County. We continue to be proud of the important work of our dedicated staff. We hope that this plan can serve as a living document that energizes us in working toward our vision of "a leading County with a healthy and productive community."

The development of this plan involved stakeholders at all levels through a consultative phased process. We would, first and foremost, like to thank the Governor and his office, the County Assembly Committee on Health, and the County Government in general, non-state actors including donors, private sector among others for their commitment and support.
We also wish to recognize the commitment and active participation, in the development and review of the plan, by the County Health Management Team (CHMT), sub-county teams, and representatives from Coast Provincial General Hospital, Port Reiz, Tudor and Likoni hospitals as well as select key partners working within the county.

Lastly, we would like to acknowledge USAID Afya Pwani Project leadership for their support, the Lead Consultant among numerous other development partners and community members, for their technical input and support in the development of this plan.

Thank you.

Dr. Khadija Sood Shikely
Chief Officer – Medical Services
Mombasa County

Ms Aisha Abubakar
Chief Office - Public Health
Mombasa County

Executive Summary

The second Mombasa County Health Sector Strategic and Investment Plan (CHSIP II) for 2018-2022 will guide the department's strategic directions and priorities over the coming five years. It highlights key areas where DoHS seeks to make significant improvements in the delivery of health services to residents of Mombasa County. The priorities under each programme area have been set within the context of emerging challenges and opportunities presented by a devolved health system. The plan emphasizes on improving the county's response to prevailing disease burden and maintaining a focus on vulnerable populations and highlights key areas where to plan the investments for optimal impact in the coming five years. The key strategic objectives and outcomes have been aligned to the Kenya health policy 2014-2030 objectives and policy orientations which provide the policy framework to progress towards attainment of vision 2030 goal for the health sector and universal health coverage. The strategic plan is anchored on the six policy objectives seeking to eliminate communicable diseases, halt and reverse burden of non-communicable diseases, reduce the burden of violence and injuries, provide essential health care, minimize the exposure to health risk factors and strengthen collaboration with other sector actors. In addition, the plan has also been aligned to aspirations of the second Mombasa County Integrated Development Plan (CIDP) 2018-2022, health sector MTP III and Sustainable Development Goal (SDG 3). Specifically, the department will focus on the key outcomes captioned below aimed at mitigating identified challenges.

The plan aims to increase:

a) Immunization coverage from 83% to 95%
b) Eligible HIV clients on ARVs from 71% to 90%
c) Increase the HIV+ pregnant mothers on preventive ARV from 64% to 90%
d) Deliveries conducted by skilled attendants from 70% to 75%
e) Women screened for cervical cancer from 1.2 to 20%
f) Women receiving family planning from 39% to 54%

The plan also targets to:

g) Reduce the burden of drugs and substance abuse from 51% to 25%
h) Reduce facility-based maternal mortality rate from 195 to 64
i) Reduce facility-based under-five deaths from 3.2% to 1.5%

The department has reviewed its organization structure and will invest in building the capabilities of its leadership and governance functions, improve health infrastructure, human resources for health, streamline procurement, storage, distribution and rational use of health products and technologies, and invest in domestic resource mobilization and effective use of available financial resources.

The total county resource requirement estimates for the strategic period 2018-2022 is **Kshs. 16.8 billion**, an average of approximately **Kshs 3.4 billion** per year over the next five years. To achieve the department's aspirations, DoHS will work with other county government departments and entities; donors, private sector and other non-state actors implementing health programmes in Mombasa County.

Dr. Shem Patta
County Director of Health
Mombasa County

1 COUNTY INSTITUTIONAL REVIEW

1.1 About Mombasa County

Mombasa County is in the South-Eastern part of the Coastal region of Kenya. It covers an area of 229.9 Km² excluding 65 Km² of water mass which is 200 nautical miles inside the Indian Ocean. It borders Kilifi County to the North, Kwale County to the South West and the Indian Ocean to the East. The County lies between latitudes 30 56' and 40 10' South of the Equator and between longitudes 390 34'and 390 46'east of Greenwich Meridian. The County also enjoys proximity to an expansive water mass as it borders the Exclusive Economic Zone of the Indian Ocean to the East. The total population of the county in 2009 was 939,370 persons of whom 486,924 were male and 452,446 were female. The total population is projected to be 1,266,358 persons in 0032018 and will rise to 1,433,689 persons by 2022. 47 percent of the county's population in 2018 comprised of youth between age 15 and 35 years. The high population densities concentrated in Mvita, Changamwe and Nyali are attributed to proximity to vital infrastructures such as roads, water, electricity, and employment opportunities due to the presence of industries like the Export Processing Zones and other physical facilities such as the Mombasa Port and the Moi International Airport, Mombasa. Kisauni (1,829 persons/Km2), Jomvu (3,537 persons/Km2) and Likoni (4,039 persons/Km2) are the least densely populated sub-counties in the county. [1]

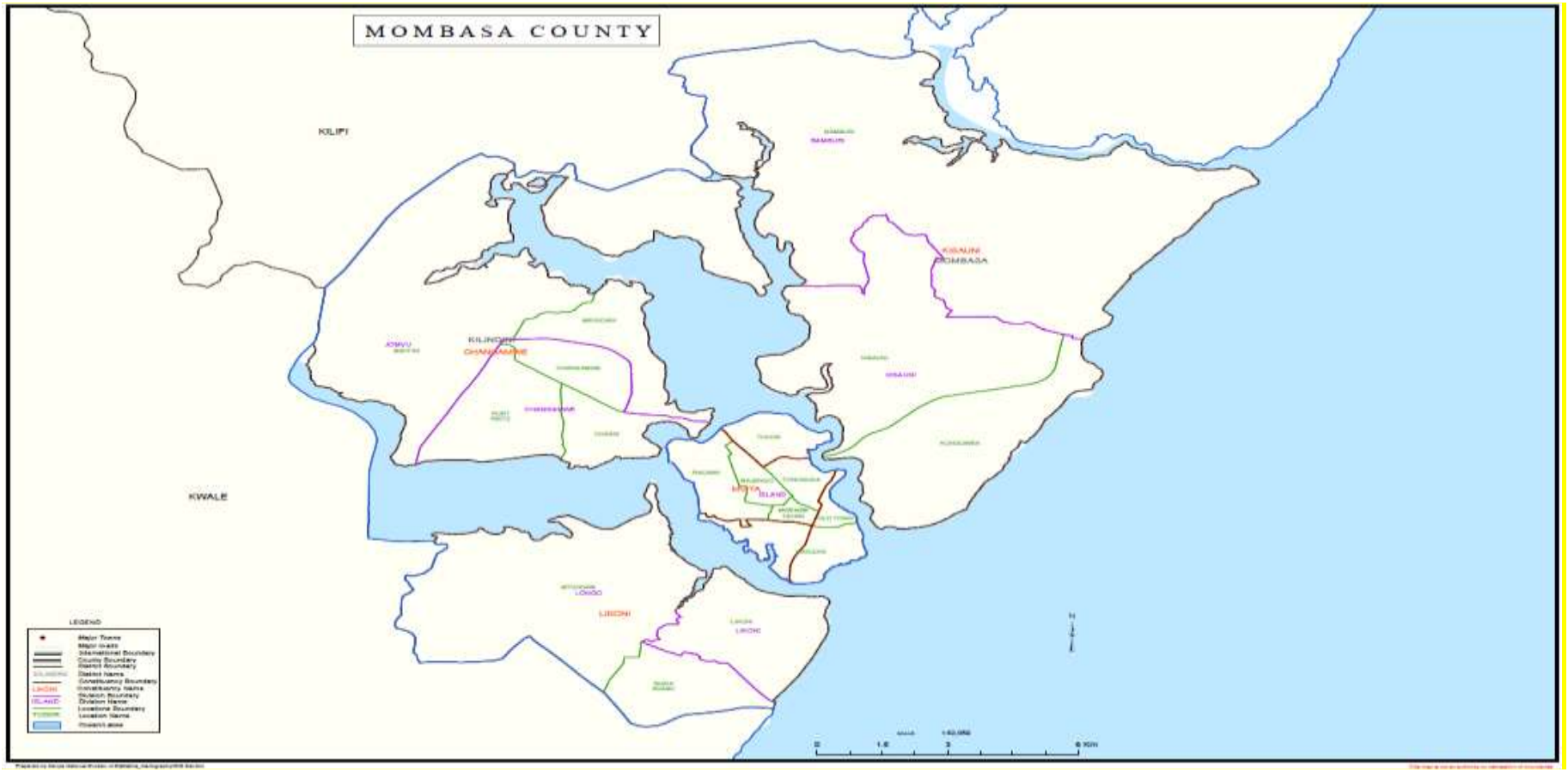
Administratively, the County is divided into six sub-counties namely: Mvita, Nyali, Changamwe, Jomvu, Kisauni, and Likoni and thirty county assembly wards. These are further sub-divided into thirty locations and fifty-seven sub-locations as shown in Table 1 and map showing county administrative/political units below.

Table 1: Administrative Units by Sub-County, 2017

Sub-County	Divisions	Wards	Sub-Locations	Villages
Changamwe	1	4	10	58
Jomvu	1	3	7	65
Kisauni	3	6	9	200
Nyali	2	4	8	55
Likoni	2	6	9	145
Mvita	1	7	14	134
Total	**10**	**30**	**57**	**657**

Source: Second CIDP 2018-2022

[1] **Source**: Second CIDP 2018-2022



Source: Kenya National Bureau of Statistics, 2010
Figure 1: Map showing County Administrative Units

1.2 Population Demographics

According to the 2009 census, Mombasa County had a population of 939,370 persons of which 486,391 and 452,109 were male and female respectively. Using County population growth rate of 3.5% per annum, the population of Mombasa County was projected to be 1,135,933 persons by 2014 and 1,322,408 persons by 2018. This is without the inclusion of local and international tourists and unexpected influx. Kisauni constituency has the highest population representing 20.7% of the county population. More than one-third of the population is under 15 years old. Table 2 below shows Mombasa county population trends and projections by constituencies from 2017 up to the year 2022 based on the 2009 population census. Table 3 below shows the county's population by cohort and key population indicators.

Table 2: Population by Cohorts & Key population indicators

#	Description	Pop estimates	Target population			
			2018	2019	2020	2022
1	**Total population**		**1,266,358**	**1,307,942**	**1,347,440**	**1,433,689**
2	Children under 1 year (12 months)	3.10%	39,257	40,546	41,771	44,444
3	Children under 5 years (60 months)	16.20%	160,481	211,887	171,125	182,079
4	Under 15 years population	38.50%	399,972	503,558	425,791	453,046
5	Women of child bearing age (15 – 49)	24.60%	373,548	321,754	397,495	422,938
6	Estimated Number of Pregnant Women	3.70%	46,855	48,394	49,855	53,046
7	Estimated Number of Deliveries	3.70%	46,855	48,394	49,855	53,046
8	Estimated Live Births	3.70%	46,855	43,394	49,855	53,046
9	Total number of Adolescent (15-24)	24.70%	271,076	323,062	328,775	349,820
10	Adults (25-59)	32.80%	561,540	429,005	596,916	635,124
11	Elderly (60+)	4.10%	33,769	53,626	36,381	38,710

Source: DHIS, KNBS

The population cohorts have been adopted nationally for purposes of estimating requirements for health services delivery in line with the Kenya Essential Package for Health (KEPH). For example, the population under 15 years of age (children) constitutes the largest population proportion at 38.5% while pregnant women constitute 3.70% of the population. Each population cohort has its unique health services needs and requirements that this strategic plan has taken into consideration.

1.3 County Health Sector

The Mombasa county health delivery system is organized into 4 tiers of care as per the norms and standards. These tiers include community, primary care, primary referral, and secondary referral. The community services focus on demand creation for the services, while the primary care and referral services focus on responding to the demand.

The county hosts the Coast Level Five Hospital which is a referral facility serving the entire coast region. Level four (4) public hospitals include the Port Reitz, Tudor, Likoni and the Kenya Navy. There are 11 health centres and 26 public dispensaries. These are further

complemented by other notable private hospitals which include the Aga Khan Hospital, the Mombasa Hospital, and Pandya Memorial Hospital, Nursing homes and private health clinics.

The prevalence of the three major communicable diseases in Mombasa County stands at 4.1% for HIV/AIDs, 700/100,000 for TB and 8% for malaria. There is an increase in non-communicable diseases (NCDs) such as hypertension and cervical cancer, drug and substance abuse. Although no comprehensive data exists; Cancer and cardiovascular diseases are emerging as the leading causes of mortality and morbidity. This has resulted in a big disease burden in the County. The facility based Maternal mortality rate as at 2017 stood at 195/100,000 live births, under-five mortality 32.3/1,000 and Infant mortality rate 57/1,000; all of them below the national average. Drug and substance abuse is a high burden in the county, with three functional drug rehabilitative centers in the County serving over 600 clients. Despite apparent political goodwill and development partner support, there is still inadequate funding for the health department. The end-term review of CHSIP 2014-2018 revealed that there is inadequate access to quality services due to inadequate health infrastructure and equipment, shortage of qualified and motivated staff, inadequate supply and distribution of health products, quality of health information as well as limited capacity and resources among health workers to handle the county's health system challenges.

1.4 Purpose of the Second County Health Sector Strategic and Investment Plan (CHSIP II) 2018-2022

The health sector's overall goal is to attain the highest possible standards of health to all in line with the constitution of Kenya and Vision 2030. The constitution provides the overarching legal framework to ensure the comprehensive right based approach to health delivery. One of the goals of vision 2030 is to improve the overall health outcomes and indicators of Kenyans by shifting focus from curative healthcare to preventive and promotive health care. The second Mombasa County Health Sector Strategic and Investment Plan (CHSIP II) for 2018-2022 will guide the department's strategic directions and priorities over the coming five years. It highlights key areas where DoHS sought to make significant improvements in the delivery of health services to residents of Mombasa County. The priorities under each programme area have been set within the context of emerging challenges and opportunities presented by a devolved health system. The plan emphasizes on improving the county's response to prevailing disease burden and maintaining a focus on vulnerable populations and highlights key areas where we plan to invest and realize significant impact in the coming five years.

The strategic plan's key strategic objectives and outcomes have been aligned to the Kenya health policy 2014-2030 objectives and policy orientations which provide the policy framework to progress towards attainment of vision 2030 goal for the health sector and universal health coverage. The strategic plan is anchored on the six policy objectives seeking to eliminate communicable diseases, halt and reverse burden of non-communicable diseases, reduce the burden of violence and injuries, provide essential health care, minimize the exposure to health risk factors and strengthen collaboration with other sector actors. In addition, the plan has also been aligned to aspirations of the second Mombasa County Integrated Development Plan (CIDP) 2018-2022, Mombasa Vision 2035, Jumuiya Ya Kaunti Za Pwani (JKP). health sector MTP III, Sustainable Development Goal (SDG 3) as well as

other county sectoral plans. Specifically, the department will focus on the key outcomes captioned below aimed at mitigating identified challenges.

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1.5 County Performance Management Framework

In 2017, the Council of Governors (COG) rolled out County Performance Management Framework (CPMF). The framework aims at guiding counties on how to effectively measure the impact and outcomes of county investment in projects and programmes by institutionalizing performance management tools such as M&E, PC, strategic planning, PAS, and RRI. This will help managers make course correction decisions when development objectives are not achieved and manage for results. Successful achievement of development objectives of the CIDP contributes towards the achievement of the objectives of the 10-Year spatial and sector plans and subsequently the achievement of the aspirations of Vision 2030[2]. CHSIP II is aligned to the CPMF. Figure 1 below schematizes the County Performance Management Framework.

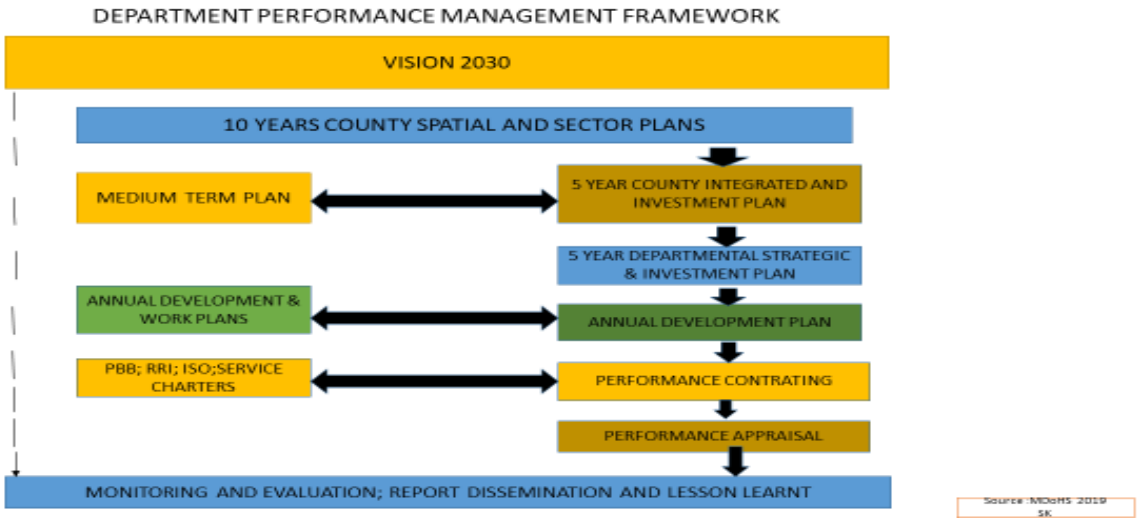

Figure 2: Performance Management Framework for County Governments

[2] Source: County Performance Management Framework, 2017

1.6 The Planning Process

The strategic planning process was conducted within the county health planning framework. The CHSIP process was launched in early April 2018 by the county leadership. The appointed Task Team constituted technical teams/work streams with representatives from facility, sub-county and county levels who were tasked with the responsibility of conducting an end-term performance review of CHSIP 2013/14-2017/18 and technical input at all stages of the planning process. This draft was generated through a three-day planning process that brought together key internal stakeholders drawn from CHMT, SCHMT, and representatives from different tiers of the county health system. This first draft plan will be refined further by technical peer reviewers, led by the County Director of Health. The draft was subjected to review before circulation to key health stakeholders including development partners for final input prior to stakeholder validation workshop.

The final draft was shared with the County Assembly (CA) committee on Health for their inputs before being presented to the County Cabinet by the County Executive for Health. Finally, the new strategic plan was tabled at the County Assembly for approved and later launched by the Governor. The diagram below illustrates the eight (8) key steps followed to develop, validate, approve and adopt the new strategic plan

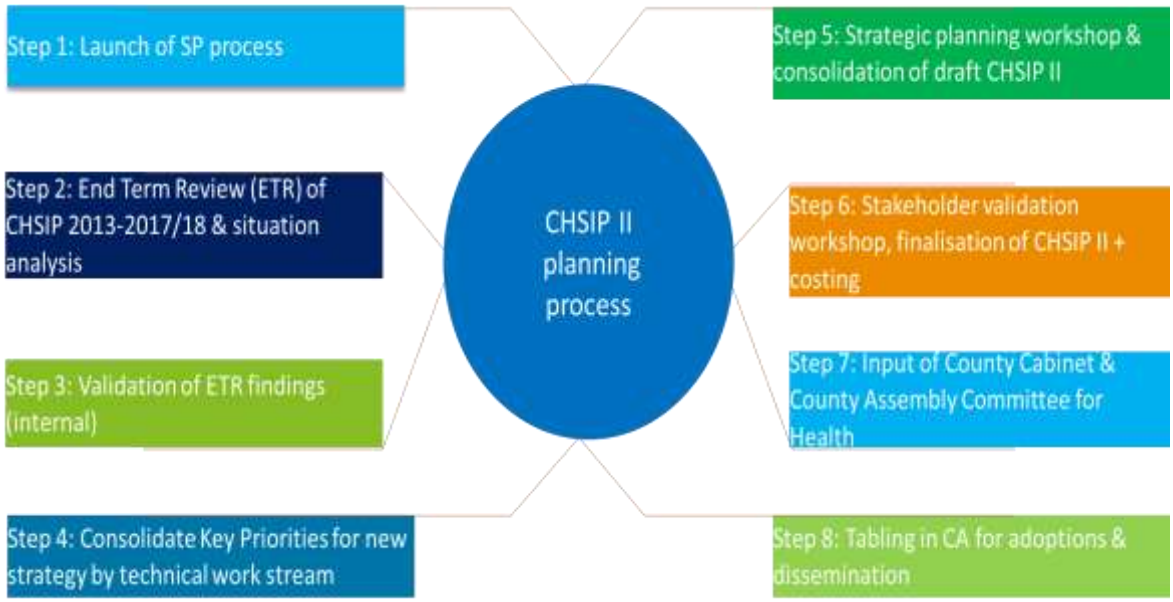

Figure 3: Strategic planning process

1.7 Mission, Vision and Values

Mission	Vision
To provide the highest attainable standards of quality, responsive and comprehensive health care services to all citizens through innovative, efficient and effective health systems	A leading County with a healthy and productive community

Figure 4: Core Value

2 SITUATION ANALYSIS

2.1 Summary of County Health Sector Performance 2013/14 – 2017/18

Over the last five years the sector has achieved considerable outcomes including but not limited to a reduction of Under-Five Mortality (U5MR) from 65 per 1,000 live births in 2013/14 to 33 per 1,000 live births in 2017/18 and Infant Mortality rate from 36 per 1000 live births to 11 per 1000 live births in the same period. The reduction of infant and child mortality rates is attributed to intensified immunization activities including mass campaigns, early detection and case management of Malaria as well as proper use of Long Lasting Insecticidal Mosquito nets to avert malaria incidences. Provision of LLITN's targeting pregnant women increased from 60% to 69%. Additionally, the increase in health facility deliveries, the proportions of assisted births by skilled health providers during delivery and post-natal care are also cited as factors that lowered both neonatal mortality and Child Mortality.

The End-Term Review (ETR) of Mombasa County's first Health Sector Strategic and Investment Plan 2013 – 2017 aimed at assessing progress in the achievement of targets, build on the gains from the current strategic plan to inform the development of the second departmental strategy for 2018 – 2022. The review focused on strategic priorities for CHSIP 2013-2017 and health investments (county health systems building blocks). The health priorities and investments for 2013-2017 implementation period aimed at overcoming health challenges in the county and the investments were expected ***to increase*** health services such as, Immunization coverage from 83% to 95%, eligible HIV clients on ARVs from 65% to 80%, increase the HIV+ pregnant mothers on preventive ARV from 54% to 100%**,** deliveries conducted by skilled attendants from 61% to 86%**,** women screened for cervical cancer from 10% to 55%, and increase women receiving family planning from 49% to 74%. Additionally, the county purposed ***to reduce*** facility-based maternal deaths from 249 to 64 and facility-based under-five deaths from 6.5% to 1.5%.

Maternal mortality reduced from as a high of 488/100,000 to 195/100,000. In the period under review, contraceptive prevalence increased from 45% to 55% while HIV and AIDS prevalence reduced from a high of 11%, 7.5% to 4.1% in 2018. National Health Insurance Fund Coverage increased from 25% to 31.8%. However, the proportion of fully immunized children according to DHIS2 data went down from 82% in 2013 to an average of 78% in 2017. This drop was attributed to persistent health workers industrial unrest and a shortage of frontline health workers (HWs). The graph below depicts the performance of key health service outcomes and indicators. The degree of achievement on each target has been averaged over a period of five years.

2.2 Situation Analysis

2.2.1 Major Causes of Morbidity and Mortality

Although no comprehensive data exists; cancer, diabetes and cardiovascular diseases are emerging as the leading causes of mortality and morbidity. Sedentary lifestyles of smoking and alcohol consumption influenced mostly by tourism continues to be a major risk factor contributing to the prevalence of these diseases. The prevalence of the three major communicable diseases in the county stands at 4.1% for HIV/AIDs, 700/100,000 for TB and 8% for malaria. Poor hygiene, overcrowding, poor waste disposal and environmental pollution have also led to increased incidences of diarrheal and respiratory diseases, contributing to the breeding of vectors and infectious micro-organisms. This has, in turn, led to the sporadic outbreak of communicable diseases.

Non-communicable diseases (NCDs): There is also an increase in non-communicable diseases (NCDs) such as hypertension, oncology cases, drug and substance abuse. Drug and substance abuse is high with only three functional drug rehabilitative centers and eight outpatient detoxification centers in the county serving over 600 clients. The burden of violence and injuries associated with risky cultural practices and beliefs is high as indicated by 0.7% for under 5 and 0.6% for over 5 years for road accidents and 277 for under 5 years and 1,877 for over 5 years for domestic violence cases especially in the population under 18yrs and women of all ages. This keeps the burden of injuries and violence high and puts massive pressure on the county health system and resources. The stigma associated with gender based violence (GBV) and culture prohibits reporting to relevant authorities for relevant actions to be taken. In response, the county government has just completed three level 4 facilities and three new community units to improve the quality of healthcare. Awareness campaigns have been mooted as the strategy for promoting proper social behavior.

Community Units: There are currently 44 community units (CHUs) cover approximately 17.3 % of the county opposed to the standard requirement of 254. This represents 82.7% gap in CHUs coverage and a very significant lag in community outreach services. Therefore, there is a need to significantly increase the number of CHUs that are equitably distributed across the county. With an extensive community outreach system and strategy, it will be possible to create the much needed wider and deeper awareness in the community through Community Health Units by CHVs on the risk factors associated with the key conditions causing morbidity and mortality in the county and to support positive behavior change through community health dialogues, health education at different forums at community and facility levels, schools and colleges on topics such as healthy lifestyle, risk factors, risky behaviour and cultural practices that put the community at risk of ill health as well as conducting outreaches for screening.

2.2.2 Service Delivery

The county rolled out several service delivery initiatives to improve the provision of essential services. These initiatives included community services, outreach services, supportive supervision, emergency preparedness planning, patient safety initiatives, and clinical audits, on the job training, referral health services among others. Although a large set of milestones were not achieved, the county excelled in supportive supervision to facilities by SCHMT, maternal deaths audit, dissemination of referral services management guidelines and medicines and therapeutic review meeting. Interventions at the community level were low due to the number of functional CUs. Other challenges cited include inadequate funding, industrial unrest, erratic disbursement of funds and weak support supervision mechanisms. One of the notable achievements on HIV/AIDS prevention, the DoHS initiated HTC services at Huduma center

2.2.3 Health Infrastructure

The required health facility per population ratios are 20 hospitals, 480 primary care and 210 community units against the current establishment of 16 hospitals, 343 primary care and 44 community units. The county has a total of 206 functional facilities excluding CUs. Out of the total number, over 80% are privately owned facilities. Majority of the private/NGO facilities are medical clinics. The number of established community units (CUs) is only 42, well below the recommended number of 210. There is an overall, public facilities coverage/10,000 person

of 70% as compared to private facilities coverage of 226%. This carries the implications of a need for an additional 30% coverage whilst also regulating the private/NGO facilities to ensure they provide balanced access and quality services. There is, for instance, an oversupply of the private medical clinics across the county in 4 out of 6 sub-counties especially in Mvita with medical clinics coverage/10,000 persons of 339% and Kisauni medical coverage of 247%.
This imbalance is particularly in the distribution of tier 2 (specialized public medical clinics) and tier 4 (sub-county referral hospitals). There is only one public specialized clinic located in Changamwe with no referral hospitals in Nyali, Kisauni and Jomvu. Mvita and Likoni have 2 referral hospitals each. Even though the number of community units (CUs) across all sub-counties is low, there is an almost equal distribution with each sub-county currently having between 5 to 7 CUs. However, it was observed that most of the facilities do not meet the required minimum standards for the provision of services especially specialized clinics, emergencies, life support, operative surgical cases and other critical services.
To achieve the goal of increasing service delivery points equitably, there is a need for at least one hospital in each sub-county and health centers and dispensaries in areas currently not served or underserved with priority being given to populous areas like Jomvu, Mlaleo and Kisauni. The graph below shows the number of functional health facilities, both public and public, in tiers two to five excluding community units.

2.2.4 Health Workforce

The County continues to experience shortage of health workers across all cadres hindering the delivery of health care at all levels. As at May 2018, the county had a total of 1,677 or 37% staff against projected compliment of 4,483. This means that overall; the county department for health is understaffed by about 63%. This implies that there were minimal efforts to increase staffing of critical cadres. Another key challenge deduced from ETR HRH analysis is an unequal distribution of available staff. About 41% of HWs are deployed at Coast referral hospital also known as CGH while 17%, 9% and 19% of staff are deployed at level 4, 3 and 2 respectively. The total number of staff executing administration role is 233 representing 14% of the total headcount. Figure 5 below shows the distribution of HWs by the level of care.
A further analysis of workload per staff per month on selected level 4 and CGH shows a grieving trend. CGH's workload per staff is estimated at 22 while that of Likoni District hospital, Tudor District hospital, and Port Reitz sub-county hospital is estimated to be 192, 121 and 75 respectively. The workload in some health centers is as high as 562. The department should prioritize re-deploying staff from CGH to address the workload at level 2-4 as it plans to hire additional staff. The development of the new County HRH plan 2018-2022 should be informed by in-depth health workforce analytics, lessons learned over the last five years and best human resource (HR) practices to ensure that the county adopts a high impact HRH model that will maximize on available HWs.

2.2.5 Health Information and Research

Over the past five years, there has been an improvement in quality and accuracy of information generated and use. However, there is a need to strengthen data demand and use at the facility level to improve quality of data and decision making.
The county depends on the sub-county and facility health records and information management staff to record, analyze, report on health services using the national HMIS tools and guidelines and to submit health information in the DHIS. At facility level, there are 15 (20.7%) qualified Health Records and Information Officers against the ideal requirement of 92. Equally, the department has adapted the HIS policy and guidelines. Funding for Health

Information M&E activities is limited and there is often erratic development, dissemination of HMIS tools that also impacts on the number of health indicators being captured.

2.2.6 Health Products and Technologies

The administration and management of health products and technologies (HPTs) include selection of HPT based on affordability, acceptability, and availability, stock taking of facility HPTs, quantification based on workload, ordering, procurement, warehousing, distribution, reporting on the use and restocking. Currently, the County conducts an annual Forecasting and Quantification to enable it to estimate its annual commodities and financial requirement. There also exists a functional County Commodity Security Technical Working Group (CSTWG) which meets on a quarterly basis. Procurement of commodities for level II and III facilities is done through the County upon quantification by the individual facilities while procurement for level IV and V facilities is done directly by the facilities through KEMSA.

KEMSA remains the primary source for health products, because of competitive prices, extensive distribution system and quality of the products; but alternate sources can be utilized when a commodity is not available at KEMSA. Redistribution of commodities is carried out between facilities within the County when necessary. Commodity data review meetings are held on a quarterly basis to monitor the quality of commodity reports. County reporting rates for program commodities remain above 80%. Low fill rates by KEMSA affect the availability of commodities at facilities while price and poor distribution system by local suppliers constrain the same. An above 90% fill rate by KEMSA is required to have a fully functioning supply chain. Existing gaps in commodity management and security have to be strengthened as the priority by ring-fencing funds and building capacity of staff targeting order processing, forecasting, inventory management, stores management, reporting and use.

2.2.7 Health Financing

Allocations to health department constituted on average 23% of total county budget allocation over the past years. The department's total health expenditure was Kshs. 6,973,899,702 billion for a period of 4 years, FY 2013/14 to FY 2016/17. Of this, the recurrent expenditure accounted for 83%. Most of the recurrent expenditure was compensation to employees compared to the recommended 50-60% by the 2014 Kenya Senate Bill while development expenditure only accounted for 17% of the department's expenditure. Further, it was observed that the health budget needs are not met across all facilities. Amounts received and collected from all possible sources (revenue) do not adequately meet the outstanding financial obligations (expenditure). This can be attributed to diminishing national government direct allocation to health facilities without a replacement by county government allocations.

The department's budget is usually funded from four main sources namely, allocation from national shareable revenue, conditional grants from the National Government, external grants and loans; and local revenue mainly user fees from county public hospitals. The national shareable revenue constitutes the highest share at approximately 69% while conditional grants, local revenue, and external grants and loans share 25%, 4.4% and 1.3% respectively. [3]

2.2.8 Leadership and Governance

The county leadership and governance team is responsible for ensuring that the department for health is adequately guided, led, managed and governed for effective and efficient delivery of quality health services. The county executive leadership is in the process of reviewing the current organization structure for the department to re-define the relationship between the

[3] Source: Public Expenditure Review for Health, Mombasa County FY2016/17

executive, CHMT, SCHMTs, HMTS, facilities, and stakeholders in the sector and community. Even though the CHSF (county Health sector forums) has been constituted, it has not been very active. Plans are underway to nominate board members for the three sub-county hospitals and facility management committees.

County policies, guidelines, and procedures exist with the need to adopt more from the national government. This is an ongoing process with old laws being reviewed and customized in readiness for adoption. One of the key priorities is the development of and assent to the hospital boards and facility management committees to provide strong leadership and governance to hospitals and facilities. A good number of health leaders and managers in the county have also been trained in leadership, management and governance courses including Senior Management, Leadership Development Program, Health Systems Strengthening, Strategic Leadership Development Program and LEHHO. However, there has been a challenge with stakeholders' engagement and there is need to ensure greater focus and effectiveness in resource mobilization. As proposed in the 2013-2018 strategic plan, there is still need for a county resource mobilization team with clear terms of reference and performance targets to be constituted to support resource mobilization efforts.

3 SECTOR STRATEGY PILLARS, STRATEGIC OBJECTIVES, OUTCOMES AND KEY PERFORMANCE INDICATORS

3.1 Strategy Pillars

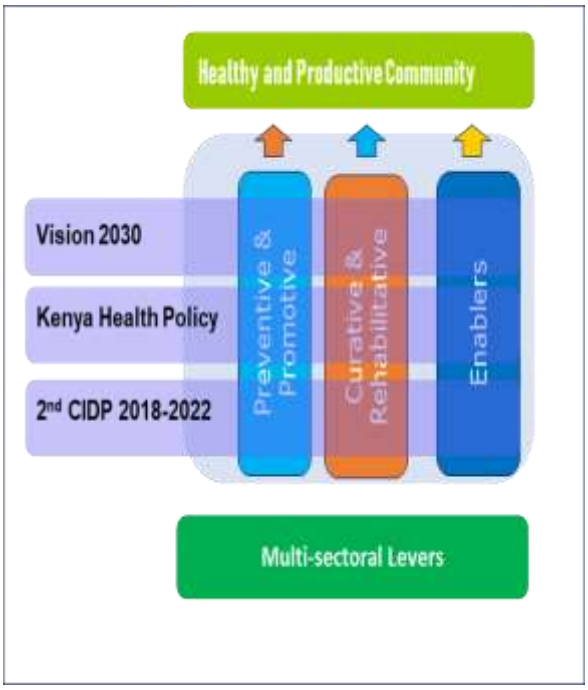

Figure 5: *Strategic Pillars*

To improve operational efficiency and effectiveness of service delivery, the department of health services (DoHS) has adopted a programme-based approach with clearly defined strategic pillars, objectives, outcomes and key performance indicators.

The department will implement health solutions under three key pillars namely **Preventive & Promotive; Curative & Rehabilitative,** and **Enablers** pillars**.** The focus on strategic pillars will guide the county health sector's response to disease both acute (emergency) threats and chronic (ongoing), promote health and address health systems challenges at county and sub-county levels. The pillars have been aligned to the country's Vision 2030, Kenya's Health Policy, the County Integrated Development Plan (CIDP) and Sustainable Development Goals (SDG 3).

3.2 Overview of Strategy Pillars

The strategic pillars seek to deliver three key outcomes under each programme area. These include improved healthy community outcomes, reduced morbidity and mortality, and provision of high-quality service delivery in an informed, supportive and conducive environment. Below is a highlight of the three pillars.

3.2.1 Pillar 1: Preventive and Promotive Services

The pillar aims to minimize the burden of diseases and associated risk factors through the implementation of responsive strategies. Quality of social, behavioral and environmental factors significantly contributes to the health status of both individual and populations. Interventions on preventive and promotive health will focus on disease prevention practices and promotion of healthy behavioral practices that keep people healthy and empower individuals and communities to engage in healthy behaviors. The investment under this pillar is expected to improve healthy community outcomes.

Table 14: Preventive and Promotive services key outcomes and indicators

n and incidences of preventable diseases and associated mortality

comes

	Key Performance Indicator	Baseline (2018)	End-Term Target (2022)
	• % of adult population with BMI over 25	45%	40%
	• No. of women screened for cervical cancer	4421	7120
	• No. of new outpatients with high blood pressure	22,365	26708
	• % salt brands adequately iodized	90%	100%
nce abuse in	• No. of clients successfully complete rehabilitation	600	900
	• No. of functional MAT centers	1	4
	• No. of clients ever enrolled on methadone	820	3500
	• No. of functional rehabilitation facilities	3	4
e conditions	• Percentage of Fully Immunized Children	85%	90%
HIV response	• At least 50% of HIV budget financed by the county	0.4%	5%
ention	• Rate of HIV and AIDS prevalence	7.4%	6%
	•	82%	90%
	• % of HIV positive clients receiving treatment	90.9%	100%
	• % of patients on ARV virally suppressed		
	• % school age children dewormed	87%	100%
	• A	75%	80%
	• Number of schools with wash activities	91%	100%
	• No. of epidemics reported and responded to appropriately e.g. cholera, chikungunya and Dengue fever	2 Episodes	0 Episodes
	• Non-polio AFP rate 4/100,000 of <15 years population	2.4	5
orne diseases	• No. of households accessing treated water	156847	200183
	• Number of households with functional latrines	243671	359810
	• Number of food handlers medically examined and certified number of wells chlorinated	3400	5000
	• Number of water samples collected and tested	824	3704
rvices	• No. of functional community units established and operationalized	44	56
	• Number of clients referred	336	1296
	• Number of community health dialogues conducted	220	176
	• No. of CHVs enrolled	1500	5080
	• No. of youth-friendly services established	6	14
	• % of adolescents accessing Youth – friendly services		
	• % of women of reproductive age accessing FP commodities	39%	54%
	• % of adolescents accessing FP commodities		
5 years	• % of under 5 years stunted	21%	16%
	• % of under 5 years who are underweight	9.6%	4.6%
	• % of children12-59 months supplemented with vitamin	91%	100%
	• % of children below 6months on exclusive breast feeding	68%	80%
es	• % of clients completing 4th ANC	54%	70%
	• % of deliveries conducted by skilled attendant in health	70%	80%

	• % of fresh still birth rate (per 1000 live births)		18
	• Number of facility-based maternal deaths audited		
hed with	• % reached with CSE message	2%	35%
	• Percentage of children under 1 year provided with LLITN	44%	100%
	• % of pregnant women distributed with LLITN	73%	80%
	• Rate of malaria prevalence	8%	4%
	• % of pregnant women provided with IPT	74%	85%

3.2.2 Pillar 2: Curative and Rehabilitative Services

Curative and rehabilitative health services include all the aspects of care given for medical conditions with the aim of achieving cure and preventing adverse consequences. Both curative and rehabilitative health programs are concerned with improving the quality of life for both individuals and society. The pillar will seek to offer quality curative, rehabilitative health care services which are accessible to all citizens of Mombasa County. The key outcome of this pillar is to reduce morbidity and mortality rate in the county.

Table 15: Curative and Rehabilitative services key outcomes and indicators

Strategic Objective: To offer quality curative, rehabilitative health care services which are accessible and affordable to all citizens **Outcome:** Reduced Morbidity and Mortality			
Key Outcome	**Key Performance Indicator**	**Baseline (2018)**	**End-Term Target (2022)**
4.2.1.18 Improved access to specialized care services	• Number of dialysis machine and beds	14	18
	• Number of paediatric ICU cots with monitor and ventilator	2	5
	• Number of radiotherapy machines procured	0	1
	• Number of Cath lab for cardiac surgery	0	1
	• Number of operational theatres	15	17
	• Number of operational Dental clinics providing ccomprehensive dental care (extraction, restoration, rehabilitation)	1	3
4.2.1.19 Improved access to psychiatric and rehabilitative care	• Number of rehab centers operationalized /functional	1	3
	• Number of rehab centers refurbished	3	6
	• Upgrade Port-Reitz mental unit to hospital status	0	1

Strategic Objective: To offer quality curative, rehabilitative health care services which are accessible and affordable to all citizens

Outcome: Reduced Morbidity and Mortality

Key Outcome	Key Performance Indicator	Baseline (2018)	End-Term Target (2022)
4.2.1.20 Strengthened intermediate referral services	• Number of sub-county hospitals providing comprehensive emergency obstetric care • Number of sub-county hospitals with fully functional maternity, postnatal and new-born unit • Number of sub-county hospitals providing comprehensive rehabilitative services (physiotherapy and occupational therapy) • Referral Guidelines available and implemented with tools and quarterly supervision and reports	1 0 1 1	4 2 4 1
4.2.1.21Increased hospital deliveries	• Number of deliveries conducted by skilled attendant	30,476	58,389
4.2.1.22Reduced diarrhoea cases	• Number of children under 5 years treated for diarrhoea	32,277	23,530
4.2.1.23Reduced average length of stay in hospital	• Average Length of stay (ALOS)	6	5
4.2.1.24Improved infection prevention at workplace	• No. of nosocomial infection reported		
4.2.1.25Improved survival	• % of facilities with oxygen delivery facilities	36%	50%
4.2.1.26Strengthened laboratory and radiological diagnostic services	• No. of sub-county hospitals that have undergone full laboratory accreditation • No. of sub-county hospitals with basic lab equipment(chemical analyzer and haematology machine) • No. of QC lab established • No. of sub-county hospitals with Basic radiology equipment (X-ray and Ultrasound)	0 1 0 2	2 4 2 6
4.2.1.27Increase % of TB Treatment completion	• % of TB clients completing treatment	88%	90%
4.2.1.28Increased number of pregnant women accessing timely	• Fresh stillbirth rate/per 1000 live births	558 52	135 18

Strategic Objective: To offer quality curative, rehabilitative health care services which are accessible and affordable to all citizens **Outcome:** Reduced Morbidity and Mortality			
Key Outcome	**Key Performance Indicator**	**Baseline (2018)**	**End-Term Target (2022)**
FANC services and delivering in health facilities	• No. of facility-based maternal deaths audited		
4.2.1.29 Established diagnostic Lab services in primary health care service	• Number of primary care facilities providing basic lab services	27	30
4.2.1.30 Improved access to primary health care services	• Number of primary health care facilities conducting deliveries	15	17

3.2.3 Pillar 3: Enablers – Health Investment and Support Services

Delivery of efficient quality health services is largely dependent on the establishment of strong health administration and governance structures to drive achievement of county health program objectives. There is, therefore, need to strengthen county health systems institutional framework as enablers of efficient and effective service delivery. To achieve aspirations in pillar 1 and 2, the county will invest in innovative health financing models, agile leadership, management and governance (LMG) system; responsive human resources for health (HRH) management system, and interoperable health management information systems among other health systems building blocks.

Table 16: Health Investment and support services key outcomes and indicators

Strategic Objective: To enhance institutional framework for efficient and effective delivery of health services **Outcome:** Provision of high-quality service delivery in an informed, supportive and conducive environment			
Key Outcome	**Key Performance Indicator**	**Baseline (2018)**	**End-Term Target (2022)**
3.2.3.1 Increased financing for county health services	• % increase in resource allocation	23%	30%
	• % increase in revenue collection	-	15%
	• No. of health financing policies enacted	3	8
	• No. of facilities using automated financial management system	4	5
	• Increased absorption of allocated funds budget	83%	100%

Strategic Objective: To enhance institutional framework for efficient and effective delivery of health services

Outcome: Provision of high-quality service delivery in an informed, supportive and conducive environment

Key Outcome		Key Performance Indicator	Baseline (2018)	End-Term Target (2022)
3.2.3.2	Institutionalized quality assurance and practice	• No. of functional Quality Improvement teams and Work Improvement Teams in Health Units	0	1
		• Development of departmental annual Quality Improvement Plan	0	1
		• Develop Mombasa County DOHS quality management policy	0	1
		• Biannual KQMH Assessment of Health Facilities	1	10
3.2.3.3	Improved policy implementation	• No. of health policies/ guidelines implemented & legislated	3	8
3.2.3.4	Strengthened planning, and implementation of sector plans	• Review and develop health sector investment and strategic plan	1	1
3.2.3.5	Strengthened monitoring and evaluation of county health programs	• Number of Performance review and reports prepared and disseminated	1	5
		• Sector working group development Report (MTEF)	1	5
		• No. of AWP developed and implemented	1	5
		• No of integrated data quality audits conducted/support supervision	15	20
		• Revitalized and functional Health integrated M& E TWG	1	1
		• Increased reporting rate	80%	91%
		• No of facilities with revised HMIS tools	50	260
		• No of facilities with integrated EMR	0	4
		• No of facilities with integrated County and sub-county integrated LMIS(software/hardware)	0	3
		• Computerization of EMMS Management system in pharmacy(level 4&5)	0	1
		• Develop and cost county HMIS/M&E strategic plan	0	1
		• County health ICT strategic plan developed	0	1

Strategic Objective: To enhance institutional framework for efficient and effective delivery of health services

Outcome: Provision of high-quality service delivery in an informed, supportive and conducive environment

Key Outcome	Key Performance Indicator	Baseline (2018)	End-Term Target (2022)
3.2.3.6 Improved commodity management	• Annual Forecasting and quantification reports prepared	1	5
	• Timely quarterly commodity order placement	4	20
	• Commodity order fill rate	68%	100%
	• Proportion of expired drugs	10%	3%
	• No. of health workers trained on commodity management and appropriate drug use	50	60
	• No of facilities equipped by MES	2	2
	• Updated inventory of assets	20	44
3.2.3.7 Strengthened evidence use in decision making	• Functional Research framework	0	1
	• Functional database for health research established	0	1
	• No of research resource centers	0	1
	• Annual county health Research symposium	0	1
3.2.3.8 Improved oversight and accountability	• Reviewed and operationalized departmental organizational structure	1	1
	• No. of Hospital Management Boards established for level 4	0	6
	• No of health facilities committees trained	16	25
	• No of health workers trained on senior management roles	45	65
3.2.3.9 Improved access to KEPH services	• No. of level 2/3 facilities renovated/constructed with maternity unit	1	6
	• No. of new drug rehabilitation centers in place	3	6
	• No. facilities upgraded to level 4	4	6
	• No of facilities refurbished	7	35
	• No. of new level 4 facilities completed	0	5
	• No. of container clinics operationalized in the informal settlements	0	6
3.2.3.10 Improved staffing with right skills set	• No. of health workers recruited	376	2052
	• No. of Job descriptions developed and issued to staff	78	217
	• No. of staff promoted	1305	1435

Strategic Objective: To enhance institutional framework for efficient and effective delivery of health services

Outcome: Provision of high-quality service delivery in an informed, supportive and conducive environment

Key Outcome	Key Performance Indicator	Baseline (2018)	End-Term Target (2022)
	• Training needs assessment report	0	1
	• Skills and competency framework developed	0	1
	• % increase in funding for training in-service and pre-service	0%	6%
3.2.3.11 Functional and up-to-date Human resource information management system	• No. of completed employee documents uploaded into iHRIS	1676	1569
	• No. of Dashboards generated for decision making	1	4
	• No. of additional HRM modules in the iHRIS	1	6
3.2.3.12 Improved performance management	• No. of performance contracts signed	0	5
	• Timely staff appraised	0	3049
	• % of staff rewarded and recognized	0	30%
	• Number of reward/recognition for best Quality Improvement	0	4

3.2.4 Proposed Flagship/Transformative Projects

Based on the emerging issues from end-term review of CHSIP 2014-2018 and in alignment with the health sector third Medium Term Plan (MTP III) 2018-2022 of Kenya Vision 2030, the county plans to implement high impact transformational projects to address the challenges experienced over the last five years and better deliver quality health services to its citizens. The department of health services (DoHS) will invest in the construction of a regional oncology centre at the Coast General Hospital and a 50-bed private wing at the same facility are envisioned to transform delivery of specialized care services and enhance the hospital's profile as a regional referral facility. The county also aims to enhance access to curative services by establishing and fully equipping additional tier 4 hospitals to coordinate and strengthen referral centres for primary health providers in the sub-counties. In addition, the department will work with the national government to realize universal health coverage for its population and eliminate financial barriers that hinder access to health services for the poor. The county purposes to pursue Private Public Partnerships (PPP) to implement the proposed flagship projects. The table below shows key proposed flagship projects.

Table 3: Key Flagship projects

Project Name	Location	Implementing Agencies
Construction of a regional oncology center	CPGH	Indian Government

Project Name	Location	Implementing Agencies
		National County Government
Construction of a 50 bed Private Wing with Doctors plaza	CPGH	County government
Rehabilitation of Mwembe Tayari Dispensary into a Detox center and MAT dispensing center	Mvita Sub county	County Government
Construction/Rehabilitation of Mrima H/C to create 50 bed capacity level 4 Hospital Theatre, labor ward, postnatal &Antenatal wards 50 bed capacity	Likoni sub-county	MSF
Placement of 6 Containers clinics in informal settlements	Mombasa County	County government
(Bangladesh, Owinoouru, Kadzandani,Timbwani,Muoroto,)		Ministry of Health
Refurbishment of ward 9 to create a burns unit	CPGH	County government
Construction & equipping Cardiac Catheterization laboratory	CPGH	County government
		Partners
Implementation of Universal Health Care project	Mombasa	County government
Equip a total of 5 level 4 hospitals which are under construction.	Various (Mtongwe, shikadabu, chaani, vikwatani, marimani)	County government
Construction of new maternity Wing	Port-Reitz Hospital	County government
Construction of warehouse for microwave for waste disposal	Port-Reitz Hospital	County government
Refurbish and equip public health laboratory	Ganjoni	County government
Malaria elimination	Mvita Sub-County	County government
Cholera eradication	Mombasa	County government

4 IMPLEMENTATION ARRANGEMENTS

The Department of Health Service (DoHS) consists of the leadership team, the County Health Management Team (CHMT) and four Sub-County Health Management Teams (SCHMT). The County Executive Committee Member for Health, the two Chief Officer of Public Health and Medical Services and the County Director of Health provide stewardship in ensuring effective implementation of the mandate of the health sector. The County Executive Committee (CEC) member retains overall political and policy responsibility for health service delivery as per the constitution.

A new organogram is has been designed considering the division of department into Public Health and Medical Services. Despite the Department of Health being headed by two Chief Officers, the divisions are interdependent and will leverage on each other's mandate to respond to the needs of the residents of Mombasa County and its environs. The Department for Health Promotion and Disease Prevention will cover Child health, Disease Control, Nutrition, health promotion and community care, Environment and Hygiene control and non-communicable disease while department for Health Curative and Rehabilitation will cover referral services, pharmaceutical, laboratory, clinical services, nursing services, quality assurance and reproductive health.

Health sector planning, coordination, and administration (infrastructure management, procurement, health information, financial management, supply chain management, logistics management, internal audit, human resource administration and accounts) will be coordinated centrally. At the operational level, the Chief Officer and County Director of Health head the County Health Teams (CHTs), while the facility in Charges manage health services at the facility level and Sub-County Health management teams supervise health activities within their respective sub-counties.

5 RESOURCE (FINANCING) REQUIREMENTS

The department has adopted programme-based budgeting (PBB) to develop budget estimates for the 2018-2022 period. Allocation of resources is based on inputs and expected outputs for each programme area. The PBB approach aims at improving the prioritization of expenditure in the budget by allocating resources to those programmes of greatest benefit to the citizens and enhancing efficiency and effectiveness of service delivery by changing the focus of public spending from input based to output-outcomes based.

The county is committed to increasing allocations to the DoHS to enable it to realize its priorities for 2018-2022 and beyond. The department has reviewed its organization structure and will continue building the capabilities of its leadership and governance functions, improve health infrastructure, human resources for health, streamline procurement, storage, distribution and rational use of health products and technologies, and invest in domestic resource mobilization and effective use of available financial resources. The total county resource requirement estimates for the strategic period 2018-2022 is **Kshs. 16.8 billion**, an average of approximately **Kshs 3.4** billion per year over the next five years.

The overall, recurrent and developmental expenditure will constitute 12% and 88% of the overall budget. The bulk of the developmental expenditure will go towards implementation of flagship projects which will impact service delivery on the three programme areas (pillars).

The department requires approximately Kshs 1.7 billion, 10% of the health budget, over the strategic plan period to implement the preventive and promotive services envisaged in this plan. The largest amount of preventive and promotive health services will be committed to alcohol and substance abuse management. This is largely due to the need to expand rehabilitation infrastructure to accommodate the demand. Other investments will be used to implement HIV, TB, RMNCH, NCDs, Malaria, immunization, and community interventions among other.

17%, Kshs 2. Billion, of the department's budget, will be used to implement curative and rehabilitative services. The largest portion of the budget, 73% (Kshs 12.3 billion, has been allocated to general administration, planning and management support. The highest consumption under this category is the purchase of health products and health infrastructural development.

Financing Gap: The department's budget is usually funded from four main sources namely allocation from national shareable revenue, conditional grants from the National Government, external grants and loans; and local revenue mainly user fees from county public hospitals. The national shareable revenue constitutes the highest share at approximately 69% while conditional grants, local revenue, and external grants and loans share 25%, 4.4%, and 1.3% respectively.

Resource Mobilization: The department for health services will focus on ensuring effective resource mobilization, allocation and efficient use of available financial resources. The Department shall constitute a Resource Mobilization Team (RMT) that will be responsible for; isolating critical financing gaps, undertaking regular resource partners analysis and assess potential public/private partnerships (PPP) and donors as well as executing resource mobilization strategy in line with the interests and concerns of the County, partners and donors. The RMT shall meet monthly to review and prioritize existing financing gaps and ensuring effective mobilization of partners through the county health stakeholders' forums, development partners' forums and PPPs forums.

6 MONITORING AND EVALUATION FRAMEWORK

Monitoring and evaluation is key to all aspects of the CHSIP II, 2018-2022. The M&E systems will be given priority and will be more accessible to all stakeholders with a renewed focus on improving data quality, demand and use of data for decision making at county and health facility levels. A detailed M&E plan will be developed to facilitate performance measurement and thus provide a basis for accountability and evidence-based decision making at all levels by all actors in the County Health Sector. This shall be achieved through a focus on strengthening of the Country capacity for information generation, validation, analysis, dissemination, and use. Monitoring and evaluation will be steered by the Division of health information and M&E Unit within the county health sector organizational structures in collaboration with health sector partners.

ANNEXES

Strategic Planning Team

	Name	Designation/Title
1.	Hazel Koitaba	CECM, Health
2.	Dr. Khadijah Shikely	Chief Officer, Medical Services
3.	Asha Abubakar	Chief Officer, Public Health
4.	Dr. Shem Patta	County Director of Health
5.	Dr. Mary Ochola	Deputy Chief Administrator-CGH
6.	Elizabeth Kivuva	Director of Nursing-CGH
7.	Dr Salma Swaleh	Division Head-Preventive Promotive
8.	Dr Khadijah Awadh	MOH-Mvita Sub County
9.	Michael Ochieng	Division Head-Administrative And Finance
10.	Esha Bakari	County Nutrition Coordinator
11.	Esha Yahya	Division Head-Curative and Referrals
12.	Florence Wachira	Sub county head of quality and standards
13.	Thani Suleiman	County Laboratory Coordinator
14.	Celine Kithinji	County Dug and substance abuse
15.	Sarah Kayanda	Division Head-Policy planning, HIM&E
16.	Josephine Waronja	Deputy County HIM&E
17.	Salim Bakari	Kisauni sub county PHO
18.	Stephen Muiyoro	HEAD Finance
19.	Pauline Oginga	Head M&E
20.	Josephine Kaikai	Human Resource officer
21.	Zaituni Ahmed	CASCO
22.	Mamu Athman	CSCFP
23.	Dr Jane Gitahi	Hospital Head Quality and Standards
24.	Dr.Mwanaisha Athman	MOH-Changamwe sub County
25.	Mohammed Hanif	Division Head-Technology and Commodity
26.	Raphael Mwanamawi	County Public health Officer
27.	Samson Kioko	County TB Coordinator
28.	Lillian Ngugi	HAO-Changamwe sub county
29.	Esha Fumo	TB Coordinator -Mvita sub County
30.	Mwanakarama Athman	Nursing officer incharge-PSCH
31.	Tumu Zaunga	MOH-Kisauni sub County
32.	Joseph Olingo	Nutritionist-Likoni sub County
33.	Mwaka J Chiti	County Malaria coordinator
34.	Paul Abonyo	Budget Analyst
35.	Tom Oneko	Senior Health Financing Advisor
36.	James Nyamosi	Lead Consultant
37.	Dr Ali Juma	Medical Superintendent Likoni Sub C.Hosp.
38.	Isaac M. Jewa	County Epi Logistician