NYAMIRA COUNTY

HRH Strategic Plan

JUNE 2017 – JUNE 2020

NYAMIRA COUNTY

HRH STRATEGIC PLAN

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FOREWORD

The Human Resources for Health (HRH) strategic plan 2017-2020 is intended to guide the County in identifying its HRH gaps and prioritise interventions to improve health workforce management. The HRH Strategic plan is a product of extensive HRH assessment, consultation and comprehensive feedback from our internal and external stakeholders. Its significance stems from the fact that HRH is a core building block of an efficient health system.

The County Government of Nyamira is determined to improve access to quality health services and ensure that the County Health Department plays its role in the realisation of the constitutional provision of the right to the highest attainable standards of health for all county residents and to contribute to the achievement of Kenya Vision 2030, County Health Strategic and Investment Plan (CHSIP) 2013/14-2017/18 and County Integrated Development Plan (CIDP) 2013/14-2017/18. The development of the HRH strategic plan provides an opportunity towards meeting this commitment. The HRH plan aligns to health sector and County HRH priorities. The HRH plan sets to improve ensure adequate, competent and well-distributed health workforce at Nyamira County.

The HRH Strategic Plan supports the County Health Department's mandate to manage all aspects of county health services as derived from the Fourth Schedule part 2(2) of the Constitution of Kenya 2010 and the County Government Act 2012. It further supports realisation of the County Health Department Vision; "*A healthy and productive county with equitable access to quality health care" and its* Mission "*To provide quality health services for socio-economic development of the people of Nyamira County"*. The county recognises that to meet its core function of proving and managing county health services, it has to address HRH challenges that hamper health services planning, health workers productivity, service delivery and the health outcomes. The development of the County HRH Strategic Plan aims at providing a roadmap to address the challenges so as to effectively improve health service delivery.

The County Health Department is committed to provide effective leadership to facilitate the implementation of this HRH Strategic Plan 2017-2020. The implementation of the HRH plan will be done jointly with other county departments, partners and other stakeholders.

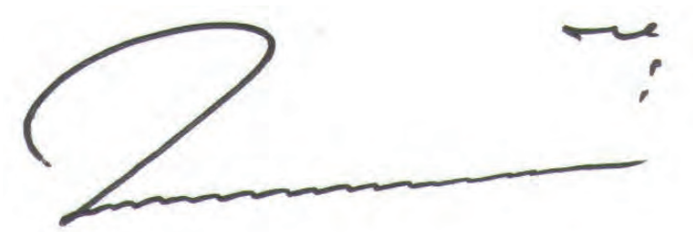
Hon. Gladys Momanyi
County Executive Committee Member for Health
Nyamira

ACKNOWLEDGEMENTS

Nyamira County HRH Strategic Plan 2017-2020 is the culmination of a consultative process that involved various stakeholders in the county under the stewardship of the County Department of Health Services. On behalf of the Department of Health Services, I acknowledge the contribution of individuals and organisations that contributed to the development of the plan. In particular, I wish to thank HE the Governor Hon John Nyagarama and his able Deputy HE Hon Amos Nyaribo for their tremendous support and guidance to the department. I also acknowledge the County Executive Committee Member for Health (CEC), Hon Gladys Momanyi, for leadership in this process, the valuable contribution of the County Assembly of Nyamira Health Committee under the leadership of the Chairperson, Hon Callen Atuya, Chairperson of the County Public Service Board Peter Nyakundi, County Director of Human Resource Shem Obworo, County Health Management Team and Sub-County Health Management Teams, officers in-charge of facilities and all health workers for their contributions towards the development of this plan. To all others who were involved in one way or the other, especially our development partners, notably Aphia Plus Western Kenya Project, we sincerely say "*Asanteni Sana*".

In a special way, we acknowledge the financial and technical support provided by the USAID-funded HRH Kenya Mechanism under the leadership of IntraHealth International in the development of this HRH Strategic Plan. Specifically, we acknowledge Mathew Thuku, Ann Malubi and Rose Ida who supported the various stages of the development of the plan. The supervision of the development of the HRH Plan from the engagement stage, situation analysis, and strategic planning, costing and validation process by the Task force led by Dr Jack Magara is highly appreciated.

The investment in the development of the HRH plan will go a long way in improving the planning, management and development of human resources for health in Nyamira County and delivery of quality health services to the public we serve. The County Department of Health looks forward to more collaboration with our development partners and collaborating institutions as we embark on the implementation of the Nyamira County HRH Strategic Plan 2017-2020.



Douglas Bosire
County Chief Officer of Health
Nyamira

EXECUTIVE SUMMARY

The Nyamira County's HRH Strategic Plan covers the county's Human Resources for Health management and development from October 2017 to 30 June 2020. The HRH plan is the County's blueprint that reflects the broader picture and priorities to achieve HRH results towards improved service delivery. The plan is linked to the Kenya Health Sector HR Strategy 2014-2018 and the County Health Strategic and Investment Plan 2013/14-2017/18 with an overall objective of supporting the County's goal of delivering high quality health services.

The purpose of this Human Resource for Health Plan is to guide the department in proper planning, development, management and effective use of human resources for health. The plan focuses on improving the following key strategic or outcome areas; *Strengthened links between HRM&D leadership and the Unions, Professional Associations, Implementation of HR Policies and Guidelines, Improved HRH performance Management, Improved Staff Training & Development systems, Strengthened information and communication systems.*

The structure of this plan document is composed of two main parts. The first part introduces the general county context and focuses on a thorough situation analysis of the human resource dimensions, including health workforce characteristics, stakeholder institutions and appraisal of HRH functions. The analysis concludes by identifying the main issues and challenges in the domain of HRH in Nyamira County. The second part of the plan outlines the strategic direction of the county, including the definition of the county's HRH vision, mission and strategic objectives together with the targets and indicators all in alignment to the CIDP, CHSIP and the Kenya Health Sector HR Strategy 2014-2018. The section concludes by a detailed action plan including timeline and budget for the plan in addition to the monitoring and evaluation framework.

The budget estimates for implementation of the plan for the entire period of three years is Sh**4,618,955,779**. The budget is broken down in terms of **Sh4,525,135,778** for total Personnel Emoluments (PE) costs for the 30% HRH gaps per WHO norms and standards, plus **Sh93,820,000** for the implementation of the HRH Strategic Plan's activities. This provision excludes county health department allocations to finance current HRH stock. There are five strategic objectives with activities to be carried out for the successful implementation of this HRH plan. The Strategic objectives are:

- **Strategic Objective 1**: To improve industrial relations mechanism by December 2019.
- **Strategic Objective 2:** Establish systems for HRM/D for effective service delivery by 2019.
- **Strategic Objective 3:** To provide policy framework for HRH leadership and management system.
- **Strategic Objective 4:** Institutionalize HRH performance management systems
- **Strategic Objective 5:** To undertake training and development of 30% of the staff by 2019
- **Strategic objective 6:** To strengthen information and communication systems for human resource and service delivery by 2019.

Despite the efforts made by the County Department of Health in staffing the health facilities at all levels, more work remains to be done. There is a general shortage of qualified staff at all levels as shown by the CARPS report of 2015, but the shortage is more evident at levels 1 and 2, and in the remote working locations. There is shortage of specialised cadres in the county.

The shortage is mainly caused by insufficient HRH financing, making it difficult to absorb the newly-qualified staff, and lack of an attractive retention scheme. The above factors are bound to improve with the implementation of the HRH Strategic Plan 2017/18-2019/2020, CHSIP 2013/14-2017/18 and CIDP 2013/14-2017/18. The establishment of the health department indicates more alignment of

HRH to county health delivery needs. The demand for more human resource for health will increase the need for more training and making available more a skilled health workforce to service delivery points.

This plan intends to minimise the problem of human resource shortage through advocacy for increased funding and redistribution of staff for optimum utilisation. There is a need to review and improve current HRH staffing in line with national HRH Norms and Standards Guidelines for the Health Sector to match the health workforce to disease burden, a growing population and workload. It also addresses the issue of skills gap by increasing training with a projection of 30% of the staff being trained by 2019. We shall endeavour to continuously assess the capacity gaps for health workers and facilitate the development of the training plan to build both management and employee capacity at all levels.

Moreover, the plan aims at increasing productivity of health workers at all levels through establishment of effective performance management systems. In the process of implementation, partnership among HRH stakeholders will be strengthened through sharing of information on the unfolding circumstances and the policy context.

Dr Jack Magara
County Director of Health Services
Nyamira

LIST OF ABBREVIATIONS

CDC	Centers for Disease Control
CDF	Constituency Development Fund
CDH	County Director of Health
CEC	County Executive Committee
CHAs	Community Health Assistants
CHEWs	Community Health Extension Workers
CHMT	County Health Management Team
CHSIP	County Health Strategic and Investment Plan
CHSSP	County Health Sector Strategic Plan
CHVs	Community Health Volunteers
CIDP	County Integrated Development Plan
COH	Chief Officer for Health Services
CPSB	County Public Service Board
DHIS	District Health Information System
DOD	Department of Defence
FBO	Faith based Organisations
HMT	Health Management Team
HRH	Human Resources for Health
HRHO	Human Resource for Health Officers
HRIMO	Health Records Information Management Officer
HRM	Human Resource Management
HRM/D	Human Resource Management and Development
HWs	Health workers
iHRIS	Integrated Human Resource Information System
IMR	Infant mortality rates
IUCD	Intrauterine Contraceptive Device
JDs	Job Descriptions
KDHS	Kenya Demographic Health Survey
KEMRI	Kenya Medical Research Institute
KEPH	Kenya Essential Package for Health
KHP	Kenya Health Policy
KHSHRS	Kenya Health Sector Human Resource Strategy
KHSSIP	Kenya Health Sector Strategic and Investment Plan
KMTC	Kenya Medical Training College
KNBS	Kenya National Bureau of Statistics
KRCS	Kenya Red Cross Society
KUCCPS	Kenya Universities and Colleges Central Placement Service
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MSF	Médecins *Sans Frontières* (Doctors Without Borders)

NASCOP	National AIDS and STI Control Programme
NCDs	Non-Communicable Diseases
NCHRHSP	Nyamira County HRH Strategic Plan 2017
NGOS	Non-Governmental Organisations
NHIF	National Hospital Insurance Fund
PAS	Performance Appraisal Systems
PNA	Performance needs assessment
PE	Personal Emoluments
PESTEL	Political, Economic, Social, Technological, Environmental and Legal analysis
PNA	Performance needs assessment
PSC	Public Service Commission
PPP	public-private partnership
SCHMT	Sub-County Health Management Team
SMART	Specific, Measurable, Attainable, Realistic and Time-bound
SWOT	Strengths weaknesses opportunities and threats
TNA	Training needs assessment
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER 1

1.0 INTRODUCTION

1.1 Introduction on Human Resource for Health

Human Resource for Health is one of the core building blocks of a health system. Global evidence points to a direct correlation between the size of a country's health workforce and its health outcomes. Health systems can only function with health workers; improving health service coverage and health outcomes is dependent on their availability, accessibility, and capacity to deliver accepted and quality services.[1] This explains the growing centrality of health workforce management and planning to improvement of health systems with a view to improving health system functioning and effectiveness. This need is even greater with the devolving of the health function from national to county governments. The advent of devolved management of health workers was heralded by major HRH challenges that exposed the need to develop county-specific health systems aligned to the disease burden and other challenges facing the counties.

1.2 Rationale for Nyamira County HRH Strategic Plan

The Constitution of Kenya 2010 provides for the right to the highest attainable standards of health to every Kenyan, and places a fundamental duty on the State to take legislative, policy and other measures, including the setting of standards, to achieve progressive realisation of the rights set out under Article 43, which include the right to health. These constitutional provisions determine the roles and obligations of the health sector to facilitate progressive realisation by all to the right to health. In 2013, health service delivery and management of resources including health workers was devolved to counties.

The transition encountered a number of challenges that included lack of systems for health worker management, undeveloped devolved HRH policy framework, shortage of key cadres, maldistribution of HWs, inadequate HRH financing and resistance from health workers characterised by HWs unrest. This HRH Strategic Plan lays the framework for HRH actions at all levels of service delivery at Nyamira County. The 2017-2020 Nyamira County HRH Strategic Plan supplements efforts made by the County to improve the management of the human resource towards better health outcomes. The plan provides elaborate focus on the County HRH in addition to the prioritised HRH contribution in reduction of the HIV prevalence currently estimated at 6.4%[2] against the national average of 5.6%. The County Health Department enjoys cordial political will and commitment on HR issues from the government and development partners. This provides opportunities for addressing HRH management concerns and financing, which are factors conducive for the development and implementation of the Nyamira HRH plan.

1 WHO Global Strategy on Human Resources for health: workforce 2030, January 2016

2 Nyamira County AIDS Strategic Plan, covering the period 2014/15 to 2018/19

1.3 The Objective of Nyamira County HRH Strategic Plan

The Nyamira County HRH Strategic plan aims at supporting the County Vision **"A healthy and productive county with equitable access to quality health care".** The plan provides county focus on HRH requirements and needs projections for different cadres and staff categories, contribution of HRH plan to CHSSP and CIDP, county HRH financing requirements for the period of the plan towards attainment of HRH projections specifically key interventions for addressing staffing gaps, training, performance management, labour relations and motivation of HRH to attain service delivery targets.

The main objective of this HRH plan is to prioritise the needs and provide a framework for addressing the identified HR management and development needs towards better management of the HWs at Nyamira County. The plan envisages that through better management of the HWs, the county will address bottlenecks to staff motivation, cordial labour relations, performance, attraction, retention and subsequently improved service delivery. The plan further introduces the framework for further development of HRH annual operational plans that will define activities to meet identified strategies at the County Department of Health.

1.4 Policy Context

This strategy has been developed within the policy framework of a number of key planning documents. At the global level, the WHO health systems action framework identifies health workforce as one of the key pillars of an effective health system. The framework uses a population-based ratio that recommends a threshold of 23 doctors, nurses and midwives per 10,000 populations. This ratio was established as necessary to deliver essential maternal and child health services. WHO Global Strategy on Human Resources for health: workforce 2030 states that health systems can only function with health workers; improving health service coverage and health outcomes is dependent on their availability, accessibility, and capacity to deliver accepted and quality services.

At the national and county level, the HRH strategic plan is aligned to the Constitution of Kenya 2010, Kenya Health Policy 2013-2030[3], Kenya Human Resource for Health Strategy 2014-2018[4], MOH, HRH staffing norms and standards (2014)[5], the Nyamira County Health Strategic and Investment Plan 2013/14-2017/18[6], the First Nyamira County Integrated Development Plan (CIDP) 2013-2017[7], Nyamira County HIV & AIDs Strategic Plan (2014/2015-2018/2019[8] and Nyamira County Public Service Board – Strategic Plan 2013-2017[9]. The HRH plan is, therefore, aligned to the policy and planning documents at global, national and county levels.

The Kenya Health Sector Human Resource Strategy (KHSHRS) 2014-2018 has greatly informed this HRH plan. The strategy articulates the HRH strategic dimensions in light of the devolved system of health management and work towards supporting the goal of Kenya Health Sector Strategic and Investment Plan 2014-2018. The strategic issues similar to the KHSHRS 2014-18 that the county is focusing on in its policy and planning are inadequate and inequitably distributed workforce, institutional frameworks to support training and workforce performance, human resources development systems and practices and inadequate financial resources to support investments in HRH. The county is making

3 Kenya Health Policy 2013 - 2030.

4 Kenya Human Resource for Health Strategy 2014-2018

5 MOH, HRH staffing norms and standards (2014),

6 Nyamira County Health Strategy and Investment plan 2013/14-2017/18

7 Nyamira County Integrated Development Plan (CIDP) 2013 - 2017

8 Nyamira County HIV & AIDs Strategic Plan (2014/2015 - 2018/2019

9 Nyamira County Public Service Board – Strategic Plan 2013 - 2017

efforts towards addressing these challenges. The strategy is also aligned to Kenya health policy 2013–2030, which identifies the following areas: improving the production of health workers (numbers and quality); reviewing and applying evidence-informed health workforce norms and standards for the different tiers of services; ensuring the appropriate and equitable distribution of health workers in facilities and improving attraction and retention packages and incentives for health workers.

MOH, HRH Norms and Standards Guidelines 2014-2018 has defined for each facility level, the minimum number of health workers, by cadre, and sub-category, needed to assure provision of the Kenya Essential Package for Health (KEPH). Nyamira County Health Strategic and Investment Plan (CHSIP) 2013/14-2017/18 articulate the need for a well-motivated and self-driven health workforce and CIDP 2013-2017 identifies shortage of skilled staffs as a major challenge. It puts doctor-population ratio at 0.01/1000 and nurse population ratio at 0.41/1000.

According to the CHSIP, Nyamira County aims to achieve the county health vision of "**having a healthy and productive county with equitable access to quality healthcare**" through focusing on implementation of a broad base of health-related services that will impact on health of persons in the county. It places main emphasis on sustainable systems that would ensure the department delivers on its mandate of human resource recruitment, development and management as outlined under the fourth schedule of the Constitution of Kenya, County Government Act 2012 and Legal Notice No. 112 of August 2013 on core functions of County Department of Health and therefore contributes towards the overall development goals of the County Government of Nyamira.

The CHSIP also identifies that county health sector faces significant HRH shortages and inadequate skills mix. In that respect, HRH investments are prioritised to address availability of appropriate and equitably distributed health workers, right skills mix, attraction and retention and inculcating health leadership. County Public Service Human Resources Manual 2013[10] is the primary document of reference for counties on all aspects of health workforce policy and management. The county has been using the manual to support management of health workforce and becomes a reference document in the HRH strategic planning.

1.5 The Process of Developing the Nyamira HRH Strategic Plan

The technical approach for developing the Nyamira County HRH Strategic plan adopted significantly the WHO framework/guidelines for conducting HRH policies and planning. The planning process was undertaken by the County Department of Health through a taskforce that was technically assisted by the HRH Kenya Mechanism technical team. The taskforce sought views from the County Department of Finance and Economic Planning, County Secretary's Office, County Public Service Board (CPSB), the Department of Public Administration and Coordination of Devolved Units' under which the County HR is domiciled and the Department of Health. Other stakeholders who made input at various stages of the process from situation analysis stage included the implementing partners, FBOs, private sector players, members of the County Assembly and training institutions.

The planning process involved setting the terms of reference, nomination of task force members, and conducting a HRH situational analysis that identified the current HRH situation at Nyamira County and the current staffing. This was followed by a strategy development workshop in Vittoria Suites in Kisumu in which an internal HRH rapid assessment was conducted using the HRH maturation tool and HRH priorities of the county set. Desk review of key county documents was undertaken. The human resource requirements for delivering health services were identified and systematically planned through a three-year strategic plan period. A consensus-based decision-making approach was extensively used around issues of priority for strengthening the County's HRH. The HRH management and development planning process was structured as follows;

10 County Public Service Human Resources Manual 2015

a) Assessment of the County's HRH Strategic Needs

The first stage of the development of the HRH Strategic Plan was a *Situation Analysis* of the County's Human Resources for Health that included generating HRH databases. Desk review of implications for human resources for health drawn from the CHSIP and CIDP was carried out to draw historical perspective and trends. The situation analysis findings were validated during the planning workshop held in Kisumu based on a rapid internal HRH rapid assessment to define the County's existing HRH capacity and gaps for the delivery of the identified health services priorities. Participants carried out detailed group review followed by plenary discussion to reach consensus on the immediate-to-medium-term priorities for the Human Resources for Health for Nyamira County, which will enable efficient and effective service delivery. The planning team further carried out SWOT analysis and PESTEL to form opinions on the challenges, opportunities and choices on which the County HRH must act during the 2017-2020 strategic plan period.

b) HRH Strategic Visioning and Planning

Drawing from the detailed findings and preliminary exploration of available options as raised by the above *situation analysis* the participants developed the following:

- The Vision, Mission and Core Values that would shape the HRH priorities Nyamira County would pursue during the 2017-2020 period.
- The outcome areas and strategic objectives that the County HRH should commit to achieve during the three years. Effort was made by the planning working groups to ensure that the strategic objectives were Specific, Measurable, Attainable, Realistic and Time-bound (SMART).
- This was followed by outlining the principal strategies to be carried out over the Strategic Plan period, and identification of outputs to be monitored as the indicators to be used in evaluating how well the strategic objectives were being achieved.
- Finally, timelines and responsibilities were assigned for the carrying out of the tasks with an M&E framework before noting and highlighting important assumptions and risks likely to be expectedly and addressed in the successful implementation of the HRH Plan.

The HRH plan development process was followed by design and drafting of the Nyamira HRH strategic Plan. In this phase, inputs from the stakeholders were incorporated. The planning process also involved estimating the future requirements for HR and identifying efficient ways of providing those requirements. A consultative process was undertaken, which included costing of the plan, followed by validation.

CHAPTER 2

2.0 COUNTY PROFILE

2.1 Demographic profile

Situated in the Western Highlands of Kenya, Nyamira County covers an area of 894km² with a population of 683,979, comprising of 328,973 males (48%) and 355,006 females (52%). Children below 15 years constitute 43% of the population, while youth aged 15-24 years constitute 20% of the population (2015 KNBS Population Projections). The population density is 724 persons per square kilometre with a growth rate of 2.4% (KNBS 2010)[11]. It borders the counties of Kericho to the East, Bomet to the South-East, Kisii to the South, Nyamira to the West and Kisumu to the North-West. The county is divided into five sub-counties, namely, Nyamira, Borabu, Masaba North, Nyamira North and Manga. Women of reproductive age (15 – 49 years) constitute 25% of the population and the total fertility rate in the county is 4.6. The median age is 18.8 years, depicting a generally young population in the county[12]. Life expectancy is currently estimated at 60 years (KNBS, 2008) and the male to female ratio is 49.5:50.5 showing that the county is almost at gender parity.

Table 1: Population projections by Age Cohort

Age Cohort	2009 (Projections)			2012 (Projections)			2015 (Projections)			2018 (Projections)		
	male	female	total	male	female	total	male	female	Total	male	Female	total
0-4	48,879	48,112	96,991	51,640	50,830	102,470	54,554	53,698	108,253	56,591	55,703	112,294
5-9	43,767	43,997	87,764	46,239	46,482	92,722	48,849	49,106	97,954	50,672	50,939	101,611
10-14	39,723	39,093	78,816	41,967	41,301	83,268	44,335	43,632	87,967	45,990	45,261	91,251
15-19	34,125	34,553	68,678	36,053	36,505	72,557	38,087	38,565	76,652	39,509	40,005	79,514
20-24	23,204	32,604	55,808	24,515	34,446	58,960	25,898	36,390	62,288	26,865	37,748	64,613
25-29	18,831	26,035	44,866	19,895	27,506	47,400	21,017	29,058	50,075	21,802	30,143	51,945
30-34	16,004	18,418	34,422	16,908	19,458	36,366	17,862	20,557	38,419	18,529	21,324	39,853
35-39	13,490	16,282	29,772	14,252	17,202	31,454	15,056	18,173	33,229	15,618	18,851	34,469
40-44	9,967	10,847	20,814	10,530	11,460	21,990	11,124	12,106	23,231	11,540	12,558	24,098
45-49	10,861	11,293	22,154	11,475	11,931	23,405	12,122	12,604	24,726	12,575	13,075	25,649
50-54	8,072	8,244	16,316	8,528	8,710	17,238	9,009	9,201	18,210	9,346	9,545	18,890
55-59	5,764	5,521	11,285	6,090	5,833	11,922	6,433	6,162	12,595	6,673	6,392	13,065
60-64	4,785	4,812	9,597	5,055	5,084	10,139	5,341	5,371	10,711	5,540	5,571	11,111
65-69	2,949	3,159	6,108	3,116	3,337	6,453	3,291	3,526	6,817	3,414	3,657	7,072
70-74	2,654	5,715	2,804	3,234	3,234	6,038	2,962	3,416	6,379	3,073	3,544	6,617
75-79	1,719	1,833	3,552	1,816	1,937	3,753	1,919	2,046	3,964	1,990	2,122	4,112
80+	2,254	3,340	5,594	2,381	3,529	5,910	2,516	3,728	6,244	2,610	3,867	6,477
TOTAL	**287,048**	**311,204**	**598,252**	**303,263**	**328,783**	**632,046**	**320,377**	**347,338**	**667,716**	**332,337**	**360,304**	**692,641**

11 Kenya National Bureau of Statistics 2010

12 Nyamira County Health Strategy and Investment plan 2013/14-2017/18

Table 2: Health Facilities per Sub-County level of care. (Public & Faith-based Organisations)

Sub-County	Level 4 County Primary Hospitals	Level 3 (Health Centres	Level 2- Dispensary	Level 1 Community Units
Borabu	1	6	13	13
Manga	2	7	5	15
Masaba North	2	3	11	19
Nyamira South	1	18	4	22
Nyamira North	2	5	10	16
Total	**8**	**39**	**43**	**85**

Source: KMHFL 2017

2.2 County health indicators and profile

Based on the County health Strategic plan 2014-2015, Nyamira County has a death rate of 13 per 1,000 people with an infant mortality rate of 46 per 1,000 births and child mortality rate of 58 per 1,000 births. The maternal mortality rate is 385 per 100,000 births according to 2013 estimates. HIV prevalence is currently projected to be 6.4%, a significant increase from 3.8% in 2009 (NASCOP 2013; NASCOP 2009). Among children under five years of age, 3.4% are underweight. Table 3 represents selected county health indicators.

Table 3. County selected health indicators and profile

Indicator	County ratio	Source
Doctor to Patient ratio	1: 16,850	HMIS 2017
Nurse to Patient ratio	1: 1,566	HMIS 2017
Clinical Officer to Patient ratio	1: 6,676	HMIS 2017
HIV/AIDs Prevalence	6.4	NASCOP
Child Mortality rate	50	KDHS, 2014[1]
Children under I year Fully (FIC) Immunised	86.8	KDHS, 2014
Percentage with at least 4 ANC visits	51	KDHS, 2014
Percentage delivered by a skilled provider1	74.1	KDHS, 2014
Percentage delivered in a health facility	74.3	KDHS, 2014

2.2.1 The HIV/ AIDS Situation at County and Sub County Level

HIV prevalence in Nyamira is at 6.4% (Kenya HIV Estimates 2015). HIV prevalence among women in the county is higher (6.9%) than that of men (5.9%) (NASCOP, County HIV Profiles 2012) indicating that women are more vulnerable to HIV infection than men in the County. Nyamira County contributed to 1.6% of the total number of people living with HIV in Kenya, and is ranked twenty-first nationally. By the end of 2015, a total of 24,357 people were living with HIV in the County, with 22% being young people aged 15-24 years and 6% being children under the age of 15 years.

The Nyamira County HIV/AIDS strategic plan identifies shortage of qualified staff and competent human resource, uneven geographical distribution of health workers, high levels of staff turnover, inadequate functional structures to support performance, weak linkage mechanisms between training institutions and health facilities and lack of proper remuneration for personnel working in the community units. The strategic directions is to strengthen integration of health and community systems and its expected result is to increase health workforce for the HIV response at the county level by 25% by 2019.

2.2.2 Prevalence of five most common diseases

According to the DHIS2 2016, the leading causes of morbidity and mortality in Nyamira County are respiratory tract infections, HIV and AIDS, perinatal conditions, tuberculosis, malaria, skin conditions, accidents and diarrheal diseases. There is increasing burden of Non-Communicable Diseases (NCDs) such as cardiovascular diseases, diabetes and cancers, which currently account for 11 to 13% of disease burden. The five most prevalent diseases (Source: DHIS2 2016) are (1) Diseases of the respiratory system (2) Skin diseases (3) Upper respiratory tract infections (4) Arthritis-joint pains, and (5) Confirmed malaria

2.2.3 Gender perspective

In Nyamira, women constitute 50.5 per cent of the county's population. Although the majority, they are generally left out of development decision-making processes through lack of representation. Policies, plans and strategies rarely take into consideration gender roles and responsibilities. Considering that in 2009, 41,539 out of the 131,039 households (37%) in Nyamira County were female-headed, they were certainly more disadvantaged and more likely to be poor compared to other households headed by men. Factors exacerbating gender disparities in the county are rooted in socio-cultural practices such as ownership of production resources (land, capital), participation in decision-making and early/child marriages. Other factors include consequences of poor health, which are greater in women than in men due to their role in child-bearing and lack of skills due to low education standards.

2.2.4 Sexual, Reproductive and Adolescent Health

The Kenya Demographic and Health Survey (KDHS) 2014 reports that the total fertility rate by women aged 15-49 years is 3.2% in Nyamira against the Nyanza average of 4.3% and national average of 3.9%. According to the KDHS, 2014, the use of any method of contraceptive is recorded at 67.9% in Nyamira, above the Nyanza average of 56.4% and national average of 58%. Use of modern methods of family planning is at 64.2% against the Nyanza average of 53.9% and national average of 53.2%. The number of women not currently using family planning at the county is reported at 32.1% lower than the Nyanza average of 43.6% and national average 42%. This means more investment is needed to raise the level of awareness and acceptance of family planning as a measure to bring population growth in line with expected welfare growth.

Table 4: Sexual, Reproductive and Adolescent Health (Including statistics on Family Planning)

INDICATOR	PER CENT (%)
Total Fertility Rate	3.5
Family Planning Prevalence	67.9
Modern method	64.2
Female Sterilisation	4.2
Intrauterine Device (IUD)	3.9
Implant	8.2
Injectable	42.6
Pills	3.5
Male condom	1.2
LAM	0.3
Not using FP method	32.1

Source: KDHS 2014

In Nyamira County, up to 79% of births are assisted by a skilled provider, which is above the current national average of 62% and Nyanza average of 65%. Maternal mortality is one of the indicators of reproductive health status of the population. The women of child-bearing age constitute 25% (179,160) of the Nyamira county population, with an estimated number of pregnancies at 3.4% (24,431) delivering the same number of children per year. The estimated live births are lower at 3.2% (23,209) for the year 2017 as shown in the table below. (KNBS2017).

Table 5: Reproductive Health demographic profiles.

Description	Population estimate		Target population			
	Proportion %	**2014**	**2015**	**2016**	**2017**	**2018**
Women of child-bearing age (15-49) years	25.1	166642	170179	175326	179160	183077
Estimated number of pregnant women	3.4	22724	23206	23908	24431	24965
Estimated number of deliveries	3.4	22724	23206	23908	24431	24965
Estimated number of skilled (birth) deliveries	79	17054	17416	17943	18335	18736
Estimated number of unskilled (birth) deliveries	21	4533	4630	4770	4874	4981
Estimated live births	3.3	21588	22046	22713	23209	23717

Source: KNBS 2017 (Projected)

2.3 Child Health

Vaccination against vaccine-preventable diseases is a very important means of disease prevention. In Nyamira County, 86.8% of children under one year are fully immunised against the Kenya full immunisation of children, which is 68%. The infant-and-under-five mortality rates in the Nyanza region as a whole (IMR 60/1000 live births, U5MR 91/1000 live births) are higher than the national total figures reported in the last Kenya Demographic Health Survey (KDHS) 2014. At the county level, huge regional disparities exist with Nyamira County having infant and under-five mortality rates (IMR 46 per 1000 live births) as reported in the KDHS 2014. According to routine data collected from health facilities, the major causes of child mortality are respiratory infections, pneumonia, diarrhoea intestinal worms and HIV/AIDS related illnesses. (DHIS2 2016)

Table 6: Child Health Indicators.

INDICATOR	PER CENT (%)
Children under one year immunised with BCG	99
Pentavalent 3 coverage	97.6
OPV3 coverage	91.8
Pneumococcal 3 coverage	94.6
Measles coverage	98
Children under one year fully immunised (FIC)	86.8
The infant and under five mortality rates (IMR per 1000 live births)	46

Source: KDHS 2014

Table 7: The major causes of infant /child mortality

No	Diseases (New cases only)	Number of cases	Per cent (%)
1	Upper Respiratory Tract Infections	70187	38
2	Other Diseases of the Respiratory System	46865	26
3	Diarrhoea	13616	7
4	Diseases of the skin	8912	5
5	Intestinal worms	7438	4
6	Confirmed Malaria (only positive cases)	7121	4
7	Suspected Malaria	4609	3
8	Pneumonia	4290	2
9	Ear Infections/Conditions	3123	2
10	Eye Infections	2962	2
	All Others	13222	7

Source: DHIS2 2016

2.3.1 Nutrition status

According to KDHS 2014, about 26% of children under five are stunted with the proportion severely stunted being 9.5%. Wasting prevalence is 4%. Ten per cent of children in the county as per the First Nyamira County Integrated Development Plan 2013/14-2017 /19, are classified as underweight, while three per cent are overweight or obese. Vitamin A supplementation of children aged 6-59 months stands at 39 per cent.

Table 8: Nutrition status

INDICATOR	County	Kenya
Children under 5 years who are stunted (moderate or severe) (%)	26	26
Children under 5 years who are wasted (moderate or severe) (%)	4	4
Children under 5 years who are underweight (%)	10	11
Children under 5 years who are overweight or obese (%)	3	4

Source: KDHS 2014

2.3.2 Water, Hygiene and Sanitation (WASH) County coverage

Nyamira County is endowed with natural water resources, namely, rivers, shallow wells, springs and boreholes. Water resources availability varies significantly between seasons as well as across regions. The resources are plenty during the rainy season and scarce during the dry periods. Most parts of the county have two rainy seasons. The long rains are typically from March to May, while short rains are typically from October to November without distinct dry spells.

The county has 18,826 shallow wells and 4,097 springs, 1,762 protected springs, and over 2,335 unprotected springs. The distance to the nearest water point in the county is from zero to four kilometres. On average 7.8 per cent of the population takes one-to-four minutes to fetch water, 2.4 per cent of the population takes five to 14 minutes, while 49.3 per cent take 15 to 29 minutes and 30.5 per cent take 30 to 59 minutes.

Table 9: Water, Hygiene and Sanitation (WASH) County coverage

Data element	Number Existing	Number Protected	Approximate Households served
Springs	4,097	1,762	330,568
Shallow wells	18,826	4,872	71,908

Source: DHIS2 2016

The MIC Survey 2011 indicates that about 53per cent of households in Nyamira County had access to water in 2011 through a protected well or spring. About 26 per cent have access to unprotected water from the well and spring. With regard to rainwater harvesting, it is estimated that five per cent of households have made provision for roof catchment systems.

2.4 Financing allocations for the Provision of Health Services

The health sector is the most devolved of all sectors under the Fourth Schedule of the Constitution of Kenya 2010. About 40 per cent of the entire county workforce in Nyamira is in the Department of Health, and with over one 100 health facilities to provide for, this sector is given priority consideration in budget making. The department has consistently been allocated at least 30 per cent of the total county government budget. Salaries and personal emoluments for the over 1,438 health workers is first ring-fenced through the programme-based budgeting system, and the next priorities are the medical commodities and products such as medicine and non-pharmaceutical items. Infrastructural development, such as equipment and renovation/rehabilitation, is then considered to ensure service delivery is not hampered.

In view of the fact that the resource basket is extremely limited, the department has embarked on an aggressive agenda to leverage on technology and private-public-partnerships (PPP) in order to bridge the financing and technology gap. Several concepts are currently in the pipeline with the PPP proposal for the reconstruction of a Nyamira County Referral Hospital on a Build Operate Transfer (BOT) basis already under consideration at the PPP unit of the National Treasury.

The Department of Health identifies the following modes of financing health services: National government funding through grants (HSSF) for primary care facilities Level 1-2 and maternity fee reimbursements to all GOK facilities; County government funding user fees, through out of pocket payments directly by clients and donor partner contribution. This is only in hospitals' health insurance schemes (NHIF and private insurance), PPP and funding from NGOs/FBOs/Private organisations. The table below highlights funding sources;

Table 10: Financial Allocation for the years 2013/14 to 2017/18 financial years

Allocation	Financial Year 2013 /14	Financial Year 2014 /15	Financial Year 2015 /16	Financial Year 2016 /17	Financial Year 2017/18
Health Department Allocation	1,112,272,052	1,430,274,636	1,590,436,547	1,844,489,197	1,852,491,945
Percentage Annual Increase in allocation	-	11.2%	31%	16%	0.4%
Recurrent Expenditure (Mainly HRH)	868,040,000	1,227,057,933	1,075,117,783	1,347,335,797	1,452,069,377
Development Estimates	244,232,052	203,216,703	515,318,764	497,153,400	400,422,568
% of Recurrent to Development Estimates	**78% : 22%**	**86% : 14%**	**68% : 32%**	**73% : 27%**	**78%: 22%**

Note: Estimates from the county budget

2.5 Partnerships and Donor Support

Due to its unique health issues especially the high prevalence of HIV/AIDS, Nyamira County enjoys collaboration with a wide range of partners notably, DANIDA, World Bank, NHIF and the National Ministry of Health. Partners like USAID-APHIA Plus support the county to bridge the HRH gaps by hiring health workers and posting the workers to county health facilities. This has been mainly in HIV/AIDS service provision. The county under this HRH plan period could engage more with the partners for additional HRH support as well as HRH systems strengthening. The huge number of partner-supported health workers is also an indication of the huge HRH gap at the county. This needs to be addressed since partner support is not guaranteed upon project closure. See below the partner analysis.

Table 11: Partners Analysis

Partner	Partner Expectation	Our Expectation
USAID APHIA Plus Western	• Accountability in resource use • Timely reporting • Transition of contract workers as per MOU	• Joint planning and responsiveness • Timely replacement of contract workers • Information sharing on service delivery • Disbursement of funds • Mutual respect
HRH Kenya Mechanism (IntraHealth)	• Accountability in resource use • Participation in activities • Timely reporting	• Resources and capacity building.
Vertical Programmes – NASCOP, TB, Malaria Control etc.	• Proper utilisation of resources	• Provision of relevant, guidelines and protocol • Capacity building
World Vision	• Conducive environment, providing • linkages to community, and policy guidelines • Accountability	• Adherence to standards and guidelines for public works • Timely completion of projects • Accountability
PSI (K)	• Timely reporting • Accountability	• Consistent and timely distribution of commodities
Kenya Medical Supplies Authority (KEMSA)	• Timely ordering of commodities • Timely payment • Comprehensive list of health facilities • Supply of quality, affordable health • Commodities • Timely processing and delivering of orders	• Supply of quality, affordable health commodities • Timely processing and delivering of orders

CHAPTER **3**

3.0 HRH SITUATION ANALYSIS

3.1 Overall Staffing Levels and distribution

3.1.1 County HRH situation Analysis based on National HRH Norms and Standards

According to the county HRH Unit iHRIS Nyamira, has a total of **1,158** MOH-recognised cadres of health workers comprising of 510 (**44%**) males and 648 (**56%**) females distributed across the tier 1 to 4 of the health facilities. The distribution of health workers is consistent with the distribution and level and number of facilities, with the majority concentrated in the Health Centre's and Sub-County Hospitals. Those in the administration are 6% of the total health workforce.

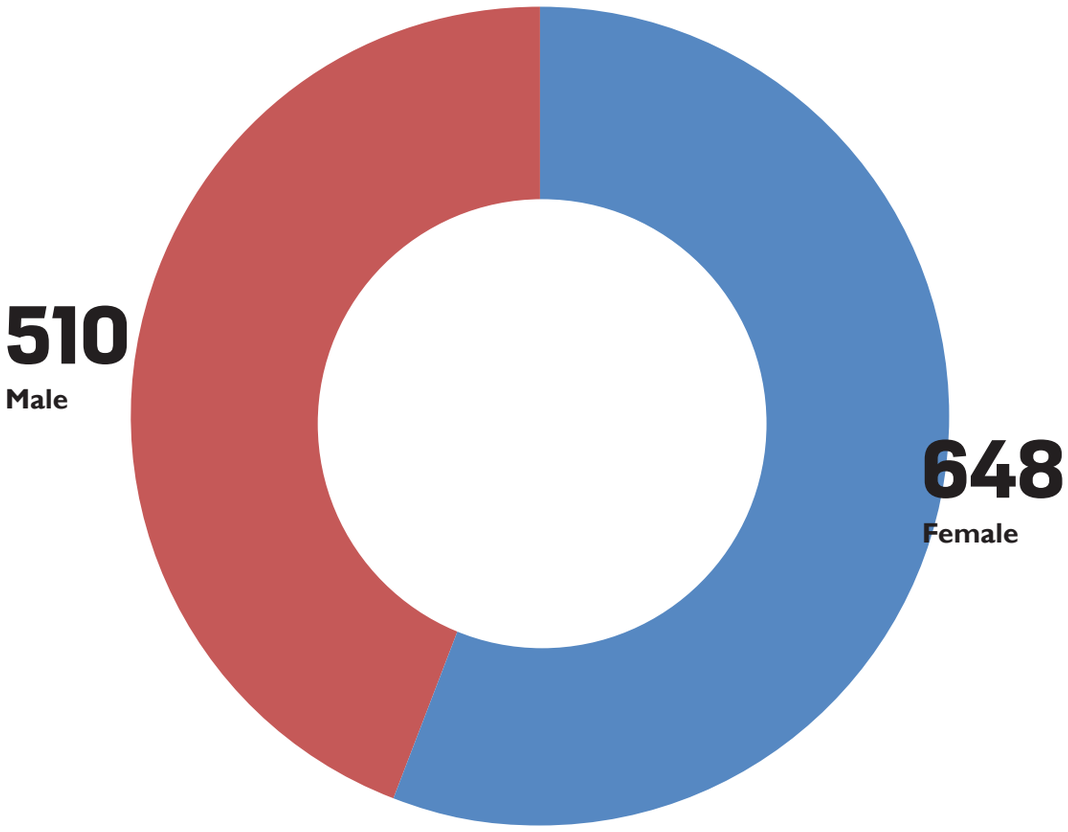


Figure1: Gender Distribution in Nyamira County

Table 12: Data on Health Workers Stock by Sub-County

Staff Category (cadre)	Sub categories	Borabu	Manga	Masaba north	Nyamira North	Nyamira South	CDH	Total
		GoK	GoK	GoK	GoK	GoK		
MO & Specialists	Medical Officers	1	2	3	2	26	0	34
	Medical Officer Interns	0	0	0	0	6	0	6
	Paediatrician	0	0	0	0	1	0	1
	Ob/Gyne	0	0	0	0	2	0	2
	Epidemiologist	0	0	0	0	1	0	1
	General Surgeon	0	0	0	0	2	0	2
	Physician					1		1
	Radiologists	0	0	0	0	1	0	1
	Public Health Specialist	0	0	0	2	1	0	3
Clinical Officers	General Clinical Officers (Diploma)	16	16	2	18	22	0	74
	Graduate Clinical Officers	0	0	14	0	0	4	18
	Clinical Officer ENT/ Audiology	0	0	1	0	1	0	2
	CO-ophthalmology cataract surgeon	0	0	0	0	3	0	3
	CO Paediatrics	0	0	0	0	1	1	2
	CO Anaesthetists	0	0	0	0	4	0	4
	CO –Psychiatry/ Mental Health	0	0	0	0	0	0	0
	CO Oncology/ Palliative Care	0	0	0	0	0	0	0
Nurses & nurse specialist	BSN Nurse	4	3	6	2	4	0	19
	Kenya Enrolled Community Health Nurse	23	5	10	13	89	1	141
	Enrolled Nurse	6	7	1	17	4	0	35
	Kenya Registered Community Health Nurse	12	26	56	38	69	0	201
	Kenya Registered Nurse	0	2	2	1	2	2	9
	Cardiology nurse	0	0	0	0	0	1	1
	Dental Nurse	0	0	0	0	2	0	2
	Nephrology Nurse	0	0	0	0	5	0	5
	Palliative Care Nurse	1	0	0	0	0	0	1
	Registered Midwives	0	0	0	0	1	0	1
	Theatre Nurses	0	0	0	0	2	0	2
Pharmacy Staff	Pharmacist	2	3	2	3	7	1	18
	Clinical Pharmacist	0	0	0	0	0	0	0
	Pharmaceutical Technologist	1	0	3	1	10	0	15
Plaster staff	Plaster Technicians/ Technologists	0	0	1	0	2	0	3
Rehabilitative staff	General Physiotherapist	0	0	2	0	3	0	5
	Orthopaedic Technologist	0	0	1	0	2	0	3
	Occupational Therapist	0	0	1	1	4	0	6
Dental staff	Dental Officers	0	0	1	0	3	1	5
	Dental Technologists	0	0	0	0	1	0	1

Staff Category (cadre)	Sub categories	Borabu	Manga	Masaba north	Nyamira North	Nyamira South	CDH	Total
		GoK	GoK	GoK	GoK	GoK		
	Community Oral Health Officer	0	0	0	1	0	0	1
Diagnostics & Imaging	General Radiographer	0	0	1	1	4	0	6
Medical Social Worker	Medical Social Work	1	1	1	0	2	1	6
Health Administrative Staff	Deputy Director – Medical Services	0	0	0	0	0	1	1
	Health Administrative Officers	1	2	2	3	2	0	10
	Human Resource Management Officer	0	0	0	0	0	1	1
	Clerical Officers	1	3	0	2	5	1	12
	Secretaries	1	1	1	2	1	3	9
	Accountants	1	1	1	1	2	3	9
	Supply Chain Mgt. Assistant	0	0	0	0	2	1	3
	Procurement Officer	0	0	0	0	0	1	1
	Health Records Information Mgt. Officer (HRIMO)	1	0	1	1	2	1	6
Health Information ICT	Health Records Information Technician	0	0	0	0	0	0	0
Medical Engineering Staff	Medical Engineering Technologists	1	1	2	1	3	0	8
	Med Lab Technologist	11	12	10	11	27	0	71
Medical Laboratory Scientist	Med Lab Technicians	0	0	0	0	1	2	3
	Nutrition & Dietetic Officer	1	0	1	2	2	1	7
Nutrition staff.	Nutrition & Dietetic Technologist	0	1	0	0	0	1	2
	Public Health Officers	13	8	10	11	10	0	52
Environmental Health Staff	Assistant Public health officer	0	1	0	0	0	3	4
	Public Health Technician	1	0	0	1	0	0	2
	Community Health Service Personnel (CHEWS)	4	5	0	7	11	0	27
Community Health Service Staff	Community Health Assistants	23	24	2	12	9	0	70
	Community Health Volunteers(CHVs)/VCT Counsellors	26	0	80	6	279	0	391
	Cooks	0	3	0	0	1	0	4
Support staff	Drivers	1	5	0	1	6	0	13
	Support Staff	27	0	16	62	48	3	156
	Mortuary Attendant	0	0	0	0	1	0	1
	Cleaning Staff Supervisor	12	0	0	7	5	0	24
	Security	0	0	0	0	0	0	0
	Total HRH Establishment	193	135	236	228	713	34	**1539**

Source: County HRH Database as at June 2017

3.1.2 Stakeholders Analysis

One of the most critical elements in strengthening the health sector will be the development of strong and effective partnerships between the County Department of Health and key stakeholders. The following table sets out a brief summary of the expectations of the stakeholders and the Department of Health's expectation towards health workforce management and health service delivery in the county that could be tapped in implementation of the HRH plan.

Table 13: Summary of the roles and capacities of HRH stakeholders in Nyamira County

Stakeholder	Stakeholders Expectation	Our Expectation
County Government	• Quality, efficient service delivery • Better HWs management • Clear policies and guidelines • Participation and involvement	• Prompt personal emoluments • Clear policies and guidelines • Financial support
National Government	• Align county plans to the national guidelines • Execute functions as spelt out in Schedule 4 of the Constitution	• Technical and financial support • Development and dissemination of policies and guidelines
Political leaders (Members of County Assembly, Members of National Assembly, Civil societies)	• Quality health services to their constituents • Construction and equipping of new health facilities • Enactment of relevant laws and legislations • Carry out oversight roles	• Provide support for infrastructure development (through CDF) • Approve health budgets and enact county specific health laws • Approval of budget • Political support
Opinion Leaders	• Quality health services	• Facilitate and participate in health promotion • Feedback on health care services
Community	• Quality health services	• Co operate • Seek and utilize health services • Adhere to the health instructions • Feedback on health care services
Health Workers	• Better working conditions • Good labour relations • Improved employee welfare and motivation	• Commitment, professionalism and delivery of quality health services • Feedback on health care services • Submit timely and complete • required reports
Health workers' unions and associations	• Better working conditions for their members • Union dues	• Work with county governments to meet members' expectations
Non-State Actors, FBOs HRH Financing – County CDH allocation	• Provide staff • Support training • Provide quality services	• Provide quality services • Reports • Regular updates • Collaborate on human resource
Private Practitioners	• Public private partnership	• Professionalism • Public private partnership
Implementing partners (NGOs)	• Support of trainings courses infrastructure and hiring	• Adhere to guidelines and plans
Health Training Institutions	• Quality training courses • professionalism	• Quality training courses • Professionalism • Research

3.1.3 Contract HRH Staff Recruited and Supported by Partners

The key governmental stakeholders in the health sector are the Ministry of Health (MOH) of the National Government, the County Department of Health, and other County governments, Faith Based Organizations, Private Sector, Training Institutions and Non-Governmental Organizations all of whom contribute immensely in the overall development of the workforce. Partners like APHIA Plus support the County to bridge the HRH gaps by jointly hiring health workers with the help of county public service board to minimize the impact of health workforce shortage on the HIV/AIDs service delivery points. The available data on the number of partner supported health workers at the County indicate they are 223 translating to equivalent of 14.4 % of the County HRH stock excluding CHVs as at June 2017. The available data on the number of partner supported health workers at the County are as indicated below;

Table 14: Summary of Partner-supported Contract Health Workers

County	Male	Female	Total	% of Contract HWs to County HWS
Nyamira County	49	174	223	**14.4%**

Source: Donor partners coordination report June 2017

3.1.4 Community Health Workers

The community health service personnel are **391,** comprising of 27 CHEWs and 70 CHAs and 294 CHVs. There are 86 community units. The CHEWs are fewer than what the community health strategy defines and they are not able to meet the supervision of the health promotion and prevention activities carried out by CHVs at community level. All villages are at least covered by the CHVs, but the coverage differs from village to village and sub-county to sub-county.

The Community Health Strategy guides the implementation of Level 1 health services, which are aimed at empowering Kenyan households and communities to take charge of improving their own health. A major strategic objectives of the Community Strategy is to "strengthen the community to progressively realise their rights for accessible and quality care and to seek accountability from facility-based health services".

3.1.5 HRH Projections as per Staffing Norms and Standards

The projections of the workforce requirements for the county have been guided by the evidence from the MOH HRH norms and standards, 2014, for the different tiers/levels of healthcare. The norms and standards refer to the minimum and appropriate mix of human resources required to serve the expected populations at the different levels of the system. Nyamira County HRH stock is below 20 per cent of requirements as per norms and standards. The county has a HRH stock of 1539 comprising 1148 **r**ecognized MOH cadres and **391** CHVs and CHAs. According to the Capacity Assessment and Rationalization Program (CARPs) carried out in 2015, the department requires a total of 1968 HRH stock excluding CHVs. The gap, according to CARPS in 2015 is therefore **728** HWs. The main projection per staff classification is outlined in the database. A synopsis on the projections to meet 100 per cent gap and 30 per cent gap is as outlined in the table below.

The county has a total of 1,539 health workers of various cadres. However, there is a shortage both in numbers (none of the cadres meets the established staffing norms) and skills mix to effectively respond to the health needs in Nyamira County.

Table 15: HRH Projections

HRH Stock (MOH Cadres)	HRH Stock Including CHVs/ CHAs		Total gap	Projections 100% of gap			Projections 30% of gap		
				2018	2019	2020	2018	2019	2020
1148	**391**	**15,233**	**13,684**	**4561**	**4561**	**4561**	**1368**	**1368**	**1368**

3.1.6 Age, Education and Gender Analysis of the MOH Workforce

Nurses represent the highest number of health workforce at 489 (36%) followed by clinical officers 99 (8%) and environmental health staff at 58 (4%) and Medical officers 36 (3%). The rest take up 49 per cent of the MOH cadre HRH stock. The number of health specialists is 29 consisting of six medical specialists, 14 clinical officer specialists and nine post-basic nurse specialists. However, there are three more medical specialists currently on administrative duties. The health specialists are as outlined in the Annex

3.2 Human Resources Management

According to the County Health Department leadership, until late 2015, HRH matters were handled from the Directorate of Administration through the HR Director's Office that is responsible for all HR matters in the county. There is now a remarkable improvement in the handling of HRH matters since the establishment of a HRH unit in the Department of Health to manage HRM issues. A deputy director of Administration Office has also been established to support the HRHO with issues requiring prompt administrative intervention. This has also partially contributed to the mitigation of industrial unrest amongst health workers with the deployment of an HR Officer at the Health Department. The officer has instituted mechanisms for prompt communication with staff through the sub-county and facility leadership structure, support supervision and open-door policy in addressing staff concerns. The updating of iHRIS database has also accelerated with the new structure. The CPSB is mandated to establish positions, carry out recruitments, determine terms and conditions of service, address inter-county transfers requests, maintain disciplinary control and conduct staff promotions. These services are not specific to HRH; rather, they apply to all county employees. The uniqueness of HRH needs required that a specific HR leader be identified and given the mandate of managing HRH for the county. This has been done, but adequate infrastructural support and budget is required to ensure the smooth running of HRH.

3.2.1 Organisation structures for HRH management

Since the inception of the devolved system of government in 2013, Nyamira County has made efforts to put in place structures, policies and processes to operationalise the devolved system of government and enhance service delivery to its people. This is evident in CIDP 2013 -17 and the CHSIP 2013/14 - 2017/18. In policy dimension, there has been adoption of the County Training Policy on Human Resource Development, the performance management guidelines that the County Health department has customised from the PSC and MOH policies. However, due to shortages of qualified HR personnel, quite often, respondents repeatedly reiterated that the Health Department has relied on non-HR staff to manage HR issues in the facilities and sub-counties; this was also validated by the HR Officer, who also noted existence of budget constraints as the main driver for this anomaly.

With the use of the iHRIS, the county is using the data to inform on the county needs, and that would be addressed in subsequent recruitments. The notable gaps were for oncologists, general surgeon, dermatologist, family health physician, clinical officer oncologist, clinical officer reproductive health

and nurse specialists; oncology nurse, accident and emergency nurse, and neonatology nurses, among others. There is an ongoing process to continually update staff particulars its iHRIS database.

A major gap in the management of HR issues in the county, however, was the fact that many of the employees felt that HR decisions are often made without consulting the HRH unit and County Health leadership. Quite often, the guidance given on prioritised areas is not often implemented. With the acute shortage of health workers, the employees felt that the county should have hired more health workers for effective service delivery than the enforcement officers who did not meet the needs for facilities. It is some of these measures that impact negatively on the morale of staff.

3.2.2 Staff recruitment

The county has recruited staff in key areas of shortage. However, the number is still insufficient compared to the identified gaps, due to shortfalls in budgetary allocation and restrictions on total staff expenditure as a percentage of the total expenditure. The CPSB handles recruitment and selection based on projected needs and in accordance to qualification guidelines in the schemes of services, "To ensure that the county public service reflects diversity of the Kenyan communities, the county government will endeavour to address inclusiveness through recruitment, deployment, training and promotion." (Public Service Commission of Kenya - County Public Service Human Resource Manual D 14 (2) Page 24). The Board aligns recruitment to this guideline to ensure gender parity and regional representation.

An area of need for further improvement is coordination between the Department of Health, Directorate of Human Resource Management and CPSB to ensure that recruitment and deployment to facilities is based on the most critical needs by each facility. Nyamira County being rural, attraction and retention of medical specialists is a challenge.

3.2.3 Staff orientation

The county has in place a staff induction programme for staff joining the health sector, but inadequate funding has limited the scope of the induction. Among the areas of improvement suggested by staff from the focus group discussions are career progression, county pension scheme and training opportunities, implementation of the occupational health and safety guidelines, and lack of the job descriptions.

3.2.4 Staff performance management

A policy on staff performance management is available for use by the county. It includes the county performance management framework, signing of performance contracts, the performance appraisal system, objectives of performance appraisal, scope of application, work planning and setting of performance targets. Values and competencies assessment, appraisal period, continuous performance appraisal, mid-year performance review, reporting frequency, end-of-year appraisal process, county performance management steering committee and departmental performance management committee are its other parameters.

The implementation of performance management has not been fully rolled out up to the individual level, but performance contracts have been signed at the CEC, COH and Director level. From the interviews, staff also noted that currently, the HRM interventions are not evaluated at all level for effectiveness and this creates a disconnect between the planning and management functions. Nyamira County Department of Health has a division that undertakes monitoring and evaluation (M&) activities and is expected to address the gap on HRM interventions and evaluations at all levels.

3.2.5 Staff discipline and grievance procedures

The powers of disciplinary control and removal of county public officers from the service are vested in the CPSBs or Authorised Officers as specified in the County Government Act, 2012. Though a long process steeped in bureaucracy, the system is available and is being administered. The department through its structures from facility level to county level has a mechanism of addressing disciplinary control. The regulatory bodies also play a critical role in disciplinary matters especially as relates to professional misconduct. However, the procedures are not effective, and disciplinary cases take long to be concluded.

3.2.6 Career progression of key cadres

In general, career development provides opportunities that can be mutually beneficial for both employees and employers. Employees who participate in job training, continuing education and other types of professional development can refine and acquire new skill that could help advance their career. Building more well-rounded employees by preparing them to better handle tasks and be successful in their roles helps organisations become more effective and efficient.

The County has been able to promote most of the staff, who had stagnated for over 15 years. However, there is need to develop a staff establishment for identification of existing vacancies in the health department and facilitate resource advocacy that will enable the CPSB recruit personnel required to fill the gaps.

3.3 Training and Development

The training of health workforce for both in-service and pre-service is done by the National Government as a policy. Universities offering degree programmes in health carry out the selection of the candidate for both pre- and in-service training, while the Kenya Medical Training Colleges (KMTC) carry out selection for pre-service training. The National Government does the university selection through the Kenya Universities and Colleges Central Placement Service (KUCCPS). For the private students, admission is done by specific universities and colleges. The counties' function is to release and forward the names of the selected candidates through the CPSB to the national level for training. However, counties also conduct skills upgrade short courses under their sponsorship or through support of development and implementing partners. On-job training also exists, although it's not comprehensive.

Several health workers, who have been supported, attend in-service training courses by the national and county government. Staff are undertaking different post-graduate studies. Lack of a comprehensive need-based training plan for all levels of training, including in-service, has previously prevented the county from fully taking advantage of available sponsorship opportunities at the national level. Other challenges include lack of a clear and institutionalised mechanism for selecting staff for all forms of training; poor record-keeping on training conducted and limited budgetary allocation.

3.3.1 Training output by cadre trained and status

Nyamira County has supported a couple of training courses. These are geared to identifying skills gap in the county as evidenced by the training needs identified in the County Health Department Training Needs Assessment and the National Training Needs Assessment conducted in May 2015. Some of the training courses are illustrated on the following page.

County supported training	2013	2014	2015	2016	2017	Totals
Total No of Staff who underwent training.	387	427	636	537	681	2668
No of staff who underwent more than one training.	0	0	0	0	0	0
No of staff who underwent a similar training more than once.	0	0	0	0	0	0
	387	**427**	**636**	**537**	**681**	**2668**
PMTCT	50	50	0	0	0	100
Infant and Young Child Feeding	0	25	25	0	0	50
ART TOT	6	8	0	0	0	14
Cervical Cancer Screening	15	10	15	16	0	56
Commodity Management	10	25	15	0	0	50
Adult ART Management	30	30	30	0	0	90
CHMT Induction	0	0	0	0	0	0
IMCI	21	0	0	0	0	21
New ART Guidelines	0	30	30	30	0	90
Leadership and Management	0	0	0	5	0	5
KMC	0	0	0	0	0	0
MSDR Supervision	0	0	0	0	0	0
HRH Workshop	0	0	0	3	0	3
MPDSR Pre Conference	0	0	0	0	0	0
KQMH	0	0	0	0	0	0
MNCH Integration	0	0	0	0	0	0
RMNCAH scorecard	0	0	0	0	0	0
BEmONC	44	48	48	50	0	190
CEmONC	0	0	0	0	0	0
Financial Management	0	0	80	0	0	80
Vector Surveillance Monitoring Insecticide Resistance	0	0	3	0	0	3
Quality Improvement Monitoring Perinatal death	0	0	11	0	0	11
Focused Antenatal Care	0	0	0	78	0	78
LARC	0	0	45	27	0	72
Reproductive Maternal Health	0	0	0	75	0	75
Epidemiology	0	0	0	7	0	7
PM+ Master Trainers	0	0	0	0	3	3
PM+ Health Care Workers	0	0	0	0	30	30
Paediatric TB	0	0	0	0	50	50
CHESS	0	0	0	14	0	14
Integrated Human Resource Information System	0	0	15	0	0	15
HMIS	0	0	0	0	173	173
EMR	0	0	0	0	23	23
Gender-Based Violence	0	28	0	0	0	28
LLTNS	150	0	0	0	0	150
Senior Management	0	0	11	11	18	40
End TB in Universal Health Coverage	0	0	0	0	1	1

County supported training	2013	2014	2015	2016	2017	Totals
Masters Trainings	0	0	0	0	1	1
Business Administration in Health Care Management	1	1	0	0	0	2
	0	1	0	0	0	1
Radiology and Imaging	0	0	0	1	0	1
General Surgery	0	0	0	1	0	1
	0	0	1	0	0	1
Ophthalmology	0	0	1	0	0	1
Anaesthesiology						
Family Medicine						
Paediatrics						
Biomedical Engineering	0	0	0	1	0	1
Medical Microbiology	0	1	0	0	0	1
Palliative care	0	1	0	0	0	1
Perioperative Care Nursing	0	0	0	3	0	3
Prevention and Control of Diseases	0	0	0	0	1	1
HTC New Algorithm	0	0	50	50		100
Malaria Case Management	60	60	60	135	141	456
Early Infant Diagnosis	0	0	20	0	0	20
Ambulance Operator	0	22	0	0	0	22
Earlier Infant Diagnosis	0	0	10	0	0	10
MDR TB	0	21	0	0	0	21
Pharmacovigilance	0	30	30	30	0	90
Pharmacovigilance (TOTS)	0	6	4	0	0	10
Health System Strengthening	0	14	0	0	0	14
Post-abortion Care	0	0	28	0	0	28
Biosafety	0	0	28	0	0	28
Gene Expert	0	0	30	0	0	30
Couple Counselling	0	8	0	0	0	8
IFAS	0	0	31	0	0	31
Behavioural Change Communication	0	0	15	0	0	15
Trained on Ebola (TOTS)	0	8	0	0	0	8
Community Malaria Case Management	0	0	0	0	240	240
Total	387	427	636	537	681	2668

Source: County HRH Database as at June 2017

3.4 Human Resources for Health Databases

3.4.1 Integrated Human Resource Information System (iHRIS)

The County uses the iHRIS in maintaining HWs data. However, the data is not up-to-date. Concerted efforts have been put in place to update the data and a dedicated person has been deployed to speed up the process. There are existing discrepancies between data in iHRIS and the manual data based on staff returns. Generation of HRH dashboards is thus hampered by the inaccuracy of the database.

3.5 SWOT Analysis

As part of the situation analysis, a thorough analysis of the strengths, weakness, opportunities and threats (SWOT) in the current HRH situation was conducted. The following table shows the findings:

Table 17: SWOT Analysis for the Internal and External Environment

Environment	Variable	Weakness	Strength
Internal Environment	Strategy/focus	• Polices and guidelines in draft form • Poor implementation of policies	• Availabilities of draft Bills and policies • Availability of vision and mission statements • Availability of plans
	Structure for implementation	• No defined governance structures (amorphous CHMT) not institutionalised. • Some cadres lack representation at management level	• Availability of skilled human capital at CHMT and leadership level
	Systems to support implementation	• Inadequate staff • Inadequate skilled personnel • Poor finance flow/guidelines for implementation • No approved governance structures	• Availability of programme-based budget • Availability of health products
	Shared values within the County Management Team	• Core values not institutionalised	Core values identified and aligned to the Health Strategic & Investment plan
		No clear chain of command	Facilitative
	Staffing – (Executive, CHMT, HWs, CHVs)	Inadequate HWs and CHVs Demotivated staff (CHMT) and (SCHMT) Poor deployment	Trained and committed staff at all levels
	Linkage with other core departments (CPSB, County Directorate of Administration, County Public secretary Office, County Assembly)	Not well defined, especially Finance Department	When need arises the departments coordinates well
	HRH Financing – County CDH allocation	Bureaucratic finance procedure	Considerable county allocation to CDH
	Training of HWs	Inadequate resources for training No County HR policies on training Inadequate specialised trainings Skewed training opportunities	Training Opportunities Budgetary Allocation for training Availability of partners support

Environment	Variable	Opportunities	Threats
External Environment	Political factors (Good will/ Support) Resource mobilisation/ provision)	Goodwill from the political arm of the county.	Different political interests overriding merit in prioritisation, especially in health projects. Poor involvement in health development issues/ interference. Lack of resource mobilisation skills
	Industrial Issues (Interest in management of HWs, National level, Impacts of Unions/Associations)	Knowledge of rights to formation of Unions and Associations. Avenue for dialogue or work council meetings with unions	Labour unrest Inadequate knowledge of labour laws No structure to address labour unrest. Union leaders also at management levels
	Social factors (community, culture, perceptions about HWs)	Good health seeking behaviour by the community.	Cultural barriers (ebibiriria) Stigma
	Legislative Issues – Legal framework, labour laws, policies, constitutional provisions	Accessibility of policies and guidelines in Human Resource for Health Availability of HRM unit	Inadequate knowledge in interpretation and implementation of policies Inadequate staffing Inadequate HR professionals
	Other stakeholders (Collaborators, partners, other counties, regional block)	Resources from different partners, Stakeholders forums and Capacity-building Members of regional blocs	No mechanism for sustainability on resource mobilisation Transfer/deviation of resources from intended use
	Training of HWs (Education sector, Health Training Institutions)	Availability of partner support in training (AEF). Availability of National training fund. E-learning platform.	High demand but limited resources. Partner / National funding is specific and counties have no control. Lack of ICT infrastructure.
	HRH Financing (Treasury, Partners, PPPs)	Availability of financial support	Inadequate funds Lack of involvement of HRM personnel in budget processing Lack of skills in planning and budgeting Late and inadequate disbursements to spending units Lack of prioritisation

CHAPTER 4

4.0 STRATEGIC DIRECTION

4.1 Vision, Mission, Core Values and Outcome Areas

This chapter quotes the vision, mission statements, and core values and summarises the main strategic statements and outcomes set in this HRH plan.

OUR VISION

An honest and committed workforce

OUR MISSION

Attract, retain and develop a competent and diverse health workforce for effective service delivery

OUR VALUES

Core values

- **Teamwork:** We intend to inculcate team spirit in our staff to improve service delivery
- **Integrity:** All staff are expected to uphold integrity, moral and ethical standards in all their undertakings
- **Competence:** Staff are expected to maintain professionalism through good judgement and appropriate behaviour
- **Innovations:** The department will encourage creative ideas and novel solutions that will improve the health status of our people
- **Customer focus:** The leadership and staff will treat all in fair and just manner, respecting the rights of all individuals

4.2 Strategic Objectives

Nyamira County HRH plan 2017-2020 outlined the following Outcome areas upon which strategic objectives are drawn: ***1. Strengthened link between HRM and Development leadership and the Unions/Professional Associations. 2. Improved Staff training and development systems. 3. Implementation of HR policies and guidelines. 4. Improved HRH performance management. 5. Strengthened information and communication systems.***

A motivated health workforce is essential to a well-functioning health system and motivated employees are likely to be more productive. In general, there is evidence that strong industrial relations support and promote positive employment relations, which translates to improved worker performance. This includes administration of acceptable minimum terms and conditions of employment, and providing workplace dispute resolution services. The county department of health will work with stakeholders and partners to conduct an employee satisfaction survey and develop clear channels of communication with the union leaders and the employees to create an employment relations climate that supports effective health worker performance, competitiveness and prosperity. The department will also work to improve staff training and development systems for effective service delivery that will include putting in place elaborate structures, for example training committee and technical working groups, implement existing HR policies and guidelines for better management of the health workforce, improve HRH performance management to include conducting performance needs assessment, performance appraisal and enhancing supportive supervision. The county will further strengthen information and communication systems to ease access to information amongst staff as well as decision-makers. The strategic objectives and the strategies are outlined below.

Strategic Objective 1: To improve industrial relations mechanism by December 2019

Strategies:
1.1 Develop clear channels of communication.
1.2 Develop and implement feedback mechanism
1.3 Conduct an employee satisfaction survey
1.4 Provide workplace dispute-resolution mechanisms

Strategic Objective 2: Establish systems for HRM/D for effective service delivery by 2019

Strategies:
2.1 Establish a departmental training committee with clear TORs
2.2 Establish a HRM/D TWG with clear TORs
2.3 Train the HRM/D TWG and the training committee
2.4 Convene the HRM/D TWG on quarterly basis
2.5 Develop the short-term and long-term training plans
2.6 Develop an M&E framework to track implementation
2.7 Conduct quarterly M&E to track the implementation

Strategic Objective: 3: To undertake training and development of 30% of the staff by 2019

Strategies:
3.1 Carry out training needs assessment/projections of all staff
3.2 Update iHRIS quarterly
3.3 Identify post-service training institutions
3.4 Develop a budgetary allocation for training courses

Strategic Objective 4: To provide policy framework for HRH leadership and management system

Strategies:
4.1 Customise key HRH policy manuals and guidelines

4.2 Disseminate policy documents to health workers
4.3 Create a framework for implementation of HRH policies and guidelines
4.4 Institutionalise the training policy
4.5 Create awareness on training policies

Strategic Objective 5: Institutionalise performance management systems

Strategies:
5.1 Conduct performance needs assessment (PNA) to identify existing HR performance gaps
5.2 Disseminate PNA findings and draw an action plan
5.3 Develop Job descriptions for all health workers
5.4 Implementation of performance appraisal systems (PAS)
5.5 Develop mechanism for M&E
5.6 Develop HRH supervision tool
5.7 Train all managers on supervisory skills
5.8 Conduct regular support supervision

Strategic objective 6: To strengthen information and communication systems for human resource and service delivery by 2019

Strategies:
6.1 Carry out baseline survey
6.2 Provide ICT infrastructure
6.3 Support for internet connectivity
6.4 Develop e-record of personnel
6.5 Link telemedicine to sub-county hospitals
6.6 Develop e-learning virtual platform.

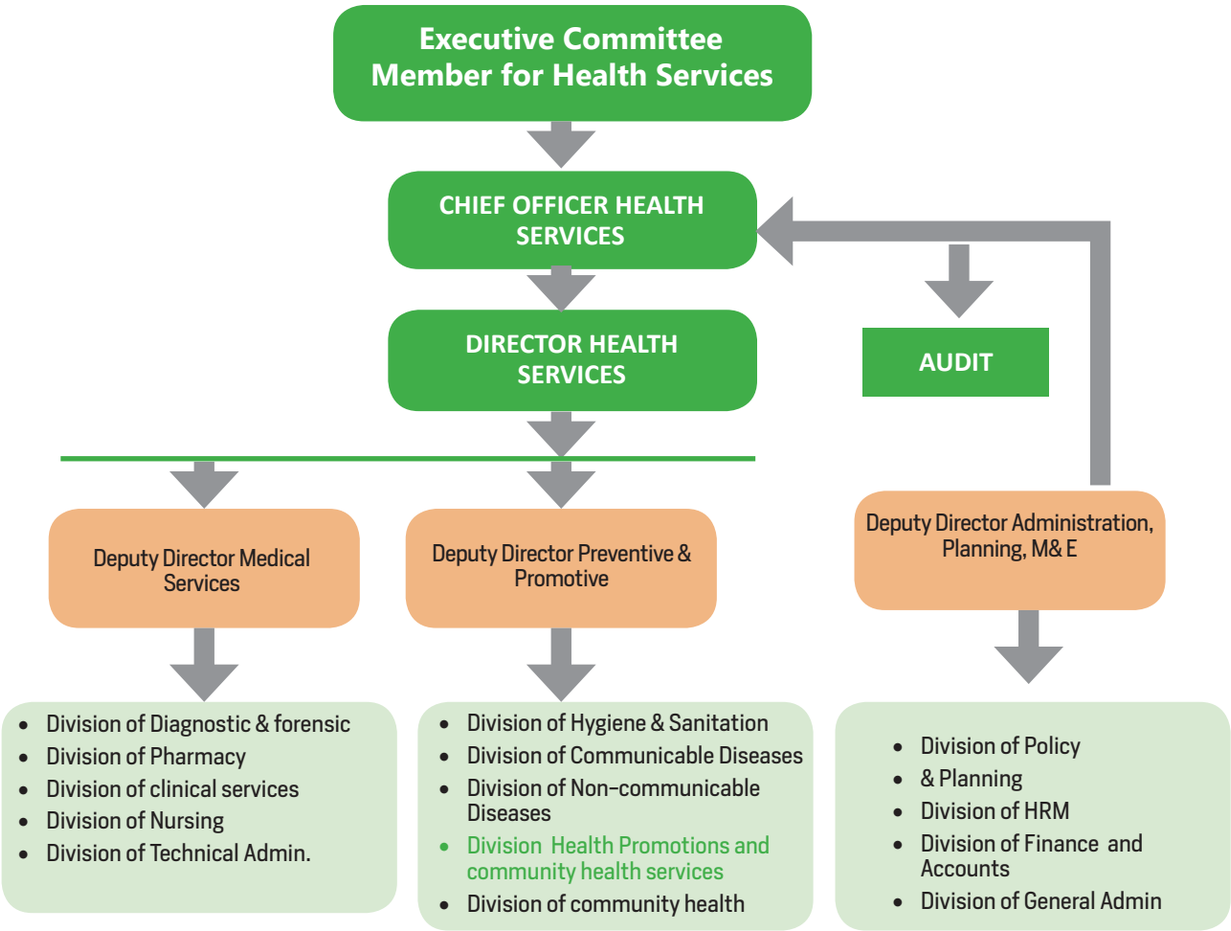
CHAPTER **5**

5.0 STRATEGIC INTERVENTIONS, IMPLEMENTATION & M&E

5.1 Organisational Structure

This section outlines the county department of health leadership and governance structure that will facilitate achievement of this plan. Health sector leadership and governance focus is built around three thematic areas of focus: Improving health stewwardship, building appropriate systems for health governance, and consolidating health partnership arrangements. It is envisioned that this team will provide the overall leadership to ensure all the strategic objectives of this plan are realised on time.

Figure 2: Nyamira County Department of Health Management Structure



As highlighted in the organogram, the key oversight functions are managed through the Executive Committee Member (CECM). The CECM is responsible for policy matters and overall guidance in the department, while the Chief Officer oversees the implementation of county policies and legislations that concern the department. The Chief Officer being the accounting and authorised officer ensures the department is effectively facilitated to perform its functions. The Director of Health Services will be the main coordinator of technical functions of the Department of Health to ensure the department achieves its targets.

5.2 Partnership Framework

Full implementation of this HRH plan will require multi-sectoral effort and approach with various health stakeholders playing different roles, which are complimentary and synergistic at all levels of healthcare service in the devolved government systems. These responsibilities and roles are geared towards realisation of the right to health. The various stakeholders in the health sector include:

- **Clients:** These represent the core reason for the existence and activities of the sector. For attainment of health goals, individuals are expected to exercise appropriate health and healthcare seeking behaviour required to maintain their health, seek healthcare intervention at the earliest possible moment, and take up healthcare services made available to maintain their health, particularly disease prevention and control services.
- **State actors:** The public sector (MoH-National and County, other ministries, Regulatory bodies (Boards and Councils) and professional bodies/associations whose mandates are drawn from those of the State and have an effect on health and HRH.
- **Non-state actors**: The private sector, NGOs, CSOs, FBOs, media, and all other persons whose actions have an impact on health, but don't draw their mandate from the state

5.3 Financing the Plan

In order to meet the expenses of this budget, it is envisaged that the county will allocate enough financial resources. It will also seek development partners' support in cash and kind to supplement the budgetary allocation. The total budget will cost **Sh4,618,955,779** comprising Sh**4,525,135,778** for personal emoluments and **Sh93,820,000** for activities.

Table 17: Summary of Strategic Objectives Activities Budget & PE Budget

Strategic Objective	2017/18	2018/19	2019/20	Total KES
1.1: To improve industrial relations mechanism by December 2019	2,300,000	2,400,000	2,500,000	7,200,000
2.1. Establish systems for Training and Development for effective service delivery by 2019	11,550,000	4,000,000	4,000,000	19,550,000
2.2: To undertake training and development of 30% of the staff by 2019	2,850,000	710,000	710,000	4,270,000
3.1. To provide policy framework for HRH leadership and management system	-	2,300,000	2,100,000	4,400,000
4.1. Institutionalise performance systems	2,800,000	3,000,000	200,000	6,000,000
4.2. To implement the supportive supervision and performance monitoring by June 2018	3,500,000	3,400,000	3,400,000	10,300,000
5. 1. To strengthen information and communication systems for HR and service delivery	15,900,000	13,100,000	13,100,000	42,100,000
Total	**38,900,000**	**28,910,000**	**26,010,000**	**93,820,000**
Personal emoluments	1,508,378,593	1,508,378,593	1,508,378,593	4,525,135,778
Grand Total	**1,547,278,593**	**1,537,288,593**	**1,534,388,593**	**4,618,955,779**

5.3.1 Available financing and financing gaps

During the three-day workshop, the county collated information on all known or anticipated strategies that will potentially be available for implementation during the five years of implementation.

Sources of funding

Budgetary allocation or technical support from:

- County Government
- Partners
- National Government

Strategies to ensure current available human, financial and physical resources are sustained

- Strengthen public private partnerships;
- Develop a preventive maintenance plan for infrastructure and equipment;
- Conduct mid-term expenditure framework analysis;
- Inter-sectoral collaboration with medical training institutions; and
- Conduct annual staff performance appraisals.

5.4 Risk Management and assumptions

Assumptions

1. The HRH Strategic Plan will be completed within the stipulated time
2. Adequate resources to implement the plan will be available
3. There will be goodwill from the politicians and other stakeholders
4. Support from the top management at the county

Risks

1. Change of management
2. Inadequate funding
3. Resistance from stakeholders, especially trade unions
4. Lack of commitment

Risk mitigation

1. Advocacy through wide dissemination of the plan
2. Resource mobilisation
3. Public-private partnership
4. Development of annual HR plans to address the strategies
5. Leveraging the plan in the annual programme-based budgeting

5.5 Implementation Framework

Responsibility

1. Executive Committee Member
2. Chief Officer of Health Services

Evaluation

1. The evaluation of the HRH Strategic plan will be conducted on midterm and end-term basis.
2. Monitoring to be conducted on quarterly basis

Table 12: Nyamira County HRH Plan Strategic Plan Results and M&E Framework

Strategic Objectives	Strategies				TIME FRAME						
					2017/18				18/19	19/20	Risks & Assumptions
		Outcome Indicator	Means of Verification	Responsible	Q1	Q2	Q3	Q4			
Outcome 1: Strengthened link between HRM & D leadership and the Unions/Professional Associations											
1.1: To improve industrial relation mechanism by December 2019	1.1.1. Establishment of effective channels of communication	Effective channels of communication established	Availability of communication channels	Chief Officer				Jun 18			The channels of communication will be consistently and effectively used
	1.1.2. Develop and Implement feedback mechanism	Feedback mechanism developed and implemented	Team meeting minutes Suggestion boxes available and in use	HRHO			Jan 18				Feedback mechanisms will be used
	1.1.3. Conduct employee satisfaction survey	Number of employee satisfaction surveys conducted	Satisfaction survey report	HRHO			Jan 18	Jun 18	Jan 19	Jun 19	Survey findings will be acted upon
	1.1.4. Provide workplace dispute resolution mechanism	Dispute resolution mechanisms provided	Presence of dispute resolution guidelines	D/CDH		Oct 17					Dispute resolution services will minimise employee unrest
Outcome 2: Improved systems for staff training and development											

Strategic Objectives	Strategies				TIME FRAME						
					2017/18				18/19	19/20	Risks & Assumptions
		Outcome Indicator	Means of Verification	Responsible	Q1	Q2	Q3	Q4			
2.1. Establish systems for HRM and Development for effective service delivery by 2019	2.1.1. Establish a Training Committee with clear TORs	Training Committee established	Availability of Training Committee	CDH			Mar18				Training Committee will carry its mandate
	2.1.2. Establish HRM&D TWG with clear TORs	TWG established with TORs	Presence of TWG with TOR	CDH			Mar18				
	2.1.3. Train HRM&D TWG and Training Committee.	Training conducted	Training Report with list of trainees	CTC				May 18			
	2.1.4. Convene the HRM/D TWG on quarterly basis	Quarterly TWG meetings held	TWG meeting minutes	CTC				Aug 18	Nov 18	Feb 19	
	2.1.5. Develop a short term and long term training plan	Training plan developed	Training Plan In place	CTC	Dec 17						
	2.1.6. Institutionalisation of the training policy	Training policy adopted by county	Meeting minutes	COH				May18			
	2.1.7. Develop an M&E checklist to track implementation	M&E checklist developed	M&E checklist available	HRIO				May18			
	2.1.8. Conduct M&E on implementation of the systems quarterly	M&E conducted	M&E Report	HRHO				Aug 18	Nov 18	Feb 19	

Strategic Objectives	Strategies				TIME FRAME						
					2017/18				18/19	19/20	Risks & Assumptions
		Outcome Indicator	Means of Verification	Responsible	Q1	Q2	Q3	Q4			
	2.2.1. Carry out training needs assessment (TNA) and projections of all staff	TNA carried out Staff Training Projections	TNA Report Projection Report	**CTC**	**Oct 17**						TNA report will be implemented
	2. 2.2. Update trainings in iHRIS quarterly	Quarterly iHRIS updated sessions	iHRIS updated Reports	**HRHO**	X	X	X	X	X		Consistent Internet
	2. 2.3. Identify in-service training institutions	In-service training institutions identified	List of Institutions	**HRHO**			**Jan18**				
	2.2.4. Mobilisation of resources for implementation of training plan	Resources mobilised	Resource mobilisation report	**COH**			**Feb 8**				Budgets will be allocated and used for training
Outcome 3: Implementation of HR Policies and Guidelines											
3.1. To provide policy frame work for HRH leadership and management system	3.1.1.Customise key HRH policies and guidelines	Key HRH policies & guidelines customised	Availability of customised policies & guidelines	D/CDH			**Mar18**				
	3.1.2.Disseminate policy documents to health workers	Policy dissemination done	Dissemination report	D/CDH				Oct18			
	3.1.3. Create a framework for implementation of HRH policies and guidelines.	Framework created	Availability of Framework	CDH				Oct 18			Skilled team on PNA
Outcome 4: Improved HRH Performance Management											

Strategic Objectives	Strategies				TIME FRAME						
					2017/18				18/19	19/20	Risks & Assumptions
		Outcome Indicator	Means of Verification	Responsible	Q1	Q2	Q3	Q4			
4.1. Institutionalize performance management systems	4.1.1. Conduct performance needs assessment (PNA) to identify existing HR performance gaps	PNA conducted	**PNA Report**	CHRMA	Oct17						
	4.1.2. Disseminate PNA findings and draw an action plan	PNA findings disseminated & action plan drawn	**Dissemination schedule & Report**	CHRMA			Jan18				
	4.1.3.Develop Job Descriptions for all cadres	JDs developed for all cadre	**Availability of JD**s for all cadres	HRHO			Jan18				
	4.1.4. Implement the PAS	PAS implemented	PAS report	HRHO			X	X	X	X	**PAS will be supported by rewards and sanctions**
	4.1.5. Develop framework for monitoring and evaluation.	M&E framework developed	Presence of M&E framework	CDH				Apr18			
	4.1.6. Develop HRH supervision tool	**Supervision tool developed**	**Existence of tool**	HRHO	Sep17						
	4.1.7. Train all managers on supervisory skills	**Training conducted**	Training report and list of trainees	CTC	Oct17						
	4.1.8. Conduct regular support supervision.	**Support supervision conducted**	Supervision Reports	CHRMA			Jan18	**May18**			**Budget availability**
Outcome 5: Strengthened information and communication systems											

Strategic Objectives	Strategies				TIME FRAME								
					2017/18					18/19	19/20	Risks & Assumptions
		Outcome Indicator	Means of Verification	Responsible	Q1	Q2	Q3		Q4			
51. To strengthen information and communication systems for HR and service delivery by 2019	5.1.1. Carry out baseline survey	Baseline survey carried out	Survey Report	HRHO				Jun18			Survey report will be implemented	
	5.1.2. Provision of ICT infrastructure	ICT infrastructure provided	ICT inventory of infrastructure	COH				Sep18				
	.1.3. Support for internet connectivity	Internet connected	Availability of internet	DCDH				Sep18				
	5.1.4. Develop e-record of personnel files	e-records developed	e-record in place	CHAO					Oct 18			
	5.1.5. Link telemedicine to sub-county hospitals	Telemedicine linked to sub-county hospitals	Availability of connection	CDH						Jan18		
	5.16. Develop e-learning virtual platform	Virtual platform developed	Existence of e-learning platform and in use	HRHO						Feb18		

HRH STOCK AGAINST NORMS AND STANDARDS

HRH Database & Projections based on HRH Norms & Standards

Staff cadre	Staff Sub-categories	REQUIRED HRH PER NORMS & STANDARDS					AVAILABLE- HRH STOCK							NYAMIRA COUNTY HRH NEEDS (GAPs)								
		County Referral Hospital (L4)	County (primary)	Health Centre-L3	Dispensary-L2 *	Community	County Head Office (CHO)	County Referral Hospital (L4)	County (primary Hospital -L4)	Health Centre-L3	Dispensary-L2	Community Unit L1	Total Available HRH Stock	CHO	County Referral Hospital (L4)	Sub-County (primary)	Health Centre-L3	Dispensary-L2	Community Unit	Grand Total (GAP)	PROJECTIONS	
		Hospital L4	hospital-L4 -*7			Unit-L1*										hospital-L4			Unit-L1			
		1	7	39	43	85															30% Gap 2016-2018	Annual 100% Gaps 2017-2020
Medical Officers & Specialists	Medical Officers	50	112	74	0	0	0	26	6	1	0	0	33	0	24	106	73	0	0	203	20	68
	Medical Officer Interns	0	0	0	0	0	0	6	0	0	0	0	6	0	-6	0	0	0	0	-6	-1	-2
	Anaesthesiologist	6	14	0	0	0	0	0	0	0	0	0	0	0	6	14	0	0	0	20	2	7
	General Surgeon	4	14	0	0	0	0	0	0	0	0	0	0	0	4	14	0	0	0	18	2	6
	Orthopaedic Surgeon	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	ENT surgeon/ Entomologist	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	Ob/Gyne Specialist	3	14	0	0	0	0	0	0	0	0	0	0	0	3	14	0	0	0	17	2	6
	Neonatologist	1	7	0	0	0	0	0	0	0	0	0	0	0	1	7	0	0	0	8	1	3
	Nephrologist	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	Neurologist	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	Ophthalmologist	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	Optometrist	1	7	0	0	0	0	0	0	0	0	0	0	0	1	7	0	0	0	8	1	3
	Dermatologists	1	7	0	0	0	0	0	0	0	0	0	0	0	1	7	0	0	0	8	1	3
	Paediatrician	4	14	0	0	0	0	1	0	0	0	0	1	0	3	14	0	0	0	17	2	6

	Pathologist	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	Psychiatrist	4	14	0	0	0	0	0	0	0	0	0	0	0	4	14	0	0	0	18	2	6
	Radiologists	4	14	0	0	0	0	1	0	0	0	0	1	0	3	14	0	0	0	17	2	6
	Specialist Physician(Internist)	4	14	0	0	0	0	0	0	0	0	0	0	0	4	14	0	0	0	18	2	6
	Family Health Physician	1	7	0	0	0	0	0	0	0	0	0	0	0	1	7	0	0	0	8	1	3
	Public Health Specialist	1	7	0	0	0	1	1	0	0	11	0	13	-1	0	7	0	-11	0	-5	-1	-2
Clinical Officers	General Clinical Officers(Diploma)	44	308	222	86	85	5	13	19	25	0	0	62	-5	31	289	197	86	85	683	68	228
	Graduate Clinical Officers	7	98	37	0	0	0	0	8	3	0	0	11	0	7	90	34	0	0	131	13	44
	Clinical Officer ENT/ Audiology	4	14	37	0	0	0	1	1	0	0	0	2	0	3	13	37	0	0	53	5	18
	Clinical Officer Lung & Skin	2	28	37	0	0	0	0	0	0	0	0	0	0	2	28	37	0	0	67	7	22
	CO-ophthalmology cataract Surgeon	2	28	0	0	0	0	1	0	0	0	0	1	0	1	28	0	0	0	29	3	10
	CO Paediatrics	6	14	37	0	0	0	1	0	0	0	0	1	0	5	14	37	0	0	56	6	19
	CO Reproductive Health	2	14	37	0	0	0	0	0	0	0	0	0	0	2	14	37	0	0	53	5	18
	CO Dermatology/ Venereology	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	CO Orthopaedics	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	CO Anaesthetists	15	42	0	0	0	0	3	0	0	0	0	3	0	12	42	0	0	0	54	5	18
	CO -Psychiatry/ Mental Health	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	CO Oncology/ Palliative Care	2	7	0	0	0	0	0	0	0	4	0	4	0	2	7	0	-4	0	5	1	2
Nurses and specialist nurses	BSN Nurse	12	28	0	0	0	1	2	8	4	24	0	39	-1	10	20	-4	-24	0	1	0	0
	Kenya Enrolled Community Health Nurse	250	700	444	172	85	0	67	10	22	14	0	113	0	183	690	422	158	85	1538	154	513
	Enrolled Nurse	10	42	148	86	0	0	2	10	10	45	0	67	0	8	32	138	41	0	219	22	73
	Kenya Registered Community Health Nurse	260	350	296	86	85	2	27	63	68	0	0	160	-2	233	287	228	86	85	917	92	306
	Kenya Registered Nurse	80	140	74	0	0	1	2	1	2	0	0	6	-1	78	139	72	0	0	288	29	96
	Cardiology nurse	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2	0	1

Staff cadre	Staff Sub-categories	REQUIRED HRH PER NORMS & STANDARDS					AVAILABLE- HRH STOCK							NYAMIRA COUNTY HRH NEEDS (GAPs)								
	Critical Care nurse	20	0	0	0	0	0	0	0	0	0	0	0	0	20	0	0	0	0	20	2	7
	Dental Nurse	8	56	74	0	0	0	2	0	0	0	0	2	0	6	56	74	0	0	136	14	45
	Forensic nurse	2	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	2	0	1
	Nephrology nurse	10	0	0	0	0	0	0	1	0	0	0	1	0	10	-1	0	0	0	9	1	3
	Oncology Nurse	10	14	0	0	0	0	0	0	0	0	0	0	0	10	14	0	0	0	24	2	8
	Ophthalmic Nurse	6	14	0	0	0	0	0	0	0	0	0	0	0	6	14	0	0	0	20	2	7
	Paediatric Nurse	10	14	0	0	0	0	0	0	0	1	0	1	0	10	14	0	-1	0	23	2	8
	Palliative Care Nurse	6	28	0	0	0	0	0	1	0	0	0	1	0	6	27	0	0	0	33	3	11
	Psychiatrist Nurse	20	42	0	0	0	0	0	0	0	0	0	0	0	20	42	0	0	0	62	6	21
	Registered Midwives	60	140	222	0	0	0	0	0	1	0	0	1	0	60	140	221	0	0	421	42	140
	Sign Language Nurse	2	7	37	0	0	0	0	0	0	0	0	0	0	2	7	37	0	0	46	5	15
	Theatre Nurses	60	70	0	0	0	0	2	0	0	0	0	2	0	58	70	0	0	0	128	13	43
	Anaesthetist Nurse	4	42	0	0	0	0	0	0	0	0	0	0	0	4	42	0	0	0	46	5	15
	Accidents & Emergency Nurse	10	70	0	0	0	0	0	0	0	2	0	2	0	10	70	0	-2	0	78	8	26
Pharmacy Staff	Pharmacist	6	28	37	0	0	1	2	4	0	0	0	7	-1	4	24	37	0	0	64	6	21
	Clinical pharmacist	4	14	0	0	0	0	0	0	0	0	0	0	0	4	14	0	0	0	18	2	6
	oncology pharmacist	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0
	Pharmaceutical Technologist	10	56	148	43	0	0	7	4	4	0	0	15	0	3	52	144	43	0	242	24	81
Plaster staff	Plaster Technicians/ Technologists	6	28	74	0	0	0	2	1	0	0	0	3	0	4	27	74	0	0	105	11	35
Rehabilitative staff	General Physiotherapist	12	42	111	43	85	0	3	1	0	0	0	4	0	9	41	111	43	85	289	29	96
	Orthopaedic Technologist	6	21	37	43	0	0	0	1	0	0	0	1	0	6	20	37	43	0	106	11	35
	BSc Physiotherapy	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	Specialized Physiotherapists	2	14	74	0	0	0	0	0	0	0	0	0	0	2	14	74	0	0	90	9	30
	Occupational Therapist	12	70	111	86	85	0	3	1	0	0	0	4	0	9	69	111	86	85	360	36	120
Clinical psychologists	Clinical psychologists	1	7	0	0	0	0	0	0	0	0	0	0	0	1	7	0	0	0	8	1	3
Dental staff	Dental Officers	10	28	37	0	0	0	1	1	0	0	0	2	0	9	27	37	0	0	73	7	24
	Oral maxillofacial surgeon	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3

	Paediatric Dentist	6	14	0	0	0	0	0	0	0	0	0	0	0	6	14	0	0	0	20	2	7
	Orthodontist	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	Dental Technologists	10	42	74	0	0	0	2	0	0	0	0	2	0	8	42	74	0	0	124	12	41
	Community Oral Health Officers	0	14	148	86	85	0	0	0	0	0	0	0	0	0	14	148	86	85	333	33	111
Diagnostics & Imaging	General Radiographer	10	42	74	0	0	0	3	2	0	0	0	5	0	7	40	74	0	0	121	12	40
	Ultra-sonographer	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	Dental Radiographer	2	7	0	0	0	0	0	0	0	0	0	0	0	2	7	0	0	0	9	1	3
	Mammographer	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0
	CT Scan /MRI Radiographer	3	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	3	0	1
Health Promotion Staff	Health Promotion Officers	6	28	148	86	170	1	0	0	0	0	0	1	-1	6	28	148	86	170	437	44	146
Medical Social Worker	Medical Social Work	8	42	74	43	85	0	2	1	0	0	0	3	0	6	41	74	43	85	249	25	83
Health	Medical Superintendent	1	7	0	0	0	1	1	1	0	0	0	3	-1	0	6	0	0	0	5	1	2
	Deputy Director – Medical Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Assistant Director of Medical services	0	0	0	0	0	1	0	0	0	1	0	2	-1	0	0	0	-1	0	-2	0	-1
	Health Administrative Officers	2	14	37	0	0	1	2	5	0	0	0	8	-1	0	9	37	0	0	45	5	15
	Human Resource Management Officer	2	14	0	0	0	1	0	0	0	3	0	4	-1	2	14	0	-3	0	12	1	4
	Clerks	20	70	148	86	0	2	5	6	0	1	0	14	-2	15	64	148	85	0	310	31	103
	Secretaries	2	7	0	0	0	2	1	5	0	1	0	9	-2	1	2	0	-1	0	0	0	0
	Accountants	6	14	0	0	0	1	2	2	0	0	0	5	-1	4	12	0	0	0	15	2	5
	Supply Chain Mgt. Assistant	6	28	37	0	0	1	2	0	0	0	0	3	-1	4	28	37	0	0	68	7	23
	Supply Chain Mgt. Officer	2	14	0	0	0	1	2	0	0	0	0	3	-1	0	14	0	0	0	13	1	4
Health Information ICT	Health Records Information Mgt. Officer (HRIMO)	12	56	148	43	0	1	2	2	1	0	0	6	-1	10	54	147	43	0	253	25	84
	Health Records Information Technician	0	0	0	0	0	0	0	0	3	0	0	3	0	0	0	-3	0	0	-3	0	-1
	ICT Officer	4	14	37	0	0	0	0	0	0	0	0	0	0	4	14	37	0	0	55	6	18

Staff cadre	Staff Sub-categories	REQUIRED HRH PER NORMS & STANDARDS					AVAILABLE- HRH STOCK							NYAMIRA COUNTY HRH NEEDS (GAPs)								
Medical Engineering Staff	Medical Engineers	2	0	0	0	0	0	0	3	1	0	0	4	0	2	-3	-1	0	0	-2	0	-1
	Medical Engineering Technologists	8	35	0	0	0	0	3	0	0	0	0	3	0	5	35	0	0	0	40	4	13
	Medical Engineering Technician	6	14	74	0	0	0	0	0	0	8	0	8	0	6	14	74	-8	0	86	9	29
Medical Laboratory Scientist	Med Lab Technologist	50	280	370	86	0	2	13	20	29	0	0	64	-2	37	260	341	86	0	722	72	241
	Med Lab Technicians	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	-1	0	0	-1	0	0
Nutrition staff	Nutrition & Dietetic Officer	20	70	74	0	0	1	0	2	0	0	0	3	-1	20	68	74	0	0	161	16	54
	Nutrition & Dietetic Technologist	12	56	148	86	85	0	2	0	0	0	0	2	0	10	56	148	86	85	385	39	128
	Nutrition & Dietetic Technician	4	28	74	43	85	0	0	0	0	0	0	0	0	4	28	74	43	85	234	23	78
	Cateress	2	14	0	0	0	0	0	0	0	4	0	4	0	2	14	0	-4	0	12	1	4
	Public Health Officers	4	28	74	43	170	2	2	9	26	1	0	40	-2	2	19	48	42	170	279	28	93
	Assistant Public health officer	0	0	0	0	0	0	0	1	0	0	0	1	0	0	-1	0	0	0	-1	0	0
	Public Health Technician	0	0	74	86	340	0	0	1	1	5	0	7	0	0	-1	73	81	340	493	49	164
Community Health Service Staff	Community Health Service Personnel(CHEWS)	0	0	0	0	425	0	1	5	21	0	0	27	0	-1	-5	-21	0	425	398	40	133
	Community Health Assistants	0	0	0	0	0	0	0	1	1	68	0	70	0	0	-1	-1	-68	0	-70	-7	-23
	Community Health Volunteers(CHVs)/VCT Counsellors	0	0	0	0	850	0	3	42	275	1	0	321	0	-3	-42	-275	-1	850	529	53	176
Support staff	Cooks	20	70	74	0	0	0	1	0	11	3	0	15	0	19	70	63	-3	0	149	15	50
	Drivers	15	84	148	0	0	3	4	4	0	41	0	52	-3	11	80	148	-41	0	195	20	65
	Support Staff	60	280	370	172	0	3	16	40	61	1	0	121	-3	44	240	309	171	0	761	76	254
	Mortuary Attendant	10	42	74	0	0	0	1	0	0	7	0	8	0	9	42	74	-7	0	118	12	39
	Cleaning Staff Supervisor	0	0	0	0	0	1	5	9	21	4	0	40	-1	-5	-9	-21	-4	0	-40	-4	-13
	Security	16	70	148	86	0	0	6	0	61	51	0	108	0	10	70	87	35	0	202	20	67
	TOTAL HRH STOCK	1438	4,452	5,032	1591	2,720	36	257	302	653	301	0	1539	-36	1181	4,150	4,379	1,290	2,720	13684	1369	4561

Source: County HRH Database as at June 2017

Annex 1 County Activity Budgets

Strategic Objectives	Activities	Items	2017/2018	2018/2019	2019/2020	Total Budget
			KES	KES	KES	KES
1.1: To improve industrial relation mechanism by December 2019	1.1.1. Establishment of effective channels of communication	Create online platforms WhatsApp, Twitter, Facebook Internet connectivity Intercom, Bulk SMS platform	1,200,000	1,300,000	1,400,000	3,900,000
	1.1.2. Develop and Implement feedback mechanism	suggestion boxes	500,000	500,000	500,000	1,500,000
	1.1.3. Conduct employee satisfaction survey	DSA& tools Data analysis	600,000	600,000	600,000	1,800,000
Subtotal			2,300,000	2,400,000	2,500,000	7,200,000
2.1. Establish systems for training and Development for effective service delivery by 2019	2.1.1. Establish a Training Committee with clear TORs.	Conference package DSA & printing	500,000	500,000	500,000	1,500,000
	2.1.2. Establish HRM&D TWG with clear TORs.	Conference package for TWG meeting	100,000	100,000	100,000	300,000
	2.1.3. Train HRM&D TWG and the training committee.	Conference package Training materials Facilitation fee DSA	2,500,000	-	-	2,500,000
	2.1.4. Convene and attend HRM/D TWG meetings on quarterly basis	Conference package for TWG meeting DSA	3,000,000	3,000,000	3,000,000	9,000,000
	2.1.5. Develop a short term and long term training plan.	DSA Conference package Stationery Printing costs Consultancy services	3,600,000	-	-	3,600,000
	2.1.6. Institutionalization of the training policy	Conference package DSA for facilitators & participants Printing of Training manuals & policy (7 sensitisation)	850,000	-		850,000
	2.1.7. Develop an M&E checklist to track implementation.	DSA Printing costs	600,000			600,000
	2.1.8. Conduct M&E on implementation of the systems quarterly.	Fuel costs DSA	400,000	400,000	400,000	1,200,000
Subtotal			11,550,000	4,000,000	4000,000	19,550,000

Strategic Objectives	Activities	Items	2017/2018	2018/2019	2019/2020	Total Budget
			KES	KES	KES	KES
2.2: To undertake training and development of 30% of the staff by 2019	2.2.1.Carry out training needs assessment (TNA)/ projections of all staff	DSA Conference package Develop & printing of the TNA tools Data analysis Dissemination of findings Report writing	2,000,000			2,000,000
	2. 2.2. Update the HRM & training data in iHRIS on monthly basis	Modems bundles	500,000	360,000	360,000	1,220,0000
	2. 2.3.Identify in-service training institutions	Airtime/bundles	50,000	50,000	50,000	150,000
	2.2.4. Mobilization of resources for implementation of the training plan.	DSA Airtime Conference package	300,000	300,000	300,000	900,000
Subtotal			2,850,000	710,000	710,000	4,270,000
3.1. To provide policy frame work for HRH leadership and management system	3.1.1.Customize key HRH policies and guidelines	Human Resource manual Training policy Recruitment & Promotion policy Job descriptions Schemes of service Employee relations guidelines		1,700,000	1,500,000	3,200,000
	3.1.2. Disseminate policy documents to health workers	Conference package Printing the documents	-	600,000	600,000	1,200,000
	3.1.3. Create a framework for implementation of HRH policies and guidelines.	-	-	-	-	
	Subtotal			2,300,000	2,100,000	
4.1. Institutionalize performance management systems	4.1.1. Conduct performance needs assessment (PNA) to identify existing HR performance gaps	DSA Develop & print the tool Refer to TNA		2,000,000		2,000,000
	4.1.2. Disseminate PNA findings and draw an action plans.	DSA Conference package		300,000		300,000
	4.1.3. Develop JDs for all cadres	DSA, Consultant. Conference package. Transport. Printing of tools		2,800,000		2,800,00,

Strategic Objectives	Activities	Items	2017/2018	2018/2019	2019/2020	Total Budget
			KES	KES	KES	KES
4.2.To implement the supportive supervision and performance monitoring by June 2018	4.1.4. Implement the PAS	Print the tools Conduct quarterly reviews	300,000	200,000	200,000	700,000
	4.1.5. Develop framework for monitoring and evaluation.		2,500,000	-	-	2,500,000
	Subtotal		2,800,000	3,000,000	200,000	
	4.2.1.Develop HRH supervision tool	Conference package Print the tools	100,000	-	-	100,000
	4.2.2. Train all managers on supervisory skills	30 per year	3,000.000	3,000.000	3,000,000	9,000,000
	4.2.2. Conduct regular support supervision.	DSA Transport	400,000	400,000	400,000	1,200,000
Subtotal			3,500,000	3,400,000	3,400,000	10,300,000
5.1. To strengthen information and communication systems for HR and service delivery by 2019	5.1.1. Carry out baseline survey		500,000	-	-	500,00
	5.1.2.Provision of ICT infrastructure	ICT equipment's	5,000,000	3 ,000,000	3,000,000	11,000,000
	5.1.3. Support for internet connectivity	Modems Airtime	2,800,000	2,800,000	2,800,000	8,400,000
	5.1.4. Develop e-record of personnel files	Scanner Modem Airtime	300,000	-	-	300,000
	5.1.5. Link telemedicine to sub-county hospitals	Internet connectivity ICT infrastructure Consultants fee	7,000,000	7,000,000	7,000,000	21,000,000
	5.1.6. Develop e-learning virtual platform	Subscription fees	300,000	300,000	300,000	900,000
Subtotal			15,900,000	13,100,000	13,100,000	42,100,000
Grand Total			**38,900,000**	**28,910,000**	**26,010,000**	**93,820,000**

Annex 2: List of Contributors in Development of the HRH Strategic Plan

Hon Callen Atuya – Chairperson of Health Committee of the 1st County Assembly of Nyamira

Hon Mr Richard Bosire – D/Chair of Health Committee of the 1st County Assembly of Nyamira

Hon Gladys Momanyi – County Executive Committee Member of Health

Douglas Bosire – Chief Officer of Health

Dr Jack Magara – County Director Health Services

Dominic Barare – Deputy County Director Health Services.

Jairus Onganga – County Medical Laboratory Services Coordinator

Rosemary A. Otiende – County Nutrition Coordinator

Albert Mosagwe - Administrator, County Public Service Board

Siruel Ongera – Senior Communication Officer

Lewis N. Oburu – Deputy Director/HRM

Esther B. David – County HR Management Officer, Health Services

John Monyancha – County Health Records & Information Officer

Francis Makau – County Public Health Officer

Gabriel Onyansi – County Training Coordinator

Leonard M. Oinde – County Chief Nursing Officer

Thomas Obuya Moenga – County Health Administrative Officer

John Kaniu Kamundia – County Disease Surveillance Coordinator

Callen Ateka – Chief Nursing Officer

Felistus Muma – County Clinical Officer/TB & Leprosy Coordinator

Assumpta Omweri – Chief Human Resource Management Officer

Carolyne Abuga - Health Administrative Officer

Gladys Jebet – Administrator County Assembly of Nyamira

Mathew Thuku – IntraHealth-led USAID-funded HRH Kenya Mechanism

Ann Malubi – IntraHealth led USAID funded HRH Kenya Mechanism

Rose Ida – IntraHealth led USAID funded HRH Kenya Mechanism

Nyamira County HRH Strategic Plan June 2017 – June 2020

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