COUNCIL OF GOVERNORS

A COMPENDIUM OF COUNTY INNOVATIONS & BEST PRACTICES ON FACILITIES IMPROVEMENT FINANCING (FIF) AND COMMUNITY HEALTH SERVICES (CHS)

4TH EDITION

FEBRUARY 2023

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Maarifa Centre
Sharing Kenya's Devolution Solutions

amref health africa

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Maarifa Centre

Maarifa Centre is the premier subnational knowledge hub established to serve as Kenya's knowledge sharing and learning platform to support effective governance and service delivery at the County level. The vision of the Centre is "To be Kenya's Premier Knowledge Sharing and Learning Platform for Effective Governance and Service Delivery for Sustainable Development".

CoG Vision

Prosperous Counties that are drivers of socio-economic growth and development and quality service delivery.

CoG Mission

To deepen devolution through coordination, consultation, information sharing, capacity building, performance management and dispute resolution.

CoG Values

Collaboration and Partnership; Integrity; Diversity, Equity, and Inclusion; Innovation; Professionalism

CoG Motto

48 Governments, 1 Nation

Maarifa Centre Motto

Sharing Kenya's Devolution Solutions

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TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS	iv
FOREWORD FROM THE COG CHAIRPERSON	v
FOREWORD FROM AMREF	vi
ACKNOWLEDGMENT	vii
BACKGROUND	viii
Part 1.0: Facility Improvement Financing (FIF)	9
1.1 The County Government of Nakuru Facility Improvement Fund Implementation: Model is a Trendsetter in Securing the Financial Autonomy of its Health Facilities for Quality Healthcare Delivery	9
1.2 County Government of Meru's FIF Journey to Financial Autonomy and Enhanced Service Delivery for Health Facilities	11
1.3 County Government of Makueni Successfully Ring-Fences Health Funds through the Facility Improvement Fund (FIF)	13
1.4 County Government of Mombasa Facility Improvement Funds Helps to Create Autonomy and Improved Financing of Health Facilities	15
1.5 County Government of Kilifi Facility Improvement Funds Greatly Improves Health Service Delivery and Financial Autonomy for its Hospitals	17
Part 2.0: Community Health services (CHS)	20
2.1 County Government of Makueni Establishes a Revolving Fund to Empower its Community Health Volunteers for Sustainable Livelihoods	20
2.2 County Government of Nakuru Successfully Combines Different Initiatives to Motivate and Retain Community Health Volunteers	22
2.3 The County Government of Kilifi Implements Income-Generating Activities as a Long-term Solution to Community Health Volunteers' Sustainability	24
2.4 County Government of Meru Response to Non-Communicable Diseases with support of Community Health Volunteers	27
2.5 Kisumu Revolutionalises Community Health Volunteers Reporting Structure	31
Appendixes	34
Appendix 1: County Logos	34
Appendix 2: List of Authors, Assistant Authors and Editors	35

ABBREVIATIONS AND ACRONYMS

AIE	Authority to incur Expenditure
CBOs	Community Based Organisations
CECM	County Executive Committee Member
CHVs	Community Health Volunteers
CHU	Community Health Units
CHA	Community Health Assistant
CHS	Community Health Services
CHAIEC	County Health AIE Committee
CHMT	County Health Management Team
CHEWs	Community Health Extension Workers
CHAO	County Health Administration Officer
CTL	Uraia and Centre for Transformational Leadership
CRF	County Revenue Fund account
CO	Chief Officer
CoG	Council of Governors
EEC	Executive Expenditure Committee
FM	Finance Manager
FIF	Facility Improvement Financing
FY	Financial Year
HSIF	Health Services Improvement Fund
HMIS	Health Management Information Systems
HODs	Head of Departments
HMTs	Health Management Teams
IGA	Income generating Activity
IFMIS	Integrated Financial Management Information System
KCB	Kenya Commercial bank
KEMSA	Kenya Essential Medical Supply
Ksh	Kenya Shillings
MEDS	Mission for Essential Drugs and Supplies
MoH	Ministry of Health
NCD	Non Communicable diseases
NHIF	National Hospital Insurance Fund
OAG	Office of Auditor General
ODF	Open Defecation Free
PFM	Public Finance Management
PGH	Nakuru General Hospital
PHO	Public Health official
PWDs	Persons living with disabilities
UHC	Universal health coverage
USAID	United States Agency for International Development
SCHMT	Sub County Health Management team
SCCHFP	Sub-county Community Health Focal Person
SCHRO	Sub-county Health Records Officer

FOREWORD FROM CoG CHAIR

> This is why the FIF model has found traction at the County level as it enables facilities to plough back user fees for purposes of funding.....

It is my honour to present to you the Fourth Edition of the Compendium of County Innovations and Best Practices on Service Delivery. I pen this foreword at a time when County Governments are still settling down after the transition in August 2022. At the Council of Governors (CoG), we have been joined by twenty-eight (28) new Governors and eight (8) pioneer Governors who led their respective Counties from 2013 to 2017 are back in leadership. It is a privilege and great honor to serve as the Chair of CoG at such a time when devolution has already taken off, and is contributing to significant transformation of our communities.

The first and second generations of County Governments have placed devolution on a path of innovation and adoption of good/best practices owing to the fact that Counties have a majority stake in service delivery. Indeed, this third cycle of County Governments stands at an advantage of learning from the previous regimes on what worked and what did not and this will make delivery of essential public goods easier to navigate. The CoG knowledge hub-Maarifa Centre- has continually documented the innovations and good/best practices emerging from Counties and this compendium is one of the Centre's products aimed at consolidating service delivery success stories. Reading through this publication amplifies my hope in devolution as it demonstrates that County Governments are providing local solutions to local problems.

This edition focuses on what Counties have done on Facility Improvement Financing (FIF) and the Community Health Services (CHS). The provision of accessible, quality and affordable health services to a population is always a priority for any government. Over the years, the provision of health care has been the recipient of the largest budgetary allocations in Counties. Investing in health services that reach all communities and sustaining financial flows to health is a balance that County Governments continue to struggle with. This is why the FIF model has found traction at the County level as it enables facilities to plough back user fees for purposes of funding operational and maintenance costs. Additionally, Counties are aware that CHS is an integral part of the health system and in this regard are putting efforts towards injecting sustainability in this area.

With success stories from Makueni, Nakuru, Kilifi, Meru, Kisumu and Mombasa, this edition showcases how these Counties have overcome different challenges and implemented FIF and CHS in their own unique ways. In July 2022, Maarifa Centre in collaboration with Amref organized a physical peer to peer learning, where fifteen (15) Counties visited Kisumu to learn their CHS model. Such inter-County exchanges are critical in service delivery since they trigger upscaling and piloting of innovations and good/best practices picked from other implementing Counties.

I would like to convey heartfelt appreciation and gratitude to Amref and Jacaranda Health for their support in documenting and publishing this Compendium. CoG also appreciates all other partners who have collaborated with the County Governments in FIF and CHS. I am hopeful that the challenges identified in these two areas will be turned into solutions by those Counties that have prioritized FIF and CHS in the next five (5) years.

To everyone who was involved in compiling this document at the CoG secretariat, and County officials who were invaluable key informants, kudos! This would have not been possible without your contribution and effort. To the readers, we hope this document gives you a better perspective of what Counties are doing on matters FIF and CHS. A soft copy of this publication, and the previous three (3) editions of the Compendium can be accessed at https://maarifa.cog.go.ke/

H.E. Anne Waiguru, EGH
Chair, Council of Governors

FOREWORD FROM AMREF HEALTH AFRICA IN KENYA

> I am incredibly grateful for our partnership with the Council of Governors in developing a stronger Maarifa Centre.....

The release of the Fourth Edition of the compendium of County innovations and best practices on service delivery is a hallmark achievement in fostering knowledge sharing and collaborative learning in the Country. This remarkable achievement underscores the success and impact of the Maarifa Centre at the Council of Governors.

Amref Health Africa in Kenya is proud to have contributed to the development of this compendium. It highlights the transformative power of devolution in enhancing governance, partnerships, and service delivery.

The Maarifa Centre, as the driving force behind this publication, has been pivotal in ensuring that local solutions are shared, adapted and scaled to enhance service delivery in various sectors.

This compendium edition features inspiring success stories from six Counties, showcasing their innovations and best practices in Facility Improvement Financing and Community Health Services aimed at strengthening Primary Health Care (PHC). By sharing these achievements, the compendium is a valuable resource for other Counties looking to invest in these critical drivers of PHC in Kenya. The lessons and insights gleaned from this publication will contribute to strengthening systems for PHC services toward achieving UHC for the people of Kenya. I call upon all County leaders to utilize this resource as they endeavor to improve systems for PHC in their counties.

I want to express my heartfelt appreciation to all who contributed to bringing this Fourth Edition to fruition. I thank county officials, contributors, editors, development partners, and the dedicated Maarifa Centre staff for their crucial role in demonstrating the effectiveness of devolution. Their collective efforts have made a tangible impact on the lives of Kenyans by showcasing the effectiveness of devolution and fostering a culture of learning and collaboration.

Furthermore, I am incredibly grateful for our partnership with the Council of Governors in developing a stronger Maarifa Centre. I would also like to commend all partners and stakeholders who have made this edition a reality. In particular, I commend Jacaranda Health for their support in printing this edition. Such strategic collaborations are crucial to achieving our shared goals, advancing sustainable development, and fostering a brighter future for all.

As we celebrate the completion of the Fourth Edition of the Compendium of County Innovations and Best Practices on Service Delivery, let us remember that this is just one milestone in our ongoing journey toward sustainable development and improved quality of life for all Kenyans. Together, let us continue learning from one another to drive positive change and transformation across Kenya.

Dr. Meshack Ndirangu
Country Director, Amref Health Africa- Kenya

ACKNOWLEDGEMENT

The Maarifa Centre is CoG's knowledge platform- providing the public, County Governments and other devolved jurisdictions in the continent and the world, scholars, policy and law makers, development partners and researchers with an array of local solutions that have been adopted to improve service delivery at the County level. Since its establishment in 2018, the e-repository has proved to be a useful tool for promoting County to County learning and sharing of information on innovations and good/best practices being applied in delivery of key services.

Maarifa Centre produces bi-annual compendia which highlight County success stories from different sectors in order to spur learning amongst Counties and ultimately contribute towards improved service delivery. I am delighted that this fourth edition, covering the period from June 2022 to December 2022, put together carefully selected innovations and good/best practices on FIF and CHS- areas that are at the heart of provision of healthcare. Six (6) Counties are highlighted in this edition- Nakuru, Kilifi, Makueni, Mombasa, Kisumu and Meru. My hope is that any Counties that are planning to make investments towards FIF and CHS can learn from these Counties and innovatively surmount those challenges that their six (6) peers faced. Maarifa Centre will continue to document the innovations and good/best practices in the health sector and I encourage any County that is successfully implementing FIF and CHS, and did not make it to this edition for one reason or the other, to reach out to us through the email maarifacentre@cog.go.ke and share with us your story.

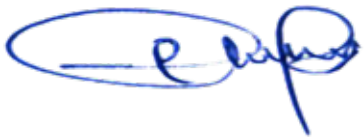
> "To all the contributors, the editors, and to the Maarifa Centre staff- I commend your commitment and thank you sincerely for making this edition a reality.

To all the County officials who wholeheartedly offered their time in interviews- asanteni sana. I admit that my team received a lot of cooperation and support from the six (6) Counties and I applaud their willingness to share information.

To all the contributors, the editors, and to the Maarifa Centre staff- I commend your commitment and thank you sincerely for making this edition a reality. Your efforts continue to affirm to all and sundry that indeed devolution is working. I celebrate you all and I am already looking forward to the 5th edition of the compendium.

To Amref- who partnered with us to deliver the Strengthening Maarifa Centre project- we say thank you. It is through this project that the development of this compendium received immense support. To Jacaranda Health- for supporting the printing of this edition- we appreciate you. At CoG, we are cognizant that such strategic partnerships are instrumental in achieving the goals set in our Strategic Plan.

Download a copy of the Fourth Edition of the Compendium on the Maarifa Centre website https://maarifa.cog.go.ke/ and you can also follow us on Twitter @Maarifa_Centre to learn more on what Counties are doing in various sectors.



Mary Mwiti
Chief Executive Officer,
Council of Governors

BACKGROUND

This Compendium is the Fourth (4th) edition of a bi-annual publication pioneered in 2021 by the Council of Governors' knowledge hub, the Maarifa Centre. The inaugural edition was a collection of County success stories in the fight against COVID-19.

This compendium has put together best practices and innovations emerging from the Counties on two subject areas: Facility Improvement Financing (FIF) and the Community Health Services (CHS). The two are entwined because health care service delivery is a continuum system from the community to the referral hospitals. The community plays a major role in advocating for preventive and promotive health care to reduce incidences of illness that would require medical treatment. It is in this regard that public health is included as an important component of FIF to facilitate support for public health activities at the community level.

Both levels of health care face different dynamics but the facility based curative is more financial intensive hence the need to address the financial resource access in a more comprehensive manner especially since health care needs have continued to increase over the years without government matching the same with financing. Kenyans are entitled to quality, accessible and affordable health care. Cost sharing is seen as a source of revenue to supplement the government revenues to achieve affordable health care for all. It is this revenue that is being called Facility Improvement Financing (FIF).

The principle of allowing hospitals and health facilities to collect, retain and use own revenues is not new. Cost sharing and user charges were introduced in government hospitals in December 1989. Fees are however waived for those patients who cannot afford to pay. Other services that benefit society in general (e.g covering pregnant women and children under five) are provided free of charge.

Between 1999- 2001 some of the hospitals tripled their cost sharing revenue. Some of the factors that contributed to this good performance include: good management; active involvement of the in-charge; setting targets and monitoring performance.

Out of total collected, 75% of the revenue was retained for use by the generating hospital and the balance was used to finance primary and preventive health care activities in the district where the money was collected. This resulted in improved health services. In 2002, the Ministry of Health provided an operational manual for health centers and dispensaries. This manual was meant to support health facility improve collection, use of the funds and enhance patients and staff's satisfaction with services.

After devolution, Counties re-centralized revenue collection from hospitals and health facilities under the County Revenue Fund account (CRF). This meant facilities lost the revenues they collect. On the other hand, disbursements from the CRF were delayed, and because of competing priorities, hospitals got far less than they had collected. With unpredictable resources, and far less amounts when finally disbursed, services delivery was impacted negatively. In some Counties health services almost became non-existent.

Counties like Nakuru established legal frameworks that allowed the Nakuru Referral Hospital and level 4 hospitals to retain the collected revenues with very impressive results in improved health care. Other Counties have come on board using different methodologies. Some Counties have passed the FIF law allowing hospitals to retain the collected revenues. The success of FIF implementation has been varied, depending on the legal framework a County is applying. It is behind this backdrop that the CoG commissioned an assessment on FIF and CHS, aimed at examining the status of implementation of the FIF and CHS and documenting success stories on the same subjects. This Compendium brings together all the best/good practices and innovations that are being practiced by Counties on FIF and CHS.

PART 1.0: FACILITY IMPROVEMENT FINANCING (FIF)

1.1 The County Government of Nakuru Facility Improvement Fund Implementation: Model is a Trendsetter in Securing the Financial Autonomy of its Health Facilities for Quality Healthcare Delivery

Introduction

Like all other Counties, Nakuru recognized it was facing the problem of inadequate resources for health services. This recognition led the County administration to take measures that ensured the amounts of money collected by the facilities was retained and accounted for at that level. Using a pre-devolution mechanism to manage the funds through the hospital accounts meant that bureaucratic processes were reduced, thus removing delays for hospitals to access the collected money. Nakuru started this process with Nakuru Level 5 Hospital before moving to other hospitals in the County. Currently, Nakuru has implemented FIF in all level 4 hospitals. Thus, by removing all bureaucracy in processing the approvals of budgets and hospital plans, Nakuru County ensured that facilities faced no delays in accessing and using the funds in the hospital accounts, thereby solving financial resource problems that would affect hospitals' capacity to deliver quality, affordable health services.

Because Nakuru implemented this process as soon as devolution was started and has improved the administration and management of the funds through automation of the revenue collections, Nakuru has become a trendsetter in managing FIF, and other Counties are drawing valuable lessons from Nakuru.

How the problem impacted the population

Those affected by unavailable resources for health services included patients, health facilities' in-charges, and the County Government Health Departments. Some of the effects of the problem were:

- Inadequate financing affects health facilities' capacity to plan and deliver quality and affordable healthcare services. This means populations continue to suffer from poor healthcare because they cannot access the services.
- Inadequate finances and the inability of the staff to manage the resources collected also affects their motivation. The staff has limited ownership over the funds they collect to provide services and improve health outcomes. Underfunding of health facilities leads to the County Government's inability to deliver on its goal of achieving universal health coverage (UHC) for its citizens.

Main activities carried out

- The hospital FIF accounts used before devolution were closed, and the monies were transferred to the County Revenue Fund (CRF). New County hospital accounts were opened under the County Government, and the County transferred the funds from CRF to the new hospital accounts.
- Nakuru has 16 hospitals, one of which is a level 5 hospital, and the other 15 are level 4 facilities. All the hospitals are allowed to collect, retain, use, and account for the FIF funds.
- Implementation of FIF in Nakuru benefited from the experience of the first finance officer who had worked with FIF before devolution. The Finance Officer, Chief Officer for Health, and the County Health Management Team (CHMT) had political goodwill of the Governor, who supported the proposed continuation of the existing FIF model, thus maintaining the new hospital account. There was thus no need to channel the revenue collected to the CRF and back to the hospital account.
- The Hospital Management Boards continued post-devolution, comprising the Medical Superintendent (Med Sup), hospital procurement head, pharmaceutical officer, head nurse, and the hospital accountant.
- The hospital management team also remained the same; members include the Med Sup hospital accountant (for each facility), department accountant, procurement head, pharmaceutical officer, head nurse, and hospital administrator who provides secretarial support to the Med Sup.
- The Nakuru Referral Hospital account has three signatories, i.e., the Chief Officer of Health, Med Sup, and the Department Accountant. The hospital has 2 COs - Med Sup and the Hospital Administrator.
- Other Level 4 health facilities have two signatories, i.e., the Medical Officer of Health (MoH) and the Facility Accountant.
- A Health Management Board comprises 7 members from the community, including the Chair, Vice Chair, and a representative each for faith-based organizations, women, youth, and persons living with disabilities (PWDs). The Med Sup, the overall supervisor of the hospital facility, is the secretary. The Board is mandated to review the work plans and budgets while the Chief Officer of Health issues AIE. The Chief Officer or his representative sits in the Board meetings.

- Hospital account management starts with the heads of departments (HoDs) preparing work plans and budgets commensurate with the amounts collected in the last quarter. They then present them to the Hospital Management teams (HMT) to rationalize the allocations according to respective revenue collections from the previous quarter before approval. This cycle repeats itself every quarter.
- The Board approves the work plans and budgets after reviewing the previous quarter's performance based on the approved AIE of that quarter. They also discuss next quarter's budget and give the Med Sup the go-ahead to spend and continue to collect revenues for the next quarter. Through the AIE, the hospital's departments through the Med Sup can hire casuals and do renovations. However, the Health Department does major renovations, e.g., the construction of a ward, and the department account must approve the building. The County Public Service Board hires technical staff.
- The approved work plans and budgets go to the Health department accountant, who verifies that the requested items are reflected in the County budget and vote book. The Chief Officer also verifies and approves budgets before issuing AIE to the Med Sup with copies to the hospital accountant and the procurement officer. There is no need to take the documents to the Treasury.
- Hospitals have their own vote books kept by the hospital accountants, and departments have their own vote books held by the department accountants because they both have to reconfirm. This constitutes internal control.
- All processes happen a month before the end of the quarter because the AIE is already issued by the start of the next quarter. This seamless processing enables early planning by facilities.
- Once AIE is issued, the user departments at the hospital raise requisition, and the Med Sup approves the procurement from pre-qualified suppliers. Once deliveries are done, invoices and vouchers are raised by the department account and carried in their original form to the hospital departments. Hospital departments start spending by raising vouchers checked by the hospital accountant and hand them in their original form to the department accountant, who also verifies that the vouchers reflect what is in the vote books and work plans before writing and signing the cheques. The Med Sup and the Chief Officer also sign. The Med Sup and the Hospital Accountant sign cheques for Level 4 hospitals.
- The original vouchers remain with the hospital accountant for future audits.
- The Nakuru General Hospital (PGH) collects an average of Ksh 800,000 per quarter and gets a conditional grant from the National Government and an allocation from the County Treasury. All other facilities collect about Ksh 350,000 quarterly. The total averages over Ksh 1 billion.

Resource implications

- All resources collected by the hospitals become the resources that fund about 40% of the total hospital expenditures. The grant from the National Government and the allocation from the County Treasury cover the balance.

County plan to sustainability

- By ensuring the funds are used for the purpose they are collected for.
- Also ensuring governance structures are followed, including strong internal controls.

Key activities that led to positive results

- Strong and focused leadership led to implementing FIF, providing predictable financing to Nakuru County hospitals.
- Automation of revenue collection, leading to increased revenues contributing towards improved health services.
- Hospital Boards oversee the management of revenues and service delivery. This results in transparent and accountable governance by the hospital managers.
- Overall, implementing FIF has positively impacted the health facilities, leading to improved quality of care for the Nakuru population.
- The Department of Internal Audit's strong risk management has strengthened financial delivery systems annually. External audit done once annually confirms improved management of funds by hospitals.

Key challenges

- Delay by the Kenya Medical Practitioners and Dentists Council in licensing level 2 and 3 health facilities that provide maternal health services hinder them from receiving reimbursements from NHIF for Linda Mama, which would increase their resources, and by extension improve health services.
- NHIF delayed reimbursements affect timely service delivery. NHIF must address the bottlenecks to

enable all hospitals and especially level 3 facilities to be self-sustaining.

Lessons learned

- Nakuru health facilities collect, retain, and manage revenue in hospital accounts. This means money does not move from one account to another. It is received and utilized from the same account. AIEs must, however, be issued every quarter to enable expenditures.
- Automation of revenue collection has closed all loopholes and improved collections; total hospital collection is estimated at KSh.1.5 billion quarterly. Hospitals also get 100% of what they collect.
- The system involves all relevant County departments, including County Treasury, department of health, and hospital management, making it easier to appreciate the hospital's needs. The Treasury accountants support with financial paperwork at the facility level, thus saving time.

Recommendations

- Nakuru County Government strongly recommend using IFMIS to reduce the manual processing of funds. IFMIS autogenerates vouchers and financial reports.
- So far, Nakuru has been on a positive trajectory, and any challenges have been addressed as the hospitals mature in managing the revenues available to them. Implementing FIF through IFIMs would help reduce the department accountant's manual reporting.

1.2 County Government of Meru's FIF Journey to Financial Autonomy and Enhanced Service Delivery for Health Facilities

Introduction

Meru County health facilities needed additional funding to care for increased demand for health services. The County Government also needed to decentralize the FIF funds to facilities to improve health services. As a result of expanded financial availability from the hospital collections, the hospitals also required additional staff, especially in finance, procurement and administration. The funding availability addressed problems of patients, health workers and health facility committees.

How problem impact the population

Increased demand for health services in Meru led hospitals experiencing financial strain. Health facilities needed more resources that were predictable for them to be able to offer quality care. Due to this financial distress, the County Government was failing in its mission of providing affordable healthcare.

Apart from the general inadequate of resources, the little that was available was seriously affected by disbursement delays. Delays in payments due to bureaucratic processes impacted supplier confidence leading to poor hospital supplies and implementation of planned activities resulting in poor service delivery.

Hospitals failed to ensure that critical utilities such as water and electricity, essential to the health service provision, were reliably available.

Main activities carried out

- To address the financial problem, Meru developed a bill to provide for FIF, but this bill is yet to be approved by the County Assembly. However, the County Government of Meru has chosen to continue with the standard cost-sharing system using hospital accounts similar to practice before devolution.
- The money is pooled into one health department account from where all funds collected by all the health facilities are channeled. The health facilities get to spend 100% of what they collected once they get AIE.
- Recruitment/deployment of accountants and procurement officers has been done to enhance the administration of the FIF at the facility level.
- FIF has governance structures that include Hospital Board/ facility committees and expenditure committees for overall management and oversight of the funds.
- There is an Executive Expenditure Committee (EEC) comprising the Medical Superintendent, Nursing Manager, Procurement Officer, Accountant and Heads of Departments that approve the hospital plans and budgets.
- Departments make requests equivalent to their revenue collections, and the EEC reviews them by checking the budgets and rationalize them based on the needs and money available. The Board/EEC approves and develops minutes with which the Chief Officer for health (CO) can issue the AIE.
- The CO issues AIE to spend from the pool account whose signatories include the CO Health, CO Finance, and FIF manager.

- To access the money, hospitals prepare vouchers based on the vote book. The vouchers are submitted to the FIF Secretariat, who verifies them for Finance Manager (FM) approval, after which cheques are drawn, signed by the signatories and dispatched to the facilities for issuance to the payees. The vouchers remain with the departmental health accountant for custody and future audits.
- The entire approval process takes about three days.

Key implementers and collaborators

- The Executive Expenditure Committee that oversees budget preparation and implementation.
- Hospital Management Team (HMT), who prepares annual and quarterly budget and ensure efficient and effective utilization of FIF funds.
- Hospital board oversees the hospital management and approves budgets submitted by the HMT.
- Chief Officer, the accounting officer under whom lays the responsibility to administer FIF and issue AIE to hospitals and facilities for expenditure to occur.

Resource implications

The resources for daily operations come from 100% patient fees charged by health facilities. The County also provides additional resources from the CRF for capital expenses, e.g., expanding infrastructure like wards and facilities for service delivery.

How the County plans to sustain the best practice in the future

- By enacting legislation to allow facilities to collect and use their funds at the facility level.
- Ensure all facilities have the required staff to support the management and administration of the funds.
- Establishing County health facilities as procurement entities in line with the Public Procurement and Asset Disposal Act of 2015 and the Public Procurement and Asset Disposal Regulations of 2020. This will provide financial autonomy to all health facilities.
- has established an ad hoc expenditure committee to hasten process of perusing and approval of the FIF annual work plans and budgets.
- Has in place robust internal controls to ensure proper management of the FIF following relevant financial systems and reporting.
- Frequent supportive supervision and audit of the funds to ensure funds are used as planned.
- Has automated revenue collection to ensure increased revenues.
- Investing in Health Management Information Systems (HMIS) to improve service delivery.
-
- Results of the practice (outputs and outcomes)
- Owing to revenue collection automation (cashless revenue) and the heavy workload, the Meru Teaching and Referral Hospital collects about KSh.10 million monthly.
- Of the 16 Sub-County health facilities, only four qualify for level 4 because of workload. These facilities are allowed to collect revenues.
- With increased financial resources, health services are improving.
- There is also improved governance of the funds due to putting in place the oversight committees.
- Planning and budgeting has improved, and hospitals can justify using resources.

Key activities that led to positive results

- Strong political goodwill

Lessons learned:

- The County was able to retain the FIF funds without taking the funds to the CRF account by adopting the cost-sharing guidelines that were in place before devolution.
- The best way to success is to give every facility autonomy allowing for control of its funds.
- Success was facilitated by goodwill from the Executive.

What did not work.

- The pool account is not fully ringfenced, and inter-departmental borrowing is happening.

Challenges experienced during implementation.

- There is some interdepartmental borrowing from the pool account, and the money borrowed is mostly never refunded or is refunded late or partially. This depletes the pool account, thus delaying 100% of transfers to hospital accounts.
- Frequent NHIF reimbursement delays is affecting

funds availability to hospitals. For example, NHIF owes Meru Teaching & Referral Hospital over Ksh 40 million. It also owes the other facilities a substantial amount. NHIF needs to improve disbursement to facilitate effective and efficient service delivery. Free services such as CT scans are affected and health facilities offering this service are relying on patient fees.

- Money from facility reimbursements used to be channeled to the CRF, causing further delays. FIF has mitigated this risk. All facilities now operate exclusive NHIF-collecting accounts and spend the money once they receive AIE. Facilities submit consolidated accounts after reconciliation at the end of a given quarter.
- Reconciliation is often challenging because of the many deposits made into the facilities' accounts.
- There is inadequate supervision and routine audit due to lack of facilitation.
- Revenue leakages are being addressed by automation.
- Reimbursement delays by other medical schemes such as the scheme for the poor and vulnerable indigents, Linda Mama (free maternity program), Edu Afya (free for all public secondary students), civil servants' capitation, personal contributions etc.
- Increased waivers and exemptions without corresponding reimbursement of the user-forgone fees from the government.
- Some politically appointed boards are making the running of the facilities difficult.
- Failure by the Executive and Assembly to prioritize and pass the FIF Act.

Recommendations

- The County should use the FIF funds to improve health services and avoid diversion of the funds to other County activities.
- It is important to ringfence the funds.
- Meru County should ensure they get their County Assembly's support to pass the enabling legislation.

What to avoid

- Avoid inter-interdepartmental borrowing of the funds meant for health services.
- Avoid the pool account; each facility should open its account.
- Avoid control of the funds at the headquarters and by the Executive.

Further reading

- FIF Manual
- Meru County Health Act

1.3 County Government of Makueni Successfully Ring-Fences Health Funds through the Facility Improvement Fund (FIF)

Introduction

The Public Finance Management Act of 2012 established the CRF. All County Governments directed that health providers transfer all revenue to the County Revenue Fund. This move saw a drastic decrease in the FIF collections across the country.

In 2014 and 2020, the Ministry of Health advised the 47 Counties to develop FIF Acts through their respective County Assemblies. This empowered public health facilities to raise, retain and utilize their revenues. Makueni County needed to develop a FIF Act, which would give 100% financial autonomy to health facilities to guarantee quality healthcare services.

How the problem impact the population

The County Government doesn't collect enough revenue to run the health facilities. Without enough revenue, health service delivery to the County population was affected. The problem of limited resource for health affected the general population, the health facilities, and the County Government of Makueni.

The main activities carried out

- The County Government of Makueni took over the Facility Improvement Fund account from the National Government and replaced one of the signatories, the district accountant, with the hospital accountant. The other two remained as they were, i.e., the Medical Superintendent and the county hospital administrative officer (CHAO).
- The hospital accounts before devolution was adopted and continue to operate.
- The County Government of Makueni enacted its FIF Act, based on the national Public Finance Management (PFM) Act, Section 109(2b), which allows facilities to raise, retain and utilize their own revenues. Facilities are recognized as procurement entities entitled to procure approved commodities and services.

- Heath facilities in Makueni raise funds from various sources, including user fees, grants from National/ County Government/Development partners, insurance schemes (NHIF Schemes and other schemes), NHIF super-cover (In-patients, out-patient, and Edu Afya), Linda Mama antenatal clinics (Ante-Natal Care – 4 visits, Delivery and Post-natal), and Universal Health Coverage (UHC).
- All revenues collected by facilities are banked 100% in the facility bank account.
- The Heads of Departments (HoDs) meet the Hospital Management Board quarterly to present their respective budget proposals. The HoDs include the nursing officer in-charge (nursing budget), the lab technician in-charge (budget for reagents, etc.), and the administrator (budget for casuals, transport, food rations, etc.).
- The budgets are subjected to the Executive Expenditure Committee (EEC) to review them and ensure they are within the resource available envelope for that quarter. The EEC comprises the Medical Superintendent, Health Administrative Officer, Accountant, Nursing Officer In-charge, and Pharmacist In-charge. The EEC submits its deliberations to the Finance & General-Purpose Committee for further deliberation; the outcome of this committee is submitted to the full board committee for approval and onward submission to the Chief Officer of Health Services. The Finance & General Purpose Committee considers the previous year's allocations and the AIE (expenditure returns, bank balances, and quarterly collections).
- Once the plans and budgets get to the health department, the CO constitutes a team of HoDs from the County health management team (CHMT), called the County Health AIE Committee (CHAIEC), to go through the submitted budgets and recommend funding. The Committee visits hospital facilities to verify if the facilities are doing what they said they would do in the previous budget cycle.
- This Committee comprises various of the different department heads. This committee recommends the CO to issue AIE, the budget is taken to the County Treasury for review and signing by the CO Finance, giving authority to expend. The hospital only requires AIE since the money is already in their hospital account.
- Makueni County has set up internal hospital control that reduces financial risks by ensuring financial systems are followed.
- All Hospitals have a procurement entity managed by supply chain management officers.
- The approval process takes about one to two weeks, with the expenditure committee taking two days to review the budgets from the 15 hospitals.

Key implementers and collaborators

The management of health facilities, departments, and the county Treasury.

Resource implications

- The 15 health facilities in Makueni collect more than KSh.200 million per month. They plough it back into the facilities to improve their services.

County plan to sustain the best practice in the future

- By maintaining the systems and structures and ensuring they work as intended.

Results of the practice

- Going paperless has reduced instances of misappropriation because the staff do not handle cash, resulting in increased collected revenues.
- Health facilities have enough funds to run their units; thus, the quality of health service at the County hospitals has improved.
- Healthcare workers are motivated to work since they get facilitated promptly and have the required supplies and equipment.
- Retaining money at the facility for immediate use by the health facility.

Lessons learned:

- Political goodwill is needed to enable money to be collected, retained and managed by hospitals for effective health service planning and delivery.
- Autonomy of health facilities encourages collectors (health facilities) to collect more and use it responsibly by putting in place internal controls.
- It is easier to access funding from within the health facility than from the CRF. It takes only 1–2 weeks to get AIE and access funds in Makueni County.
- When NHIF reimbursements are delayed, health facilities request emergency AIE.
- Automation of collections has seen increased revenues for health facilities in Makueni County. The 15 health facilities in Makueni collect more than KSh.200 million per month. Patients pay through a Till Number.
- All health facilities have CCTV cameras to deter

employees from stealing and scoring, i.e., duping patients into paying cash, allegedly for faster or more services etc.

- The funds retained at the facility are used to employ additional staff on locum, both support and technical staff. Some of the funds are used for assets and infrastructure improvement, e.g., the construction of wards.
- With increased reimbursement by NHIF to the facilities through Edu Afya and Linda Mama covers, the facilities can lobby for additional resources.
- The County Health AIE Committee is critical in assisting the CO in reviewing and approving facility budgets.

Best practice

The Makueni model of implementing FIF has completely ringfenced the FIF for hospital use only. It is considered a best practice worth emulating by other Counties. About seven Counties have been taken through the Makueni model. Makueni used its model to train Isiolo County health officials. The County is happy to share lessons and build the capacity of other Counties.

Recommendations

- The CoG needs to support Counties by developing a policy modeled on success stories to ensure health facilities retain the money they collect rather than sending it to the County Revenue Fund, which may be redirected to other functions.
- When health facilities are given financial autonomy, they can complement other essential health services and commodities procured by the County from KEMSA, MEDS, or other local suppliers, avoiding commodity shortages.
- For meaningful impact, health facilities must manage and account for the funds well to ensure effective and efficient service delivery.
- Makueni County shows that there is no need to establish Hospital Management Fund, as health facilities can manage the funds they collect.
- It is essential to digitize the FIF process to seal loopholes for human interference in handling the funds.
- The Ministry of Health should continue working closely with the County governments to support increased health service coverage and improved health outcomes by developing guidelines and policies for access to quality and affordable health care for our communities.
- Counties should avoid systems that require them to send money collected by health facilities to the CRF, which may reallocate the funds to other sectors, overlooking the urgent services required at the health facilities to save lives.

1.4 County Government of Mombasa Facility Improvement Funds Helps to Create Autonomy and Improved Financing of Health Facilities

Introduction

Devolution bequeathed counties health functions and all the systems and health facilities from level 5 to the lowest level-community health services. Mombasa County required all health facilities to deposit the revenues collected into the CRF. Most of the times funds were not returned to hospitals. This impacted the health delivery negatively. To address the financial problem faced by health facilities, an executive order was issued allowing the hospitals to retain the collected funds 100%. Though at the beginning, there were challenges, following the accounting procedures as provided under PFM has facilitated effective process of the management resources by health facilities.

The county further amended the health policy to allow for the retention of the revenues collected at facility level. Regulations to guiding the process are however yet to be passed by the county Assembly. However, the action by the executive has ensured facilities have access to the resources they collect and delivery of services is not hampered.

How the problem impacts the population

Without enough revenue to run the health facilities, service delivery to the population would be affected.

Implementation of key activities

- The process of FIF started with all health facilities depositing money collected in the CRF. Through an Executive Order by the Governor, health facilities were allowed to retain all (100%) of the collected money.
- The Executive Order was aligned with the system before devolution, where facilities used to collect and use money. Governance institutions that manage and oversee existing funds have been retained, such as hospital boards and hospital management committees.
- The Board helps manage the funds by approving budgets and work plans as per the available funds

and requests AIE from the Chief Officer. Normal accounting procedures take effect.

- The Executive Order depends on the Governor's goodwill as no Bill or policy exists. Successive Governors could revise it. However the amendment of the Mombasa County Health Act mentioned FIF and its management. Regulations to guide the FIF are in draft form, waiting to be passed by the County Assembly.
- Regulations to effectively run the FIF have not been passed.
- Before 2017, there was a challenge with collection at source. For children under 5 years, services remain free. Currently, the Coast General Hospital sets the targets for collections.
- The County has implemented a cashless system – a KCB Cashier collects and banks the money.
- The County has established a paybill number through which patients remit their payments for services. The hospitals also have a waiving system- currently standing at KSh.60,000 worth of waivers per year. Approved waivers are receipted to allow for proper accounting. The hospital accountant reconciles the bank agent's and hospital receipts to ensure that what is banked equals what is received.
- Quarterly collections vary depending on workload.
- Budgets are made quarterly, and AIEs are issued.
- All funds are banked in the County Medical Revenue account for Level 4 and newly upgraded health facilities. Level 5 hospital (Coast General Hospital) is semi-autonomous with its own account.
- Each hospital has a quarterly budget for medical supplies, food rations, lab, reagents, utility vehicles, fueling ambulances, generators, and paying casuals and workers on contract.
- Human Resources and procurement of bulk pharmaceuticals and non-pharmaceuticals are not under the FIF.
- The Hospital Board provides minutes to justify the expenditure, accompanied by work plans and budgets and requests for AIE from the Chief Officer of Health. Once the AIE is issued, the department accountant prepares the vouchers and transfers funds from the Medical Revenue Account back to health facilities. This takes 2 weeks.
- The County uses vote book system for expenditure - the system is manual and not linked to IFMIS. All bulk commodities are purchased from KEMSA. However, the County tenders for commodities from other sources. Vouchers are kept at the hospital, and the FIF accountants do expenditure reports.

Key implementers and collaborators:

The health facilities collect, manage, and use the funds. hospital board provides oversight on the management of FIF. An expenditure committee reviews all AIE

requests and approves them. The County Director of Health is the overall manager of the FIF and constitutes the committee that reviews AIE requests.

Resource implications:

Resources collected and used are dependent on the workload of individual facilities. All resources collected are used for the provision of health services. Mombasa County allows facilities to plough back 100% of all collected resources.

County plan for sustainability:

- The County intends to pass the FIF regulations to improve the collection, management, and use of FIF revenues.
- Continuous capacity building of health facilities and all parties/staff involved in FIF.

Results of the practice:

- Hospital facilities get funds within 2 weeks of requesting. This has led to improved quality of care and service delivery as all hospitals have the equipment and adequate commodities, and the frequency of stockouts has been reduced. Additionally, the facilities staff are motivated as their working environment has been improving as utilities are paid for promptly.
- The facility collection has increased from KSh.647,518,000 (2018–2019) to KSh.1,111,755,677 (2021–2022).

Challenges

- The Executive Order provided the health facilities with autonomy and has led to better management of the collected resources for the purpose it was meant for.
- The County is concentrating on onboarding more people to NHIF instead of Linda Mama because NHIF pays more for services provided.
- All patients who require surgery are encouraged to pay for NHIF before being booked for the surgery. All the patients who are waived are advised to pay for NHIF coverage.

- Facilities have engaged NHIF clerks to follow up on the claims.

Lessons learned:

- Giving health facilities full autonomy to collect and use the funds improves patient care.

Recommendations

- Counties should ring-fence FIF to guard against avoidable challenges which can demotivate health workers and lead to poor accountability for money generated at health facilities. If health facilities are sure of retaining 100% of the funds collected, they will work hard and protect the funds.

1.5 County Government of Kilifi Facility Improvement Funds Greatly Improves Health Service Delivery and Financial Autonomy for its Hospitals

Introduction

Before implementing health facility funding, hospital budgets were not transparent and credible but were regarded as "wish lists" since they did not translate to actual resources. This, in turn, caused operational challenges, including fuel shortages and stockouts of essential medicines, medical, and cleaning supplies. This situation negatively impacted health care services.

Hospitals had no financial autonomy, and the flow of funds to hospitals was characterized by unpredictability in amounts and timing, leading to procurement delays. The County health departments undertook all procurements on behalf of hospitals. Delays in procurement and inadequate supplies affected service delivery and poor health outcomes for the Kilifi County population.

To address the challenges, the County Government of Kilifi implemented the Health Services Improvement Fund (HSIF), which gives autonomy to health facilities for improved service delivery.

FIF Implementation

Kilifi County has implemented FIF activities in the health facilities for the past two years.

Level 4 hospitals collect money via the pooling Kilifi Revenue Collection FIF Account controlled by the County Treasury. The funds are then transferred to the Kilifi Health Service Improvement Fund Account as a consolidated amount for all the collection health facilities.

The Fund Manager then transfers the money back to respective health facility expenditure accounts based on the amount collected.

The Fund Manager appointed by the County Executive Committee Member (CECM) for Finance, according to PFM Act, Section 116, is the fund's secretary, according to KHSIF Act, Section 14A.

The Hospital Management Team comes up with a quarterly budget that is forwarded to the Health Management Board comprising public and hospital management committee members. Every quarter, the Hospital Board meets to ratify the budget and deliver it together with the work plans to the County HSIF Board.

The County HSIF Board reviews the hospital work plans and budgets and approves them, then forwards them to the Fund Manager, who issues AIE to hospital managers to start spending.

When AIE is approved, the funds are transferred from the Kilifi Health Service Improvement Fund Account to hospital accounts. Out of the total funds collected by the facilities, 3% is provided to Fund Managers, 5% to County Hospital Management Team, and 20% to Subcounty Medical Officer of Health (MoH). The remaining 72% is sent to the facilities. This means the facilities do not get the total money they collected. At the hospital level, the money is used for operations and maintenance, employing casuals and paying staff on locum (medics working on a temporary basis). It can also be used by procuring equipment and supplementary health products to ensure there are no stockouts. These funds are also used to develo small infrastructures like putting up a dental unit. The County caters for HR and vehicle maintenance separate from the FIF or large infrastructure projects like putting up a ward.

Malindi Subcounty Hospital collects approximately KSh.4 million per month, and Kilifi Hospital KSh.7 million, before adding NHIF and Linda Mama resources.

Key Implementers and their Roles

The key implementers are the Fund Board, the Hospital Management Fund Board, and the hospital management team. They:

a) Provide oversight of the administration of the money drawn from the Fund.

b) Mobilize resources for the Fund.

c) Guide the management Fund Boards on: -

- Proposals on user fees where the management Fund Board seeks to propose new user fees or changes to the old fee structure.
- Disciplinary matters including but not limited to theft of funds, spending of revenue at source,

spending without proper authorization, fraud, abuse of powers of exemptions and waivers.

- Monitor the performance of the hospital management Fund Boards.
- Receive reports from the management Fund Boards for consideration and adoption.
- Develop criteria for the granting of waivers and exemptions.

Resource Implications

Fund administration is at the cost of 3% of the total collection. 5% is provided to the hospital management teams for supportive supervision and HSIF boards, and 20% to support the operations of the sub-counties' health officials.

Sustainability

- Continuous collection, retention, and use of funds by health facilities provides the best sustainability strategy for the facility resources for improved health care services. The collected funds allow facilities to access predictable financing on a timely basis.
- However, there is a need for the County to increase allocation to hospitals from the exchequer in line with the health services requirements because what is collected is not enough. It suffices to note that only 72% is ploughed back to health facilities.
- Systems to manage and plan need to be strengthened to improve the efficiency of revenue collection and utilization.
- Advocacy and educating the public to register to NHIF and Linda Mama will ensure more funds are generated for health care services.
- Entrench the fund manager to insulate the office from political interference to ensure continuous and efficient management of the Fund.
- The fund enabled health facilities to respond swiftly to emergency and immediate needs, especially during the COVID-19 pandemic.
- The health facilities can acquire lab equipment and other supplies efficiently as the dealers are assured of their prompt payments.
- Health care services are improving across the County, albeit slowly, because facilities can pay for the operations and maintenance.

Key activities that led to positive results

- Since the implementation of HSIF, hospitals can pay for their operations and maintenance.
- Facilities can also constantly procure the supply of pharmaceuticals and non-pharmaceuticals promptly. This has led to improved healthcare services.
- Due to increased finances, hospitals can promptly make decisions and effect them. This has also improved the motivation and ownership of healthcare providers and hospital staff. This also positively impacts the provision of services to the community.
- There is also a marked increased demand for services at the health facilities due to improved services.
- Staff motivated through recognition and award ceremonies and team building.
- Continue encouraging the hospitals to continue collecting money for the services offered to increase their revenues.
- Work with other County departments to increase the enrolment of NHIF to increase the funds' the facilities can collect.

The downside of the Fund:

- The Fund Manager is dependent on the goodwill of the Governor and/or the CECM, without which he/she can be removed, as there is no tenure of the office. The Fund Manager's position must be anchored in law or policy to ensure a 3-year term.
- There are budget ceilings for health facilities, and when facilities collections surpass their ceilings, the budgeted activities are not undertaken. To solve this problem, a supplementary budget has to be done, which may introduce delays to spending.
- The management process of the Fund works against the interest of the health facilities as only 72% of the collected funds are ploughed back into the collecting facility. In addition, there is a lot of interference from the County Treasury, including inter-departmental borrowing which funds are not returned. This means money collected by hospitals ends up being used for other purposes other than for health services.
- The funds are not managed through the National and County Government Integrated Financial Management Information System (IFMIS), making accounting and traceability difficult. The fund prepares manual quarterly and annual financial statements submitted to the County Treasury,

County Assembly and Controller of Budget. This process is cumbersome and time-consuming - a process that can be made easier by using IFMIS.

- The fund is subjected to an internal audit at the County level to ensure proper systems and internal controls are applied and an external audit by the Office of the Auditor General (OAG).

Lessons learnt:

The HSIF is immensely supported by all hospital management - Chief Officers, Director of Health and the CECM in actualizing HSIF.

What has not worked

- The entire process (from the Hospital Management Team to the Hospital Board to the Fund Manager) takes a month, which introduces chronic delays in FIF management, impacting the availability of funds to the hospitals.
- The Fund Manager issues annual AIE based on estimates rather than the availability of funds. This creates debts for hospitals that can be avoided if funds are provided on a timely basis.
- The Fund is not fully ringfenced as it is accessible to the County Treasury; inter-departmental borrowing negatively impacts the fund, leading use of the money for purposes other than health services interference.

What to do differently

- Provide the hospitals 100% of the funds they collect and let the County Treasury allocate CHMTS and the sub-county health officials.
- Waive the 3% Fund administration fee and pay the fund Manager from other sources of funds.
- Return the issuance of the AIE back to the Chief Officer of Health, who is the accounting officer for the health department - a role provided under PFMA.
- Consider reviewing the establishment of the Fund Manager to manage FIF without the Fund implication to address bureaucratic processes that result in delays.

Recommendations

- Issue quarterly AIE capped at the amount of collections for that quarter.
- Automated EMR to improve revenue generation efficiencies in all facilities and reduce leakage.

Compilation of CHS report at Milalani Dispensary Kilifi

PART 2.0: COMMUNITY HEALTH SERVICES (CHS)

2.1 County Government of Makueni Establishes a Revolving Fund to Empower its Community Health Volunteers for Sustainable Livelihoods

Introduction

The County Government of Makueni recognizes Community Health Volunteers (CHVs) as major players in the implementation of primary healthcare. CHVs play the critical role of mobilizing and educating communities on health care, especially about preventing diseases, keeping the environment clean, and referring them to health facilities for curative care when needed.

The County Government of Makueni has, over the years, recruited 3,722 CHVs whose specific role is to support maternal and child health by ensuring mothers attend the 4 Ante-Natal Care, ensure mothers go to hospitals to deliver under skilled birth attendants, children are immunized, and the community has an improved environment to ensure communities have clean water, sanitation, and hygiene (WASH).

To effectively undertake community health services, the CHVs undergo capacity building through the 14-module program provided by the National Government.

The CHVs are managed under Community Health Units (CHUs). Makueni County has 240 CHUs, and each CHU has about 10–15 CHVs. The target is 50 CHVs per CHU, but the attrition rate is high.

It takes time and resources to train CHVs. Hence, it is essential to ensure high retention of trained CHVs. In this regard, Makueni county committed to providing a monthly stipend of KSh.2,000 to keep the CHVs motivated and reduce the problem of attrition. This became unsustainable after only four (4) months. Makueni County Government has come up with other income-generating activities (IGAs) that would support CHVs, thus addressing the problem of CHVs attrition.

The population that was affected

- Makueni County realized that CHVs are critical to the success of community health services. Without them, women of childbearing age (aged 15-49), pregnant women, and children under five years would be the most affected. Other groups include people living with non-communicable diseases like diabetes and hypertension and people living with HIV/AIDS.
- The general population that learns about WASH would also be affected by the high attrition of CHVs.
- With the reduced number of CHVs, accessibility to information on reproductive health to women would be hampered.
- The tracing of mothers not attending ANCs would increase, putting the life of the mother and the unborn child in danger.
- CHVs address maternal health issues by ensuring mothers are delivered by skilled attendants by referring them to health facilities. With reduced CHVs, maternal deaths would likely increase. It is also possible that the immunization rate would go down.
- General healthcare information to the community would reduce, leading to increased incidences of illnesses that would otherwise be preventable.

The main activities carried out?

- The 2015 review of the Community Health Strategy found that supporting the Community Health Units to come up with Income-Generating Activities (IGAs) would be much more sustainable.
- A Makueni County study by Dr. Peter Kithuka identified that support to the CHUs would motivate the Community Health Volunteers (CHVs). This was corroborated by the County Public Health officials, who confirmed that IGAs are the most impactful way to support the CHVs.
- The County Department of Public Health started by piloting a savings and loaning scheme among 15 community health units (CHUs) with a seed capital of KSh.100,000 per CHU to be loaned to CHVs to enable them to start income-generating activities for improved livelihoods. The CHVs themselves run the scheme - they keep their record books at the health facilities where they are attached.
- Another 95 CHUs received a donation of 95 motorbikes (1 bike per CHU) from the County Government to be used for patient referrals, transporting CHVs during home visits, and as boda boda (motorbike taxi).
- The monthly meetings allow CHVs to discuss the IGAs and the community health work undertaken during the entire month. Each CHV is expected to visit between 20-50 households for those working in remote rural areas, while the CHVs located in urban settings are expected to report on 100 households.
- CHUs are organizing peer-to-peer learning forums dubbed 'food festival' funded by the Domestic

Resource Mobilization initiative comprising the County Government of Makueni and Nutrition International, a Canadian INGO. The festival aims to showcase locally available nutritious foods to help fight non-communicable diseases (NCDs).

When and where were the activities carried out?

- From 2021 to date, the following Community Health Units operate loaning and saving schemes in Kalawa Wards: Mutembuku, Ndauni, Kinyau, Kathulumbi, Thwake, Syotuvali, Katangi, Miangeni, Kimeeni, and Kalawa.

The key implementers and collaborators, and their roles

- Community Health Services Unit and Public Health Department are the key implementers, supported by development partners such as World Vision Kenya, Finance Alliance for Health. and Nutrition International
- The 15 CHUs running IGAs have been trained by World Vision and given seed money. Finance Alliance for enhanced the capacity of the Community Health Management Team (CHMT) and supported the development of the 5-year Community Health Strategy 2015–2020 and its implementation plan.

County plan on sustainability

The County is launching a Public Health Improvement Fund to strengthen public health across all levels of health care, including community health. The fund envisions supporting the CHS and the CHVs to facilitate their work, especially supportive supervision.

The County is also piloting a reporting tool to make the CHVs work easier. To this end, the Department of Public Health has procured MOH 513 (HH Register), MOH 514 (Service Delivery Log), MOH 515 (CHEW Summary), and MOH 100 (Community referral Form) to support data collection and to report for both the CHVs and Health Care Workers.

The County Government is mobilizing resources for sustaining community health activities and has budgeted for payment of CHVs stipends on performance-based evidence. For example, several CHVs have been enlisted to work in Wote Hospital to support screening patients for NCDs. Such CHVs are paid KSh.2,000 per month for their efforts. As a strategy for early detection, the County partnered with Medtronic Labs and trained 5 CHVs from each CHU on screening diabetes. The CHVs are now offering screening services to the community and making referrals to hospitals — this is happening in 11 hospitals but will be scaled to health centers from next year.

Close, supportive supervision for CHVs activities is also being monitored closely to build trust and confidence between the health officials and the CHVs.

Results of the practice

- Since the start of the IGAs, all the CHUs that started economic activities have reported steady growth.
- Provision of seed cash for implementing IGAs has resulted in the growth of the kitty to KSh.600,000 from KSh.50,000 – from earning interest from the loans to members. This shows that members of these CHUs have remained active as CHVs because they are benefiting from the loans they are getting. As a result, they are also helping the community.
- CHVs have acquired outside-catering equipment and tables and chairs thus increasing their earnings from hiring them out, rearing goats, and nurturing tree seedlings and nurseries for sale. 20 out of 95 CHUs that got seed funding for the tents, goats, and beekeeping have started savings and loan schemes from the money they have earned.
- The thriving IGAs show that CHVs benefit financially and are not dropping out. The community health coordinator confirms that because of this economic benefit, CHVs are also doing better in their service delivery. It is, however, recommended that a survey be done to quantify the level of improved CHS services.
- With thriving IGAs, the CHVs are no longer skipping work to look for money; they have that sorted through the IGAs they run.

Lessons learned

- Disseminating health messages to the community using CHVs selected by the community is more impactful.
- CHVs teamwork helps with peer-to-peer learning.

What did not work

Some CHVs have minimal academic qualifications, which means some are slow learners and need more time to grasp the content. Currently, the minimal requirement for CHVs is to be able to read and write. So, a CHV can be a Class 8 or Form 4 graduate. The community selects the CHVs whom they want to serve them. Soon, the County will require that CHVs must be able to use smartphones for digital messaging and reporting.

Recommendations

CHVs assist the Public Health Department in reaching households with critical health messages easily, something a nurse cannot afford the time to do. Counties, therefore, need to:

- Allocate substantial budgetary funds for the motivation of CHVs.
- Encourage partner support towards community health activities.
- Support CHVs' activities by closely monitoring their monthly performance through supervision meetings and following each CHV on their household visits at least once a month.
- Set up a system of recognizing and rewarding the best CHV performances in public to motivate them.
- Organize continuous learning forums such as retreats and workshops for the CHVs to improve their skills and knowledge.
- Allow CHVs to run IGAs and offer them supervisory support to ensure good record-keeping and sustainability.

What to avoid?

- Overreliance on limited donor support
- Giving stipends has proved unsustainable unless it is for specifically targeted performance.
- Increase supportive supervising of CHVs, especially concerning disseminating health care practices and information. Correct health messages must be delivered to the community.
- Ensure that community health services are well funded.

Further reading:

Kithuka, (2017) Predictors of Community Health Workers Retention in Service in Makueni County, Kenya [Doctoral dissertation]

A photo of Kalungu Community Health Unit in Kibwezi West Sub County, monthly meeting and reporting

2.2 County Government of Nakuru Successfully Combines Different Initiatives to Motivate and Retain Community Health Volunteers

Introduction

Nakuru County has been implementing Community Health System (CHS) since 2006. At some point, the County Public Health Officer (CPHO) had the added task of manning the CHS docket; however, balancing administration and program activities became challenging. Over time, the Community Health Committees were forgotten and needed to be revamped.

Nakuru County has inadequate Community Health Assistants (CHAs) whose work is to supervise CHVs. There are 28 CHAs for the 3,000 CHVs.

Nakuru County is yet to digitize CHS reporting, and producing copies of the MoH reporting tools for household data during CHV visits has been difficult without a budget. Other departments have assisted the CHS Focal Person in developing the tools by photocopying.

In Nakuru, experienced shows that CHVs had difficulties operating in affluent neighborhoods. They also had peculiar problems working in the slum areas, including trying to address open defecation by street families.

Population was affected?

- Nakuru community, health facilities, and the County Government.

How did the problem impact the population?

With poor CHS, most community members, especially in rural areas, become inadequately informed on health issues, including the benefits of public health and the health services offered in health facilities. This affected their health-seeking behavior and exposed the public to the risk of ill health.

Non-availability of CHVs' reporting tools resulted in irregular data collection, affecting informed decision-making. This has a negative implication on the outcomes of health indicators.

Inadequate human resources to support community health led to the lack of prioritization of public health, exposing members of the public to the risk of infectious diseases.

Main activities carried out?

- A CHS focal person at the County level was appointed to support and coordinate all CHS activities. The Community Health Units (CHUs) have expanded from 155 in 2019 to 318 in 2022. Currently, there are about 3,000 CHVs. The minimum qualification for CHVs as per policy is a KCSE certificate, but some CHVs who started before this policy are primary school leavers. Continuous training helps to bridge the education gap.
- Nakuru County supported CHVs who organized themselves and started income-generating activities (IGAs) coordinated at the CHU level. This helped reduce attrition of CHVs because the CHVs are benefiting from the IGAs. Nakuru County did not provide seed money, unlike other Counties. Instead, CHVs used money from their small businesses.
- Nakuru also piloted the provision of KSh.2,000 monthly stipends in 2019. This stipend was rolled out in 2021. This has further led to reduced attrition. Nevertheless, natural attrition cases are promptly replaced.
- As noted above, working in slum areas was difficult. However, incorporating members of the street families as CHVs helped address the problem of open defecation leading to an improved environment and reducing risk to public health. The COVID-19 period is a good example of where CHVs helped sensitize communities on hygiene practices to minimize transmission.
- Among the affluent population, significant inroads have been made by identifying members of these neighborhoods willing to take up the role of CHV. Examples of such members are association leaders or retired professionals. One of the CHC members in the affluent areas of Nakuru is a retired hospital human resource manager. Such members help quash the notion that CHVs are semi-literate people who may not know much about public health.
- Training of CHUs members on a new curriculum that includes social accountability and community scorecards is ongoing. Nakuru County also supports dialogue days and action days. Evidence of these activities' impact on community health support needs budgetary allocation from the County. Trained CHVs are used to disseminate public health messages.
- To support the effective supervision of CHVs, the County has retained 216 community health extension workers (CHEWs). CHEWs are either PHOs or nurses. The PHOs combine their core work at the community level with the support and supervision of CHVs. Nurses also undertake household visits.
- The County Government also inherited the current CHAs from the National Government. There are also CHAs who are volunteering.
- The CHS Focal Person has provided the revised reporting tools but due to inadequate budget, only a few copies have been provided.
- Nakuru has also piloted digitization (eCHIS) in Kuresoi Sub-county. The eCHIS is meant to make CHVs reporting efficient.
- The CHC is also responsible for social accountability that involves holding health facility and facility committee leaders accountable for the provision of service delivery. Social accountability was initiated by National Government with support from partners (Uraia and Centre for Transformational Leadership – CTL) and is meant to hold levels 2–4 health facilities accountable for health service delivery in their facilities.
- A partner implementing sensitization on non-communicable diseases (NCDs) in different sub-counties involved the CHVs monitoring of NCDs and advocating for value of nutrition in preventing and/or controlling NCDs. The CHVs are trained on NCD prevention and control and are encouraged to use the knowledge for economic benefit. Thus, they sell nutritional products (nutrient-enriched/ quality-improved flour, peanuts, etc.) to boost

the health of NCD patients. The CHVs were offered entrepreneurship training and provided smartphones to monitor sales of the nutrition products. The CHVs repay the cost of the phones through money earned selling the products.

- CHUs use scorecards to confirm the quality of community and facility health services. The scorecards allow members of the community their views on the service delivered to them by the CHVs and the health facilities. Some questions include whether CHVs visit their respective households, timeliness of health service delivery at the facility level, availability of drugs, cleanliness, and security of the facility. The documented feedback is shared with the health facility and the staff, which helps address identified challenges or seek interventions from County authorities. Out of this social accountability process, Langalanga Health Center has been upgraded to a sub-county health facility because of the improvements realized and in response to the increased workload.

When and where were the activities carried out

- CHCs hold forums in the community using a scorecard with 9 indicators to measure community access and response to health services.
- The CHS focal person participates in the social accountability process. Civil Society Organisations have supported social accountability and submit a report to the County Governments when they complete a social accountability exercise.

Key implementers and collaborators

County Public Health Department and Community Health Services Unit.

Resource implications?

Technical and financial support is mainly from development partners and National and County Governments.

The County plan on sustainability

The County will continue improving the work environment of CHVs and, by extension, community health by:

Which critical activities undertaken ultimately led to which positive or negative results?

- Appointing a CHS Focal Person who streamlined CHS activities and implemented different initiatives to motivate the CHVs.

Lessons learned

- It is essential to appoint CHVs specific to the communities they live in. Those selected should be credible and well-respected in their communities.
- It is critical to advocate for communities to welcome CHVs to their homes and support their work during home visits. CHVs selected from among the people in a particular community are received well as they are already known to the community.
- Monthly review meetings under CHUs allow the CHVs to bond and share experiences and lessons.

Recommendations

- There is a need for County Governments to provide resources through a budget line to support community health services. This could be done through public health.
- County Governments to consider supporting diverse IGAs for CHVs and the production of reporting tools.

2.3 The County Government of Kilifi Implements Income-Generating Activities as a Long-term Solution to Community Health Volunteers' Sustainability

Introduction

Kilifi County Government aims to ensure that the County has a sustainable healthcare system that provides accessible and affordable health services for all the people of Kilifi. To this end, the County Government is committed to implementing Universal Health coverage that guarantees quality promotive, preventive, curative, and rehabilitative health services reducing financial hardship for the population.

The health services range from hospitals, mainly for curative services, to community health services, primarily preventive and promotive. At the community level, health services are organized through community health units (CHUs) that bring together a number of community health volunteers (CHVs) responsible for several households.

Kilifi County has varied settlement patterns with densely populated urban settings such as Kilifi Town, Mtwapa, and Malindi and sparsely populated rural settings such as Kaloleni, Ganze, and Magarini. Both settings require the services of CHVs to reach underserved communities to help them navigate healthcare and social service systems.

The challenge the County Government sought to address was the attrition of CHVs. CHVs play a key role in

promotive and preventive health. They are expensive to train and maintain. Hence, attrition makes it more difficult for the County to recruit more CHVs. Among the reasons for the attrition is that the CHVs have to be engaged in other economic activities to generate resources for their livelihood.

Additionally, the CHUs lack adequate supportive supervision making them less organized and functional. CHVs deliver services in a defined geographical area covering a number of households. CHVs depend on supportive supervision to follow up on their reporting through a health facility. Limited supportive supervision leads to low motivation, and CHVs drop out of service.

How did the problem impact the population?

- Health is a right of the people and a responsibility of the Kilifi County Government. A County Government that cannot promote healthy communities due to inadequate health infrastructure, including its human resource, leads to poor health indicators.
- Due to financial constraints, Kilifi health services have been inadequate. At the community level, Kilifi has depended on CHVs to support health services. CHV attrition negatively impacts access to community health services, especially preventive and promotive health. In addition, CHVs also help the community make an informed decision on curative health services.
- Population affected include the Kilifi communities, health facilities, and the County Government.

The main activities carried out?

- The Kilifi Department of Public Health undertook desk reviews of Migori, Homa Bay, Turkana, Tana River, and Kajiado Community Health Services Acts and Policies to learn how these Counties deal with the attrition problem.
- Kilifi also benchmarked on best practices in addressing CHV issues. A team comprising the Community Health Services (CHS) Focal Person, the County Public Health Officer (1), 2 Sub-County CHS Focal Persons, 2 CHVs, 1 Health Records Officer, 1 Reproductive Health representative, 1 Sub-County Ministry of Health (MoH) and 1 Community Health Assistant/Community Health Extension Worker (CHEW) visited Taita Taveta (2015), Makueni (2019), and Nyeri (2019).
- Kilifi County provided a budgetary allocation to cover the stipend cost for the CHVs. Each CHV received a monthly stipend of KSh.3,000.
- To date, the County has 3,815 CHVs spread across sub-counties. Some CHVs in urban areas have a target of up to 200 households per month, while those in rural settings have between 10–100 households due to the distance between households. The Community Health Units (CHUs) are 249 against a target of 317. 1 CHU has 10 CHVs.
- Most CHVs have completed primary education, with a few having completed secondary and college education.
- Because of the low numbers of CHAs, CHEWs continue to play a supportive role in CHS. Together they total 160 against a target of 300.
- The Health Department, in support of CHVs, has set up welfare, income-generating activities (IGAs) to support increased CHVs' income and hopes to retain them for community health services.

Key implementers and collaborators, and what were their roles

- The Health Department spearheaded the setting up of income-generating activities (IGAs) for CHV motivation. It worked in collaboration with other departments, such as the Agriculture Department, for agriculture-related IGAs like keeping poultry and goats, conservation farming, gardening, etc.
- A Technical Working Group with membership from the Department of Health included the CHEWs Sub- County focal person, PHOs Sub-county focal person, and Head of the Divisions of preventive, promotive health, health products, Family Health, planning/M&E, spearheaded the development of a Bill and policy that would provide support to CHVs.
- The draft policy and bill are shared with other departments for input.

Technical and financial support from donors.

- For the drafting of the Bill and policy, the following donors have extended support:
    - USAID Stawisha assisted with the inception meeting of the County Health Management Teams (CHMT) and Sub-County Health Management Teams (SCHMT).
    - UNICEF is supporting the drafting workshops and also document validation.
    - World Vision will continue to support public participation in drafting the Bill and Policy.
    - ACHAP and Population Services Kenya (PS Kenya) have shown interest in supporting part of the process.
- For the IGAs:
    - World Vision issued CHVs with Galla goats which

are said to be rich in milk production. They also supported poultry farming in parts of Ganze Sub-county.

- Agha Khan University provided seed capital of KSh 100,000 and training to Rabai and Kaloleni CHVs who started gardening and poultry keeping.
- The Department bought 7 Makiga brick-making machines and distributed them to the sub-counties (1 each). Plan International added 3 machines to 3 CHUs in Ganze and Kilifi South.

The County sustainability plan

- CHV stipend is a flagship project in the current County Integrated Development Plan (CIDP).
- The County will append subsidiary legislation to the CHS Act to entrench IGAs as part of the CHV sustenance mechanisms. The Finance Economist has been co-opted to help with this.
- To maintain the CHV numbers, the County replaces CHVs who leave and undertakes on-the-job training for the new CHVs.

Results of the practice

- Since 2013, the Public Health Department has initiated and supported income-generating activities (IGAs) that contribute to reducing CHVs attrition and assuring continued volunteering for the CHS.
- Thriving IGAs include interlocking brick-making, gardening, poultry, Galla goat keeping, and hiring out of tents and chairs.
- Other IGAs include solid waste management in Mtwapa, where they charge KSh.50 per household per month. This project has enhanced sanitation and hygiene.
- The brick-making IGA helps to ensure families live in decent, affordable housing and build toilets for proper sanitation.
- IGAs have held CHVs together because of the frequent interactions at the IGAs and during the monthly meetings to share field experiences.
- Since most of the IGAs are nutrition-related, this has helped improve communities' health.
- The health department has followed these IGAs and noted a positive correlation between CHVs motivation and reduced attrition. This has led the County to develop a Bill and policy to entrench these CHVs' supportive supervision and the IGAs' activities. The Bill and policy are with the County Assembly for approval.

Key activities undertaken that ultimately led to positive results

- Involving CHVs in all public health campaigns, such as Mass Drug Administration (MDA) programmes and national immunization days. Participating in such forums shows that CHVs' work at the community level is recognized and appreciated. Participation in these campaigns also provides CHVs with more health information.
- The collaboration with the Finance Department in drafting the Policy and Bill has ensured a smooth process as the finances for the process are provided. Other departments that support public health service forums where CHVs are involved include Environment, Water and Agriculture.
- Development partners such as World Vision, USAID Stawisha, ACHAP, UNICEF, AMREF, and PS Kenya have provided financial and technical support.

What worked really well

- Political goodwill has ensured sustained financial support for these 2 initiatives – the stipend and the IGAs. Drafting the Community Health Bill and Policy requires many meetings, reviews, and validation processes by diverse stakeholders. The entire process is costly and time-consuming. However, the process is completed.
- The IGAs are a standing agenda in the monthly CHEW review meetings with CHVs to help review the progress of the IGAs, provide advice, capacity-build on the management of the IGAs and motivate the CHVs. The CHUs run the IGAs but require support to strengthen accountability.
- The CHUs have committees - a good governance system supporting accountability.
- The interest of the CHVs has also contributed to the success of the IGAs, motivated by the income they generate.

What did not work

- IGAs on table banking have not worked well for all CHUs, hence not benefiting all CHVs as expected.
- The IGAs committees have a 3-year term and are renewable once. While this is a good governance system, there is evidence that replacing committee members is difficult because of the investment the CHVs IGAs committee members have made in the IGA.
- Some IGAs have not done well, threatening the CHU stability.

What to do differently

- Developing clear guidelines on the CHUs in the IGAs are required to ensure the investments are safe and secure after they leave the CHUs. Being permanent committee members and not respecting the 3-year term is a poor governance practice that must be discouraged.
- IGAs involving table banking/loaning of CHUs members need to be reviewed to tighten the rules on repayment.
- Have clear business plans, follow-up, and supportive strategies to ensure IGAs survive and thrive.
- Sensitize CHUs to diversify their IGAs to include health-related products, e.g., selling mosquito nets, selling/promoting sanitation materials, etc.

Lessons learned:

- Training CHVs on entrepreneurship before the IGA is critical to the success and flourishing of economic activities.
- Registration of the CHUs as self-help groups and CBOs will help open more funding available at the community level.
- Promote cross-learning between CHUs for the CHVs to learn from each other and promote recognition of good practices.

Recommendations

- A County requires a clear roadmap before starting the legislating process.
- Ensure adequate funding is identified, as both the legislating and policy processes and the motivation of CHVs is expensive.
- Prioritize public participation by involving community members in the entire process from inception to implementation, monitoring, and reviewing policy and legislative processes.
- Secure political goodwill and the buy-in of the County Government and County Assembly for support to IGAs for the CHVs because this involves funding. Additionally, the proposed legislation and policy will entrench the support and funding of the IGAs for CHVs.
- Empowering CHVs through IGAs is a good mechanism for motivating them, which the County Government should continue supporting.

A photo of a community formed committee to organize on building a toilet for one member of the community in Nakuru County

A photo of a community formed committee to organize on building a toilet for one member of the community in Nakuru County

2.4 County Government of Meru Response to Non-Communicable Diseases with support of Community Health Volunteers

In Meru County, the incidences of non-communicable diseases (NCDs), such as heart disease, stroke, cancer, chronic respiratory diseases, and diabetes, are increasing. These diseases are starting to be the leading cause of mortality.[1] Most of the affected patients were unaware of their status. There is a general lack of awareness of NCDs and how to prevent or control them, and most patients are not sure where to go for more specialised care.

Most people with NCDs are from poor and vulnerable households. Most people are not seeking health services for fear of the associated costs.

Meru County has been using Community Health Volunteers (CHVs) to mobilize communities and advocate for seeking health services. The CHVs also support the

[3] https://www.who.int/data/gho/data/themes/noncommunicable-diseases

collection of critical demographic data from households. To keep the CHVs motivated, the County provides a stipend of KSh.5,000. The promise to pay this stipend was made in 2018. The purpose of the stipend was to show appreciation for the CHVs' work and to try and reduce the attrition rate. It was hoped that with reduced attrition, more CHVs would be available to support the County's community health services, thus helping the County address and promote the preventive approach to health, thus reducing the burden of disease, especially the NCDs among the Meru County population.

Population impacted by the problem

Meru County is faced with increased incidences of NCDs affecting the population. Increased NCDs mean increased cost of health care, yet prevention and promotive approaches are effective ways to stem the increase.

The presence of motivated CHVs is meant to support the County in addressing the increasing cases of NCDs by ensuring appropriate information reaches the households on prevention measures such as the need for physical exercises, good nutrition, and a clean environment.

Evidence shows that people from poor and vulnerable households have poor health-seeking behaviours; normally, they seek health services when it is too late. CHVs support ensures that sick people are referred to health facilities to seek appropriate health services.

The main activities carried out

- The Department of Health has enlisted 41 Public Health Officers to complement the work of the 57 CHAs for better supervision of CHVs.
- The Department used the CHVs to register poor households supported by the County to access National Health Insurance Fund (NHIF) benefits. Out of the 120,000 registered, the CHVs were able to help the County Government identify 26,671 considered to be the neediest to benefit from NHIF to enable them to access health services at a subsidised cost under the UHC programme.
- The Department of Health hosts CHVs for health forums to train CHVs and provide them with information on health services offered to be equipped at the community level.
- CHVs are included during the Department awareness walks that disseminate information on disease outbreaks and other health-related information.
- CHVs also participate in multi-stakeholder sporting events at sub-county levels: events are useful in creating awareness and education on healthy lifestyles, including exercising, to prevent and/or control NCDs.
- In some health facilities, CHVs are the main Community Health Referral Desk. The CHVs support the hospitals in screening patients referred during the CHVs' household visits. The Community Health Referral Desk helps the patients navigate the hospital by directing them to the appropriate offices for services.
- The CHVs in the field have also been issued with blood pressure monitors and glucometers to conduct NCD screening at the household level.
- CHVs support the Community Psychosocial support groups for non-communicable diseases (NCDs). The patients meet regularly within these groups to share experiences and help one another.
- CHVs also participate in supporting deworming children and provide information to households on the need for periodic deworming. CHVs are also involved in Vitamin A provision.
- CHVs are participating in Income-Generating Activities (IGAs), where 83 CHUs have received from the County seed money to support the income-generating activities. Some of the economic activities the CHUs are engaged in include beekeeping, farming, merry-go-round, table banking, etc.
- There has been an increased establishment of Community Health Units from ~220 (60%) in 2018 to 290 (92%) in 2o22. Meru County is close to meeting the total number of CHUs required - 309 CHUs.

The key implementers and collaborators

- The public health department under the community health services programme is responsible for community health services and hence supervises the work of the CHVs.
- The Community Health services are among the devolved health functions; hence the County has been mobilising resources to support the CHVs and their work. Other partners include Amref, AIC Health ministries, Food for the Hungry, Mt Kenya Trust, NCD Alliance of Kenya (NCDAK), etc.

The resource implications?

- The County has not been able to provide budgetary allocation for the CHVs, making it challenging to estimate the resources required to operationalize the community health system fully.
- However, the provision of finances to support IGAs is remarkable and is likely to result in better retention of CHVs who will be motivated to continue supporting community health services.

How does the County plan to sustain the best practice in future?

The Department is lobbying so that the County Assembly allocates sufficient funds for CHS activities while it continues to mobilise partners.

Results of the practice

- Increased awareness of NCDs in the community. This result is supported by the increased number of people screened for NCDs - estimated at 154,000.
- Other indicators that have been positively impacted include the following:

Indicator	From (2020)	To (2021)
Vitamin A supplementation at the household level	Less than 30%	Over 86%
Non-communicable diseases referrals	9,856 persons	16,270 persons
Latrine coverage	66%	95%
Immunization defaulters		
New functional community health units	60%	925

- Remarkable reduction of CHVs attrition is attributed to an increased number of IGAs established - about 84 IGAs that are thriving.

Lessons learnt

- Close supervision of CHVs keeps them motivated as their challenges are addressed promptly. The monthly feedback meetings allow them to share knowledge and experiences as they bond.
- Continuous training of CHVs is essential, despite the budget constraints.
- Multi-stakeholder involvement, especially during public health campaigns such as the human papillomavirus (HPV) and COVID-19 vaccination, is key to success. Due to this approach, there is steady acceptance of vaccination in Meru County.
- Strengthened partnership with development partners is critical.

What did not work

Challenges while implementing some of the CHS improvements included:

- CHS activities are almost 100% dependent on development partners making sustainability difficult.
- Partial training of CHVs; the partners supporting CHS usually cannot support the comprehensive training of all CHVs, and thus some CHVs receive less training than others.
- Some health facilities are not supportive of the community health desk in the health facility. This makes the working conditions of the CHVs difficult.
- Some outreach campaigns often meet resistance from community sections, fuelled by some opinion leaders. For example, some religious leaders have advised their followers not to receive COVID-19 vaccination.
- Limited supervision of CHVs and lack of appropriate working tools make the work difficult, e.g., manual reporting is tedious and leads to loss of data or inaccurate and incomplete records due to their bulkiness. Counties need to invest in smartphones with soft copies of the reporting tools for real-time reporting and timely discovery of data entry errors.

Recommendations

- Involve CHVs in all CHS programmes as the community already trusts them, and they can mobilize the community to participate in public health events.
- CHS cost is not yet established. This makes it difficult to plan and mobilize adequate resources and implement identified activities. However, partnerships help to bridge budgetary limitations.
- There is a need for supportive supervision of CHVs to keep them motivated, ensure their challenges are addressed and acknowledge their contribution to CHS's improvement.
- The manual reporting system is cumbersome, and the tools are costly to print. Counties should seek solutions and support migrating to electronic reporting using smartphones.
- Liaise with the link health facilities to offer support to the CHVs. The CHVs need to be facilitated to improve their working conditions in those facilities that have established community health Desks.

Health Awareness walk

SCMOH Muthara Hospital addressing community members in a dialogue meeting on TB and cancer prevalence rate, transmission, treatment and prevention. SCCHSFP and CHAs were present.

Community Health Day

CHV monthly feedback meeting

2.5 Kisumu Revolutionalises Community Health Volunteers Reporting Structure

Introduction

CHVs work involves households visits. During the visits, the volunteers collect data that is used to report on the community health status. The processes of data collection in Kisumu County is well developed and digitized, making it easy for the volunteers to report. However, despite the efforts addressing data collection, accessing the data for planning and decision making by Kisumu County authorities was problematic. This led Kisumu County to enhance the reporting structures to ensure collected data reaches the County administration to support planning and decision making for health.

By establishing a reporting structure, CHVs reporting in Kisumu has become consistent, complete and easy to access by the health department that uses the data for planning processes.

How the problem impacts the population

Population affected by the problem include the community health volunteers, the Department of health and general population.

Data is a key element in decision making, planning and resource allocation for interventions that impact on population. When such data is not available or does not reach the intended user, this impacts negatively on planning and the decision-making process on community health issues. In this regard, response to community health or public health issues is hindered. Additionally, the problem affected the accuracy of information provided and timeliness of reports by the community health volunteers.

The main activities carried out

- Designing a reporting structure
- Disseminating the different levels of reporting structures to the CHVs.
- Capacity building on reporting requirements at each level- CHVs on data collection and reporting, CHAs - on reporting tools, data validation and supportive supervision, Sub-county community health focal persons on data validation and reporting tools, and supportive supervision.
- Data review on a regular basis to validate and confirm what the data collected.

The initial cohort was trained in 2020 and subsequent trainings followed in cohort II in 2021 and cohort III trained in 2022. All the trainings were done at the community level either at the local community halls, local churches and the local schools. The trainer of trainers took lead in the trainings and brought on board the CHU supervisors as they would be key in continuous mentoring and supporting the CHVs to use the digital system.

Key implementers and collaborators and their roles

The Ministry of Health- Division of Community Health was the key collaborator providing the policy and strategic direction on community health services. MOH provided the framework that defined the different levels of reporting structures that would facilitate the movement of collected data from the CHVs, through to CHAs to Sub- County health management teams (SCHMT) and finally to the CHMT.

The frame work also provided for digital interventions under the eCHIS strategy 2020-2025 in addition to community health policy and strategy.

Kisumu County as the implementer, adopted and domesticated the CHS policy, strategy and eCHIS that formed the basis for the digitization of data collection for the CHVs. Additionally, Kisumu County funded capacity building on the use of the e-system and the reporting structure to all County staff across the County health service delivery system and the CHVs. Capacity for supportive supervision coupled with mentorship has been enhanced across all levels including at community level.

Living Goods came in as partners and supported the process by providing phones and tablets for all the CHVs and CHAs.

Resource implications

The resource requirement covered trainings, commodities for the CHVs kits and a budget for CHVs incentives. The budget for the above was provided by the County.

Living Goods provided phones and tablets and data bundles.

County sustainability plan

- The reporting structure is embedded in the existing County health delivery system (the health facility linkage) and health administrative structure (sub-county management teams). This means the structure start at the community level, through to the CHAs, to the sub- county management teams (SCHMT). The Sub-county Records and Information officer (SCHRIO) ensures the data is captured through the Kenya Health Information System

(KHIS) to enable the data is accessed by the CHMTs and MOH if necessary. Furthermore, the community units are organized around a health facility where they meet monthly and discuss their reports.

- The monthly meeting allows the health facilities to capture the information generated by the data provided by the CHVs through the eCHIS. The anchoring of the reporting structure and data collecting mechanism to existing structures will ensure sustainability of the good practices already reported.

Results of the practice

The extension of reporting structures and subsequent training of CHVs and CHAs to the community level has resulted in:

- CHVS are able to report on a timely manner, all reports are made by 7th of every month.
- The reports are complete and easy to validate because there is no time lag between data collection and reporting.
- The system has led to standardising/harmonizing the data collecting tool by use of MOH 515 by CHVs facilitate reporting on the same indicators thus providing data that supports health interventions both at community and primary health care levels.
- The success of eCHIS piloted in Isiolo and Narok other Counties has informed its scale up.
- Upon the verification of the data by the CHAs, the data is then pushed up to Sub-county Community Health Focal Person (SCCHFP) who upon verification submit the same to the KHIS for validation by the Sub-County Health Records and Information Officer (SCHRIO). This structure ensures the data is integrated into the KHIS, making the data accessible for use the policymakers both at County level and the national level.
- With this data available, monthly reviews are done on every 15th of the month (supported by the Living Goods) either at the sub-county or at community level at the beginning of operationalizing the structure.
- However, reviews are now done at the link facility enabling the facility staff, CHVs review the data. This is aimed at strengthening the link between the facility and CHVs reporting structure.
- A dashboard on the reporting is added as a tool that shows performance on the reporting. This allows the sub-counties and counties management teams to view the performance of each sub-county and address challenges that may be hindering CHVs form reporting.

Key activities undertaken that led to which positive

- Monthly data reviews have been critical to the positive outcome it is easy to identify challenges affecting the reporting requirements and have them addressed.
- Digitizing the reporting tool has contributed to the easy reporting of data through the established structures, facilitating timely and complete reporting.
- Capacity strengthening and supportive supervision of the CHVs and close follow ups by the CHAs is further strengthening the reporting system.
- Linking the County reporting structure to the KHIS ensures data collected at the community level is available for decision making by the County health department. It also enables the County to respond to issues that affect the community health services.
- Undertaking the data reviews at the facility level strengthens the collaboration between community health services and the primary health care system.

Lessons learnt: what worked

- Regular monthly data reviews have strengthened the link between the community health services and the primary health care provided by the link facilities.
- Identifying the best performing CU, CHAs and CHVs and awarding them with certificates and trophies serves as motivation to other CUs, CHVs and CHAs. This has led to healthy competition among the CHAs and CHVs leading to more dedication to their work.
- The County has easy access to better information for decision making and resource allocation for health in general and community health services.

What did not work

- The reporting structures are still new and there is need for continued capacity strengthening.
- The new reporting structures at the sub-county and community level had delinked facility from the reporting structures thus affecting the information necessary to support primary health care. Nevertheless, this has been addressed.
- Over-reliance on use of phones by the CHVs is a problem especially when the phones are lost and replacement takes long. In this regard, there is need to have both digital and manual reporting tools to reduce over reliance on the phone.

Recommendations

- Ensure from the onset, the link between the CHVs and the link facility is not disrupted to facilitate strengthened reporting mechanism.
- Have both manual and digital reporting to reduce over reliance on the phone.

CHVs training on digital reporting in Nyando

Data review meeting at a CU level in Kibos CU

A CHV presents her data in Kasule B data review meeting

Presentation of yearly award to the best CU- Masogo in Muhoron

A section of SCHMT attending a data review meeting at CU level in Kisumu East

APPENDIX 1: COUNTY LOGOS

 Nakuru 032	 Meru 012
 Makueni 017	 Mombasa 001
 Kilifi 003	 Kisumu 042

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