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NAIROBI CITY COUNTY HEALTH SECTOR STRATEGIC AND INVESTMENT PLAN

2013/2014 – 2018/2019

(Revised 2017)

FOREWORD

Nairobi is the main commercial centre of the country with a well-developed infrastructure, including modern financial and communications systems. Leading domestic and international banks operate from Nairobi. It hosts the country's largest industrial centre which accounts for almost 20 percent of the gross domestic product (GDP). The County's population of 3,138,369 in 2009 is projected to increase to 4,390,158 in 2018. This population is distributed in 17 administrative Sub Counties which have been merged to 10 health Sub Counties for ease of health administration. With the increasing County's burden of non-communicable and communicable diseases including HIV/AIDS and Tuberculosis there is need for concerted efforts to improve the health of the City residents.

Nairobi City County is committed to providing quality and targeted health services that respond to the unique challenges that come with the high populations in Capital cities. This Health Strategic and Investment plan gives the clear direction on the key steps the county has committed to take towards addressing the health challenges. This plan is in line with the overall vision of the Nairobi City County government which is **'to be the City of choice to invest, work and live in'**.

This strategy is guided by the Kenya Health Policy (2014 - 2030), Kenya Health Sector Strategic and investment Plan (KHSSP) 2014-2018, Nairobi City County Strategic Plan (2015-2025), Nairobi City County Health Policy (2015-2020 among other key documents. In-addition the plan has set up a structure in line with the devolved government under the leadership of the Governor to ensure that high level management of the health sector.

This Strategic and investment plan will enable the health sector in Nairobi City County to play its role in the realization of the national objectives outlined in the Economic Recovery Strategy, the Millennium Development Goals and Vision 2030 and overall the Sustainable Development Goals (SDG).

It is my hope that we will have a well-coordinated approach in our interventions that translates into better health outcomes and improved health status of the population in Nairobi City County and its environs.

Dr. Benard Muia

County Executive Committee Member Health
services, Nairobi City County

Preface

This revision of the Nairobi City County Health Sector Strategic and Investment Plan 2013/2014 – 2018/2019 is based on the experience of the first three years of implementation of the current plan. The objective was to align the content and strategies of the previous draft Strategic and Investment Plan to the NCC policy documents particularly the NCC strategic Plan, NCC Health Policy (2016 – 2020) and the Nairobi City County Human Resource for Health Policy (2016-2020) which were formulated after the first draft Strategic plan was completed. This .revision has also been greatly informed by the Kenya Health Policy (2014 - 2030), Kenya Health Sector Strategic and investment Plan (KHSSP) 2014-2018, and the Nairobi Health Sector Medium Term Expenditure Framework (2014-2018).

The plan focuses on the six health sector objectives: 1) elimination of communicable conditions, 2) halting and reversing the rising burden of non-communicable conditions 3) reducing the burden of violence and injuries 4) provision of essential health care 5) minimizing exposure to health risk factors 6) strengthening collaboration with health-related sectors and the seventh objective that is specific to the County 7) Improving emergency, referral and rehabilitative services. This plan provides direction on implementation, coordination and monitoring of health services delivery in Nairobi City County. The County government is determined to improve access to quality health services with a special focus on the urban slums through targeted interventions.

The implementation of this plan requires hard work and needs everybody's commitment: County departments, the Private sector, Development partners, Non-Governmental Organizations, Faith-Based Organizations, trade unions, academic institutions and the communities.

As a county we will be open to collaboration and welcome our partners and other stakeholders to join and support us in realizing a successful implementation of our planned strategies.

I wish to thank all the officers, individuals, organizations and stakeholders who gave input during the development of this plan.

Dr. Sam Ochola

Chief Officer for Health Services
Nairobi City County

ACKNOWLEDGEMENT

Revision of the Nairobi City County Health Sector Strategic and Investment Plan (2013 -2018) was accomplished through collaborative and consultative efforts spearheaded by the County Health Management Team Technical Working Group and USAID Afya Jijini project.

I acknowledge the contributions that were made through write ups, dialogue, debate, research, comments and suggestions. In particular, I would like to acknowledge the dedication of the Technical Working Group led by Dr. Lucina Koyio, Deputy Director Health Policy Planning and Research, and the County Health Management Team.
I also extend my gratitude the Sub County Health Management Teams and Hospital Management Teams for their invaluable inputs in various workshops and meetings.

Special thanks to the County Executive Committee member for Health Services Dr. Bernard Muia and County Chief officer of Health Services Dr. Sam Ochola for their leadership and support during the development of this plan.

Many thanks go to our partners who supported the initial processes up to the to completion; USAID Leadership, Management and Sustainability Program; Health Strat, USAID- APHIA-plus Nairobi Coast; USAID Afya Jijini Project, and particularly Josephine Mbiyu-Kinyua (Health Systems Strengthening Director) for providing technical guidance during the revision process.
Finally, we wish to thank all those who contributed in one way or another in the development of this County Health Strategic Plan 2013-2018.

Dr. Thomas Ogaro
County Director – health services
Nairobi City County

EXECUTIVE SUMMARY

The reviewed Nairobi City County Health Strategic and Investment Plan (2013 – 2018) plan is divided into 6 sections:

Section 1: Introduction

The County's population of 3,138,369 in 2009 is projected to increase to 4,390,158 in 2018. This population is distributed in 17 administrative Sub Counties which have been merged to 10 health Sub Counties for ease of health administration.

The first Health sector strategic plan 2013 -2018 Nairobi City County government was done immediately after devolution of health services from the National level to the Counties. This section presents the justification and process of reviewing the strategic and investment plan.

Section 2: Situation and problem analysis

Problem analysis is done by seven investment areas: Health Service Delivery, Leadership and Governance, Health Workforce, Health Financing, Health Information Systems, Health Products and Technologies and Health Infrastructure.

The County's burden of communicable diseases has doubled including HIV/AIDS, Tuberculosis and the top five ranking diseases include diseases of the respiratory system, diarrheal diseases, ~~and~~ diseases of the skin, malaria and pneumonia.

Non-communicable diseases of rising public health concern that are on the rise include; diabetes, hypertension, cancers, mental health disorders, violence and injuries ~~and~~ inclusive of sexual and gender-based violence.

Section 3: Strategic direction

The County has seven policy objectives which provide strategic direction for the health sector: elimination of communicable conditions, halting and reversing the rising burden of non-communicable conditions, reducing the burden of violence and injuries, improve emergency, referral and rehabilitative services, provide essential health care and minimizing exposure to health risk factors.

Section 4: Implementation arrangements

The implementation of this strategic plan calls for partnerships in health at all levels of care. This section outlines the organization of the County Health Services and Operational Functions of the Executive, County, Sub-County, health facility levels and, identifies the stakeholders

The monitoring and evaluation plan/framework emphasizes on the use of standard indicators, standard electronic data system (such as the District Health Information System (DHIS) and other data aggregator systems (IFMIS/IHRIS), Data Quality Audits, Annual Work Plans and performance reviews at all levels of care, including community.

Section 5: Resource requirements and financing

Under the medium-term expenditure framework (MTEF) program based budgeting (PBB), the County plans with 3 programs, 12 subprograms and 22 delivery units in line with the policy objectives.

The implementation of this Health Strategic and Investment Plan will require a total of Ksh. 88.8 billion in five years which is an average of Ksh. 17.6 billion annually. The County allocation to the health sector however is barely half of the estimated cost. Currently households are the major financiers of health care, contributing more than half of the total health expenditure while the County Government contributes 18.1%. Strategies to increase financing to bridge the gap are discussed to enable the implementation of this plan.

Annex 1: Achievements as at 2015/2016

This section presents the current achievements FY 2015/2016 as compare to the baseline and the end terms targets FY 2018/2019

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ACRONYMS

AHF	AIDS Healthcare Foundation Kenya
AMREF	African Medical Research Foundation,
APDK	Association of Physically Disabled of Kenya
APHIA	AIDS, Population and Health Integrated Assistance.
APHIA-plus	APHIA People-centered, Local Leadership, Universal Access, Sustainability
APHRC	African Population and Health Research Center
ARV's	Anti-retrovirals
BEOC	Basic Emergency Obstetric Care
CCNHD	City Council of Nairobi Health Department
CDC	Center for Disease control
CDF	Constituency Development Fund
CDMS	County Director of Medical Services
CDPH	County Director of Public Health
CECM (H)	County Executive Committee Member for Health
CEOC	Comprehensive Emergency Obstetric Care
CEO	Chief Executive Officer
CFK	Carolina for Kibera
CHAK	Christian Health Association of Kenya
CHEW	Community health extension workers
CHMT	County Health Management Team
CHSSIP	County Health Sector Strategic and Investment Plan
CHWs	Community Health Workers
CIDP	County Integrated Development Plan
CME's	Continuous Medical Education
COH	Chief Officer of Health
CMMB	Catholic Medical Mission Board
CRA	Commission for Revenue Allocation
CSOs	Civil society organization
CU	Community Unit
DANIDA	Danish International Development Agency
DfID	Department for International Development (UK)
DHIS2	District Health Information System 2
DHMT	District Health Management Team
DoD	Department of Defence
DSW	Deutsche Stiftung Weltbevoelkerung
EDARP	Eastern Deanery Aids Relief Program
EMR	Electronic Medical Records
FBOs	Faith Based Organization
FHI360	Family Health International 360
FMC	Facility Management Committees
GBV	Gender Base Violence
GIZ	Gesellschaftfür Internationale Zusammenarbeit
HCSM	Health Commodities Services Management program

HFMT	Health Facility Management Team
HIS	Health Information System
HIV/AIDS	Human Immuno- Deficiency Virus/ Acquired Immune Deficiency Syndrome
HMSF	Hospital Management Services Fund
HMT	Hospital Management Teams
HPP	Health Policy Program
HRIS	Human Resources Information System
HSSF	Health Sector Services Fund
HSK	Health Strat Kenya
ICC	Inter-Agency Coordinating Committee
ICF Macro	Inner City Fund
ICT	Information Communication Technology
IFMIS	Integrated Financial Management Information System
IOM	International Organization for Migration
JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
JICA	Japan International Corporation Agency
KAIS	Kenya AIDS Indicator Survey
KAPTLD	Kenya Association for the Prevention of Tuberculosis and Lung Diseases
KAWE	Kenya Association for the Welfare of People with Epilepsy
KDF	Kenya Defence Forces
KDHS	Kenya Demographic Health Survey
KEC	Kenya Episcopal Conference
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KHSP	Kenya Health Sector Policy 2012-2030
KNBS	Kenya National bureau of Statistics
KNH	Kenyatta National Hospital
KWAHO	Kenya Water for Health Organisation
LATF	Local Authority Transfer Fund
LMS	Leadership Management Sustainability
MCH / FP	Maternal Child Health/ Family Planning
MICS	Multiple Indicator Cluster Survey
MLK	Mama Lucy Kibaki Hospital
MNCH	Maternal Neonatal Child Health
MoOH	Ministry of Health
MSF	Medicines Sans Frontiers
MSH	Management Sciences for Health
NCCHD	Nairobi City Council Health Department
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHIF	National Health Services Insurance Fund
NHMB	Nairobi Health Management Board
OLMIS	Orphans and Vulnerable Children Longitudinal Management Information System
OPD	Out Patient Department

OSH	Occupational Safety and Health Hazards
PHMT	Provincial management team
PSI	Population Services International
RH	Reproductive Health Services
SAPTA	Support for Addiction and Prevention in Africa
SCHMT	Sub-County Health Management Team
SO	Strategic Objective
SRH	Strategic Resources for Health Kenya
STI	Sexually Transmitted infections
SUPKEM	Supreme Council of Kenya Muslims
SWOT	Strengths Weaknesses Opportunities and Threats
SWOP	Sex workers Outreach Program
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Agency for AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations Humanitarian Council for Refugees
UNICEF	United Nations Children's Fund
UON	University of Nairobi
UOM	University of Maryland
USAID	United State Agency for International Development
WASH	Water, Sanitation and Hygiene
WB	World Bank
WFP	World Food Program
WHO	World Health Organization

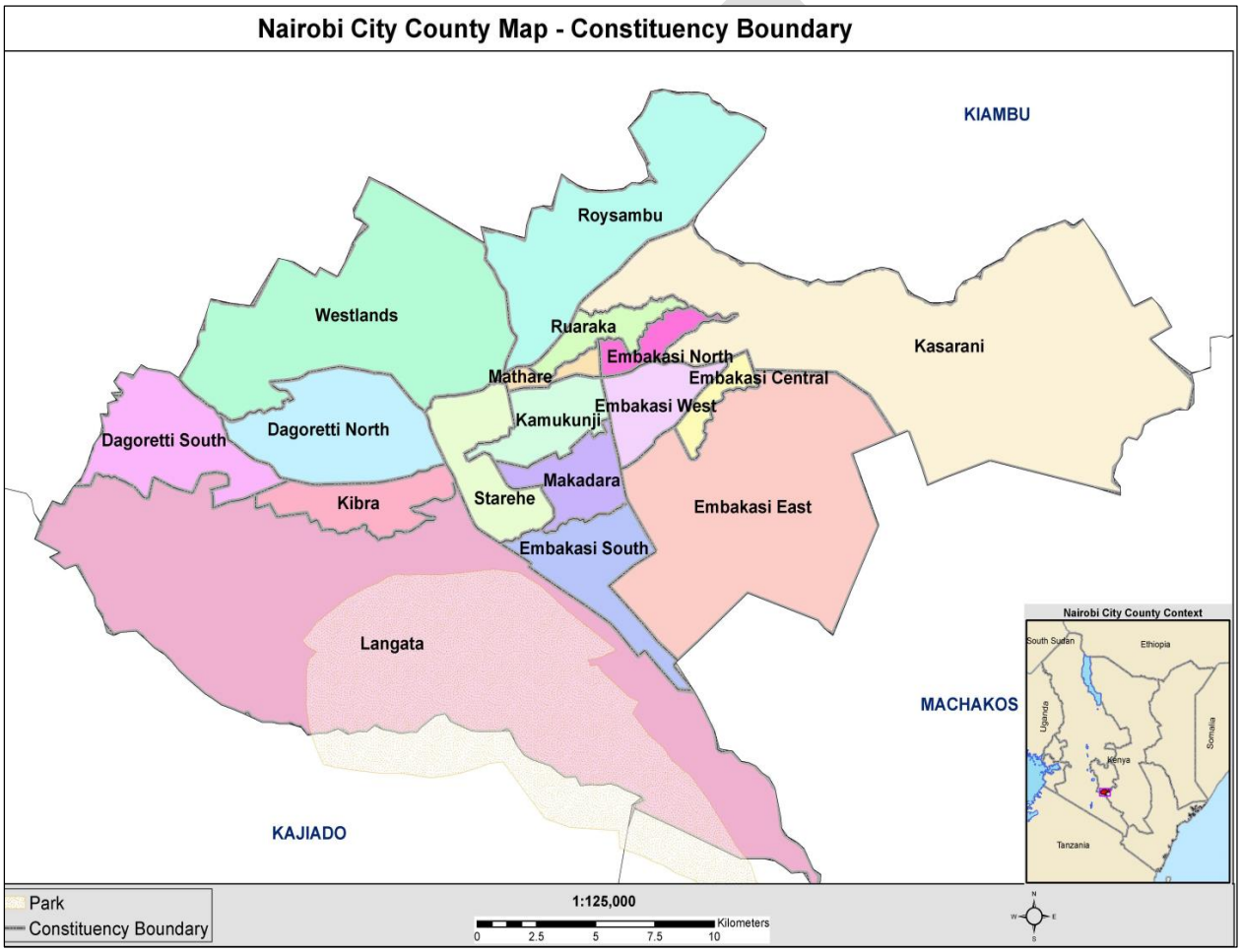
SECTION 1: INTRODUCTION

1.1. Background

1.1. Geographical location

Nairobi City County consists of 17 Sub counties and 85 wards. It borders Machakos County, Kiambu County and Kajiado County, and covers an area of 695 square kilometres (Figure 2).

Figure 1: Map of Nairobi City County



1.2. Population Demographics

From the 2009 population census, the County population is estimated at 4,157,757 comprising 1,995,723 females and 2,162,034 males, and has an annual growth rate of 3.8%. The population distribution shows the age group of the under 15 accounting for 40.7% of the total population, the young adult age groups of 15-29 years accounting for 38.6%, the reproductive age groups of 15-49 years accounting for 40.7%, with figures of 22% and 18% for males and females respectively. The proportion of those over 60 years is 2% of the population (Table1).

1: Population Projections by Age Cohorts

AGE GROUP	2009	2013	2014	2015	2016	2017	2018
Population	3,134,798	3,577,982	3,771,695	3,969,582	4,171,082	4,381,062	4,591,042
0 - 4	397,161	480,022	515,859	551,231	586,180	605,066	623,952
5 - 9	306,877	359,941	384,507	408,652	432,184	467,687	503,190
10-14	246,965	265,453	286,985	311,096	336,458	361,006	385,554
15-19	270,064	293,598	300,348	309,038	318,059	338,036	358,013
20-24	477,396	482,226	462,452	444,567	434,737	439,839	444,941
25-29	462,753	524,887	551,664	572,078	584,042	572,169	560,295
30-34	324,129	385,385	419,832	453,565	484,153	507,745	531,337
35-39	229,632	271,120	286,430	304,819	327,624	359,231	390,838
40-44	146,601	186,618	204,649	222,652	239,802	257,083	274,363
45-49	107,003	121,560	131,013	141,804	154,320	170,989	187,659
50-54	66,576	80,298	88,162	96,326	104,675	114,437	124,199
55-59	39,285	50,684	55,423	60,650	66,464	73,854	81,243
60-64	25,166	31,189	34,854	38,629	42,474	47,083	51,692
65-69	13,022	18,328	20,426	22,774	25,413	28,700	31,987
70-74	8,702	10,804	12,223	13,705	15,226	17,119	19,011
75-79	4,943	6,529	7,083	7,767	8,592	9,702	10,812
80+	8,523	9,340	9,785	10,229	10,679	11,317	11,955

Source: *KNBS, 2009 Kenya National Housing and Population Census*

Many citizens work in the City during the day but reside in the neighbouring counties such as Machakos, Kiambu and Kajiado. This Transit day population is estimated at about 1 million people.

The four most densely populated Sub Counties are Mathare, Embakasi North, Ruaraka and Kamukunji, with a population densities of over 20,000 people per square kilometre. The least densely populated Sub counties are Westlands, Langata, Kasarani and Embakasi East. Furthermore, it is estimated that about 58% of Nairobi's population live in slums or slum-like conditions (UN Habitat 2010) and that there are about 55, 000 refugees and asylum seekers living in the City (UNHCR 2013).

1.3. Key Health Indicators

Key health indicators are shown in Table 2 below.

Table 2: Selected Health Indicators Performance

Indicator	County estimates	National estimates	Source
Life Expectancy at birth for females (years)	**	62	KNBS
Life Expectancy at birth for males(years)	51	58	KNBS
% Population Growth rate(between 1999-2009)	2.9	3.14	KNBS
Neonatal Mortality Rate (per 1,000 births)	**	31	KNBS
Infant Mortality Rate (per 1,000 births)	60	52	KDHS
Under 5 Mortality Rate (per 1,000 births)	64	74	KDHS
Maternal Mortality Rate (per 100,000 births)	**	488	KDHS
Fully Immunized population < 1 year (% 2012/13)	97	64	MoH Fact sheet
TB incidence per 100,000 persons (2012)	514	238	MoH Fact sheet
HIV prevalence rate (2012)	6.1	5.6	KAIS 2012
Number of People living with HIV	199,100	34,338	KDHS
New HIV infections	13,510	2,217	MoH Fact sheet
Malaria cases (per 100,000)	4,601	21,945	MoH Fact sheet
Malaria test positivity rate (%) in 2012	18	30	
Contraception prevalence (%) in 2012	38.7	45	MoH Fact sheet
Births delivered at health facilities (%)	78.9	37.5	CRA fact sheet
% of deaths due to injuries	20.2	**	DHIS

*__Sources:__ Kenya Demographic Health Survey (KDHS) 2009, Nairobi City County Health Fact Sheet by MoH and Nairobi City County Fact Sheets developed by Commission for Revenue Authority (June 2013) and MoH (2013)

** Data not available.

1.4. Devolved Health Functions

Nairobi City County government assumed office in April 2013 after the 2013 Kenya's general elections with a vision to make Nairobi **"The city of choice for all to invest, work and live in"**. The Constitution of Kenya 2010, through Article 43, entrenched the rights based approach to health and provided for the devolution of health services to County governments.

In the Sessional Paper number 6 of 2012 on the Kenya Health Policy (2012-2030), the National government has crafted a draft health policy framework that guides health service delivery in line with the Constitution and with Kenya's Vision 2030. Under the Legal Notice Number 137 of 9th August 2013 and in line with the County Government Act 2012, the Transitional Authority formally transferred the following health service functions to the Nairobi City County government:

1. Promotion of primary health care;
2. County health facilities and pharmacies;
3. Ambulance services: including emergency response and patient referral system;
4. Licensing and control of undertakings that sell food to the public;
5. Enforcement of waste management policies, standards and regulations;
6. Veterinary services; to carry out, coordinate and oversee veterinary services.

1.5. The County Health Strategic and Investment Plan 2013 - 2018

The first Strategic Plan 2013 – 2018 was formulated to give direction on what the health sector planned to achieve in a five-year period from. It provided an overall framework for planning and implementation of County health priorities to realise the County Vision. The National Health Strategic and Investment Plan (2013 -2017) and the National Health Policy (CHP) 2016-2025 guided the process. In addition, various legislative and policy documents particularly the Constitution of Kenya, County Government Act 2012, Vision 2030 the draft Kenya Health Policy 2012-2030, the Kenya national strategic plan were referenced

1.6. Rationale of Revision of the County Health Strategic and Investment Plan

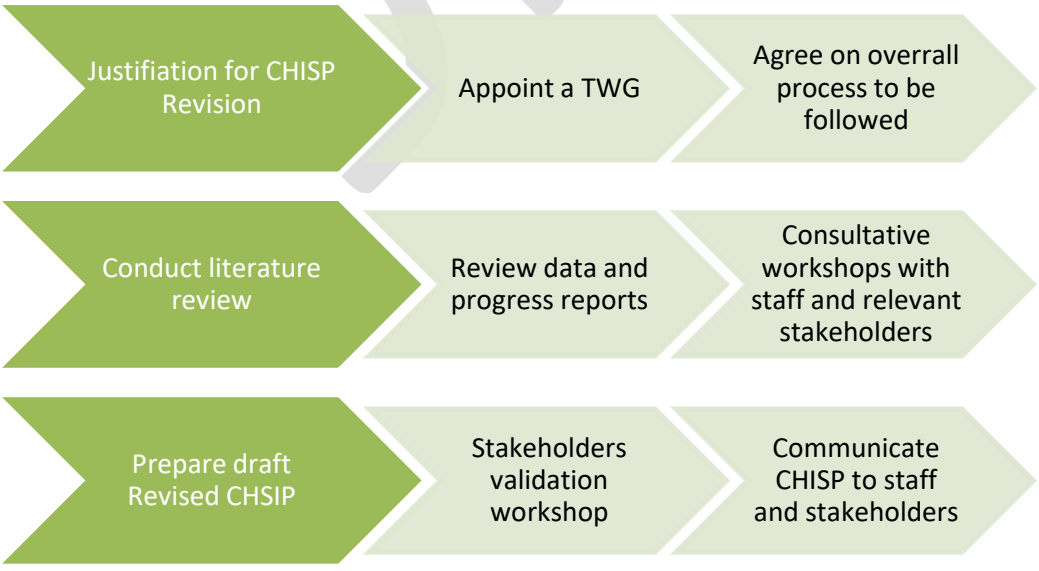
The CHSIP was formulated before launching the County Strategic Plan 2015-2025 County Health Accounts 2015/2016 and the County Health Policy 2016 – 2025 in 2016. Therefore, there was need to revise the CHISP to align it with the three documents.

The County Health Technical Working Group (CHTWG) in collaboration with the County Health Management team (CHMT) and Sub County Health Management teams and various health partners attended various workshops to revise the CHSIP 2013-2018 in the following areas:

i. Literature review – including County Strategic Plan 2015 - 2025, the MTEF reports, County Health Accounts 2015/2016 and County Human Resource for health Plan 2016 -2015 and progress reports
ii. FY 2015/2016 performance review
iii. Key Issues and County priorities
iv. Indicators and targets
v. Goals and objectives

These workshops resulted in a draft strategic plan that was further reviewed and validated in separate meetings with Members of Nairobi City County Assembly Committee for Health, Nairobi Health Management Board and Partners. The activities are summarised in Figure 1.

Figure 2: Process of revision of the County Health Strategic and Investment Plan



SECTION 2: SITUATION AND PROBLEM ANALYSIS

This section focuses on health services indicators, disease burden and health systems supporting health service delivery. A SWOT analysis completes the section. Table 3 summarizes key health indicators of Nairobi City County in comparison to the country.

Table 3: Nairobi County Key Health Indicators

Health Indicators	Nairobi County	Nairobi County	Kenya
	2012	2015	2015
POPULATION			
1 Total	3,445,387	3,666,576	45,108,414
2 Male	1,762,265	1,875,400	22,422,667
3. Female	1,683,122	1,791,176	22,685,748
4 Under Age 5 years	437,564	465,655	936,691
5. Over Age 5 years	1 103,362	109,997	1,425,787
NUTRITION			
Underweight (weight for age) (%)	9	3.8	11
Stunted (height for age) (%)	2.8	17.2	26.1
CHILD HEALTH			
Children (12–23 months) immunized (%)	94.5	60.4	67.5
MATERNAL HEALTH			
Births delivered at a health facility (%)	53.3	88.7	61.26
Contraceptive prevalence (%)	38.7	58.3	53.2
HIV/AIDS, TB, AND MALARIA			
Number of people tested for HIV	1,012,929	1,043,317	7,161,215
Number of people living with HIV on antiretroviral treatment	82,446	89,366	561,225
Mother-to-child transmission of HIV (%)	14	6.2	8.5
Malaria test positivity rate (%)	18	50	41
Malaria cases 8 (per 100,000 people)	4,756	3,875	20,252
Malaria admission	2,880	2,775	17,9966
Tuberculosis (TB) prevalence (per 100,000 people)	475	405	208
Tuberculosis incidence (per 100,000 people)	167	156	79
HEALTH PERSONNEL—PUBLIC			
Nurses (per 100,000 people)	38	53	55
Doctors (per 100,000 people)	37	14	10
Clinical officers (per 100,000 people)	14	6	21
HEALTH FACILITIES			
Public	121	161	4929
Nongovernmental	82	118	347
Faith-based	85	100	1081
Private	252	543	3797
HEALTH FINANCING			
Total government health spending (per capita, KES)	1,251	1,745	1,585
National Health Insurance Fund (NHIF) coverage (% of county population)	27	35.2	26.7

2.1. Disease Burden in Nairobi City County

This information is critical to decision making and determines setting of key priorities towards improving the health of the residents of Nairobi.

a. Morbidity

In 2012, the three leading causes of ill health, based on out-patient attendance records among the under-fives, were respiratory diseases, diarrheal diseases and skin diseases. Respiratory diseases including pneumonia, accounted for over 60% of out-patient visits. Diarrheal diseases, normally correlated with hygiene and sanitation levels, accounted for 16% of the visits. These same causes are reflected for those above five years though in a slightly different configuration, with urinary tract infections ranking fourth.

Table 4: Top Ten Causes of Morbidity

	Causes of Diseases		
	Under five years	**Over five years**	
1	Diseases of the respiratory system	1.	Diseases of the respiratory system
2	Diarrheal diseases	2.	Skin
3	Skin	3.	Diarrheal
4	Pneumonia	4.	Urinary Tract infection
5	Clinical malaria	5.	Typhoid fever
6	Confirmed malaria	6.	Clinical Malaria
7	Urinary tract infection	7.	Dental disorders
8	Ear infection	8.	Pneumonia
9	Typhoid fever	9.	Ear infection
10	Accidents	10.	Accidents

b. Mortality

Among the under-fives, the three leading causes of death are pneumonia, prematurity and diseases of respiratory system. The three leading causes of death among those over 5 years of age are general respiratory diseases, tuberculosis as a specific cause of death and other accidents

Table 5: Top Ten Causes of Mortality

	Under five years	Over five Years	
1	Pneumonia	1.	Respiratory disease
2	Prematurity	2.	Tuberculosis
3	Respiratory disease	3.	Other accidents
4	Malaria	4.	Heart Disease
5	Asphyxia	5.	Pneumonia
6	Sepsis	6.	Cancer
7	Gastroenteritis	7.	Road Traffic Accidents
8	Dehydration	8.	HIV & AIDS
9	Heart disease	9.	Malaria
10	Measles	10.	Diabetes

c. Major Morbidity and Mortality Risk Factors

The impact of health services can be significant if risk factors associated with top causes of morbidity and mortality are detected and acted upon appropriately and in a timely manner. Community based preventive interventions including behaviour change interventions or facility based screening,

prevention and treatment or plain quality service delivery can greatly reduce the occurrence and impact of top risk factors. The mortality and morbidity rates associated with these risk factors point to gaps in preventive services and coverage of interventions.

Table 6: Major Risk Factors of Morbidity and Mortality in the County

Condition	Major Risk factors
1) Diseases of the respiratory system	1) Congested and poorly ventilated households
2) Pneumonia	2) Congested and poorly ventilated households
3) Prematurity	3) Pre-eclampsia, smoking and alcohol use in pregnancy
4) Tuberculosis	4) Congested and poorly ventilated households
5) Other Accidents	5) Drug and substance abuse;
6) Cardiovascular diseases	6) Unhealthy lifestyle
7) Asphyxia	7) Prolonged labour
8) Sepsis	8) Prematurity, early labour, low birth weight, poor delivery practices
9) Cancers	9) Unhealthy lifestyle, genetics
10) Traffic accidents	10) Non-adherence to traffic rules, careless driving or road use
11) Malaria	11) Travel to malarial zone without chemoprophylaxis
12) Diarrheal diseases	12) Poor environmental sanitation
13) HIV/AIDS	13) Unsafe sexual practices
14) Meningitis	14) Poor environmental sanitation
15) Dental disorders	15) Poor oral hygiene

2.2. Current health investments

2.2.1. Service Delivery Systems

The availability of a basic package of maternal, child, and reproductive health services, the frequency with which these services are offered and the quality of their content influence how clients use these services. Strengthening service delivery is crucial to the attainment of the County's strategic objectives and health outcomes. The current KEPH is formally organized according to six levels that include:

Level 1: Community Units
Level 2: Dispensaries and Clinics
Level 3: Health Centres
Level 4: Sub-county Hospitals
Level 5: County Hospitals
Level 6: National Referral Hospitals

Within each level, a set of interventions exists for the various KEPH population cohorts.

a) The KEPH at the Community Units

The overall goal of the community strategy is to enhance community access to health care in order to improve health status and productivity and thus reduce poverty, hunger, child and maternal deaths as well as improve education performance across all the stages of the life cycle.

Each community unit (CU) should serve 5,000 people through 25-50 Community Health Volunteers (CHVs) who are identified by the community. The CHVs report to Community Health Assistants

(CHAs) who are based at the health facility within which the CUs are linked to. CHAs train and supervise the CHVs. Nairobi City County has 186 established CUs of which 130 (70%) are functional. Expansion and implementation of the community strategy relies heavily on partners.

Table 7 shows the distribution of CUs by Sub-county and the supporting partners. The 25 KEPH services at CU level are listed in **Table 10**. These includes among others;

- Case finding and screening for communicable conditions
- Child health services
- Integrated vector management
- Good hygiene practices
- HIV and STI prevention, Palliative care,
- Food quality & safety promotion
- Health promotion including health Education, with focus on violence / injuries
- Pre- hospital care
- Management for injuries and Rehabilitation
- Messaging on; Sexual education, Substance abuse and health seeking behaviour
- Micronutrient deficiency control
- Safe water, Sanitation and hygiene promotion
- Nutrition services
- Pollution control and Population management

Table 7: Distribution of Community Units by Health zone and Sub-county as at 2017

	Health Zone	Sub-county	Sub County #	Est Population Density/Km² (2015)	Established CUs	Functional CUs
1	Westlands	Westlands	274	3,067	11	7
2	Dagoreti	Dagoretti North	275	7,953	6	6
		Dagoretti South	276	8,983	12	12
3	Langata	Langata	277	1,181	9	9
		Kibra	278	18,507	13	13
4	Ruaraka	Roysambu	279	4,934	9	6
		Ruaraka	281	33,865	20	14
5	Kasarani	Embakasi North	283	41,425	19	10
		Kasarani	280	1,637	5	2
6	Embakasi East	Embakasi South	282	21,044	14	4
		Embakasi East	285	3181	9	4
7	Embakasi West	Embakasi West	286	24,273	5	4
		Embakasi Central	284	16,333	3	3
8	Makadara	Makadara	287	15,501	15	15
9	Kamukunji	Kamukunji	288	30,259	10	8
10	Starehe	Starehe	289	10,428	10	5
		Mathare	290	80,982	16	8
		Total			**186**	**130**

b) The KEPH at Primary Health Care Facilities

A total of 672 health facilities offer services at various level of care. Hospitals (9%) and Nursing homes (7%) comprise 16 % of the total number of health facilities, while primary health facilities comprise of: Clinics (55%), Dispensaries (20%) and Health centres (9%) which constitute 84% of the total number of health facilities (Table 8).

With regards to ownership, majority (52%) of the facilities is privately owned, 22% are Government owned and the remaining 27% are owned by Not-for-Profit; Faith Based Organizations (FBOs) and Non-Governmental Organizations (NGOs). Several unregistered facilities operate in underserved areas, especially in the informal settlements. The 48 services of the KEPH at Primary Care level are listed in **Table 10**.

Table 8: Number of Public, Faith based, NGO and Private Health facilities at various levels of care

Level of care	Infrastructure	Number functional, by type of provider				Total
		Public	Faith Based	NGO	Private	
County Referrals	Total facilities	**4**	**10**	**1**	**32**	**47**
	Total beds	1,048	442	0	2,425	**3,915**
	Total functional Community Units	10	0	0	0	**10**
	Total with functional boards	10	1	0	1	**12**
Primary Care facilities	Total facilities	**111**	**76**	**50**	**397**	**606**
	Total beds	537	440	40	600	**1,617**
	Total functional Community Units	120	0	0	0	**120**
	Total with functional management committee's	110	28	0	0	**138**
Overall total for County	Total facilities	**115***	**86**	**51**	**429**	**681**
	Total beds	1,725	882	40	3,025	**5,672**
	Total functional Community Units	130	0	0	0	**130**
	Total with functional Governance structure	95	2	0	0	**97**

*Details of public health facilities per sub-county are shown in Table 9

Table 9: Distribution of Health facilities by ownership per Sub-county at various levels of care and community units as at 2017

Sub county	Category	*Public	FBOs	NGOs	Private	Total
Westlands	Hospitals	0	0	0	5	**5**
	Nursing/maternity homes	0	0	0	0	**0**
	Health Centres	2	0	0	0	**2**
	Dispensaries	4	2	0	0	**6**
	Clinics	0	2	3	39	**44**
Dagoreti	Hospitals	1[a]	3	0	5	**9**
	Nursing/maternity homes	0	0	0	2	**2**
	Health Centres	2	1	0	6	**9**
	Dispensaries	5	6	2	10	**23**
	Clinics	3	2	9	34	**48**
Langata	Hospitals	1[b]	1	0	6	**8**
	Nursing/maternity homes	0	0	0	3	**3**
	Health Centres	3	1	0	4	**8**
	Dispensaries	28	5	1	14	**48**
	Clinics	0	8	0	34	**42**
Ruaraka	Hospitals	0	1	0	3	**4**
	Nursing/maternity homes	0	1	0	1	**2**
	Health Centres	7	5	0	0	**12**
	Dispensaries	3	5	0	2	**10**
	Clinics	2	2	0	33	**37**
Kasarani	Hospitals	0	1	0	1	**2**
	Nursing/maternity homes	0	0	0	8	**8**
	Health Centres	6	0	0	0	**6**
	Dispensaries	0	6	0	0	**6**
	Clinics	0	0	3	39	**42**
Embakasi east	Hospitals	0	1	0	2	**3**
	Nursing/maternity homes	0	2	0	20	**22**
	Health Centres	4	5	0	15	**24**
	Dispensaries	1	0	0	0	**1**
	Clinics	2	0	0	13	**15**
Embakasi west	Hospitals	1	0	0	0	**1**
	Nursing/maternity homes	0	0	0	7	**7**
	Health Centres	3	0	0	2	**5**
	Dispensaries	1	2	2	3	**8**
	Clinics	1	5	6	29	**41**
Makadara	Hospitals	0	1	1	0	**2**
	Nursing/maternity homes	0	0	0	0	**0**
	Health Centres	4	3	1	3	**11**
	Dispensaries	2	1	0	2	**5**
	Clinics	7	1	15	6	**29**
Kamukunji	Hospitals	1	0	0	4	**5**
	Nursing/maternity homes	0	0	1	7	**8**
	Health Centres	1	0	0	0	**1**
	Dispensaries	2	1	0	3	**6**
	Clinics	1	2	3	14	**20**
Starehe	Hospitals	0[c]	2	0	6	**8**
	Nursing/maternity homes	0	0	0	5	**5**
	Health Centres	1	0	0	0	**1**
	Dispensaries	9	5	1	9	**24**
	Clinics	7	3	3	30	**43**
Total		**115**	**86**	**51**	**429**	**681**

*Does not include National Referral Hospitals; Spinal Injury [a], Kenyatta National Hospital[b] &Mathare Mental Hospital [c]

a) The KEPH at the Hospitals

Nairobi City County has three public hospitals namely; Mbagathi District Hospital, Mutuini Hospital and Mama Lucy Hospital, and one maternity hospital -Pumwani Maternity Hospital. Several large hospitals are under private ownership. Some of them (Nairobi Hospital and Aga Khan Hospital) offer premium care not only to the County but also to the East Africa region.

Nairobi City County hosts three facilities owned by the National government (Kenyatta National Hospital, the largest referral hospital in the country; Mathare Hospital- a specialty hospital for mental health care; and the National Spinal Injury Hospital that specializes in rehabilitative care and spinal injuries. Together, these hospitals contribute significantly to healthcare delivery in the County. There is also the Armed Forces Memorial Hospital managed by the Department of Defence (DoD) that provides healthcare services to members of the Kenya Defence Forces (KDF) and their families. The main distinctive services at the hospital level include specialized clinics and advanced diagnostic, imaging, rehabilitative and 24 hr services. The 51 services of the KEPH at hospital level are listed in **Table 10**

b) The KEPH at the Pharmacies

Most recent records of the Pharmacy and Poisons Board listed **1,402** registered pharmacies in Nairobi City County. This figure includes manufacturing outlets, wholesaling and distributing outlets, hospital pharmacies as well as retail pharmacies. Nearly all pharmacies are privately owned. A considerable number of outlets are not registered and operate illegally especially in the informal settlements. This is indicative of weak enforcement of regulatory systems by the regulatory body Pharmacy and Poisons Board (PPB) as well as the County government. There is a trend where a considerable number of residents go directly to private pharmacies to purchase drugs over the counter before visiting health facilities or getting appropriate prescription. The primary explanations for this trend is that it's seen as time-saving for the client as compared to lining up at the health facility and also as a "cheaper" alternative by avoiding the costs associated with consultations. This is a major behavior challenge that needs to be address in the strategic plan period through policy review, enforcement and behavior change programming.

c) KEPH for Disaster Preparedness and Management Services

At the time of development of this strategic plan, disaster preparedness and management services within Nairobi City County are largely managed by the office of the President through the National Operations Center in collaboration with the division of disease surveillance and response under the Ministry of health at national level. The County needs to develop its own adequately staffed and equipped disaster preparedness and management department with links to the national center for coordinated and effective service delivery.

Table 10: KEPH services offered at Community, Primary Care and Hospital levels

# units currently providing service KEPH Services	Community	Primary care	Hospitals	Total Facilities
Number of Service Units >>	121	**447**	**48**	**616**
Eliminate communicable conditions				
HIV/AIDS	121	210	13	223
Malaria	121	227	5	232
Tuberculosis	121	184	6	190
Pneumonia	121	276	13	289
Measles	121	223	12	235
Worm infestations	121	256	12	268
Diarrheal diseases	121	291	13	304
Halt, and reverse increasing burden of non-communicable conditions				
Heart diseases	121	259	13	272
Cancers	n/a	262	13	275
Mental disorders	11	259	12	271
Hypertension	16	287	14	301
Diabetes	121	282	14	296
Reduce the burden of violence and injuries				
Road accidents	121	197	12	209
Domestic violence/SGBV	121	218	32	250
Suicide	n/a	208	32	240
Drowning	121	208	32	240
Wars / conflicts	4	208	32	240
Provide emergency, referral and rehabilitative services				
Accident and emergency	n/a	115	48	163
Emergency life support	n/a	112	48	160
Specialized diagnostic services	n/a	n/a	4	4
Specialized therapies	n/a	n/a	20	20
Medical rehabilitative services	n/a	9	4	13
24 hour services	n/a	15	4	19
Provide essential medical services				
General outpatient services	n/a	447	48	495
Number offering 24 hours general outpatient services	n/a	90	48	138
Integrated MCH / family planning services	n/a	337	30	367
Maternity	n/a	227	48	275
New born services	n/a	211	48	259
Reproductive health	n/a	219	30	249
In Patient	n/a	220	48	268
Clinical laboratory	n/a	187	25	212
Specialized laboratory	n/a	18	21	39
Imaging centers	n/a	21	26	47
Pharmacies	n/a	339	30	369
Blood safety	n/a	200	25	225
Rehabilitation	n/a	183	15	198
Palliative care	n/a	218	11	229
Specialized clinics	n/a	186	48	234
Integrated youth friendly services	n/a	147	3	150
Operative surgical services	n/a	162	27	189
Minimize exposure to health risk factors				
Health promotion including health Education	121	414	30	444
Sexual education messaging	121	374	48	422
Substance abuse messaging	121	374	48	422

# units currently providing service KEPH Services	Community	Primary care	Hospitals	Total Facilities
Micronutrient deficiency control	38	223	24	247
Physical activity	-	-		444
Strengthen collaboration with health-related sectors				
Safe water	121	447	48	495
Sanitation and hygiene	121	447	48	495
Nutrition services	121	447	48	495
Pollution control	12	90	48	138
Better Housing	n/a	17	3	20
School health programming	n/a	29	3	32
Water and Sanitation Hygiene	121	450	48	498
Food fortification advocacy **	n/a	n/a	n/a	0
Population management	121	447	48	495
Road infrastructure and transport	n/a	n/a	n/a	495

Notes:

- Services indicated n/a and shaded are not offered at that KEPH level.
- Some services including; Food fortification and disaster preparedness and management are addressed at the County level

2.2.2. Health Leadership and Governance

The health services management and delivery in the County are led by the County Executive Member for Health. The Chief Officer for Health provides oversight and direction for the implementation of the County policies and oversees the work of the different directors and deputy directors. The ~~wo~~ Directors lead the technical departments:

In the past, the Nairobi Health Management Board provided oversight on policy, resource mobilization, partnerships and collaboration. In line with the Kenya Constitution 2010, the Board will transit from a managerial institution to an Advisory entity that will advise the County Executive Member for Health on County health policy, health financing, resource mobilization, and ~~on~~ partnerships building and collaboration.

The former Provincial Health Management Team (PHMT) and the Nairobi City Council Health Department (NCCHD) were merged to form County Health Management Team (CHMT). The CHMT will be led by the County Director of Health Services (CDH) who reports to the Chief Officer of Health. At Sub-county level, ten Sub-County Health Management Teams (SCHMT) will represent the management structure under the leadership of the Sub-county Medical Officer of Health (SCMOH) who in turn reports to the CDHS.

County Public health facilities are led by Facility Health Management Teams (FHMTs) and facility management committees (FMCs) provide governance and oversight while the County referral hospitals; Pumwani Maternity, Mbagathi, Mama Lucy and Mutuini have hospital boards (HBs) providing governance oversight.

The FMCs and HBs have been meeting regularly but their effectiveness has been insufficient, partially due to the legal framework by which they were created and lack of the requisite induction and training. The FMCs and HBs are expected to provide effective linkages with the communities that these facilities serve as well as good governance oversight for effective; implementation of County health policies and guidelines, resource mobilization, allocation and utilization and performance of the HMTs and HFMTs but remains a challenge due to the technical capacities of the HBs and FMCs.

Nairobi City County receives funding and technical assistance support from several partners. Such partnerships have been crucial, but the coordination of their activities is often challenging which results in duplication of activities, wastage of resources and undeserving some County priorities.

There is urgent need to effectively coordinate partners under one office at the CHMT level and to continue convening annual stakeholder's forums that bring stakeholders together. Similar situations exist at Sub-County level and Sub Counties have emulated this practice. Parallel to these arrangements are numerous stakeholder meetings focusing on technical or disease based programs.

Regular sharing of information on resource gaps and ~~on~~ program performance with all concerned stakeholders and partners, in health and non-health sectors, has remained a challenge. Nairobi City County intends therefore to increase the efficiency of such arrangements through clearly spelt memorandum of understanding, better preparation, organization, design and follow up of stakeholder and other partnership forums.

2.2.3. Health Workforce

Nairobi City County HRH Mission is to "To have a motivated, adequate and effective health workforce through harmonized and improved schemes and terms of service, performance management, structured education and training programs, comprehensive databases and adequate financing". The County envisions to have a ***"A motivated, effective and competitive health workforce providing quality healthcare"***

The County has a public health workforce estimated at 3,290 of which 2,604 (79%) are technical staff. This excludes staff of national referral institutions (KNH, Spinal Injury and Mathari Hospital) and medical officers/registrars currently undertaking specialized studies. The technical staff mainly comprise of Nurses (1,379; 41.9%), Clinical officers (269; 8.2%), Public health officers (202; 6.1%), Medical Officers/Specialists (292; 5.8%) and Laboratory technologists/technicians (170; 5.2%). Table 11 below outlines the available health workforce and gaps within Nairobi City County Department for Health.

Table 11: Available Health Workforce by Cadres in the Public Sector within Nairobi City County (MTEF 2014/2015 – 2019/2020)

S/No	Cadre	In post	Required	Variance/ Gap
1	Medical Officers/Specialists*	191	377	-186
2	Dentists*	24	55	-31
3	Community Oral Health Officers*	13	30	-17
4	Dental technologists*	1	8	-7
5	Pharmacists*	38	77	-39
6	Pharmaceutical Technologists*	36	80	-38
7	Clinical officers*	269	420	-151
8	Nurses*	1,379	1,813	-434
9	Health information records officer*	43	103	-60
10	Nutritionists*	56	195	-139
11	Occupational Therapists*	24	145	-121

S/No	Cadre	In post	Required	Variance/ Gap
12	Physiotherapists*	28	96	-68
13	Orthopaedic technologists *	27	115	-88
14	Laboratory technologists/technicians*	170	250	-80
15	Radiographers*	18	40	-22
16	Medical Engineering Technologist/Technicians*	19	24	-5
17	Health promotion officers*	2	30	-28
18	Medical Social Worker*	16	63	-47
19	Public health officers*	202	342	-140
20	Malaria and pest control officers*	16	0	16
21	Community Health Officers*	0	137	-137
22	Community Health Assistants (CHAs)*	28	111	-83
23	Community Development Officers*	4	0	4
24	Health Administrative officer	7	42	-35
25	Administrative officer	9	17	-8
26	HRM/administrative clerks	5	9	-4
27	Office administrators/secretarial staff	10	25	-15
28	Copy typists	4	4	0
29	Telephone Operator	11	11	0
30	Cooks/chefs	23	37	-14
31	Drivers	43	66	-23
32	Clerical officers	197	250	-53
33	Mortuary Attendants/funeral superintendents	10	20	-10
34	Other Non-clinical staff	367	218	149
		3,290	5,208	-1,916

*Technical staff

The major challenges include the compensation package, working conditions and tools as well as uncertainty over transition to devolved health services. Occupational safety and health risks, as per MOH Occupational Safety and Hazards (OSH) risk assessment of 2012, are deemed high with a high non-compliance status attributed to lack of a clear OSH program and designated safety resource persons at facilities.

For labour related issues the County government is guided by a collective bargaining agreement signed by the County government and the MOH. This agreement needs updating since it was formulated before the advent of the County government. The County government should also establish a well-equipped medical centre to take care of its own staff and a well-coordinated referral system.

There exist variations in the terms and conditions of staff employment currently working in the County health services and drawn from the previous City Council or from the National government services. These variations affect motivation amongst staff. Although staff accept and are committed to change there are challenges in creating a harmonized and coordinated workforce at Nairobi City County owing to the fact that staff were previously managed under different structures (Nairobi City Council, Local Government and Ministry of Health), but also to the fact that many stakeholders support human resources for health: by stakeholders directly supporting staff employment in County health services (e.g. development partners) or by receiving government staff to work in their (faith based organizations and non-governmental organizations) services at equitable packages harmonization can be realized. The County will need to invest Funding for salaries and training is projected at KSh 5.9b, KSh 7.7

billion and KSh 9.9 billion in the FY 2016/17, 2017/18 and 2018/19 respectively to plan for 1,250 staff planned HRH forecast in the plan period.

a) Community Health Volunteers

The CUs in the County are served by 7,151 **CHVs**. In accordance with the staffing norms requirements for every 10,000 population in need of community units in 2013, Nairobi City County requires 0.38 Community Health Assistants (CHAs) for every CU. It requires 42 trained Community Health volunteers per CU or 7,350 CHVs when all the 217 CUs are operationalized.

These unsalaried volunteers (CHVs) provide a great contribution to preventive services and their expansion has taken place thanks to the support that Nairobi City County enjoys from partners who offer to pay for their stipends. In addition, 28 CHAs (Kindly consult on the numbers) are employed by the County government. They train and supervise the CHVs. Their limited number (28 versus 111 required) contributes to the existence of non-fully functional CUs.

b) Facility Based Technical Staff

In order to fill gaps in staffing, existing County facilities need to employ approximately **1,916 health workers** (MTEF 2014/2015 – 2019/2020), Most pressing gaps concern public health officers, doctors and nurses.

c) Administrative and Support Staff

There are 711 or 22.5% staff available of the required 1440 to provide support roles to the technical and health system management staff. This represents a significant gap that is essential to ensure effective and efficient service delivery at the County's health facilities and offices.

d) Health System Managers

Health system managers comprise of members of the County Health Management Team (CHMT), the Hospital Management Teams (HMT) and the Sub county Health Management Teams (SCHMT). Nine SCHMTs (with average 8-12 members) transited to nine (9) health zone/Sub-county teams in January 2015. Embakasi SCHMT was further split into two (Embakasi West and East) to give a total of ten Sub-county teams. The CHMT currently consists of the former PHMT and the City Hall Teams. Rationalization of their distribution to the new jobs and scheme of service is needed, as well as an assessment of their leadership and management capacity. Capacity building will then be required to meet knowledge, skills and practices gaps in order to build strong teams. There is a need to see health system managers dully prepared to take up their roles right from pre-service training in line with the current HRH policy

2.2.4. Health Financing

Under the Medium-term expenditure framework (MTEF) program based budgeting, Nairobi County will plan three health programs (namely Preventive and promotive health services, Curative care and General administration, planning and support services) and 12 sub programs and in line with the policy objectives (Table 12).

Table 12: Medium-term expenditure framework (MTEF) health programs and subprograms

Programs	Sub-Programs	(Policy) Objectives

Program 1: Preventive and promotive health services	**SP 1:** HIV/AIDS prevention and control unit **SP 2:** TB control **SP 3:** Malaria control and others communicable diseases **SP 4:** Reproductive health, Maternal, Neonatal, Child and adolescent Health (RMNCAH) (*Family Planning, Maternal and Child Health, Nutrition, Psychosocial counseling, School health*) **SP 5:** Environmental/Public Health (*Environmental Health unit, Epidemiology & Disease control unit, Health promotion unit, Oral health, Community health services, NCDs*	• To eliminate communicable conditions • To halt and reverse the rising burden of non-communicable conditions • To Minimize exposure to health risk factors
Program 2: Curative care	**SP 1:** County Referral Hospitals **SP 2:** Health Centres& dispensaries	• Provide essential emergency and medical rehabilitative services • Provide essential health care medical services • To reduce the burden of violence and injuries
Program 3: General administration, planning and support services	**SP 1**: Health policy, planning and financing *(Health policy and planning unit, M&E Unit, Health sector coordination unit)* **SP 2:** Administration/Human resource for Health* **SP 3:** Health Commodities **SP 4:** Research, Quality assurance & standards unit *(Research unit, Quality assurance & standards unit)*	• To strengthening collaboration with health-related sectors. • To provide oversight and management support required for delivery of quality health care.
	SP 5: Coroner services unit	

*sub Program comprises of I office administration of County Health Management Team, 10 Sub County Health Management Teams, County Director of Health Services, Chief Officer of Health, Nairobi Health Management Board, Ambulance services and urban Slums.

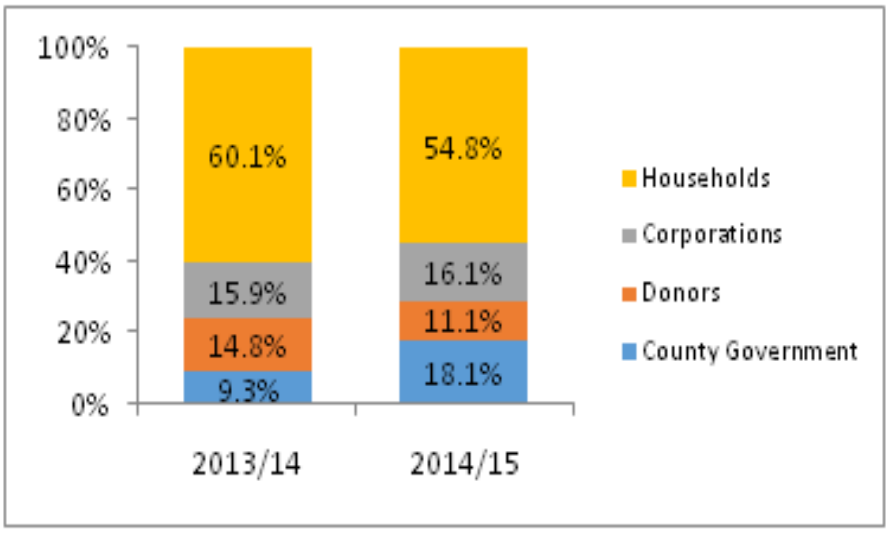
Health Expenditure

The Total Health Expenditure (THE) for Nairobi City County was at Ksh. 22.5 billion (USD 259.7 million) and Ksh. 27.4 billion (US 300.3 million) for the year 2013/14 and 2014/15 respectively. The per capita expenditure on health was Ksh. 5,992 (USD 69.1) and Ksh. 7,012 (USD 76.8) respectively in 2013/14 and 2014/15 compared to Ksh. 6,326 nationally. Although Health Expenditure as a Percent of Total County Government Expenditure increased from 8.8% FY 2013/14 to 18.1% it still remains low when compared to some Counties which had allocation of up to 56% to 55% of total County Government expenditure.

Financing sources

Nairobi City County health services are financed through national government allocations, County revenue, Corporations (including health and medical insurance), households (individual out of pocket payments(OOP) and development partner funding (donors). Nairobi City County households are the major financiers of health care, contributing more than half of the total health expenditure (NCC CHA, 2016)

Figure 3: Breakdown of THE by Financing Source, 2013/2014 and 2014/2015



Source: Nairobi City County Health Accounts, 2015

This predominant reliance on households to finance health exposes poor households to catastrophic and impoverishing expenditure.

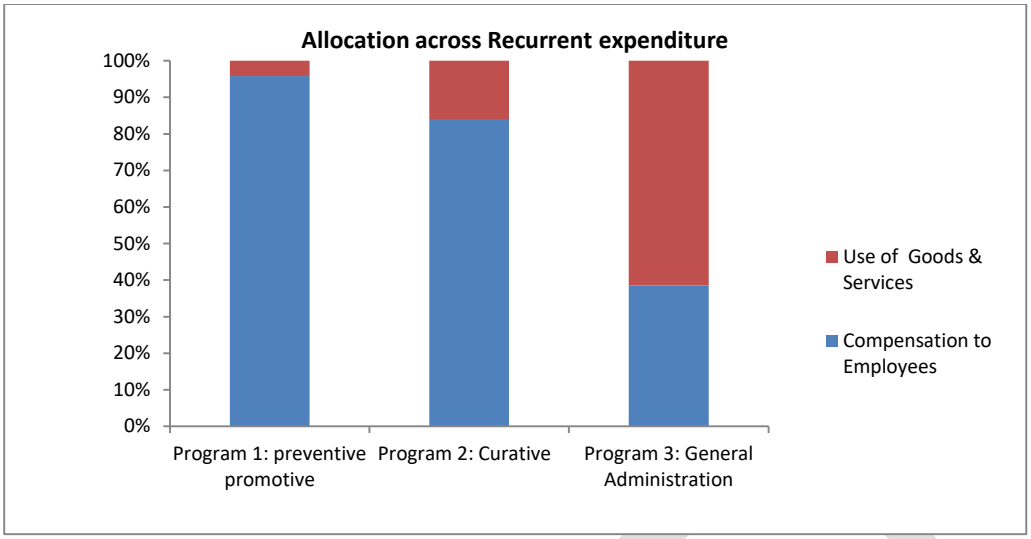
The County government financial allocation to the health sector has increased from Ksh. 3.15 billion in FY 2013/2014 to 6.7 billion in FY 2017/2018 and is projected to increase to 7.4 billion FY 2018/2019. However, the amounts allocated by the County government to the health sector over the year are barely half of the requirements (Table 13).

Table 13: Financial allocation to Nairobi County health sector FY 2013/2014 - 2018/2019

Financial Allocation	2013/2014	2014/2015	2015/16	2016/2017	2017/2018	2018/2019
Recurrent Expenditure Allocation	**2,280,486,648**	**5,229,761,157**	**5,038,443,165**	**5,450,391,916**	**5,741,000,000**	**5,771,292,271**
Personnel costs	1,787,270,187	4,429,280,761	3,673,343,302	4,161,391,916	4,645,000,000	4,465,028,979
Use of Goods & Services	493,216,461	800,480,396	1,365,099,863	1,289,000,000	1,096,000,000	1,306,263,292
Development Expenditure Allocation	**869,500,000**	**910,500,000**	**1,760,000,000**	**1,100,000,000**	**1,254,000,000**	**1,695,000,000**
Total Allocation to Health	**3,149,986,648**	**6,140,261,157**	**6,798,443,165**	**6,550,391,916**	**6,995,000,000**	**7,421,681,304**
Total amount required	**12,211,272,409**	**16,848,541,227**	**18,393,429,949**	**12,145,701,861**	**13,376,279,255**	**14,125,138,548**
Financing gap	**9,061,285,761**	**10,708,280,070**	**11,594,986,784**	**5,595,309,945**	**6,381,279,255**	**6,703,457,244**

Besides, most of the allocation in recurrent expenditure is mainly on personnel.

Figure 4: Recurrent expenditure allocation to the Health Sector per Program and sub Program



Revenue collection has not been adequate for two main reason. Firstly, the revenue streams within the health sector from; are the City mortuary, Hospitals (user fees), Ambulance fees and through the public health office for services such as Laboratory fees-water and food analysis, birth & death certificates, Food handlers license, Food hygiene license, Court fines, Institution Inspection Fees, Liquor sales premises, Export certificates, Health certificates, Inoculation, Pest control and Health occupation certificates. Revenue collection has not been adequate due to challenges in logistics such as lack of computerization of services and centralized services. Secondly, the national policy changes on healthcare financing e.g. the abolition of user fees in 2013, has affected revenue collection at the facility level. This calls for innovation and new strategies for alternative methods of resource mobilization.

Various development partners and non-governmental organizations support Nairobi City County in improving service delivery at community and facility level, in improving health information system, in strengthening health leadership and management, and addressing gaps in the health workforce and health infrastructure. The total contribution from partners remains difficult to estimate owing to inadequate coordination of resource flows to beneficiaries and the fact that most of the contribution is indirect. Individual expenditure at the private hospitals is also unknown.

Sustaining the resources in support of health services delivery in Nairobi City County is a key challenge. Delays in disbursement of funds from the national government is attributed to inadequacies in reporting and lengthy mechanisms that steer the flow of funds. However, the policy on retention of user fees collections and the facility improvement funds at facilities have been instrumental in eliminating inefficiencies and supporting continued service delivery.
The devolved system of governance envisages funds to be pooled in the County Revenue Fund. As such, management of facility user fees needs to be reviewed. Furthermore, the low coverage of health insurance requires increased efforts to recruit more people into the National Health Insurance Fund. Other pooling mechanisms need to be developed to minimize the burden of out of pocket spending on County residents.

2.2.5. Health Information System

Data management is still predominantly manual. Only 35% of level 2 and 3 and 50% of level 4 health facilities use electronic medical records systems (Table 14). At community level CHWs report to the linking Health facility using household registers. At the health facility level, data are collected using cards and registers and are then summarized and analysed together with data from the community level for onward transmission to the respective Sub-county for entry into $DHIS_2$. $DHIS_2$ is a, a web based application that also produces reports of the aggregate community and facility routine data, vital events, survey or audit data, and of certain case-based or patient-based data. DHIS2 produces data aggregated at County level.

Challenges of a manual system include overburdening of staff with too many tools and consequent poor utilization of data. Additionally, most private health facilities do not submit all their reports. Electronic Medical records system is gradually being introduced as health facility level with support from stakeholders.

Table 14: Performance on Health Information Management

#	Intervention	Previous year total (Actual)
1.	% of **level 2 and 3** health facilities with HRIOs per the standard norms	0.9
2.	% of **all health facilities** in the County that are reporting in the DHIS	79
3.	% of all health facilities in the County that are reporting **on a timely basis**	95
4.	% of **Private sector/ FBO/ NGO** facilities that are reporting	63
5.	% of public **health facilities** that are reporting	98
6.	% of **level 2 and - 3** facilities using DHIS data/ information for decision making	49
7.	% of **level 2 and 3** health facilities that are using **electronic medical records** systems	35
8.	% of **level 4** health facilities that are using **electronic medical records** systems	50

2.2.6. Health Products and Technologies

Nairobi City County estimates the need for pharmaceuticals and non-pharmaceuticals in public facilities to be KES 2.46 billion for the year 2013-2014. Circa 57% of this amount concerns products and technologies for priority programs such as Immunization, HIV/AIDS, Tuberculosis, Malaria, Reproductive Health and Nutrition, to a large extent funded by bilateral and multilateral partners. This raises obvious sustainability concerns.

Due to inefficient resource allocation criteria and reporting delays challenges exist in needs quantification and in equitable distribution of available commodities. This results in stock outs at different levels of the current pull system (KEMSA, facilities) and compromises rational drug use. A workforce not allocated on the basis of workload exacerbates this.

In 2012-2013 Nairobi City County received circa KES 155 million for Essential Medicines and Medical Supplies from the government, accounting for less than 50% of the needs. Approximately KES 50 million worth of medicines and supplies was procured using user fees collected in the facilities during that period.

Information technology successfully entered the field of commodity data management, specifically in quantification, reporting and ordering. However, a significant proportion of the public facilities still use manual systems, while inadequacies in pharmaceutical staffing exacerbate management problems. Those human resource limitations also compromise the good prescribing and dispensing practices and, combined with a weak regulatory framework, resulted in a weak quality assurance framework with regard to post-market surveillance and pharmacovigilance.

Additionally, fragmentation of procurement and supply chain programs of different partners lead to inefficiencies and duplications. The use of KEMSA for pooled procurement and distribution still provides the most cost effective purchases of quality products in a timely manner. Nearly all the community pharmacy outlets in Nairobi City County are privately owned. There is need for County owned community pharmacies.

2.2.7. Health Infrastructure

Investments in medical physical health facility infrastructure, health equipment, information and communication technology and transport need to accompany the expansion and modernization of both the primary and referral care levels. There is need to ensure that the referral level remains responsive to the demands of a wide range of quality referral care generated by a highly performing primary care system.

a) **Physical Infrastructure**

Of the 681 health facilities in the County that are shown in Table 9, only 115 (17%) are publicly owned comprising of 4 County referral Hospitals, 33 health centres, 55 dispensaries and 23 clinics (Table 15). There is need to increase the number of health facilities, to upgrade the dispensaries and clinics to health centres, and health centres to sub county referral hospitals to increase access to health services. The health facilities also need to be adequately equipped to offer services that are commensurate with their levels of care. The county also needs to collaborate with other sectors to improve access roads to some of the health facilities.

Table 15: Summary of Registered Facilities in Nairobi City County by Level of Care and Ownership

Level of care	Public	FBOs	NGOs	Private	Total
Hospitals	4	10	1	32	47
Nursing/maternity homes	0	3	1	53	57
Health Centres	33	15	1	30	79
Dispensaries	55	33	6	43	137
Clinics	23	25	42	271	361
Total	115	86	51	429	681

a) Medical equipment

The national standard norms policy guidelines set the basic type and number of equipment requirements at each level of facility. Medical equipment is available in the County owned facilities, though not at optimal levels. Key equipment is often poorly maintained mainly due to irregular financing.

b) Communication and ICT

Some of the County owned facilities use electronic medical records (EMR). This allows data collection, data analysis and data sharing from facility level to County level, and for some to the National level. Partners supported those initial initiatives. Many healthcare workers are ICT compliant but the critical mass needed to trigger the really positive results of ICT is not there yet. In health centers one finds more often 1-2 computers but often lack maintenance system. Sub-county or County hospitals are better endowed, while the three large hospitals possess their own ICT departments that can initiate basic EMR operations. CT systems are yet to start at the dispensary level.

c) Ambulances

There are 17 functional basic ambulances in the County's health department but not fully equipped. They are mainly linked to health facilities and used for the referral of patients from one health facility to another in addition to being used as utility vehicles. The discussion started at the CHSIP development process should continue and culminate at the development and Operationalization of a fully functional Ambulance services system with fully equipped ambulance vehicles.

d) Transport

There is no clarity about the status of the transport, evacuation and referral system in the County and the department responsible for this need to be established and fully operationalized. This needs to start at the development of policy and operational guidelines, assessment of the state of assets and determination of the allocation arrangements for optimum service delivery.

2.3. SWOT Analysis

The following figure summarizes the SWOT analysis for Nairobi City County department for health during the development of the CHSIP in 2013. The department for health shall seek to utilize its strengths to minimize the apparent weaknesses, take advantage of existing opportunities and be proactive in the way it manages foreseeable threats. The areas of partnerships intervention are presented in Table 22 and Table 23.

Table 16: SWOT analysis

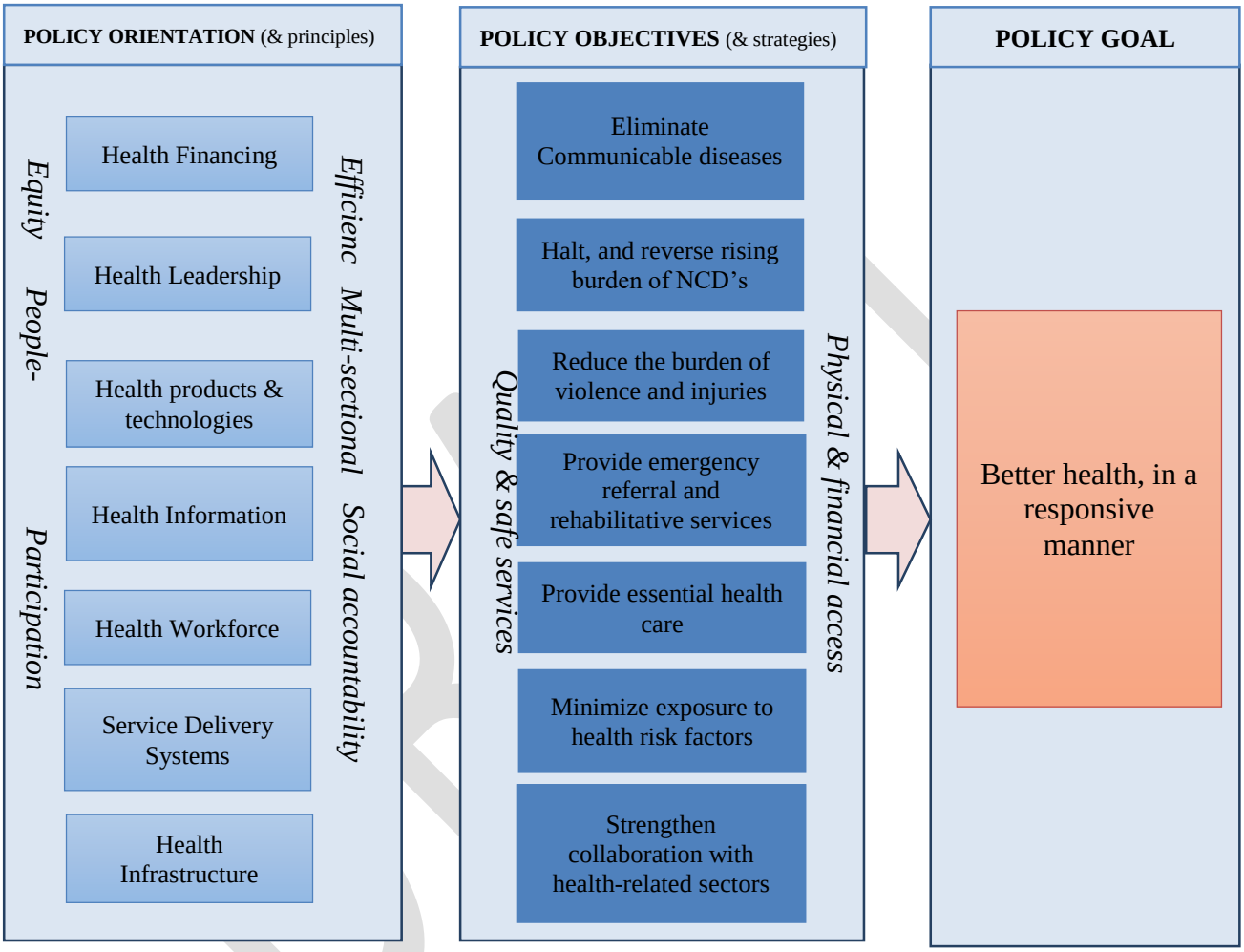
STRENGTHS	WEAKNESSES
• Common Mission and Vision and shared values exist • Governance structures are working (FMCs, HBs, SCHMT, CHMT) and meet at monthly intervals • There is accountability and there is team work amongst health care providers • Formulated work plans are being implemented • Health care workers are on performance contracts • Support supervision to effectively monitors progress • Quarterly review meetings to monitor implementation • Workforce is in place at all levels and majority of staff are on permanent and pensionable terms • Provision of funds to employ support staff • Health services are free at tier 1, 2 and some in tier 3 • Community Strategy implementation to ensure linkages • Public-Private Partnerships and Inter-sectoral collaboration	• Leadership and management skills gaps and lack of clarity on duties and responsibilities • Insufficient funding of County priority programs • Inadequate maintenance of infrastructure • Lack of coordinated planning between implementers • Sub-optimal monitoring and evaluation system and inconsistent feedback mechanisms • Sub-optimal capacity to respond to emergencies and referrals • Gaps in numbers of staff across cadres and inequitable distribution of workforce in view of workload • Non-harmonized terms and conditions of employment and lack of clear job progression paths • Irregular flow of funds which interrupts staffing • Gaps in human resources management (HRM) hence inadequate handling of chronic absenteeism, reduced productivity, which affects service delivery • Succession planning and management not prioritized • Information technology not utilized effectively to support service delivery • Data repositories for staff, infrastructure and service delivery not updated timely • High staff turnover in private facilities hampers HIS management
OPPORTUNITIES	**THREATS**
• SGD framework presents new opportunities to emphasize on investments in health • Presence of political goodwill to support health services • Commitment of stakeholders to support health programs • Emphasis on intersectoral collaboration by County government • County Government Act 2012 provides conducive environment for devolution of health services • Staff support from existing health professionals' associations • More training institutions providing more health professionals.	• Uncertainty over new County health structures and systems • Disasters and emergencies • Disease outbreaks • High dependency on donor funding, especially for priority programs • Parallel programs by development partners • Inconsistent health seeking behaviour in the population • High levels of poverty and inequality in a large proportion of the city's population • High level of rural urban migration • Low compliance with rules and regulations by professionals • Rising insecurity • Insufficient funding

SECTION 3: STRATEGIC DIRECTION

3.1. Overview of the County health policy

County Health Policy (2016 -2025), in line with the National Health Policy, is the guiding document in the formulation of the County Health Strategic and Investment Plan.

Figure 5 : Nairobi County Health Policy Framework



- The policy goal, defines the overarching intent and impact that the policy is designed to accomplish regarding the health of all citizens in Nairobi City County.
- The policy objectives define how the sector will attain the policy goal.
- The policy orientations provide a guideline relating to investments to be made in order to facilitate attainment of the policy objectives.
- Investors will use the principles in planning, implementing and evaluation of their activities

3.2. County Health Mission, Vision and Values Statements

Mission
To provide quality healthcare services that are accessible, equitable and sustainable to the population of Nairobi City County and beyond.

Vision
A city County providing world class health services

Goal:
'Attaining the highest possible standard of health in a manner responsive to the needs of the population'.

Core Values

1. Respect for human dignity and for cultural diversity
2. Professionalism
3. Innovativeness
4. Integrity
5. Responsiveness
6. Social accountability

3.3. County Policy Objectives

1. Elimination of communicable conditions
2. Halting and reversing the rising burden of non-communicable conditions
3. Reducing the burden of violence and injuries
4. Provide emergency, referral and rehabilitative services
5. Provide essential health care
6. Minimizing exposure to health risk factors
7. Strengthening collaboration with health-related sectors

3.4. Strategic objectives and Key strategies

The NCC Strategic Objectives define the County actions and initiatives that the County will undertake to achieve the Policy Objectives and to deliver its vision.
Make reference RMNCH framework

County Policy objective 1: Eliminate communicable diseases

SO 1: To improve access and quality of healthcare services at both community and facility level, with emphasis on environmental health and MNCH, through County regulations review and enforcement, increased staffing, capacity building and infrastructure development.

The key strategies are to:

i. Prioritise preventive and promotive services to manage and control communicable conditions

ii. Increase immunization coverage through immunization coverage and reduce dropout rate through, Good documentation and increased immunization service hours
iii. Create demand for immunization services through outreaches and increased immunizing facilities Increase ANC uptake through health talks in the facilities and at community levels on the importance of early FANC, Identification and referral of ANC mothers from the community and strengthening of MNCH WITs
iv. Promote inclusivity and social protection of vulnerable groups, through improved access to health services
v. Design and implement effective integrated health programs; strengthen inter – sectoral collaboration
vi. Scale up interventions towards elimination of HIV and AIDS with a focus on target populations
vii. Eradicate vector borne diseases and vermins.
viii. Promote rational use of antimicrobials and other drugs to minimize drug resistance to pathogens
ix. Control of infectious conditions at ports of entry
x. Strengthen disease surveillance and health information systems for complete and timely reporting of communicable disease incidences
xi. Scale up implementation of community high-impact health interventions through Community Health Strategy
xii. Adhere to International and National health guidelines
xiii. Scale up sanitation and hygiene activities.
xiv. Promote food and water safety.
xv. Water harvesting for cleaning purposes
xvi. Heating water from incinerations (leveraging fuel)

County Policy objective 2: Halt, and reverse increasing burden of non-communicable conditions and mental disorders

SO 2: To improve awareness of NCDs risk factors, strengthen screening programs and treatment through; health promotion and education, behavior change programs, capacity building of staff and Community Health Workforce and development of specialized clinics.

i. Prioritise and enhance universal access to interventions addressing NCDs and mental disorders
ii. Promote and strengthen advocacy, communication and social mobilization for NCD prevention and control
iii. Implement inter-sectoral programs for non-communicable disease prevention and control
iv. Strengthen screening for non-communicable diseases to enhance access and early detection and management
v. Strengthen integrated surveillance systems to monitor NCDs and mental disorder trends and conduct research to inform health policy and planning
vi. Strengthen nutrition interventions towards NCD prevention and control

vii. Strengthen health systems for NCD prevention and control across all levels of the health sector including establishment and strengthening of NCD clinics,

viii. Capacity building of health care workers and CHVS on NCDs and mental health prevention and control.

ix. Implement interventions to reduce the modifiable risk factors for NCDs at all stages of life including: healthy diet, physical activity, and reduction of harmful use of alcohol, tobacco use and environmental factors

x. Implement interventions to reduce exposure to environmental, occupational and biological risk factors such as reduction in air pollution, advocate for recreational public spaces.

xi. Prioritize management of alcohol, drug and substance abuse in the County

xii. Promote sustainable partnerships with both local and international organizations for the prevention and control of non-communicable diseases

County Policy objective 3: Reduce the burden of violence and injuries

SO 3: To prevent the main causes of injuries and improve health outcomes with emphasis on traffic and GBV injuries through review and enforcement of legislation and strengthening of multi-sectoral collaborations and programs.

Policy strategies will ensure that causes of injuries and violence are addressed with special consideration for gender, age, persons living with disability and geographical distribution.
The key strategies are to:

i. Gender mainstreaming planning and implementation of all health programs.
ii. Promote corrective and inter - sectoral preventive interventions to address causes of injuries and violence;
iii. Facilitate universal access to timely and high-quality emergency care services to manage injuries and violence, and their sequelae
iv. Scale up physical and psychosocial rehabilitation services to address long-term effects of violence and injuries
v. Promote public health aspects of buildings and road safety
vi. Integrate rights based programming and child protection approaches to promote optimal health and child survival

County Policy Objective 4: Improve access to quality emergency, referral and rehabilitative services

SO 4: To improve emergency referral and rehabilitative services in the County by capacity building of staff at all levels, expanding ambulance services and development of trauma centers.

The NCC health sector shall improve referral and emergency care services to a level capable of providing efficient and effective emergency care in to the city's population and its environs.

The key strategies are to:

i. Design, pilot and implement appropriate service delivery models for hard to reach areas and disadvantaged population groups;

ii. Strengthen coordination and functionality of referral system at community and heath facility level
iii. Renovate and equip public health facilities to offer specialized diagnostic services and, comprehensive emergency and rehabilitative care
iv. Strengthen Disaster Risk Management with an emphasis on Emergency Preparedness and Response (EPR).
v. Capacity build staff on emergency & trauma and rehabilitative care
vi. Strengthen coordination and functionality of referral system at community and facility level

County Policy objective 5: Provide essential healthcare

SO 5: To improve essential medical service delivery by expanding physical infrastructure, provision of adequate health products and technology, implementing alternative service delivery strategies and addressing human resource capacity gaps through recruitment and training.

The key strategies are to:

i. Strengthen KEPH service delivery at the defined levels of care; establish fully functional referral systems
ii. Adopt High Impact Nutritional Interventions through implementation of Community Health Strategy
iii. Design and implement appropriate service delivery models for hard-to-reach and underserved areas e.g. medical outreaches, beyond zero clinics
iv. Ensure access to comprehensive maternal, neonatal, and reproductive health services;
v. Integrate quality improvement approaches in preventive, promotive and curative services
vi. Prioritize nutritional interventions and management of NCDs
vii. Invest in and ensure access to quality diagnostic services;
viii. Ensure provision of safe and adequate blood and blood components in the County
ix. Promote establishment of institutes and centres of excellence as a means to ensure availability of highly specialised quality care in the County and in addition promote health tourism;
x. Strengthen health management information to support evidence based decision making at County level
xi. Invest in Information, Communication and Technology (ICT) infrastructure and software for the management and delivery of care;
xii. Capacity development of health workforce at facility and community levels
xiii. Establish and strengthen community health units

County Policy objective 6: Minimise exposure to health risk factors

SO 6: To reduce exposure to health risk factors through health education, behavior change intervention, advocacy and other multi-sectoral programs

To minimise health risks, the sector will strengthen health promotion interventions and facilitate the use of products and services that lead to healthy lifestyles in the population.

The key strategies are:

i. Promote healthy diets and lifestyles across all lifecycles; prevent micronutrient deficiencies and disorders through integrated programs and inter – sectoral collaboration

ii. Advocate for infrastructure changes to include walking paths, cycling lanes, playgrounds
iii. Promote appropriate infant and young child feeding practices;
iv. Promote a healthier environment and intensify primary prevention of environmental threats to health, including protection from bio-hazardous materials
v. Enforce regulations to ensure that Environmental Impact Assessments (EIA) are conducted prior to major infrastructural development projects
vi. Enforcement of public health laws
vii. Implement Behavioural Change and Communication (BCC) strategies to promote healthy practices and mitigate risk factors, particularly among target populations
viii. Institute population-based, multi-sectoral, multidisciplinary, and culturally relevant approaches to promoting health, diet, and physical activity
ix. Strengthen mechanisms for the screening of health risk factors and management of non-communicable conditions
x. Strengthen inter – sectoral collaboration mechanisms for regulation of the food industry to promote healthy products and responsible marketing

County Policy objective 7: Strengthen collaboration with private and other sectors that have an impact on health

SO 7: To build and strengthen partnerships with the public and private sectors to address priority health system needs in the county including; access roads, clean water, school health program and occupational health.

The key strategies are:

i. Adopt a 'Health in all Policies' approach to establish strong inter- sectoral linkages:
   - In the design, implementation, and evaluation of interventions
   - To address core social determinants of health in all sectors related to: women's literacy, access to safe water and adequate sanitation, safe housing, occupational hazards, road safety, security, income, and community participation, among others.
ii. Develop a framework for engagement with partners
iii. Strengthen community participation (Planning, design, Implementation & Monitoring) for service delivery through social accountability
iv. Hold quarterly stakeholder's forums
v. Establish partnerships with the private sector to ensure services are more accessible and affordable to the less privileged and marginalized communities and the under-served
vi. Establish partnerships with the private sector to ensure emergency services are more accessible to the less privileged and marginalized communities and the under-served
vii. Strengthen community participation in designing implementation and Monitoring and Evaluation

3.5. Investment areas

The seven investment areas will give a guideline related to the areas where investments will be made and will enable decision-makers to accurately track the health system progress and performance.

1. **Service Delivery Systems** refers to how health service delivery will be organized;

2. **Leadership and Governance** refers to How health service delivery will be managed;
3. **Health Workforce** refers to the Human Resources required for the provision of Health Services;
4. **Health Financing** refers to the systems needed to ensure adequate resources for service provision;
5. **Health Information** refers to systems for generation, analysis, dissemination, and utilization of health-related information;
6. **Health products and Technologies** refers to the essential medicines, medical supplies, vaccines, health technologies, and public health commodities required in provision of services;
7. **Health Infrastructure** refers to the physical infrastructure, equipment, transport, and Information Communication Technology needed for delivery of health services

3.6. Health Sector Targets

Health sector targets will effectively guide monitoring and evaluation of performance during implementation and progress of the Strategic Plan. They are categorized into three:

1. Targets for Scaling Up the Provision of KEPH Services
2. Targets for Outputs and Outcomes
3. Targets for Heath Inputs

3.6.1. Targets for Scaling Up the Provision of KEPH Services

The Kenya Essential Package for Health (KEPH) remains the framework that defines the package content for different levels of the County health system. These packages aim different age cohorts as described in the lifecycle approach. The number of Service delivery units providing the essential package of health (KEPH) at 5 levels of Care, Level 1 to Level 6 and at leadership and governance.

The 5 levels of care require a well-defined number of effectively operational units that provide quality services, accessible to County residents. In order to address the gaps that currently exist, the Nairobi City County Health Department proposes to expand the number of services available in different service delivery units as well as to expand the number of service units (Table 17).

Table 17: Current number of community units, primary care facilities and hospitals and management teams providing the KEPH.

Tier	Number of Units (Current)	Notes on Current Status	Targeted Expansion or Construction Level	Total # Upgraded or Constructed
Primary Care Level 1 (Community)	**121**	174 established, of which 121 are fully functional.	138 new fully functional CUs	**259 Community** Units
Primary Care level 2 & 3	**102**	19 dispensaries and clinics under various levels of disrepair and providing services beyond their level per the standard norms.	19 dispensaries and clinics to be upgraded to health centers	**39/102** Primary Health facilities upgraded and functional as

(Dispensary and Health centers)		12 health centers have limited 24 hrs services (11 of 12 have maternity services)	12 current and 8 new health centers upgraded to offer 24 hr services as standard health centers	health centers as per standard norms
Level 4 (Sub county hospitals)	**3**	• Dagoretti needs level 4 hospital • Delayed completion of Mathare- Korogocho • Stalled Pumwani Nyayo wards need completion to become Level 4:	Three fully functional level 4 hospitals at: • Dagoreti (Mutuini new) • Mathare-Korogocho • Pumwani Nyayo Wards	**Three f**unctional level 4 Hospitals
Level 5 County Hospitals	**0**	• Critical need for level 5 hospitals • Critical need for one Trauma Center	• Upgrade three current level 4 hospitals to fully functional Level 5 hospitals) • Construct Full Functional Trauma Center	• **3** Functional level hospitals • One functional trauma hospital
SCHMT	**9**	Transit the 9 DHMTs into 10 SCHMTs to oversee 17 administrative sub counties	10 SCHMTs offices established	**10** SCHMTs formed and offices established
CHMT	**1**	Former PHMT and NCCHD transformed into one CHMT.	One Fully functional CHMT	**1** CHMT formed

3.6.2. Targets for Outputs and Outcomes

KEPH services provided by Nairobi City County Health Sector will translate into outcomes and outputs for which the Strategic Plan sets specific targets. When outcome levels are already high at baseline, the focus will be on maintaining them and benchmarking them effectively. When outcome levels are low at baseline, an annual progress will be projected.

The success of the Strategic Plan will be measured by the achievements in the outcomes and outputs. Outcome and output targets will be reflected in Annual Work Plans of Sub- counties, hospitals and facilities and in the performance contracting plans. Health management teams at the various levels will provide performance management, supervision and support.

Table 18: Service Delivery Outcomes and Outputs

(Strategic) Objective	Indicator	Targeted trend's		
		Baseline (2013/14)	MidTerm (2016/17)	EndTerm (2018/19)
Objective 1: Eliminate Communicable Conditions **SO 1:** To improve access and quality of healthcare services at both community	% of eligible HIV clients on ARVs	75	80	85
	% HIV+ pregnant mothers receiving preventive ARVs	62	85	90
	% of mother to child transmission of HIV	8	5	3
	% of TB patients completing treatment			
	% of TB patients screened for HIV	82	94	95

(Strategic) Objective	Indicator	Targeted trend's		
		Baseline (2013/14)	MidTerm (2016/17)	EndTerm (2018/19)
and facility level, with emphasis on environmental health and MNCH, through County regulations review and enforcement, increased staffing, capacity building and infrastructure development	% of Children under 1 year of age fully immunized	72	82	86
	% of under 5's treated/managed for diarrheal diseases	3	7	19
Objective 2: Halt and reverse increase in Non-Communicable Conditions **SO 2:** To improve awareness of NCDs risk factors, strengthen screening programs and treatment through; health promotion and education, behaviour change programs, capacity building of staff and development of specialized clinics.	# of clients treated for diabetes	12,677	40,805	44,167
	% of adult population with BMI over 25	35	30	25
	% clients screened for diabetes	No Data	30	70
	% clients screened for hypertension	No Data	56	70
	% of women of reproductive age screened for cervical cancer			
	% of new outpatients with mental health conditions	0.7	0.5	0.4
	# of specialized health facilities offering specialised NCD services	0	5	10
	# of CHVs trained on NCDs Module 13	No Data	300	400
	# of community focal persons and CHAs trained on Pm+	No Data	30	50
	# of community focal persons and CHAs trained on Hypertension	No Data	30	50
	# of community focal persons and CHAs trained on Asthma	No Data	40	60
	# of community focal persons and CHAs trained on Diabetes	No Data	25	50
	# of health care workers trained on hypertension	No Data	25	50
	# of health care workers trained on Diabetes	No Data	40	70
	# of health care workers trained on Asthma	No Data	40	70
Objective 3: Reduce the burden of violence and injuries **SO 3**: To prevent the main causes of injuries and improve health outcomes with emphasis on traffic and GBV injuries through review and enforcement of legislation and strengthening of multi-sectoral collaborations and programs.	% new outpatient cases attributed to Road Traffic Injuries	2	1	1
	% of population experiencing gender based violence	1	0.2	0.1
	% new outpatient cases attributed to other injuries	1.5	1.4	1.3
	# of health facilities providing quality SGBV services	3	7	10
	# of GBV program review forums	0	4	4
Objective 4: Provide emergency, referral and rehabilitative services **SO 4:** To improve emergency referral and rehabilitative services in the County by capacity building of staff at all levels, expanding ambulance services and development of trauma centers.	Number of call centres established			
	Number of functional call centres	0	1	1
	Utilization rates for services	No data	No data	No data
	Referral rate from referring service	No data	No data	No data
	Client satisfaction with referral	No data	No data	No data
	# of persons with disabilities receiving rehabilitation services	146	1550	1650

(Strategic) Objective	Indicator	Targeted trend's		
		Baseline (2013/14)	MidTerm (2016/17)	EndTerm (2018/19)
Objective 5: Provide essential medical services **SO 5:** To improve essential medical service delivery by expanding physical infrastructure, provision of adequate health products and technology, implementing alternative service delivery strategies and addressing human resource capacity gaps through recruitment and training.	% of Pregnant women attending at least 4 ANC visits*	30	58	70
	% of Deliveries conducted by skilled health personnel*	50	73	80
	Fresh Still Births in the facility	1500	1095	900
	Maternal case fatality rate	7	4	2
	% Children under 5 years attending Child Welfare Clinics for growth monitoring (new cases)			
	% of under 5's attending Child Welfare Clinics who are under weight	8	7	5
	% of Children under 5 years attending Child Welfare Clinics who are stunted	No data	16	15
Objective 6: Minimize exposure to health risk factors **SO 6:** To reduce exposure to health risk factors through health education, behavior change intervention, advocacy and other multi-sectoral programs	% of women of reproductive age currently using a modern FP method*	523,323	3	684,460
	% of New-borns with low birth weight (LBW – less than 2,500 grams)	5010	2980	2823
	% infants under 6 months on exclusive breastfeeding	57	65	70
	% of children aged 6 -59 months receiving vat A supplements twice a year	54	60	70
	# of buildings plans vetted, approved and report submitted within 7 days	3,150	3,325	3,450
	% of households with access to a sanitary facility	7	7	10
	# of commercial premises fumigated against pests and vermins			
	% of Households provided with health promotion messages	180000	195,000	220,000
Objective 7: Strengthen collaboration with health-related sectors **SO 7:** To build and strengthen partnerships with the public and private sectors to address priority health system needs in the County including; access roads, clean water, school health program and occupational health.	No. of functional community units	50	121	239
	No. of community units with score cads	2	40	180
	# of Households with access to a sanitary facility (pit latrine/ water closet)	231,529 28%	**314,708** 37%	**380,796** 49%
	# of Households with access to safe water	231,529 28%	296,777 35%	398,909 51%
	# of biannual stakeholders' forum held	2	2	2
	% of MOUs signed with public, schools and training institution and private partners	0	50	80
	# of outlets with designated smoking zones	15,245	**16,007**	17,000
	% of schools implementing school health program	No data	168	300

Table 19: Targets for Investment Outputs

	Indicator	Targeted trend's		
		Baseline (2013/14)	Mid Term (2016/17)	Target (2018/19)
ACCESS				
Improving access to services	% of population living within 5 km of facility	80	80	85
	# of public facilities providing BEOC	16	18	30
	# of public facilities providing CEOC	3	3	4

	# of population counselled, and tested for HIV	500,00 14%	900,000 25%	1,200,000 34%
	% of facilities providing immunization	302	439	439
QUALITY				
Improving quality and safety of care	TB success rate (%)	84	87	89
	% of health facilities with Functional QITs/WITs			
	Number of laboratories with stock-outs of tracer diagnostic commodities (RTKs, Malaria, TB Stains, Urinalysis, stool o/c, Sugar)	0	0	0
	Number of laboratories ISO 15189:2012 accredited	0	5	10
	% maternal audits/deaths audits	10	90	100

3.6.3. Targets for Heath Inputs and processes

Table 20: Baseline, Midterm and end term targets for Heath Inputs and processes

Investment area	Indicator	Targeted trend's		
		Baseline (2013/14)	Mid Term (2016/17)	Target (2018/19)
Service delivery ***Policy orientation 1***: An efficient service delivery system that maximizes health outcomes	# of community units	123	123	175
	# of functional community units Established	121	121	126
	% of health workers trained or updated on emergency & trauma, care services skills			
	% of health workers trained or updated on referral care services skills	4	60	80
	# of health workers trained or updated on disability and rehabilitative care services	100	200	400
	% of health staff trained in disease surveillance and response			
Leadership and Governance ***Policy orientation 2***: Comprehensive leadership and governance that delivers on the health agenda	# Quarterly CHMT supportive supervision visits to SCHMTs and Hospitals	2	4	4
	# of Quarterly Stakeholders' meetings held	4	4	4
	CHMT and Hospital Boards operations policies and guidelines developed or reviewed	0	1	1
	Health policy developed	0	1	1
	County Strategic and Investment Plan developed	0	1	1
	County Health Sector M&E framework developed	0	1	1
	Research coordination framework developed	0	0	1
	# Monthly CHMT management meetings	4	4	4
	# of County Annual work plan developed	1	1	1
	County M&E TWG established	0	1	1
	Framework for engagement of partners developed	0	1	1
	Annual Implementation Development Plan (AIDP) Developed and implemented	0	1	1
	Staff performance appraisal system for all staff developed	1	1	1
Health Workforce ***Policy orientation 3:*** Adequate and equitable distribution of human resources	Number of facility health workers (including CHAs)	2900	3290	5208
	Number of Community Health Volunteers (CHV's)			
	Harmonize Staff salaries	0	1	1
	Formulate a HRH advisory committee to address HRHM and HRD	0	0	1
	Develop an HRH costed plan	0	1	1
	Develop and implement job descriptions with clear performance indicators	0	1	1
	Develop Clear and specific Job Description for CHMT, SCHMT and facility level management	0	1	1
	Develop HRH policy guidelines	0	0	1
Health Financing ***Policy orientation 4:*** Adequate finances mobilized, efficiently allocated and utilized, with social and financial risk protection assured	MTEF report developed	0	1	1
	% allocation of County total expenditure to the health sector	5 B	7 B	10 B
	Total available financing	12 million	18 million	19 million
	Funds from County treasury devolve to the Health sector for efficient spending	0	1	1
	Procurement plan reviewed and implemented	0	1	1
	Manage and monitor the absorption rate of capital budget (MTEF)	0	1	1
	Manage and monitor the operational expenditure	0	1	1
	Asset management plan (disposal, inventory, maintenance, repair etc.) developed and rolled	0	1	1

Investment area	Indicator	Targeted trend's		
		Baseline (2013/14)	Mid Term (2016/17)	Target (2018/19)
	% of population recruited into the National Health Insurance Fund	20	25	35
Health Information ***Policy Orientation 5:*** Adequate health information, for evidence based decision making	Integrate ICT in service delivery at the health facility level and community level			
	% of public facilities with integrated established Electronic Medical records	0	30	60
	% of health facilities submitting complete DHIS data in a timely manner*			
	# of health workers trained on integrated health information systems	20		234
Health products and Technologies ***Policy Orientation 6:*** Universal access to essential health products and technologies	% achievement of commodity security			
	% of Health facilities reporting and receiving malaria commodities	131	138	140
Health Infrastructure ***Policy orientation 7:*** Adequate and appropriate health infrastructure	# of HFs providing specialized services (MDR, peadiatric, mental methadone, SGBV)	2	4	4
	# of HFs providing rehabilitation services	10	13	15
	% of public health facilities with specialized diagnostic services	2	4	4
	Total No. of functional ambulances	6	20	22
	Number of functional call centres	0	1	1
	Total No. of functional ambulances with basic life supporting equipment and supplies	0	7	7
	% of public facilities with functional computers			
	Number of public laboratories	40	50	65
	Number of health facilities with capacity to do basic laboratory diagnosis	40	50	65
	Proportion of laboratories carrying out good Biosafety / Biosecurity practices	40%	55%	80%
	%Percentage of inspected facilities meeting safety standards*			
	Develop and implement an emergency infrastructure plan			
	Services Delivery Charter review and implemented	0	1	1

	Capital projects	Total cost	FY 2015/16	FY 2016/17	FY 2017/18	FY 2018/19
Health Infrastructure ***Policy orientation 7:*** Adequate and appropriate health infrastructure	Upgrade the Riruta Health CentreNCC	**19**	14	5		
	Upgrade the Dandora Health Centre	**21**	16	5		
	Upgrade the Karen Health Centre	**25**	15	5	5	
	Upgrade the Mathare North Health Centre	**25**	10	10	5	
	Upgrade the Mukuru Kwa Njenga Health Centre	**30**	10	10	10	
	Upgrade the Embakasi Health Centre	**25**	10	10	5	
	Upgrade the Mama Lucy hospital	**150**	50	50	50	
	Upgrade the Mbagathi hospital / mortuary	**100**	80	15	5	
	Install security cameras around the health facilites	**5**	5			
	Complete the Mbagathi hospital incinerator	**30**	25	5		
	Upgrade the Mutuini hospital to level 5 hospital	**164**	157	7		
	Upgrade Pumwani to a woman and baby hospital (Turn Key)	**500**	500			
	Upgrade and renovate the Bahati Health Centre into a paediatric centre	**20**	20			
	Upgrade the existing maternity facilities to Sub County hospitals	**115**	20	30	30	35

	Capital projects	Total cost	FY 2015/16	FY 2016/17	FY 2017/18	FY 2018/19
	Rebrand the existing health facilities	**333**	120	100	53	60
	Procure modern medical equipment	**200**	50	50	50	50
	Procure appropriate ambulances and vehicles for each Sub County, major hospital and mortuary	**210**	60	50	50	50
	Rehabilitate and expand the City County mortuary	**1200**	200	300	350	350
	Rehabilitate the Lang'ata crematorium	**40**	30	10		
	Rehabilitate the School of Midwifery	**5**	5			
	Fence the Lang'ata cemetery	**35**	10	10	10	5
	Collaborate with Ministry of Devolution to construct community clinics under the slum upgrading program	**40**	10	10	10	10
	Establish two City County Trauma Centres (in Mama Lucy Kibaki Hospital and Mbagathi Hospital)	**200**	50	50	50	50
	Upgrade Dagoretti sub County Hospital and Kasarani Health Centre into fully fledged L4 hospitals	**430**	100	100	110	120
	Upgrade five existing health centres to offer maternity services	**80**	20	20	20	20
	Upgrade five health centres to 24-hour health facilities	**20**				20
	Upgrade five dispensaries to full health centres	**80**	20	20	20	20
	Establish nine wellness centres within existing health facilities	**40**	10	10	10	10
	Establish offices for health management teams	**40**	10	10	10	10
	Establish nine medical stores	**40**	10	10	10	10
	Construct a forensic lab	**400**	200	200		
	Upgrade the training facilities	**50**	50			
	Acquire 200 acres of land to expand the current cemetery	**700**	300	400		

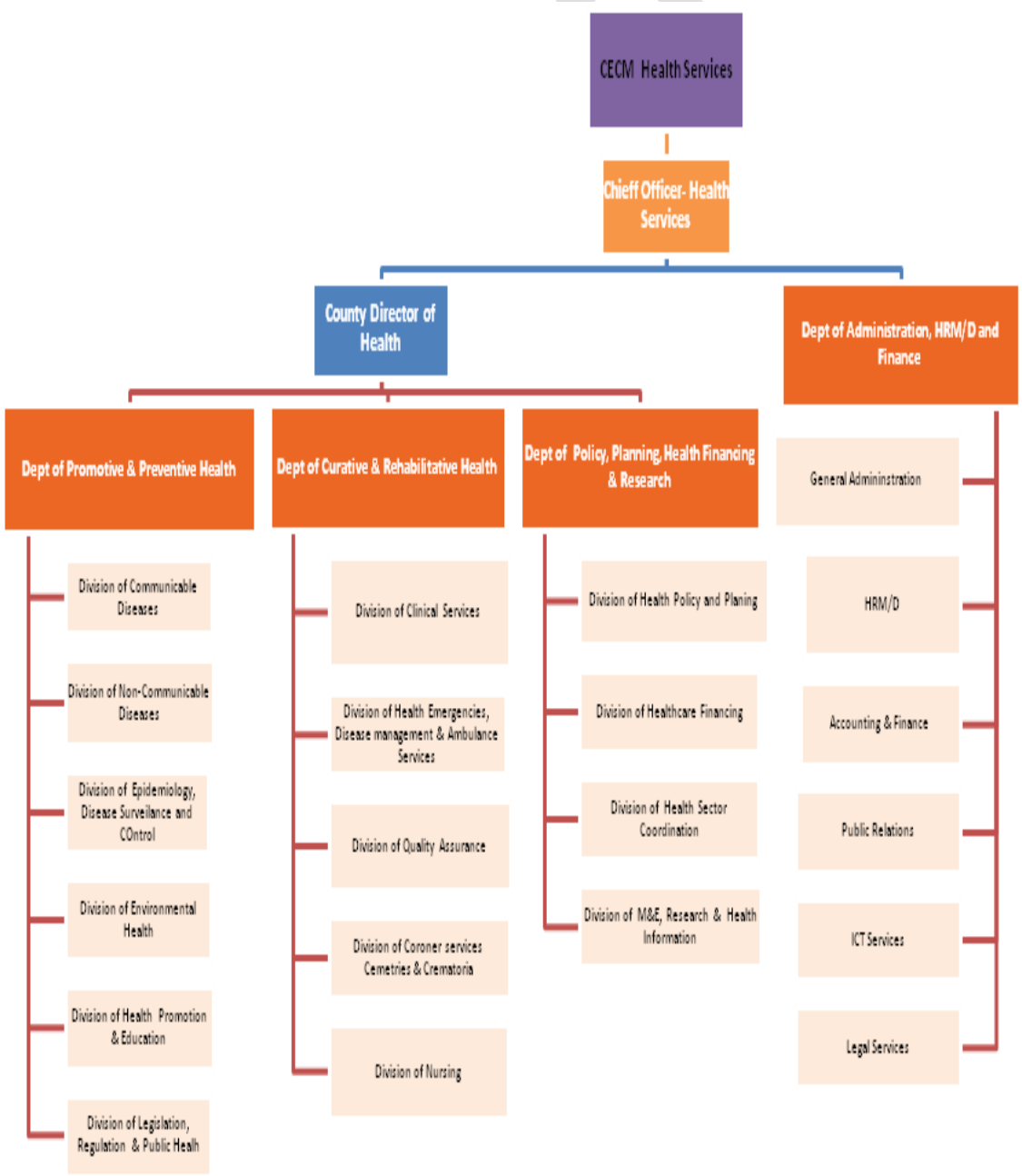
SECTION 4: IMPLEMENTATION ARRANGEMENTS

4.1. Organization Structure

This section outlines the organization of the County Health Services, including organization and implementation arrangements for realization of the Strategic Objectives. It describes arrangements for leadership and governance, for executive and operational management at County, Sub-county and facility levels and for partnership building and coordination.

The organizational structure takes into account constitutional, policy and operational requirements and considerations and outlines advisory, supervisory and communication lines.

Figure 3: Nairobi City County Health Sector Organizational Structure.



a. The County Executive Member for Health

- Appointed by the Governor and approved by the County Assembly
- Provide overall policy direction for the County health system and other functions per article 45 of the Constitution and other statutory functions and roles of the CEM for health per and County Government Act 2012
- Provide strategic direction for the County health sector and health sector.
- Provide executive leadership and management of the County health sector and links to the County Integrated Development Plan (CIDP)
- Oversee executive performance contracting and provides performance management for the COH.
- Report County health sector performance to the County Governor, the executive committee and the County Assembly

b. The Chief Officer of Health

- Appointed by the Governor and approved by the County Assembly
- Provide oversight and direction for implementation of the national and County health policy in line with the constitutional and/or other statutory functions and roles of the COH per County Government Act 2012
- Overall management and oversight of public health facilities in the County;
- Guiding Implementation of policies from the County Executive Committee Member;
- Interpreting, and integrating National Government Health Policy;
- Coordinating development and implementation of Health strategies and priorities;
- Coordinating disaster preparedness and response;
- Management of referral health services: intra- and inter County and to national level
- Principal assistant to the CEM-Health providing executive leadership to the health sector
- Execute the roles of the Chief Accounting Officer for Health
- Report the performance of the County health sector to the County Executive for Health and to the County Assembly as needed.

c. The County Director of Health (CDH)

Recruited by the County public service board in close consultation with the CEM-Health and Chief Officer, the CDH perform functions as stipulated by the County public service board including;

- Directing, planning, budgeting, implementing and evaluating County health programs
- Directing response and prevention of disease, health education, food quality control services
- Abating sanitary nuisances and offensive trade, quarantine administration
- Developing health research standards
- Providing necessary guidance, training and development of professional and technical staff in the clinical practice.
- Planning and managing County health care programs directed towards improvement of health services in the County

- Initiating and assigning in the formulation and implementation of medical policies in the County.
- Overall supervision, training and development of staff in the department
- Regularly report operational performance of the County health systems to the Chief Officer for health.

d. County Health Management Team

Appointed by the Chief Officer for Health in consultation with the CDH and the CEM-Health, the Nairobi City County Health Management Team (CHMT) is responsible for providing leadership and management of the CHSIP strategic objectives and sector targets.
The CHMT shall consist of technical officers and one directors. The CHMT shall be responsible for providing key leadership and management support services including:

- Provide strategic and operational planning including setting management and service delivery targets for improving service delivery units across the County health system Propose policy and operational guidelines for improvements on an annual basis.
- Provide linkages to the State Department for health and align to national health policies.
- Collaborate with state and non-state stakeholders within the County and externally to mobilize technical and financial resources needed to address priority health investments gaps
- Establish effective mechanisms to improve the referrals function within and between the counties, and between the different levels of the health system
- Plan, organize and coordinate execution of stakeholders' forums.
- Monitoring and evolution of the implementation of the NHSIP. Provide managerial support supervision to the Sub counties
- Provide supervision and support to the management of the County Health Facilities and the Sub-county Health Management Teams;
- facilitating County health facilities in the Sub-county to comply with the established standards

e. County Hospital Boards

In order to provide effective governance oversight to the County referral and Sub-county hospitals, the Health sector shall, through the County executive for health, appoint and regulate Hospital Management Boards (HMB) Sub-county hospitals and County referral hospitals) through County legislation and operational guidelines. The County Referral Hospitals shall constitute their own Hospital Management Teams (HMTs).

f. Sub-county Health Management Teams

Nairobi City County is divided into seventeen (17) constituencies. However, it is proposed to have 10 established administrative Sub County Health Management Teams (SCHMTs) responsible for

providing leadership and management of sector targets through improved service delivery at the Sub County level.

The SCHMTs shall consist of seven to nine technical officers chosen among the following: Medical Officer, Clinical Officer, Public Health Officer, Public Health Nurse, Health Records &Information Officer, Health administrator, Laboratory Technologist, Pharmacist and Community strategy coordinator. The SCHMTs shall be responsible for providing key leadership and management support services including:

- Provide leadership and stewardship for overall health management in the Sub counties.
- Provide a linkage between primary health care services with the County health services.
- Sub-county strategic and operational planning, allocation of planned health targets to facilities, departments and individual health workers.
- Provide technical assistance for the development and implement facility health plans (FHPs) and supervise and monitor progress in the implementation of the plans.
- Undertake leadership and management and service delivery knowledge, skills and practice needs/gaps assessments among health workers in the Sub-county and develop capacity building programs to address these gaps.
- Managerial coaching and supportive supervision to facility staff to improve services quality and access
- Technical support services to community units and health facilities to improve quality, access and coverage of health services in all health facilities (Tiers 1-3) within the Sub-county.
- Establish mechanisms for the referral function within and between the Sub counties, and between the different levels of the health system in line with the sector referral strategy
- Coordinate and collaborate with stakeholders (FBOs, NGOs, CSOs, development partners) at the Sub-county level and between Sub counties through County and Sub-county Health Stakeholder Forums
- Provide quality control and ensure adherence to national policies and County guidelines for health service management and service delivery.
- Provide supervision and support to the management of the county health facilities in the Sub-county
- Facilitate County Health Facilities to comply with the established standards

g. Health Facility Management Teams

The County health department will revitalize the formation and operation of Facility Management Committees (FMCs) through County legislation.

Each public health facility at levels 3,4 and 5 will have a Health Facility Management Team (HFMT) responsible for implementation of the daily operations of the facility per the facility annual work plan.

h. Facility Management Committees for Health Centres and Dispensaries

Health centers and dispensaries will have Facility management teams whose membership will consist of; Facility In-Charge, Public Health Officer, Laboratory Technologist, and Pharmacist/Pharmaceutical Technologist Community Health Assistant (CHAs) and any other co-opted member from other departments. The functions of the FHMTs will include:

- Development, of facility annual work health plans and budget Implementation of the facility health work plans including delivery of quality, accessible and affordable services at the health facility
- Monitoring and evaluation of facility annual work plans
- Maintain quality assurance of service delivery at the facility and ensure adherence to health facility operations and technical guidelines

4.2. Partnership and stakeholders' engagement

The county will ensure collaboration with the community and other sectors to deliver community quality, accessible health care especially in improve access roads, provision of clean water, implementation of the school health program and provision of occupational health.

The County shall collaborate with stakeholders to:

i. Improve service delivery and coordination
ii. Reduce inefficiency and duplication of services by partners
iii. Foster opportunities for innovation
iv. Improve accountability

4.2.1. The role of stakeholders

Table 21 below categorizes the County health department stakeholders

Table 21: Summary Table on County Health Department s21 Stakeholders

STATE ACTORS **National level institutions** • **Ministry of Health and Associated SAGAS** - KEMRI, KNH, NPHL, KMTC , NASCOP, KEMSA • **All National Ministries including Ministry of Defence** • **Tertiary institutions** - Government chemist, NCPD, NACC, Office of Director of Public Prosecutions, Judiciary, JKUAT, UON, • **National Assembly/ The Senate** • **Professional Bodies/Unions** **County Level Institutions** • County Assembly and Related departments/ sectors • Other County level agencies
NON-STATE ACTORS IN HEALTH

Development Partners (financiers)

Implementing Partners

- Private Sector Providers
- Faith Based Organizations
- Non-governmental organizations
- Civil Societies/Institutions

CLIENTS / CONSUMERS - Individuals, Households, Communities

4.2.1.1 State Actors

These include the public sector: Ministry of health, Semi-Autonomous Government Agencies (SAGAs), other ministries and the State Department responsible for devolution, Constitutional Commissions, Regulatory Bodies (Boards and Councils) and Professional Bodies/Associations whose mandate is drawn from that of the State, and have an effect on health.

The County Department for Health will develop strategic collaborations with these crucial stakeholders to improve health outcomes and also for resource mobilization and skills transfers to address financing and capacity gaps within the County health system.

4.2.1.2 Non-State Actors

Development Partners

These are financiers in health. They include UN agencies and various government such as the US Government, the Japanese Government, the UK Government and the Danish Government

Implementing partners

Implementing partners in health have played a significant role in social and health sector development in Nairobi, specifically making significant contribution in support for provision of health services to the community. The implementing partners will be a critical source of much needed human and monetary resources that will be needed to implement this plan.

The Private Sector (For-Profit and Not-For-Profit)/FBOs /NGOs/CSOs

Whether for-profit or not-for-profit, the private sector has previously only been partially co-opted for health development. This plan recognizes the need to improve collaboration in order to:

i. Facilitate regular consultative meetings between County Department responsible for health and private providers.
ii. Create public private partnerships that will lead to improved health service delivery and development of health facilities in under-served areas as a step to improve equity.

Untapped expertise and resources available from the private sector in Nairobi City County can provide significant support by expanding quality care to under-privileged populations. In particular, the experiences of FBOs, NGOs and CSOs in working with the community are an asset for the implementation of the KEPH at community level. The County stakeholder fora will be the platform where such collaboration will be coordinated. In addition, the County Department for Health will identify other areas of collaboration with the private sector.

4.2.1.3 Clients/Consumers

Clients represent the core reason for the existence and activities of the sector and are expected to exercise the appropriate health and health care seeking behavior, i.e. to seek health care at the earliest possible moment and take up health care services made available, to maintain their health, particularly disease prevention and control services.

Households take responsibility for their own health and well-being, and participate actively in the management of their local health services. Communities are expected to demonstrate real ownership, commitment to maximizing their health and define their priorities. They focus on ensuring that individuals and households carry out appropriate healthy behaviors and recognize signs and symptoms of conditions that need to be managed at other levels of the system. Finally, communities should facilitate community based referrals and mobilize community resources to address their identified priorities.

The County health department stakeholders will be guided by the priority intervention areas shown in Table 22 and Table 23

Table 22: Priority intervention areas for partner support in service delivery

Area of Health	Key challenges	Priority Interventions
Eliminate Communicable conditions	• Low immunization coverage • Downward trend in FIC coverage • High immunization dropout rate • Sub-optimal measles 2 coverage	• Improve immunization coverage and reduce dropout rate through, Good documentation and increased immunization service hours • Demand creation through outreaches and increased immunizing facilities
	Poor infection prevention and control at the community and health facility level.	• Increase uptake of de-worming through health education and provision of de-wormers • Improve reporting of de-worming for over 5 year olds
	• Missed opportunities in HIV positive ANC clients towards elimination of mother to child transmission of HIV • Poor viral load follow up for HIV patients in CCC sites	• Provision /adequate supply of HIV test kits • Improve uptake of HAART by HIV + pregnant mothers and infant prophylaxis to reduce risk of mother to child transmission through improved follow up and defaulter tracing and screening of all expectant mothers for HIV in all facilities • Capacity building(OJT) on new HIV guidelines to improve provision of PMTCT services; • Increase the number of sites offering comprehensive PMTCT services (mother /baby pairs) • Improve HCW knowledge on viral load tracking through capacity building • Ensure improved data use in facilities through quarterly HIV data review meetings to • Improve HIV patient follow up through quarterly clinical HIV review meetings
	• Increased no. of TB cases • Low cure rate and low case finding of TB patients • Missed diagnosis in TB especially in children. • Challenges in defaulter tracing especially referred out TB clients • Poor nutrition status of TB/ MDR TB patients	• Early detection, Health education, contact tracing • Improve linkage systems after testing and diagnosis • Improve TB cure rate through defaulter tracing • Continuous TB case finding especially for pediatric patients through active case finding and contact tracing • Improve sample networking systems • Improve MDR TB patients' nutritional status through nutritional supplementation
	High level of diarrheal diseases especially among under fives	• Reduce level of diarrheal diseases through health messages, prompt identification and intervention of all diarrheal cases • Provision of referral services from communities • Improve community knowledge on prevention and management of diarrheal diseases
	Lack of adequate diagnosis mechanism	• Strengthen Community screening • Train health workers on NCDs/Nutrition • Procurement of laboratory commodities • Rehabilitation of lab equipment

Halt, and reverse increasing burden of Non-communicable conditions	Late diagnosis of non-communicable conditions	• Strengthen NCDs care program through proper diagnosis and follow up to prevent complications from these conditions
	• Inadequate screening services for hypertension, and diabetes,	• Improved hypertension and diabetes education, screening and follow up at the community/facility level
	• Low level of awareness on mental health and epilepsy	• Implement Pm+ management for mental health in the community • Implement school health programs on epilepsy awareness
	• High numbers of Outpatients that are overweight	• Nutrition counselling and Anthropometric measurements in community and facility level to reduce number of outpatients who are over weight • Community empowerment on improved lifestyle choices
	• Poor reporting and follow up of cancer cases	• Establish Hospital based cancer registry to improve cancer cases reporting in hospitals
	• Low number of women of reproductive age screened for cervical cancer	• Strengthen outreach screening services • Ensure screening commodities/ supplies are available • Proper linkage and reporting systems
	• Inadequate Diagnostic facilities e.g. Cancer registry	• Establish Cancer diagnostic facilities and registry
Reduce the burden of Violence & Injuries	Inadequate disaster preparedness and response	• Improve disaster preparedness and response through strengthening of the emergency response and outbreak response team
	Inadequacy of medical equipment	• Improve availability of medical equipment
	Low number of survivors seeking SGBV services	• Improve awareness on SGBV services availability
	Inadequate uptake of reproductive health services	• Create awareness on reproductive health services through community dialogue and improve health education within the facilities
	Lack of Disability friendly facilities	• Establish disability friendly facilities
	Increased drug abuse and alcoholism	• Establish more Medically Assisted Therapy centers and linking them to rehabilitation centers • Health Education advocating on dangers in drug and alcohol consumption
	Inadequate community awareness on availability of SGBV services	• Increase community awareness on availability of SGBV clinic
Provide emergency and referral and rehabilitative car services	Emergency and referral and rehabilitative car services	• Establish Call centes • Train health workers in emergency care • Functional Ambulance
Provide essential Medical services	Poor referral system	• Strengthen referral systems and linkages at all levels
	Low uptake 4th ANC visit	• Increase ANC uptake through health talks in the facilities and at community levels on the importance of early FANC, Identification and referral of ANC mothers from the community and strengthening of MNCH WITs
	Poor data use for decision making at the facility level	• Improve data utilization for decision making
	High level of malnutrition	• Nutritional counselling/ education, early screening and referral of malnutrition cases

	Erratic /insufficient drugs and other medical supplies	• Ensure timely provision of drugs and all medical commodities
	Lack of Youth friendly and adolescent services	• Establish Youth Friendly Centers
Minimize exposure to health Risk factors	Inadequate Infection prevention measures at community level and health facilities	• Sensitization on infection prevention measures through IPC training and health talks
	Unavailability of safe water sources	• Increase availability of safe water through education and water treatment
	Poor hygiene practices	• Improve hygiene knowledge and practices
	Poor Nutrition practices	• Improve nutrition knowledge and practices in the community and in health facilities
	Un-coordinated school health program	• Strengthen school health program activities
Strengthen collaboration with Health-Related Sectors	Uncoordinated donor funding	• Develop partner engagement framework • Quarterly stakeholders' meetings • Legislations in leadership and governance

Table 23: Priority intervention areas for partner support in Health Inputs

Investment area / policy orientation	Priority Intervention
Service delivery Policy orientation 1: An efficient service delivery system that maximizes health outcomes	• Referral health services • Supportive supervision to lower units • Outreach services • Emergency disaster preparedness planning • On the job training • Medical commodity meetings • Therapeutic committee meetings and follow up • Patient safety initiatives • Community services • Clinical audits including maternal death audits
Leadership and Governance Policy orientation 2: Comprehensive leadership and governance that delivers on the health agenda	• County Health Strategic and investment Plan • County Health Policy • Quarterly stakeholder meetings • Formulation of Health Bills • Monthly management meetings • Annual work plan • Quarterly performance reviews • Monitoring and evaluation • Review of strategic plan
Health Workforce ***Policy orientation 3:*** Adequate and equitable distribution of human resources	• HR mapping and audit • schemes of service/ harmonized remuneration and benefit scheme • Job Descriptions for management • Awareness program for staff on complaints handling procedures • Recruitment of critical missing human resources • HRH research agenda and development plans • Staff performance appraisals • HRH policy/ HRH policy guidelines • Develop MTEF plans on HRH financing • Training programs of Health Workers in accordance with Training Needs Assessments • Staff Performance appraisal system
Health Financing ***Policy orientation 4:*** Adequate finances mobilized, efficiently allocated and utilized, with social and financial risk protection assured	• Annual formulation of Medium Term Expenditure Framework (MTEF) • Quarterly reports on status of financing for activities in AWP • County Health Accounts • Public participation forums • Annual Procurement Plans • Staff capacity building e.g. Finance for non-Financial managers training • ICT in the Public Health Department • Enrolment of community in NHIF • NHIF accreditation of (public) health facilities
Health information ***Policy Orientation 5:*** Adequate health information, for evidence based decision making	• Collate information on health actions at all levels of care • ICT equipment - Monthly compilation, and submission of Health Information using provided formats (manual / electronic) • Collate information from health-related sectors on key indicators • Update information on vital events (births, deaths and cause of deaths) • DHIS training for Private health facilities, FBOs and NGOs • Comprehensive disease surveillance activities • Quality review of Verbal Autopsies- Regular data audits • Data review meetings

Health Products and technologies ***Policy Orientation 6:*** Universal access to essential health products and technologies	• Health Products inventory development and management • Warehousing / storage of health products • Development of annual/medium term procurement/ purchase of required health products
Health Infrastructure* ***Policy orientation 7:*** Adequate and appropriate health infrastructure (Refer to Annex 1)	• Infrastructure inventory development and management • Comprehensive planning for required health infrastructure • Procurement / purchase of required infrastructure in line with norms • Routine maintenance and repair of existing functional infrastructure • Repair of existing infrastructure, to ensure full functionality

*Capital projects are specified in Table 20

4.3. Monitoring & Evaluation Framework

4.3.1. Data Architecture

Indicators used for M&E are often hand tallied from paper-based sources and reported from service outlets to Sub-counties to the County and then further to the national level. Some facilities however have adopted use of electronic medical records (EMR). Reported indicators must then be translated from raw data into useful information.

The data architecture will be comprehensively defined with data standards for all data systems. Data capture, storage, analysis, qualities, transition, applications and manipulation processes will be described. The DHIS2 framework manages all forms of health information: routine information, survey data, research information, vital registration, and surveillance data. The following activities will support improved monitoring and evaluation practices:

1. Support establishment of a common data architecture.
2. Strengthen County use of DHIS 2 and other data aggregator systems (HR, IFMIS)
3. Improve efficiency in data movement from community and facilities to Sub-county level
4. Improve efficiency in data movement into existing data reporting systems
5. Enhance data quality through regular Data Quality Audits and supportive supervision
6. Ensure that all the facilities are using electronic medical records (EMR)
7. Develop standards and guidelines for use of electronic medical or health records systems at all levels.

The County will rely on several data sources such as KDHS, Surveillance Reports, Regular Monitoring Reports, County Specific Surveys, Operations Research Reports, County Annual Review Reports and reports by development partners.

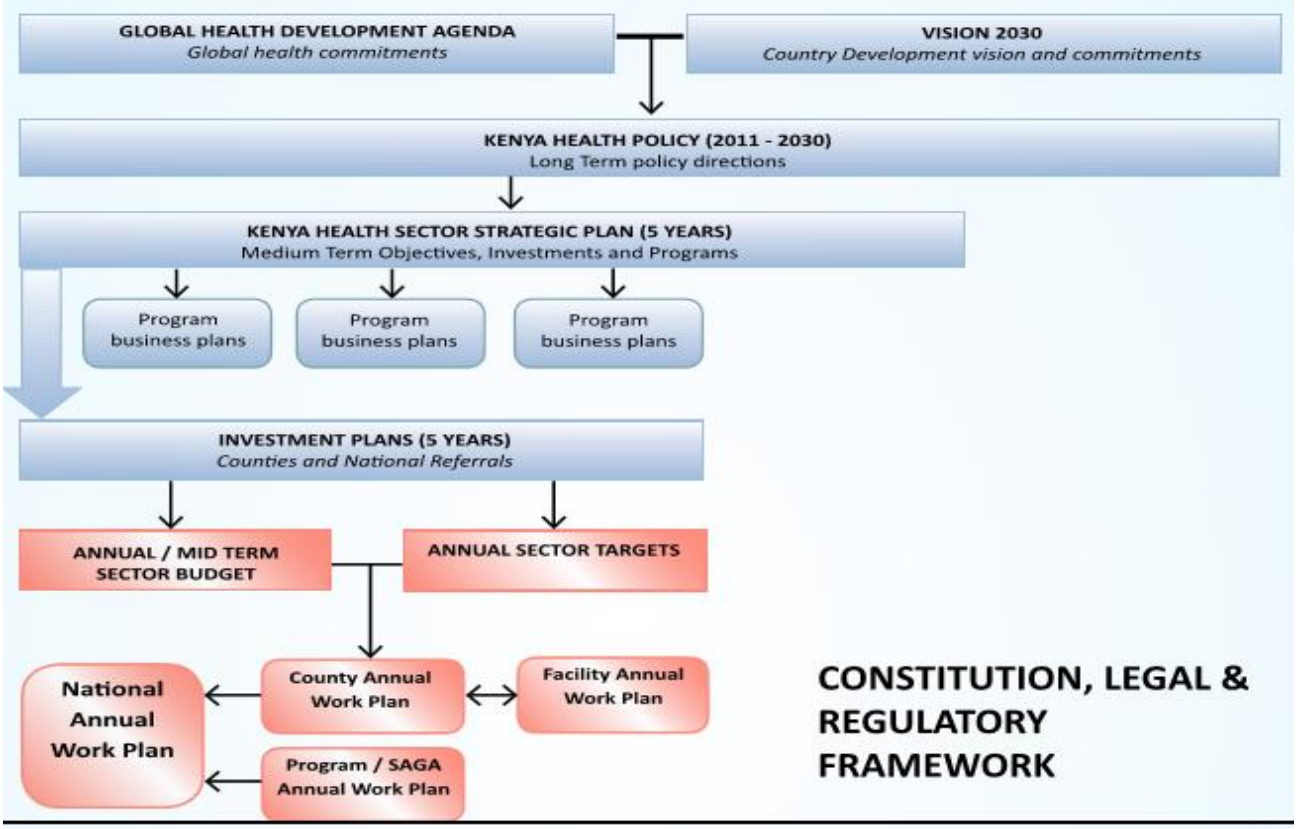
Process monitoring data will be pulled from the established systems such as DHIS2, EMR, mHealth platforms and CHIS for data capture and reporting at community and facility level. Other data for cost effectiveness analysis and impact monitoring and evaluation will be through the population level surveys like KAIS and KDHS.

4.3.2. The Monitoring and Evaluation Framework

The County will adopt the National planning and review framework shown below in Figure 6, to track performance:

This M&E plan will aim at providing quality, timely and accurate evidence for informed decision making and tracking progress. This evidence will feed into the preparation of comprehensive annual work plans at facility, Sub-county and County levels. The County already has continuous weekly, monthly, quarterly and annual processes for reviewing performance.
Other management controls will involve, Progress reports, Performance standards and targets and Performance evaluations (staff, midterm internal and external).

Figure 6: Overaching Planning and Review Framework



The Scheduled reporting and review meetings will provide opportunities for feedback to the County governance structures. The nature and scope of reporting will include: Progress made against the plan, causes of deviation from the plan and alternative solutions and areas of difficulty that may adversely affect implementation

At the **health facility level**, the County/Sub-Counties and stakeholders will need to verify that interventions progress cost effectively towards the objectives of the strategic plan. Performance monitoring of programs will focus on measuring the processes of program implementation and ultimately on increased uptake and utilization of integrated package of health services. M&E methods

will also include baseline reviews and assessments, on-going technical support for monitoring of key performance indicators, midterm & end term reviews and evaluations as appropriate.

At the **County level**, monitoring and evaluation will link program performance with the realization of strategic objectives and contribute to effective strategic information sharing between County level stakeholders. Two evaluations will be carried out during the implementation of the plan, one at the midterm (2015) and the other at the end of the plan period (2018).

SECTION 5: RESOURCE REQUIREMENTS AND FINANCING

5.1. Medium Term Expenditure Framework program based budgeting

Under (MTEF) program based budgeting guideline, the County has three programs which are aligned to sector objectives and the organizational structure for ease of financial planning and administration. The three programs are: Preventive and promotive health services, Curative and rehabilitative health and, general administration. They have respective twelve Sub Programs (Table 12) and 24 delivery units.

5.2. Resource Requirements

Resources that will be required to fund the three programs will include funds for development and recurrent expenditures. The cost estimates total to nearly Ksh. 89 billion are detailed in Table 24 below. Vaccines, anti-malarial commodities, HIV/AIDS commodities and TB drugs are drawn nationally and are therefore not included in this budget.

Table 24: County Resource Requirements versus Allocation

Program	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
Program 1: Preventive & Promotive health services						
SP 1: HIV/AIDS	71,096,973	98,096,270	107,090,985	67,642,849	242,258,577	253,903,963
SP 2: TB Control	17,047,611	20,104,213	31,116,896	53,235,106	53,767,457	54,305,132
SP 3: Malaria C/Others	129,993,252	179,358,595	185,804,474	191,216,905	197,944,074	205,220,014
SP 4: RMNCAH	635,154,933	736,357,001	756,712,566	773,215,175	789,976,106	807,807,327
SP 5: Enviro/Public H	371,625,208	512,751,040	559,766,583	603,181,570	663,498,627	729,848,490
Program 2: Curative and rehabilitative care						
SP 1: County Ref. Hosp	3,158,358,430	3,357,754,904	3,757,329,342	3,804,915,034	3,831,067,787	3,861,294,016
SP 2: H Centres & Disp	5,394,299,517	7,442,801,600	8,125,252,388	8,532,226,781	8,748,684,459	8,952,070,305
Program 3: General admin. planning and support services						
SP 1: HPPR	30,023,749	41,425,361	45,223,766	82,787,634	96,664,300	101,977,257
SP 2: Administration	486,453,725	671,186,046	732,728,926	850,222,299	872,328,472	916,156,826
SP 3: Health Commod	1,237,960,285	1,708,079,568	1,864,698,044	2,177,816,120	2,288,594,281	2,410,380,224
SP 4: Research/QA	128,459,131	177,241,887	193,493,680	195,218,166	198,528,588	201,162,842
SP 5: Coroner services	480,799,595	663,384,742	724,212,299	757,440,776	759,922,255	762,805,218
Total requirement	**12,141,272,409**	**15,608,541,227**	**17,083,429,949**	**18,089,118,414**	**18,743,234,984**	**19,256,931,614**
Total Allocation	**3,149,986,648**	**6,140,261,157**	**6,798,443,165**	**6,550,391,916**	**6,995,000,000**	**7,526,292,271**
Recurrent	2,280,486,648	5,229,761,157	5,038,443,165	5,450,391,917	5,741,000,000	5,801,292,271
Development*	869,500,000	910,500,000	1,760,000,000	1,100,000,000	1,254,000,000	1,725,000,000
Allocation as % of requirement	**26%**	**36%**	**37%**	**36%**	**37%**	**39%**
Financing gap	**8,991,285,761**	**9,468,280,070**	**10,284,986,784**	**11,538,726,498**	**11,748,234,984**	**11,730,639,343**

RMNCAH = Reproductive health, Maternal, Neonatal, Child and adolescent Health
HPPR= Health policy, planning and financing
Note: Nairobi County will need to invest Funding for salaries and training is projected at KSh 5.9b, KSh 7.7 billion and KSh 9.9 billion in the FY 2016/17, 2017/18 and 2018/19 respectively. This will cater for 1,250 staff planned HRH forecast in the plan period.

5 years Budget requirement	88,781,256,188
Ave. Annual Budget	17,756,251,238

Funds from the National Government, County revenue and development Partners and user Fees from Hospitals shall be channelled to the health sector through the County Government Treasury. Each Sub-county and each hospital has a bank account through which they receive the allocated funds. Development partners support various activities to address the financing gaps through the County Government treasury or by directly supporting the programs.

5.3. Strategies to increase funding to the health sector

The County allocation to the health sector is barely half of the estimated cost. The department for health shall focus on ensuring effective resource mobilization, allocation and efficient use of available financial resources. The following are some of the key Resource mobilization strategies by the department over the CHSIP period.

a. Strategies to increase resources for Health

The following specific actions shall be undertaken:

1. Plan for financing through program based budgeting and per the MTEF guidelines
2. Establishment of new resource mobilization mechanisms including proposals, MoUs, Joint Technical Assistance plans.
3. Advocate for increased health financial allocation to the health sector
4. Increase (efficiency in) revenue collection by a) adjusting fees and charges in various revenue streams through revision of the County Finance Act b) devolve services provided by the County health department to the Sub-county level to increase demand and access, and c) establish electronic medical records system for efficient services.
5. Develop a partnership engagement framework to streamline donor funding, to increase involvement in service delivery and accountability and to take care of partners' concerns.
6. Invest in infrastructure to expanding scope of specialized services and cost-share items such as X-Ray, Theatre services

b. Strategies to ensure available resources are appropriately allocated/Sustained

The health sector shall:

1. Adhere to the MTEF guidelines in resource allocation in order to link resource allocation and program priorities and to monitor and measure performance and s
2. Implement cost reduction measures in finds utilization
3. Develop a human resource policy to streamline staffing
4. Actively involve political leadership and public participation in budgeting and expenditure

c. Strategies to Ensure Efficiency in Resource Utilization

All expenditures shall be directed towards realization of the goals and vision stated herein.

1. The County shall Lobby for legislation to devolve funds from the County government treasury to the health sector to increase efficiency in utilization of allocated funds
2. The County shall adhere to Public financial management laws, guidelines and circulars shall be adhered to in the day-to-day management and execution of financial transactions. These efforts

are geared to uphold accountability, transparency and prudence in financial management processes. More specific interventions shall include the following;

i. Introduce IFMIS into all cost centers
ii. Carry-out periodic cost analysis
iii. Strengthen/introduce quarterly monitoring and evaluation
iv. Capacity building of financial and non-financial managers
v. Introduce ICT in the management of health services
vi. Putting appropriate health system in place i.e. introduction of ICT management
vii. Regular support supervision at all levels

Annex 1: The Technical Working Group

Nairobi City County Health Sector

1. Dr. Lucina Koyio - Chair
2. Dr. Thomas Ogaro
3. Dr. Carol Ngunu
4. Dr. Anthony Ng'ang'a
5. Dr. Judy Gichuki
6. Alice Kimani
7. Maureen Muganda
8. Lillian Mutua
9. Nahashon Marebe
10. Mr. Gideon Macharia
11. Esther Kwamboka
12. Dr. Nkatha Meme
13. Emily Orina
14. Zadock Angahya
15. Gregory Miyanga

USAID Afya Jijini

1. Josephine Kinyua Mbiyu
2. Violet Mudibo
3. June Mwende

Annex 2: Bibliography

County Health Strategic and Investment Plan 2013 -2017

Government of Kenya. 2010. Kenya Constitution 2010. Nairobi: National Council for Law Reporting with the Authority of the Attorney General.

Kenya Health policy 2012 – 2030

Kenya Health Sector Strategic and Investment Plan (KHSSP). The Second Medium Term Plan for Health. 2013 -2017

Kenya Health Strategic and Investment Plan 2013 -2017

MOH. 2009. Kenya National Health Accounts 2005/2006. Nairobi: MOH.

MOH. 2013a. District Health Information System. Nairobi: MOH.

Nairobi City County Health Accounts FY 2013/14 and 2014/15

Nairobi City County Health Policy 2016 -2025

Nairobi City County Strategic Plan 2015 – 2025

Annex 3: Achievements as at 2015/2016

Program	Sub-Programs	Delivery units	Performance Indicators	Y1 Baseline 2013/14	Y2 - 2015/16 Achievement	Target	Y3 Target 2016/17	Y5 Target 2018/19
Preventive and promotive health services	SP 1: HIV/AIDS prevention and control unit	HIV/AIDS prevention and control unit	# of eligible HIV clients on ARVs	96915	113,301	116,513	119,072	130,838
			# of population counselled, and tested for HIV	500,000	700,000	800,000	900,000	1,200,000
			# HIV+ pregnant mothers receiving preventive ARVs	3417	5,172	6,967	6,468	7,164
			% of mother to child transmission of HIV	8	6	5	5	3
	SP 2: TB control	TB control unit	# of TB patients completing treatment	11694	13,547	14,076	13,547	15,547
			# of TB cases identified and put on treatment	13319	14,131	12,782	12,774	13,551
			% of TB cases screened for HIV	84	94	93	94	96
			% of TB patients screened for HIV	82	94	93	94	96
			TB success rate (%)	84	87	86	87	89
	SP 3: Malaria control and other communicable diseases unit	Malaria control unit	# health facilities reporting and receiving malaria commodities	131	135	138	138	140
			# of meetings conducted with the SC Malaria coordinators per quarter	4	4	4	4	4
			# of supportive supervision visits conducted per quarter in the SCs	4	4	4	4	4
	SP 4: Reproductive health, Maternal, Neonatal, Child, adolescent Health (RANCH)	Family Planning, Maternal and Child Health unit	# deliveries conducted by skilled attendant	97045	94,096	117,935	99,218	108,681
			# of women of reproductive age receiving family planning services	523323	620,826	561,292	618,516	684,460
			# of newborns with low birth weight	5010	3,000	6,176	2,980	2,823
			# of fully immunized children	111910	117,304	108,008	121,219	129,328
			%of fully immunized children	72	80		82	86
		Nutrition unit	# of children under 5 years underweight	42870	45,014	63,357	66,525	73,344
			% of children under 5 years underweight	8	7	7	6	4
				57	65	75	25	40
			% of pregnant women receiving Iron Folate at least for 90 days	12	65	22	70	80
			% of persons receiving curative nutritional Services	20	65	52	65	80
			# of children aged 6 -59 months receiving vat A supplements twice a year	9204	9,664	9,553	9,664	10,655
			% of children aged 6 - 59 months receiving vat A supplements twice a year	54	60	61	70	80
			% of children under 5 years stunted	n/a	n/a	17	16	14
		Control and prevention of GBV(PSS) unit	# of survivors accessing SGBV services	800	1,500	4,331	1582	1,772
			# of health facilities providing quality SGBV services	no data	6	8	7	10
			# of GBV programme review forums	no data	4	4	4	4
		School Health Unit	# of school going children receiving health education messages	200	700		700	772

Program	Sub-Programs	Delivery units	Performance Indicators	Y1 Baseline 2013/14	Y2 - 2015/16 Achievement	Target	Y3 Target 2016/17	Y5 Target 2018/19
			# of schools going children treated and referred for special care	1600	3,700		3,700	4079
			# of schools impelmenting school health program	no data	245	300	300	350
			# of school going children with special needs rehabilitated	no data	200	204	224	260
			# of schools with improved menstrual hygiene management practice	no data	180	212	233	282
			# of school going children receiving health education messages	149,390	174,087	174,087	191,496	231,710
			# of school going children dewormed	122,071	124,088	114,707	126,178	152,675
	SP 5: Environmental/Public Health	**Environmental Health unit**	# of buildings plans vetted, approved and report submitted within 7 days	1315	1,747	1,747	1,922	2,325
			# of premises inspected and have met minimum requirement on hygiene and sanitation	15245	17,500	16,838	18,522	22,411
			# of food and water samples taken for laboratory analysis	1796	1,986	1,890	2,079	2,516
			# of Public health facilities disposing off HCW appropriately	30	35	37	41	49
			# of households with access to a sanitary facility	231529	359,707	286,098	314,708	380,796
			# of Households with access to safe water	231529	319,707	299,706	329,677	398,909
			# of villages with reduced Open defecation	13	14	10	15	34
			# of outlets with designated smoking zones	1525	1,678	1,524	1,844	2,231
			# of commercial premises fumigated against pests and vermins	1252	1,275	1,329	1,462	1,769
			# of food handlers examined and issued with medical certificates	92400	101,200	120,004	132,004	159,725
			# of court cases forwarded for prosecution	450	500	1,074	1,181	1,429
			% of HFs supervised	40	65	75	98	100
			% of suspected cases screened and investigated promptly as per standard guidelines	65	65	75	80	100
			% of health staff trained in surveillance and response	20	60	60	80	100
			% of health facilities giving weekly epidemiological data	20	40	60	80	100
			# of households reached with health promotion messages CHS	180000	230,000	241,600	274,500	293,450
		Health promotion unit	# of Health messages designed distributed and disseminated	4	20	12	20	30
			# of Stakeholders meetings held	4	4	0	4	4
			# of World Health days commemorated	10	20	12	20	22
		Community health services Unit	# of functional community units Established	61	121	121	126	136
			Number of persons referred to facility by Community Units	9678	20,364	28,887	28,987	29,187
		NCDs control and prevention unit	# of women of reproductive age screened for cervical cancer	6783	17,016	6,288	24,142	24,342
			# of clients treated for diabetes	12677	32,805	33,001	40,805	44,167
		Medical rehabilitation unit	# of persons with disabilities identified and referred for rehabilitation	47	220	270	220	260

Program	Sub-Programs	Delivery units	Performance Indicators	Y1 Baseline 2013/14	Y2 - 2015/16 Achievement	Target	Y3 Target 2016/17	Y5 Target 2018/19
			# of persons with disabilities receiving rehabilitation services	146	550	739	550	650
			# of disability days marked	1	1	1	30	5
Curative care	**SP 1: County Referral Hospitals**	**County referral hospitals**	**#** of public health facilities with specialized diagnostic services	0	3	3	4	5
			# of fully equipped Ambulances in the County	0	3	6	7	9
			# of facilities offering medical rehabilitation services	3	10	4	10	15
			# of functional Ambulances in the County	6	9	18	20	22
			# of health facilities with specialized services (MDR, peadiatric, mental menthadone, SGBV)	2	3	4		5
			% of health workers in department trained or updated on emergency & trauma, care services skills	4	60	0	60	100
			% of health workers in department trained or updated on referral care services skills	5	60	62	65	80
			# of health workers in County trained or updated on rehabilitative care services	10	120	320	360	380
			# of Health facilities with title deeds	4	7	18	1	2
			# of Hospitals with service delivery charters displayed	4	4	4	4	4
	SP 2: Health centres& dispensaries	**Health centres & dispensaries**	% of under 5's treated/managed for diarrheal diseases	3	7	18		20
			% of new outpatients with mental health conditions	1	1	0	1	1
			% new outpatient cases attributed to Road Traffic Injuries	1	2	2	2	1
			% new outpatient cases attributed to other injuries	1	1	1	1	1
			% of population experiencing gender based violence		0	0	0	0
			# of Health facilities with service delivery charters displayed	106	106	106	106	106
General administration, planning and support services	**SP 1: Health policy, planning and financing**	**Health policy, planning and financing Unit**	County health policy developed	0	1	1	1	1
			Midterm review/launch of County Strategic and Investment Plan	0	1	0	0	0
			End term review of County Strategic and Investment Plan	0	0	0	1	1
			Number of sector program policies developed	0	2	2	10	14
			County Health Sector M&E TWG established	0	1	0	1	1
			# of health bills developed	0	5	4	6	10
			MTEF report developed	0	1	1	1	1
		M&E Unit	% of staff signing performance contracts	20	100%	1	100%	100%
			Sector achievement in scheduled performance appraisals	80	80%	1	90%	90%
			# of quarterly data review meetings held (performance reviews)	4	4	4	4	4
			# of public facilities with integrated established Electronic Medical records	0	15	35	30	45

Program	Sub-Programs	Delivery units	Performance Indicators	Y1 Baseline 2013/14	Y2 - 2015/16 Achievement	Target	Y3 Target 2016/17	Y5 Target 2018/19
			# of health workers trained on integrated health information systems	20	60	36	158	269
			# of copies of data collection and reporting tools printed and distributed	1000	10,080	9437	13634	24,000
			AWP developed	1	1	1	1	1
			County M&E TWG established	0	1	1	1	1
		Health Sector Coordination Unit	Framework for engagement of partners developed	0	1	1	1	1
			# of stakeholders' forum held	4	4	4	4	4
			# of MOUs signed with public, schools and training institution and private partners	0	6	6	6	8
	SP 2: Admin/Human resource for Health	**Administration/Human Resource Unit**	# of health personnel trained on government approved trainings	40	102	0	140	140
			# of health personnel trained in technical/professional trainings	13	36	75	90	90
			# of SCHMTS supported	10	10	10	9	9
	SP3: Health commodities	**SP3: Health commodities Unit**	% achievement of commodity security	40	60	50	60	80
	SP 4: Research, Quality assurance & standards unit	**Research unit**	Research coordination framework developed	0	1	0	1	1
			Develop, authorize and roll out research programs within the health sector	0	6	12	16	16
			# of (operational) research conducted	0	2	1	1	2
			# of publications done	3	2	2	1	2
			County Subscription to HINARI	0	0	0	0	1
		Quality assurance & standards unit	# of health facilities with Functional QITs/WITs	20	80	75	80	120
			# of Health Facilities audited/Assessed for quality service delivery	20	20	12	20	60
			# of Health Facilities Supervised annually	50	60	108	70	120
			# of CHMT support supervisory visits to SCHMT	36	36	36	3	36
			# of registered and licensed health facilities	98	230	147	230	230
			# of private facilities inspected	109	260	346	260	260
			# of support supervision visits to private health facilities	75	150	163	150	150
	SP5: Coroner services unit	**Coroner Services unit**	# of acres acquired	0	200	0%	0	0
			Crematoria upgraded	0	1	0	0	1
			Modern Funeral parlour established	0	1	0	0	1
			The Langata Cemetery fenced	0	1	0	0	1
			A plan to realize the revenue collection target developed and rolled out	0	1	1	1	1

Source: Health Sector Medium term expenditure Framework Report 2017/2018