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INVESTING IN PATIENT-CENTERED SERVICES:

A COMPENDIUM OF COUNTY INNOVATIONS AND BEST PRACTICES ON PRIMARY HEALTH CARE NETWORKS (PCNS)

10TH EDITION

JULY – DECEMBER 2025

INVESTING IN PATIENT-CENTERED SERVICES:

A COMPENDIUM OF COUNTY INNOVATIONS AND BEST PRACTICES ON PRIMARY HEALTH CARE NETWORKS (PCNS)

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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".

Vision

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

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

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Maarifa Centre Motto

Sharing Kenya's Devolution Solutions

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ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral Therapy
BETA	Bottom-Up Economic Transformation Agenda
BFCI	Baby Friendly Community Initiative
BP	Blood Pressure
CHAs	Community Health Assistant(s)
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHPs	Community Health Promoter(s)
CHUs	Community Health Unit(s)
CoG	Council of Governors
CPHC	County Primary Health Care Coordinator
CSOs	Civil Society Organizations
CCHSC	County Community Health Services Coordinator
DM	Diabetes Mellitus
DRTB	Drug-Resistant Tuberculosis
EHR	Electronic Health Record
eCHIS	Electronic Community Health Information System
FIF	Facility Improvement Fund
GIS	Geo-spatial Information System
HIV	Human Immunodeficiency Virus
HIP	Health Information Point
HMIS	Health Management Information System
HMU	Health Management Unit
HTN	Hypertension
IEC	Information, Education and Communication
IGAs	Income-Generating Activity / Activities
KDDA	Kenya Diabetes and Dietetics Association
KDHS	Kenya Demographic and Health Survey
KHIS	Kenya Health Information System
KM Champions	Knowledge Management Champions
MCH	Mother and Child Health
MDT	Multidisciplinary Team
MNCH	Maternal, Neonatal and Child Health
MoH	Ministry of Health
MOPC	Medical Out-Patient Clinic
MTC	Medical Training College
MUAC	Mid-Upper Arm Circumference
MVMH	My Village My Home

NCDs	Non-Communicable Disease(s)
NDCHS	National Division of Community Health Services
NHIF	National Health Insurance Fund
OOP	Out-of-Pocket Expenditure
OTPs	One-Time Passwords
PCNs	Primary Care Network(s)
PHC	Primary Health Care
PHCNs	Primary Health Care Networks
PNC	Postnatal Care
POCUS	Point-of-Care Ultrasound
PPH	Postpartum Haemorrhage
PHEOC	Public Health Emergency Operations Centre
RCCE	Risk Communication and Community Engagement
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SCH	Sub-County Hospital
SCHMT	Sub-County Health Management Team
SDGs	Sustainable Development Goals
SHA	Social Health Authority
SMS	Short Message Service
SPICE App	Specialized EMR for Diabetes & Hypertension
TB	Tuberculosis
TBAs	Traditional Birth Attendant(s)
TOT	Training of Trainers
TV	Television
UHC	Universal Health Coverage
UHCC	Universal Health Coverage Coordinator
VSP	Vital Signs Profile
WITs	Work Improvement Teams

FOREWORD

Strengthening Primary Health Care (PHC) is central to Kenya's pursuit of equitable, people-centred, and responsive health services. The PCN approach provides Counties with a practical and sustainable framework to organize health services by linking community health units, primary health facilities, and referral systems.

This Special Edition captures practical, home-grown solutions to long-standing health system challenges: revitalisation of community health services; innovative models for Community Health Promoter (CHP) deployment and remuneration; digitisation of community data; integration of preventive, promotive and curative services at the primary level; strengthened referral systems; and multi-sectoral approaches that address the broader social determinants of health. These documented experiences show that Counties are not only implementing PHC but also re-imagining it to reflect local realities, resource constraints and community aspirations.

County-led initiatives highlighted in these case studies include strengthened community linkages, use of data and digital tools for decision-making, integration of diagnostic and outreach services, and locally driven financing and livelihood initiatives that support community health systems. These experiences emphasize the role of adaptive leadership, active community participation, and functional referral and coordination mechanisms in improving access to and utilization of primary health care.

As we celebrate the milestones documented in this 10th Special Edition, we are also reminded that much work remains. Persistent inequities in access, quality and financial protection, alongside emerging public health threats, demand continued innovation and collaboration. I call upon all stakeholders, within and beyond the health sector, to use the lessons and recommendations contained herein to deepen PHC implementation, and eventually accelerate Universal Health Coverage (UHC).

As a knowledge sharing and learning platform for County Governments, the Maarifa Centre remains committed to capturing and disseminating practical lessons from County implementation experiences. We hope this compendium serves as a valuable learning resource for Counties and stakeholders at different stages of PCN implementation.

We encourage readers to visit the Maarifa Centre website https://maarifa.cog.go.ke/ to access the full compendium, available for reading and download.

H.E. FCPA Ahmed Abdullahi, EGH
Chairperson
Council of Governors

ACKNOWLEDGEMENT

It is with great pleasure that I present this 10th Special Edition of the Compendium of County Best Practices and Innovations, focusing on the implementation of Primary Health Care (PHC) in the Lake Region Economic Bloc (LREB), Central, Coastal and Lower Eastern Counties. This edition, titled Investing in Patient-Centered Services: A Compendium of County Innovations and Best Practices on Primary Health Care Networks (PCNs) is a testament to the unwavering commitment of County Governments, health workers, communities and partners towards building a people-centred, equitable and resilient health system in Kenya.

Since the inception of devolution, Counties have been at the forefront of translating national health policies into context-specific actions that respond to the unique needs of their populations. Primary Health Care (PHC) is a strategic intervention aimed at accelerating Universal Health Coverage (UHC), specifically: bringing patient care closer to households; strengthening community health systems; and securing access, affordability and availability of services for all Kenyans. Across the four regions featured in this compendium, Counties are demonstrating that when PHC is prioritised, investments yield tangible improvements in health outcomes.

Undoubtedly, County Governments are on the right track. Their commitment to prioritising primary level services, including investments in community health, primary care networks, health workforce, commodities, and digital health, has made these best practices possible. I acknowledge the County Health Management Teams, Sub-County teams, facility in-charges and CHPs whose day-to-day dedication has turned PHC from a policy into lived reality in households, villages and urban settlements across the Counties.

As the CoG, we are deeply grateful to our development and implementing partners, civil society organisations, professional associations, faith-based organisations and private sector actors who have walked alongside Counties in designing, implementing and scaling these best practices. Their technical and financial support, as well as their flexibility in aligning with County priorities, has been instrumental in accelerating PHC reforms and innovations.

We sincerely appreciate Amref Health Kenya, Gates Foundation and the DANIDA PHC Support Programme for their invaluable support in documenting these success stories. Your partnership has significantly strengthened the production of this edition. We also extend our gratitude to all County officers who participated in the interviews that enabled the production of the edition. A special thank you for sparing your time and for all the information and data you generously provided. To the Knowledge Management and the Health Directorate teams, I recognize you for the hard work and commitment that went into generating all the PCN success stories. Asanteni sana and keep the momentum going!

To all our readers- enjoy this edition!

Mary Mwiti, EBS

Chief Executive Officer

INTRODUCTION

Primary Health Care (PHC) is the foundation of Kenya's efforts to achieve Universal Health Coverage (UHC). Under devolution, Counties are responsible for turning national PHC commitments into practical action that reaches households, communities and frontline facilities.

This compendium brings together 21 real experiences from Counties across the country, showing how PHC is being strengthened through practical, locally driven solutions. The stories encompass Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), routine immunisation, nutrition, non communicable diseases and community level preventive care. They demonstrate how Counties are using data for decision making, improving health financing, integrating digital systems, expanding diagnostic services and strengthening referral linkages within Primary Care Networks.

Several experiences highlight the power of community engagement. From zero home deliveries initiatives and father to father support groups, to community scorecards, kitchen gardens and savings models led by Community Health Promoters, the cases show how communities themselves are shaping better health outcomes. Others document system level improvements, including Geographic Information System (GIS) mapping of community units, hub-and-spoke PHC network implementation, Public Private Partnerships, portable ultrasound (POCUS) services and integrated care models for vulnerable populations.

Together, these experiences from Bungoma, Busia, Garissa, Kakamega, Kilifi, Kisumu, Kwale, Machakos, Makueni, Mombasa, Nakuru, Taita Taveta, Tana River, Tharaka Nithi, Uasin Gishu and Vihiga Counties provide practical lessons on what is working in Primary Health Care. They show that strengthening PHC is not about a single intervention, but about coordinated action across governance, financing, service delivery, community systems and partnerships.

This Special Edition captures these efforts as learning tools for Counties, policy makers and partners committed to ensuring that quality essential health services are accessible to every household.

SECTION

1

STRENGTHENING GOVERNANCE AND SYSTEMS FOR PRIMARY HEALTH CARE NETWORKS

Institutionalizing the Primary Health Care Vital Signs Profile to Strengthen RMNCAH Performance in Bungoma County

Introduction

Bungoma County is strengthening its Primary Health Care (PHC) system through the adoption of the Vital Signs Profile (VSP). The PHC-VSP is a standardized tool developed to enhance accountability and improve performance in health service delivery. It provides a clear picture of how health systems are functioning by tracking critical indicators in Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH). By simplifying complex data into a visual, easy-to-use dashboard, the tool has enabled the County to monitor progress, identify bottlenecks, and co-create solutions with stakeholders. Unlike many Counties that rarely proceed to the implementation level after trainings, Bungoma has institutionalized the use of the PHC-VSP, making it a key component of how health data is monitored, interpreted, and acted upon.

All County Governments were trained on the PHC-VSP as part of efforts to advance Universal Health Coverage (UHC) and strengthen accountability in PHC delivery. The tool was designed to provide a standardized approach to assessing service delivery, financing, and community engagement, with the goal of improving health outcomes for mothers, children, and adolescents. While progress has been uneven across the country, the VSP has been recognized as a practical entry point for evidence-based planning and resource allocation at the County level.

Bungoma successfully transitioned from training to full-scale application of the PHC-VSP. The tool has been embedded into its health management practices, used to convene multi-stakeholder review forums, and applied to guide financing and service delivery priorities. This has enabled the County to move beyond reporting, transforming the PHC-VSP into a driver of collaboration, transparency, and improved RMNCAH performance.

Implementation of the practice

In 2021, the Bungoma County Department of Health took the lead in rolling out the Primary Health Care Vital Signs Profile (PHC-VSP), moving beyond the national training phase into full-scale implementation. The process began with the development of a concept note to mobilize resources and secure buy-in from partners. With technical and financial support from Options, Mama Ye, and UNICEF, the County successfully deployed the tool across all 10 Sub-Counties.

The PHC-VSP was introduced as a County-wide performance management approach, focusing on RMNCAH indicators such as maternal and child mortality, service coverage, and financing allocations. Each quarter, health facilities and Sub-County teams submit data that is entered into a free and user-friendly dashboard. The dashboard works much like a scorecard which turns numbers into simple visuals such as charts, colour codes, and trend lines. For instance, if maternal deaths are reduced, the dashboard shows this in green; if immunization coverage is lagging, it flags the area in red. This helps both health experts and decision-makers quickly see where progress is being made and where urgent attention is needed.

A key feature of implementation has been the institutionalization of quarterly stakeholder review meetings. The discussions are based on the evidence presented in the dashboard. For instance, if the data shows a shortage of skilled birth attendants in one Sub-County, the team agrees on redistributing staff to cover the gap. Where financing shortfalls are identified, partners may commit additional resources where possible, or the County leadership documents the gaps for advocacy and future budgeting. If community uptake of services is low, local leaders are assigned the role of mobilizing households and creating awareness. These forums have created a new culture of collective problem-solving, where decisions are guided by evidence and responsibility is shared across all stakeholders.

To ensure consistency and scale-up, the County launched a PHC Vital Signs Profile Handbook in July 2022, providing structured guidelines for uniform adoption and use of the tool. Beyond reporting, the PHC-VSP has been embedded into routine County health management practices

and linked with the Primary Care Network (PCN) model to strengthen connections between community units and health facilities. This has seen the County transform the PHC-VSP from a simple monitoring tool into a management system that drives accountability, transparency, and evidence-based decision-making.

Results of the practice

The adoption of the PHC-VSP has delivered both immediate and long-term results for Bungoma County:

- The County is now able to identify gaps such as low immunization coverage or shortages of skilled staff in real time and as they emerge, rather than months later. This has allowed health managers to take appropriate measures to ensure continued service delivery.
- The dashboard has become a unifying tool, bringing together program officers, health workers, and implementing partners around shared evidence. This has fostered collective responsibility for results, rather than fragmented interventions.
- By simplifying complex data into visuals and trends, the tool has enabled both County and Sub-County leaders to understand performance easily and use it in planning and resource allocation, strengthening accountability at all levels.
- The VSP has made visible the financing gaps and allocation bottlenecks that were previously overlooked. While some gaps have been addressed immediately through partner support, others have been documented and used for advocacy with County leadership and the National Government.

Lessons learnt:

- Linking community health units with health facilities creates continuity of care and improves referrals in both directions.
- Over reliance on partner support risks undermining continuity. Counties must prioritize PHC allocations during budgeting processes.
- The involvement of communities, Civil Society Organizations (CSOs), and partners has not only improved advocacy but also strengthened support for County health initiatives.
- Organized community outreaches in target community settings reduces barriers to care and helps build rapport with households while enhancing access to services.
- Linking the PHC-VSP to broader systems ensures coherence, avoids duplication, and promotes sustainability.
- Irregular or delayed payments of Community Health Promoters (CHPs), have a negative impact on service delivery at the community level.

Recommendations:

- There is need to deepen the integration of the PHC-VSP into County health management systems so that the tool becomes fully institutionalized and not overly dependent on external support.
- Counties need to secure PHC budget lines to support scaling up of promising innovations in PHC to achieve expected health outcomes.
- It is important to increase and ring-fence budget allocations for PHC to sustain RMNCAH activities, reduce reliance on donor support to ensure continuity of services.
- Counties should institutionalize quarterly stakeholder review meetings as a routine practice to enhance transparency, accountability, and collective problem-solving.
- Counties should ensure timely remuneration of Community Health Promoters (CHPs) stipend through a structured system that keeps them motivated and effective in delivering community-level services.
- It is important to scale up and standardize the use of the PHC-VSP handbook to guide uniform adoption and support replication of the practice in other Counties.

Strengthening Primary Health Care through The Hub-And-Spoke Model: Machakos County, Kathiani Sub-County Primary Care Networks (PCN) Implementation

Introduction:

Kathiani Sub-county is one of the nine Sub-counties in Machakos County. It's among the two Primary Care Networks (PCNs) set up in the last one year. The Sub-county is committed to strengthening its healthcare delivery system, particularly in the management of Non-Communicable Diseases (NCDs), aligning with SDG 3.4 to reduce premature NCD mortality. In line with the national healthcare agenda to decentralize and enhance primary healthcare, as articulated in the Kenya Primary Health Care Strategic Framework 2019-2024 and the Bottom-Up Economic Transformation Agenda (BETA), the Sub-county has embarked on implementing a robust PCN strategy. This model establishes a "hub-and-spoke" system, where the Level 4 hospital serves as the central hub, and lower-level health facilities (five Level 3 health centers and fourteen Level 2 dispensaries) act as spokes. These facilities are intricately linked to twenty-eight Level 1 Community Health Units (CHUs), managed by four Community Health Assistants (CHAs) supervising Community Health Promoters (CHPs), forming the Level 1 component. The primary objective is to down-refer stable NCD patients from the higher-level facility to these more accessible community-based health facilities. This strategic devolution of care aims to improve patient access, reduce the burden on the Level 4 hospital, enhance continuity of care, and ultimately improve NCD management outcomes within the Sub-county.

This document details Kathiani Sub-county's PCN setup and implementation, which includes facility mapping, comprehensive capacity building initiatives (e.g., eCHIS, SPICE App training), establishing formalized referral pathways, ensuring resource availability, engaging the community through active household visits and action days and developing a robust monitoring framework utilizing health information systems. The initiative has yielded positive results such as improved patient access, a 30% reduction in hub congestion, and demonstrable improvements in NCD control rates. Lessons learned highlight critical challenges including securing sustainable funding beyond donor dependence, addressing human resource deficits, ensuring integrated interoperability of diverse Health Management Information Systems (HMIS) (Aphiaone, eCHIS, SPICE). It also aims at overcoming logistical barriers in the supply chain and other associated transport challenges. Recommendations emphasize sustained government funding, full e-health integration, and strategic human resource development for future growth and UHC attainment. This write-up outlines the implementation, results, lessons learnt, and recommendations from this critical initiative.

Implementation of the practice

The successful implementation of the PCN strategy in Kathiani Sub-county involved a multi-faceted approach, meticulously planned and executed in alignment with the Ministry of Health's guidelines for PCN establishment:

- **Facility Mapping and Categorization:**
  - ✓ Identified and mapped all public health facilities within the Sub-county, comprising Kathiani Level 4 Hospital as the designated hub, five Level 3 health centers, and fourteen Level 2 dispensaries as spokes.
  - ✓ These facilities are linked to twenty-eight CHUs at Level 1, overseen by four CHAs who supervise CHPs, forming the Level 1 component.
  - ✓ The mapping of hubs and spokes was performed during a baseline assessment, with linkage of spokes and CHUs managed by the County Health Management Team (CHMT), as documented in the 'Kathiani PCN baseline analysis report'.
- **Capacity Building and Training:**
  - ✓ Conducted comprehensive training programs for an estimated 150 healthcare workers (clinical officers, nurses) and 250 CHPs across the Sub-county in NCD management, leveraging established curricula.

Specific training initiatives included:

- ✓ eCHIS App Training: 290 CHPs were trained in March 2024 on the electronic Community Health Information System (eCHIS) for household registration and patient referrals.
- ✓ SPICE App Training: Facility Readiness Assessment was conducted in key Level 4 and Level 3 facilities, followed by Training of Trainers (TOT) and direct training for relevant healthcare workers on the SPICE App, an electronic medical record system for Diabetes Mellitus (DM) and Hypertension (HTN), implemented at Level 4 and Level 3 facilities (Mitaboni, Thinu, Kathiani Level 4, with planned rollout to Kaani and Ithaeni).
- ✓ NCD Guidelines Dissemination: 68 healthcare workers received training on updated DM/HTN guidelines.
- ✓ M&E Training: Four CHAs received training in May 2024 on monitoring and evaluation protocols for community health.
- ✓ CHP Foundational Training: The first phase of training for 30 untrained CHPs on basic modules occurred between June 18th-28th, 2024.
- ✓ Peer Support Group Formation: 20 individuals were trained to establish 6 peer support groups for DM/HTN patients across 6 facilities with support from KDDA.
- ✓ TB Program Trainings: Sensitization of 30 HCWs on DRTB new regimen and sensitization of Kaani CHPs on TB screening using eCHIS.

➢ **Standardized Referral Pathways:**

- ✓ Established clear, written referral and down-referral protocols within the Kathiani PCN network, designed to streamline patient movement from the Level 4 hub to Level 3 and 2 spokes.
- ✓ Standardized NCD care guidelines, including criteria for down-referral of stable patients, follow-up schedules, and emergency referral back to the hub, were developed and disseminated.
- ✓ Efforts included the sensitization of 285 diabetes and 242 hypertension clients on PCN structures and down-referral processes, leading to scheduling of NCD clinics at nearest Level 3 facilities, with increased down-referrals anticipated in 2025.

➢ **Resource Allocation and Supply Chain Management:**

- ✓ While essential NCD medications and basic diagnostic tools (e.g., glucometers, blood pressure monitors) are targeted for consistent availability at spoke facilities, the sub-county faces ongoing challenges with shortages in health products and commodities.
- ✓ The defined CHP kit is in place, with replenishment occurring monthly at linking Level 2 or 3 health facilities, though full implementation in most counties is an acknowledged challenge. Challenges in commodity management, particularly Malaria commodities, were identified during a 5-day support supervision. Shortages of BCG and Rotavirus vaccines were experienced in 2024 but are now stocked.

➢ **Proactive Community Engagement:**

Public awareness campaigns were conducted through CHPs, community meetings, and local media to inform residents about the PCN model and NCD self-management.

Key community engagement activities included:

- ✓ Ongoing household registration, currently at 98.2% as of September 2024, leveraging the eCHIS platform.
- ✓ 125 Action Days and 75 feedback meetings conducted since January 2024, with 23,360 household visits performed by CHPs between July and September 2024. A renewed focus on community engagements via "barazas" has been encouraged.
- ✓ Specific interventions included integrated school health programs (5 occasions, covering topics like Immunization, Health and Hygiene, Lifestyle choices, Childhood traumas), community sensitization on water treatment (3 sessions), and Hepatitis B/Schistosomiasis prevention (2 occasions).

- ✓ Commemoration of World Health Days: World TB Day (screening 112 individuals for TB, 6 GeneXpert samples taken), World Malaria Day, World Menstrual Hygiene Day, and World Breastfeeding Week.

- **Robust Monitoring and Evaluation:**
  - ✓ Developed a robust data collection system, including patient registers and standard Ministry of Health reporting forms (MOH 513, 514, 515, 521, 100), operational for NCD services at spoke facilities.
  - ✓ Monthly NCD data reporting rates from spoke facilities have increased from a baseline of 30% to over 85%, providing valuable insights for planning.
  - ✓ The Multi-Disciplinary Team (MDT) regularly evaluates the functioning of the PCN, and a dedicated research team has been formed to enhance data analysis and health research for evidence-based decision-making.
  - ✓ The eCHIS system alone facilitated 3,465 referrals by CHPs in July and August 2024, indicating improved data capture and referral efficiency at Level 1. Quarterly data review is recognized as a key area for improvement. All reports from Level 1 to Level 4 facilities are compiled and reported to the KHIS.

Results of the practice

The implementation of the PCN strategy has yielded significant positive results, both in terms of direct outputs and desired health outcomes, indicating progress towards achieving UHC goals:

Outputs:

- Patient Down-referrals: Over 70% of stable NCD patients previously managed at the Level 4 hospital have been successfully down-referred to their nearest peripheral Level 3 and 2 facilities for ongoing care, increasing patient volume at MOPC clinics within the spokes and demonstrably decongesting Kathiani L4 Hospital.
- Workforce Capacity: A total of 150 healthcare workers (clinical officers, nurses) and 250 CHVs across the Sub-county have received comprehensive training in NCD management. Specifically, 290 CHPs were trained on eCHIS, 4 CHAs on M&E, 68 HCWs on nutrition in DM/HTN, and 20 peer support group members were trained. The initial phase trained 30 untrained CHPs on basic modules. HCWs were sensitized on DRTB new regimen and TB screening using eCHIS.
- Digital Health Adoption: Over 85% NCD data reporting rates from spokes, with 3,465 eCHIS-facilitated CHP referrals (July-August 2024) demonstrating improved data capture and referral efficiency. Household registration stands at 98.2% via eCHIS, and the SPICE app is actively used in DM/HTN clinics across 4 facilities (Mitaboni, Thinu, Kathiani Level 4, Kaani).
- **Integrated Service Delivery:** Successful integrated outreaches (e.g., Eye/Dental screening for 9,123 clients with 5,928 glasses dispensed and 1,245 eye referrals, Cervical Cancer screening for 47 clients with 35 pap smears taken and 4 VIA VILIs which were all negative, comprehensive integrated outreaches reaching hundreds of clients) and public health campaigns (school health programs reaching 674 students on TB, water quality, hepatitis/schistosomiasis prevention). Immunization catch-up campaigns achieved 41% coverage despite initial vaccine shortages of BCG and Rotavirus in 2024.
- **Specialist Service Extension:** Decentralization of Mental Health (weekly at Mitaboni Level 3 Hospital) and Nutrition services (by the Sub-county nutritionist during MOPC clinic days) to Level 3 facilities. Consultations at Level 3 facilities have reduced patient transport expenditure to Kathiani Level 4.
- **Infrastructure Enhancement:** Operationalization of 3 new health facilities and upgrade of 1 dispensary in September, enhancing geographical accessibility.

- TB Control: 192 TB cases recorded in 2024, with 6 clinical DRT cases under treatment. A WHO-TB program visit to Kaviani Health Center showed good results in TB screening and documentation. School health talks on TB were conducted, reaching 674 students.
- Maternal and Child Health: 61% of 1st ANC visits were recorded, with 93% of mothers on ART and 91% viral suppression. 100% of mothers are testing for Syphilis and HIV. DEK support enabled 72 CHPs to refer 53 1st ANC clients in April. Vitamin A supplementation and deworming coverage increased from 50% to 89.9% in ECDE centers.

Outcomes:

- Enhanced Access and Continuity of Care: Patients report significantly reduced travel time and costs to access NCD services, leading to improved appointment adherence and continuity of care, fostering stronger patient-provider relationships at local levels.
- Hub Decongestion: The Level 4 hospital has experienced an estimated 30% reduction in NCD outpatient load, allowing for optimized allocation of specialized resources to complex and acute cases. Dr. Akim specifically noted the decongestion of MOPC clinics.
- Improved NCD Control: Preliminary data indicates positive trends in NCD control parameters, such as average blood pressure and HbA1c levels, attributable to consistent monitoring and treatment adherence facilitated by decentralized care.
- Increased Patient Satisfaction: Patient feedback surveys indicate higher satisfaction levels with the convenience and perceived quality of care at local facilities.
- Reduced Waiting Times: Shorter waiting times for specialized NCD clinics at the Level 4 hub.
- Public Health Gains: Vitamin A supplementation coverage increased from 50% to 89.9% in ECDE centers, and enhanced TB surveillance through eCHIS and nutrition clinics. Nutrition education is ongoing across populations.

Source of Data: Kathiani Sub-county Hospital

Lessons learnt:

The implementation process has generated critical insights into both successes and persistent challenges:

- Crucial Stakeholder Engagement & Formalization: While strong political will from County leadership and collaborative efforts with local community leaders, including the establishment of Multi-Disciplinary Teams (MDTs), have been vital (e.g., Dr. Nthusi presented PCN activities at the Machakos scientific conference, commending the MDT's work), the pending formal gazettement of the Kathiani PCN by the CHMT remains a key institutionalization bottleneck but will be overcome once the remaining PCNS are in place and all gazetted to reduce costs. SHA registration is ongoing, with 2 CHPs per facility facilitating.
- Sustained Capacity Building: Initial training, though comprehensive, is insufficient. Continuous mentorship (e.g., of Clinical Officers in OPD at L4 and L3 facilities), refresher courses, and support supervision (e.g., for commodity management, CHUs) are indispensable for maintaining competency and effective digital tool utilization. Targeted CMEs are encouraged for healthcare workers.
- Interoperability Challenges in HMIS: Despite improved data reporting, the lack of seamless interoperability between existing disparate HMIS platforms (Aphiaone, eCHIS, SPICE) creates significant data fragmentation and increases the workload on healthcare workers, impeding a unified "collect once, use many times" data paradigm. The need to incorporate the SPICE App with APhIA 1 through official requests via SCMOH to DNS has been identified. Low uptake of the SPICE App at Level 4 due to these challenges was noted, requiring further CME.
- Logistical and Infrastructure Deficiencies: Other challenges include irregular supply of essential medications and diagnostics, particularly in remote spoke facilities, leading to increased Out-of-Pocket (OOP) expenditure. A critical operational impediment is the severe scarcity of transport resources, notably ambulances and a dedicated MDT vehicle, which directly impacts emergency referrals, patient outcomes, and outreach efficacy

across challenging terrains. Shortage of small oxygen cylinders for spokes was also noted, requiring HMU support for servicing equipment. Sample networking for TB is a challenge due to lack of funding.

- Financial Sustainability & Resource Dependency: PCN financing, intended from national and County governments, remains heavily reliant on external partners (e.g., CIHEB, which suspended support due to funding issues).
- Human Resources for Health (HRH) Shortages: Significant deficits in healthcare workers across all cadres (clinical officers, nurses, medical officers, specialists) at Levels 2, 3, and 4, coupled with limited CHAs for CHU supervision, strain existing personnel and constrain service delivery capacity. Maintenance of equipment and machines needs a dedicated workplan for better service delivery.
- Mindset Transformation: Shifting ingrained patient and provider perceptions towards the efficacy and quality of care at lower-level facilities requires sustained communication and consistent positive reinforcement. This also includes focusing on mapping home visits and scheduling them.
- Research Integration: While a research team has been formed and abstracts submitted for conference presentation (e.g., on "Characterization of Lung Cancer patients attending the Cancer care Centre in Machakos level 5 hospital"), there is a recognized need for major research initiatives within the Sub-county to further guide decision-making, with members encouraged to take up research. Quarterly data review should be enhanced to inform decision making.

Recommendations:

- **To strengthen and scale Kathiani Sub-county's PCN, the following strategic and technical recommendations are paramount:**
  - ✓ Diversify and Sustain Health Financing:
  - ✓ Advocate for robust, dedicated, and sustainable budgetary allocations from both National and County Governments for PCN operations, NCD commodity procurement, infrastructure, and HRH to reduce over-reliance on partner funding. Add NCD diagnoses under primary health care services under the government insurance SHA/SHIF. To address facility health needs and strengthen availability of drugs.
  - ✓ Explore and integrate innovative financing mechanisms, including strategic public-private partnerships and optimized integration with the Social Health Insurance (SHI) package, to ensure predictable financial flows and minimize patient out-of-pocket expenses. Address funding challenges for sample networking for TB.
- **Accelerate Digital Health Integration and Interoperability:**
  - ✓ Prioritize investment in and mandate the full integration and interoperability of all existing HMIS platforms (Aphia one, eCHIS, SPICE) using Fast Healthcare Interoperability Resources (FHIR) standards. Implement the recommended integration of SPICE App with APhIA 1.
  - ✓ Establish a unified, secure data ecosystem aligned with the Kenya Digital Health Superhighway vision to enable real-time data exchange, comprehensive patient tracking, and evidence-based decision-making.
  - ✓ Ensure universal provision of mobile devices to CHPs and comprehensive capacity building for e-CHIS utilization, especially for Health facilities eg Ithaeni Health Centre and Kaani Dispensary.
- **Strategic Human Resources for Health (HRH) Development:**
  - ✓ Conduct a granular HRH needs assessment to quantify specific staffing gaps across all cadres within the PCN.
  - ✓ Implement aggressive recruitment and deployment strategies to fill critical HRH shortages at all facility levels (2, 3, 4).

- ✓ Develop and implement continuous professional development (CPD)-accredited training programs (e.g., virtual CMEs for clinical officers) and robust mentorship structures to enhance technical competencies and standardize care delivery. Targeted CMEs are crucial.
- ✓ Formalize sustainable remuneration and incentive models for CHPs and primary healthcare workers to improve motivation and long-term retention. Ensure a comprehensive workplan for servicing and maintaining equipment and machines.

➢ **Optimize Supply Chain and Logistics:**

- ✓ Implement robust supply chain management systems to ensure consistent, uninterrupted availability of essential NCD medications, diagnostics, and CHP kits at all spoke facilities, directly addressing stock-outs and reducing patient OOP costs. Ensure consistent supply of vaccines (BCG, Rotavirus).
- ✓ Prioritize procurement and deployment of adequate transport infrastructure, including dedicated MDT vehicles and additional ambulances, to ensure timely emergency referrals and effective outreach service delivery across the Sub-county's diverse terrain. Address the shortage of small oxygen cylinders for spokes.

➢ **Strengthen Institutionalization and Governance:**

- ✓ Expedite the formal gazettement of the Kathiani PCN by the CHMT to confer legal standing, clarify roles, and enhance accountability within the network.
- ✓ Formalize and strengthen feedback mechanisms between the hub and spokes, including regular multidisciplinary joint review meetings to enhance collaboration and coordinated patient care. Implement quarterly data review processes.

➢ **Expand Scope and Integrate Research:**

- ✓ Explore the feasibility of expanding the PCN model to encompass integrated management of a broader spectrum of chronic diseases and comprehensive primary healthcare interventions, guided by epidemiological data and community needs.
- ✓ Leverage the established research team to intensify health systems and operational research within the PCN, generating evidence on program effectiveness, cost-efficiency, and best practices for future scale-up and policy formulation. Encourage major research initiatives within the Sub-county.

Geo-spatial Information System (GIS) mapping of Community Health Units (CHUs) & spokes hubs to enhance access & linkage in delivery of Primary Health Care (PHC) in Kilifi County

Introduction:

Administratively, Kilifi County is divided into seven sub-counties and thirty-five wards and hosts 419 health facilities, including 156 public facilities. Despite this infrastructure, access to specialized and timely health services remains a challenge, with some residents traveling up to 120 kilometers to reach referral facilities. These barriers have contributed to delayed care, high out-of-pocket costs, and poor health outcomes, underscoring the need for equitable, networked primary health care delivery.

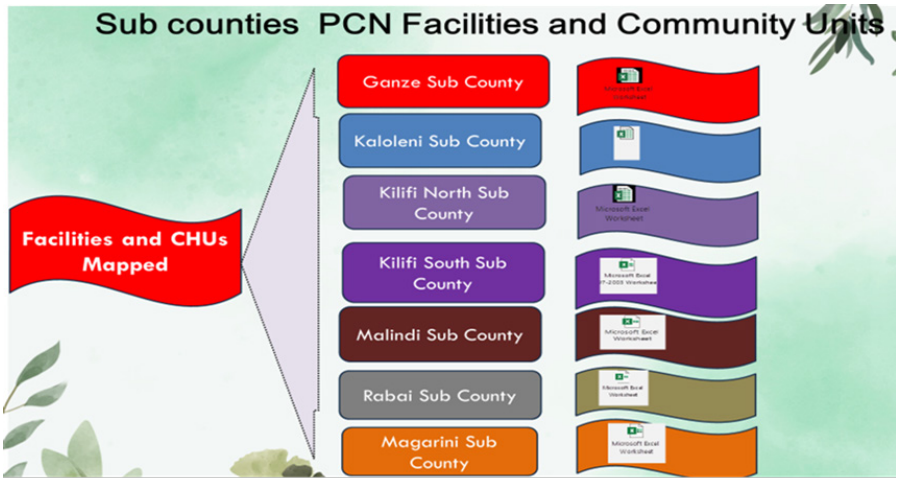
Implementation of the practice

The use of Geographic Information Systems (GIS) in healthcare, often termed Health GIS, is a powerful and effective tool that involves mapping, analysing, and interpreting health-related data in a geographic context to solve complex problems.

GIS as a tool in healthcare, is invaluable for ensuring that healthcare resources are distributed fairly and efficiently through the mapping of catchment areas of hospitals, clinics, and pharmacies. Geospatial mapping in health services is key in informing both the decision makers and the public on access as well as the challenges that prevent people from accessing health services.

To address systemic access gaps, the Kilifi County Department of Health Services adopted a GIS-enabled Primary Health Care strategy to map health services from level 1 to level 5 and operationalize a hub-and-spoke PHC network. GIS mapping was used to visualize Community Health Units (CHUs), spokes, and hubs, enabling evidence-based planning of referral pathways and outreach services.

- Mapping of Community Health Units (CHUs), spokes, and hubs to visualize service coverage and referral pathways across the County.
- To streamline coordination of primary health care services, Kilifi County Government through the Department of Health Services established seven PHC networks, each aligned with Sub-county boundaries. i.e. Ganze Sub-county, Kaloleni Sub-county, Kilifi North Sub-county, Kilifi South Sub-county, Malindi Sub-county, Rabai Sub-county and Magarini Sub-county as shown in the diagram below.
- Seven PHC networks aligned to sub-county boundaries were established, with 37 strategically located spoke facilities designated as MDT mini-hubs. Lower-level facilities were linked to these MDT sites for scheduled specialist outreaches, reducing travel distances and improving continuity of care.



Picture 1 Facilities mapped per sub-county

- The lower-level facilities were also linked to MDT sites for scheduled specialist visits, reducing the need for patients to travel long distances for care.

This model was designed to overcome the logistical limitations of deploying seven MDTs across 147 primary health facilities. By creating strategically located MDT sites, Kilifi County Government directorate of health services enabled efficient triaging, promoted referral, and delivered health services closer to communities.

Results of the practice

Using GIS to map health facilities by Kilifi County Government directly links to improved access to Primary Health Care (PHC) by turning geographical data into practical service-delivery decisions that reduce distance, delays, and fragmentation of care.

- GIS mapping identified where people live in relation to health facilities, clearly showing underserved and hard-to-reach areas. This allowed the County Government to reorganize PHC services based on actual population distribution and need, rather than administrative convenience, ensuring services were positioned closer to communities that previously travelled long distances. During the 2024/2025 financial year, 5,991 clients were served through MDT sites, with 85 referred to higher-level hubs for advanced care. Improved linkage between households, CHUs, spokes, and hubs led to earlier care-seeking, reduced travel time and costs, and improved client satisfaction. The County also optimized health workforce deployment, particularly Community Health Promoters, through coordinated outreach planning.
- GIS enabled the design of a functional hub-and-spoke PHC network by mapping Community Health Units (CHUs), lower-level facilities (spokes), MDT mini-hubs, and higher-level referral facilities (hubs). This clarified referral pathways from households to advanced care, reducing confusion, missed referrals, and unnecessary patient movement.
- By designating strategically located MDT mini-hubs using GIS evidence, Kilifi County Government brought specialized services closer to communities through scheduled outreaches. 5,991 clients accessed services locally, and only 85 required referral to higher-level hubs, demonstrating reduced travel distance, cost, and time for the majority of patients.
- GIS supported better coordination of health workers and outreach planning, particularly for Community Health Promoters and MDTs. This improved linkage between households, CHUs, and facilities, leading to earlier care-seeking, timely referrals, and improved client satisfaction—key indicators of enhanced access to PHC.

In summary, GIS transformed Kilifi's PHC system from a facility-centric model into a people-centred, networked system, where services are geographically aligned to need, referrals are predictable, and essential care is accessed closer to where people live.

Lessons learned:

- Geospatial mapping as a strategic enabler
  Geospatial mapping has proven to be more than a visualization tool as it is a strategic asset for health systems planning. By mapping Community Health Units (CHUs), spoke hubs, and MDT service points, Kilifi County Government directorate of Health Services was able to identify underserved areas and gaps in service delivery with precision and consequently prioritized infrastructure development and outreach based on population density and health burden. The initiative also supported the alignment of human resources and commodities with actual demand patterns. This data-driven approach also enabled more equitable resource allocation and improved responsiveness to community health needs.
- Network-enabled PHC delivery approach enhances system efficiency
  Organizing health facilities into a hub-and-spoke model has significantly strengthened referral pathways and continuity of care in Kilifi County. Specifically, Kilifi County was able to clearly delineate service roles across facility levels, hence reducing duplication while also improving triaging and case management from household to MDT sites. The initiative also enhanced collaboration among providers, fostering multidisciplinary care. This networked approach transforms isolated facilities into an integrated system, improving both efficiency and patient outcomes.

- Financing MDT outreaches requires long-term commitment and investment. While MDT outreaches have demonstrated impact in reaching marginalized populations, its sustainability hinges on dedicated budget lines within County health plans. Strategic partnerships with development actors and private sector Without predictable and adequate funding, MDT services risk becoming sporadic or donor-dependent, undermining continuity and scale.

In general, Geospatial mapping and classification of health facilities in Kilifi County has proven to be a powerful tool for identifying service gaps, enhancing linkages between health facilities and optimizing resource deployment for efficient service delivery. It is also worth noting the importance of network-based PHC delivery in strengthening referral systems and improving continuity of care.

Recommendations:

- It is recommended that the geospatial mapping is expanded to include the chronically ill patients for targeted follow-up.
- Institutionalization of sustainable financing mechanisms for PHC services at County level. The COG should advocate for the adoption and replication of the Kilifi County Model in running the PHC services to ensure continuity of services post donor-funding.
- It is important for County Governments to consider iinvestments in digital health platforms to support real-time data sharing, referral tracking, and performance monitoring.

From Paper to Digital: Mombasa County's Efficiency Gains in Primary Healthcare

Introduction:

The transformation of Kenya's healthcare sector hinges on the ability of primary health facilities to adopt digital systems that streamline service delivery, improve clinical outcomes, strengthen health products and technology through resource mobilization and allocation, and support real time decision making.

However, many facilities in Mombasa County including Magongo level II hospital in Changamwe, have long operated a paper-based health information systems that hinder operational efficiency affecting the quality of care. Paper records at Magongo level II hospital were prone to loss, damage and misfiling, compromising patient confidentiality and continuity of care. Manual processes slowed patient flow, increased waiting times and strained already limited human resources. The facility also faced challenges in generating timely, accurate data for planning and reporting, while physical storage space continued to shrink under the growing volume of documents. Several factors including environmental risks like moisture and pests further threatened the security of vital physical health records.

In response to these persistent challenges and in line with Kenya Digital Health Strategy (KDHS) and Universal Health Coverage (UHC) goals, the Magongo level II hospital through the Mombasa County health department, the facility-in-charge launched the digitization of primary healthcare services project. This innovative approach leverages on electronic systems to address inefficiencies, enhance patient management, and enable data driven resource allocation. Through a phased implementation of platforms such as Kenya Electronic Medical Records (EMR), SPICE App, and TaifaCare Health Management Information System (HMIS), the initiative is redefining how primary healthcare is delivered, managed and sustained at the community level.

In summary:

- ✓ **EMR** strengthens clinical care and patient management,
- ✓ **SPICE App** enhances frontline service delivery and community–facility linkages, and
- ✓ **Taifa Care HMIS** supports health system oversight, financing, and data-driven planning.

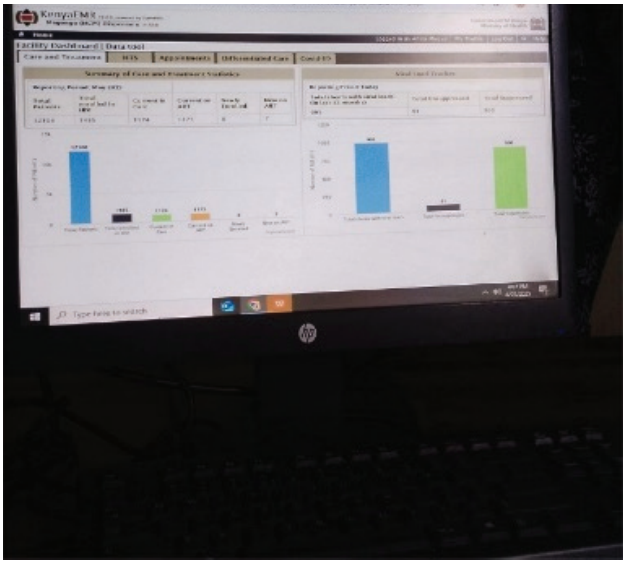
Together, these platforms create an integrated digital ecosystem that improves efficiency, accountability, and sustainability of primary healthcare services at the community level.

Implementation of the practice

Digitization was carried out through a phased and participatory implementation approach. It began with capacity building, where hospital staff and clinicians underwent rigorous medical education and hands-on training on the digitization process and use of digital tools. To ensure ownership and smooth rollout, a Digitization Technical Working Group (TWG) comprising hospital staff and clinicians was established to provide oversight, coordination, and on-site technical support.

Phase one, launched in February 2022, prioritized the digitization of health records for **People Living with HIV (PLHIV)** using the **Kenya Electronic Medical Records (EMR) system.** This involved transitioning from paper-based records to electronic patient files, including registration, clinical encounters, treatment regimens, and follow-up data. Focusing on PLHIV allowed the facility to pilot the system with a defined client group requiring continuous care, close monitoring, and strict data confidentiality. The phase improved the efficiency, accuracy, and accessibility of patient data, enabling better clinical decision-making, enhanced continuity of care, and improved treatment adherence.

Phase Two, implemented in September 2022, involved the **integration of the SPICE App** to digitize the management of **Non-Communicable Diseases (NCDs).** Building on lessons from the first phase, the facility expanded digital tools beyond HIV care to address the rising burden of chronic illnesses such as hypertension and diabetes. The SPICE App was deployed to support clinicians in capturing real-time patient data, monitoring disease progression, scheduling follow-ups, and strengthening referral and continuity-of-care mechanisms.

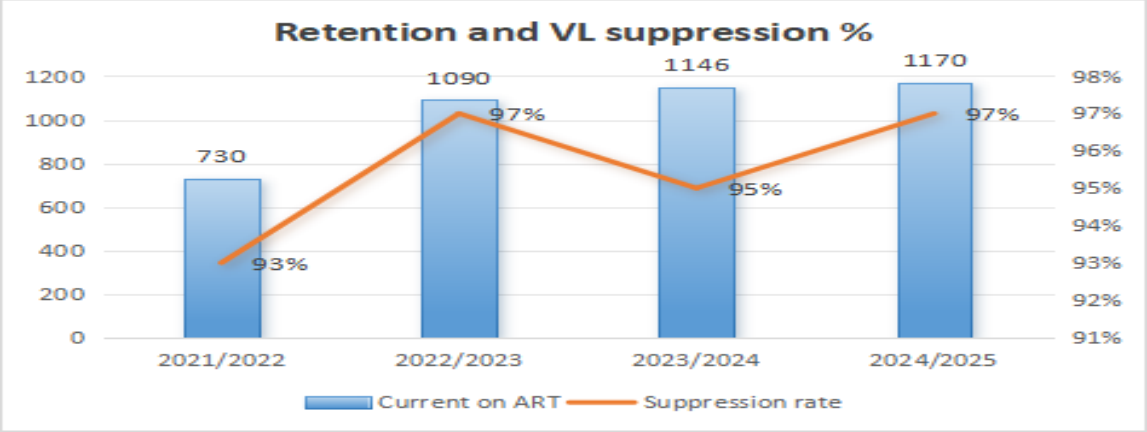


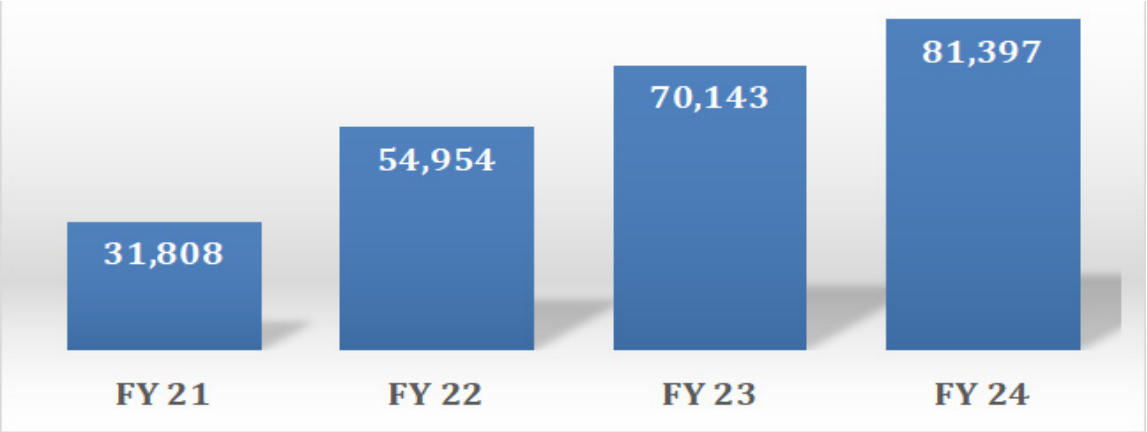
Through this integration, clinicians were able to systematically track NCD patients, document clinical encounters electronically, and monitor treatment adherence and outcomes over time. The digital platform improved clinical decision-making, reduced missed appointments, and enhanced data availability for planning and reporting. Overall, Phase Two marked a critical step in leveraging digital health solutions to improve NCD clinical care, patient management, and long-term treatment outcomes at the primary healthcare level.

Phase Three, which is currently ongoing, involves the implementation of the Taifa Care Health Management Information System (HMIS)—a national integrated digital platform designed to expand service coverage and support Universal Health Coverage (UHC). This phase focuses on integrating previously digitized services into a unified system that links patient registration, service delivery, reporting, and financing across multiple health needs.

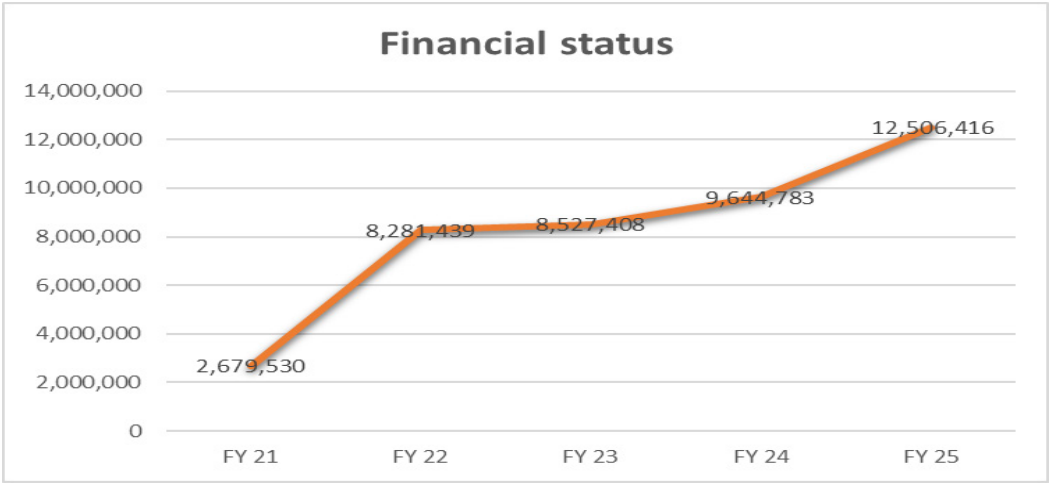
By consolidating facility- and community-level health data into a single national platform, Taifa Care HMIS enables seamless service coordination, continuity of care across departments, and standardized reporting aligned with national health priorities. The system also enhances scalability and interoperability, allowing the facility to efficiently expand digital services to additional programs while supporting data-driven planning, resource allocation, and performance monitoring. Overall, Phase Three represents a critical step toward sustained, integrated, and people-centered digital healthcare delivery.

Results of the practice



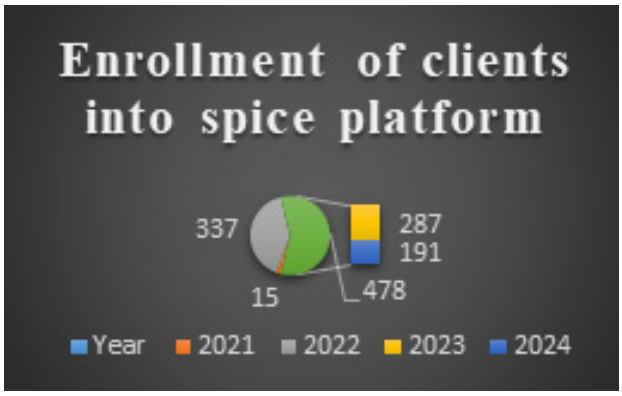


- ✓ **Increased facility workload:** The outpatients' visits in Magongo level II dispensary increased significantly from 31,308 in FY 2020/2021 to 81397 in FY 2023/2024 with improved patient flow and reduced waiting time from approximately 10 minutes to 5 minutes. (Source KHIS)
- ✓ **Boosted revenue:** Increased financial output from KES 2.6 million in 2021 to KES 12 million in 2025 from the increased workload catalysed by digitization initiative.
- ✓ **Evidence in improvement in delivery service:** The quality of health care services offered at the Magongo level II hospital improved significantly as evidenced by increased ART patient retention and viral load suppression



rates. ART retention rose from 730 patients with a 93% viral load suppression rate in June 2022 (prior to digitization) to 1,170 patients with a 97% suppression rate by May 2025. This performance surpasses the national viral load suppression average of 95.7% reported by NASCOP in 2024.

✓ **Real time access to patient care data, improving management and outcome for PLHIV, Diabetes and Hypertension patients**. With the introduction of SPICE App, for the first time the facility had real time data on cumulative number of hypertension and diabetes clients on treatment. In 2025 the facility was recognized among the only two facilities in Mombasa County that had consistently reported through the KHIS.



Picture 6: Enrolment of patients into the spice digital healthcare platform (Source, Spice App)

In 2021, the facility was among the 266 facilities in Kenya reporting Hypertension and Diabetes through KHIS. The number has since increased to 657 facilities in 2025.

Lessons learnt

- **Digitization improves care and outcomes:** Integrated digital platforms improved data quality, real-time access, and clinical decision-making, contributing to better chronic care management and improved ART viral suppression (93% in 2022 to 97% in 2025).
- **People and change management matter:** Continuous training, stakeholder engagement, and technical working groups were essential in overcoming resistance and embedding system use.
- **Integration drives efficiency:** Interoperable systems reduced silos, streamlined workflows, and enabled a unified, patient-centered view of care.
- Accountability and performance improved: Digital tracking enhanced financial transparency and resource management, increasing facility revenue from KES 2.6 million to KES 12 million.
- **Enablers and adaptability are critical:** Reliable infrastructure, phased data migration, system updates, and continuous monitoring ensured sustainability and scalability.

Recommendations:

- **Scale up gradually with stakeholder engagement:** Roll out digitization of health services should be in phases and include all stakeholders, from policymakers to frontline workers to ensure buy-in and smooth implementation.
- **Invest in digital infrastructure:** Budget allocations should cover not only software but also reliable power, internet connectivity, and hardware to ensure system continuity.
- **Strengthen continuous capacity building:** Ongoing training, mentorship, and peer support should be institutionalized to improve digital literacy and staff confidence.
- **Support data migration with clear protocols:** It is important to develop standard operating procedures (SOPs) for migrating data to ensure patient safety and service continuity during transitions.
- **Plan for Sustainability:** To sustain the digitization efforts health facilities should incorporate digital system maintenance, upgrades, and support in annual work plans and budgets under Facility Improvement Funds (FIF).

Integrated Care Delivery Strategy for Reducing the Non-Communicable Disease (NCD) Burden among Children and Young Adults in Low-Income Populations, Vihiga County

Introduction:

Vihiga County, located in Kenya's Western region, is a densely populated area with limited land resources, a largely rural population and growing urban centers such as Mbale, Luanda and Hamisi. Despite its small geographical size, Vihiga bears a disproportionately high burden of Non-Communicable Diseases (NCDs) compared to many neighbouring Counties. This trend has been driven by a combination of factors including genetic predisposition, changing dietary habits, sedentary lifestyles and low levels of preventive screening and early diagnosis.

The County's strategic position bordering Kisumu, Kakamega and Nandi Counties (regions with high prevalence of hypertension, diabetes, and sickle cell disease) has also contributed to its NCD burden through cross-border patient movement and shared socio-cultural practices. Over the past decade, Vihiga has recorded a steady rise in hypertension, diabetes, cardiovascular diseases and sickle cell disease, placing significant strain on its health system and exposing the need for a more structured approach to NCD prevention and management.

Before 2023, the County faced multiple systemic challenges in addressing NCDs. There was limited access to specialized care, with most patients relying on general outpatient services and frequently referred to higher-level hospitals in Kakamega and Kisumu due to the absence of trained personnel and diagnostic equipment. Detection and diagnosis rates were low, and NCD data reporting remained fragmented, with little or no reliable statistics on Type 1 diabetes or sickle cell disease.

Essential medications were often unavailable or unaffordable, forcing families to bear high out-of-pocket costs. Weak community awareness and entrenched cultural beliefs led to stigma and reliance on traditional remedies, particularly for sickle cell disease. The County also lacked structured referral systems, trained Community Health Promoters (CHPs) for chronic care follow-up and psychosocial support mechanisms for children and families living with NCDs.

These gaps underscored the urgent need for an integrated and specialized approach to NCD management, laying the foundation for the introduction of the Pen Plus Program at Hamisi Sub-county Hospital in 2023. Supported by the Ministry of Health, Vihiga County Government and the NCD Alliance, the initiative was designed to strengthen Sub-county capacity to manage severe and childhood NCDs, marking a turning point in Vihiga's health response to its growing NCD burden.

Hamisi Sub-county Hospital in Vihiga County is implementing the Pen Plus initiative, a specialized package for essential non-communicable diseases (NCDs) that focuses on severe conditions among children. The program, supported by the Ministry of Health, Vihiga County Government, and the NCD Alliance, is being implemented in Vihiga and Isiolo Counties as part of Kenya's national strategy to expand access to advanced NCD care at the Sub-county level.

Implementation of the practice.

The PEN-Plus Program is a program whose aim is to bring integrated care for severe chronic NCDs such as Type 1 diabetes, sickle cell disease, and heart conditions to first-level referral facilities, improving access to specialised services closer to communities in low-resource settings. At Hamisi Sub-County Hospital, the program commenced in 2023 as part of Kenya's effort to decentralize specialized NCD care to the Sub-county level. The initiative sought to strengthen Vihiga County's capacity to manage severe and childhood NCDs through integrated, patient-centered, and sustainable service delivery models.

Key steps taken included:

- Formation of a multidisciplinary team comprising clinicians, nurses, nutritionists, pharmacists, and laboratory technologists trained under the Pen Plus clinical package.
- Capacity building and mentorship for health workers to improve diagnosis, case management, and follow-up of severe NCDs such as Type 1 diabetes and sickle cell disease.
- Provision of essential diagnostic and monitoring equipment, including glucometers, HbA1c analyzers, and point-of-care devices to support accurate and timely diagnosis.
- Establishment of structured referral pathways from community to facility level, ensuring seamless patient linkage and continuity of care.
- Strengthening of data collection and reporting systems through integration of NCD indicators in the Kenya Health Information System (KHIS) and facility-level registers.
- Community engagement and sensitization through trained Community Health Promoters (CHPs) to enhance awareness, early detection, and adherence to treatment.
- Introduction of patient education and psychosocial support programs for affected children and families to reduce stigma and improve quality of life.
- Coordination with County leadership and partners, including the Ministry of Health and the NCD Alliance, to ensure resource mobilization and sustainability of services.

Results of the practice

Since the inception and implementation of the Pen Plus Program, Hamisi Sub-county Hospital has transformed into a vibrant hub for Non-Communicable Disease (NCD) care — bringing hope, healing, and specialized services closer to families in Vihiga County and beyond.

What has been achieved?

- A fully functional NCD clinic now runs dedicated days for Type 1 Diabetes, Sickle Cell Disease, Type 2 Diabetes, Mental Health and Cardiovascular Conditions, all under one roof.
- From zero, the hospital now cares for over 170 people living with Sickle Cell Disease and 27 children with Type 1 Diabetes receive consistent treatment and psychosocial support.
- Over 80 cardiovascular patients and 52 others with chronic conditions are enrolled and managed locally which means no more long trips to referral hospitals.
- Two facility staff members trained in cardiology, while others have gained new skills in NCD diagnosis, management and data reporting.
- A strengthened community referral network, powered by Community Health Promoters (CHPs) who spot cases early and link clients to care.
- A social support package ensures children get transport to clinic days and even school fee assistance, so illness doesn't mean dropping out.
- Peer support groups meet every month with safe spaces for patients to share experiences, build confidence and encourage each other.
- Regular community sensitizations are breaking myths and stigma around NCDs, making it easier for people to seek help early.
- Better data tracking now feeds into Sub-county and County health systems, helping decision-makers plan smarter.

In Vihiga County, specifically Hamisi Sub-County;

- Early diagnosis is now the norm, meaning fewer emergency referrals and faster recovery times.
- More patients are sticking to treatment, with improved quality of life for children and families managing chronic illnesses.
- Cultural barriers are fading, thanks to consistent education and community dialogue.
- Health workers are more confident and better equipped and Hamisi Sub-county Hospital is now recognized as a regional NCD Centre of Excellence, drawing patients from Kakamega, Nandi and Kisumu.
- With strong referral systems, patients receive specialized care and are smoothly reintegrated into follow-up at the Sub-county level once stabilized.
- The hospital's financial autonomy and partnerships with the Ministry of Health and the NCD Alliance are helping secure long-term sustainability.

Lessons learnt:

The experience of implementing an NCD dedicated program at Hamisi Sub-county Hospital has offered valuable lessons for strengthening NCD care at Sub-county level:

- Specialized NCD services can thrive locally. With the right training, equipment, and mentorship, Sub-county hospitals can effectively manage complex NCDs that were once only handled in referral facilities.
- Community Health Promoters (CHPs) are powerful change agents. Their close connection with households has improved early case identification, reduced stigma, and increased treatment adherence.
- Integrated social support is key. Covering transport costs and school fees for young patients has helped families stay engaged in care and reduced dropout rates from treatment and education.
- Peer support groups drive patient empowerment. Regular meetings build confidence, promote shared learning, and encourage long-term adherence to treatment.
- Continuous staff capacity building sustains quality care. Ongoing mentorship and refresher training for health workers ensure skills remain up-to-date and morale stays high.
- Community engagement transforms perceptions. Open dialogue with chiefs, religious leaders, teachers, and parents helps dismantle myths and cultural barriers surrounding chronic diseases.
- Strong partnerships enhance sustainability. Collaboration between the Ministry of Health, Vihiga County Government, and the NCD Alliance ensures consistent funding, policy alignment, and accountability.
- Financial autonomy accelerates progress. Allowing facilities to manage their own resources enables faster procurement of essential supplies and more responsive patient care.

In conclusion, the experience of Hamisi Sub-county Hospital under the Pen Plus Program demonstrates that specialized Non-Communicable Disease (NCD) care can successfully be decentralized to the sub-County level. What began as a small initiative has evolved into a model of integrated, patient-centered care; combining clinical excellence, community engagement, and social support.

Through strong collaboration between the Ministry of Health, the Vihiga County Government, and partners such as the NCD Alliance and Medtronic Labs, the program has strengthened health systems, built the confidence of healthcare workers, and brought life-changing services within reach of families once burdened by distance, stigma, and cost.

Today, Hamisi stands out as an emerging Centre of Excellence for NCD care, not only improving health outcomes for children and adults with chronic conditions but also inspiring other counties to adopt similar approaches. The success story of Hamisi proves that with commitment, partnership and innovation, Kenya can transform NCD management and ensure that no patient is left behind.

Digital Health Innovations in Kisumu County: Best Practices and Lessons for Strengthening Reproductive Health Outcomes

Introduction:

Kisumu County has steadily emerged as a model of innovation in reproductive, maternal and newborn health through its bold adoption of digital solutions that enhance continuity of care, strengthen community linkage, and empower mothers throughout their pregnancy journey. With 35 wards across the County, Kisumu has demonstrated how coordinated digital health interventions can transform service delivery. Our focus area, Kolwa East, comprising five wards, offers a compelling example of how technology, partnerships, and community engagement can converge to deliver better outcomes.

One of Kisumu's flagship innovations is the Wanda Electronic Health Record (EHR) platform, an AI-enabled digital tool designed to support expectant women by categorising them using a colour-coded risk system. This helps health workers quickly identify women who require close monitoring, follow-up, or early interventions. Through predictive analytics and continuous engagement, Wanda Health has strengthened triaging, improved response time, and supported more personalised care for mothers.

Complementing this is Safe-Mama Tech, a platform dedicated to ensuring timely attendance of antenatal and postnatal clinics. By sending automated reminders, tracking visit schedules, and flagging missed appointments, Safe-Mama Tech bridges gaps in follow-up and promotes continuity of care particularly for mothers who may face social or geographic barriers.

Kisumu has also integrated the Jacaranda Health digital prompts system, an evidence-driven platform that sends tailored messages to guide mothers through each stage of their pregnancy and postpartum period. The system reinforces key health messages, encourages early care-seeking, and provides timely alerts on danger signs. Its behaviour-change communication model has been instrumental in improving maternal knowledge, preparedness, and adherence to recommended care practices.

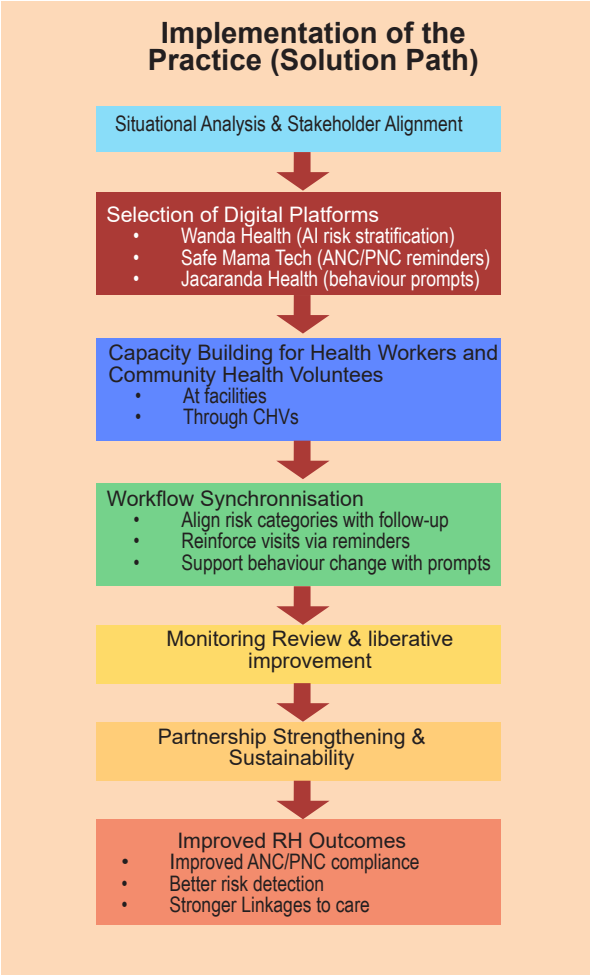
The strength of Kisumu's approach lies not only in the individual tools, but in how these platforms have been intentionally aligned to work together. Across Kolwa East, health teams, CHPs, facility staff, and digital partners collaborate to ensure that mothers are appropriately risk-stratified, reminded of key appointments, educated throughout their journey, and linked to care promptly when concerns arise. This synergy has resulted in better surveillance of maternal health risks, improved ANC coverage, reduced missed appointments, and stronger overall engagement between mothers and the health system.

Kisumu County's experience offers valuable lessons on the power of technology-driven coordination, multi-partner collaboration, and context-specific adaptation. By weaving together AI-enabled triaging tools, digital reminder systems, and personalised educational messaging, the county has created a supportive ecosystem that accompanies women from pregnancy to postpartum ultimately strengthening reproductive health outcomes and advancing progress toward eliminating preventable maternal and newborn deaths.

Implementation of the practice:

Kisumu County adopted a phased, coordinated approach to implementing its digital health interventions, ensuring that each solution was tailored to local needs while contributing to a unified reproductive health improvement strategy. The implementation in Kolwa East's five wards followed a structured pathway:

- **Situational Analysis and Stakeholder Alignment:** The County began with a comprehensive review of reproductive health trends, service utilisation patterns, and barriers affecting timely care. Through consultations with County leadership, sub-county teams, community units, and digital health partners, gaps in follow-up, risk identification, and maternal engagement were identified. This formed the foundation for selecting appropriate digital tools.



- **Selection and Integration of Digital Platforms:** Three complementary platforms—Wanda Health, Safe-Mama Tech, and Jacaranda Health's prompt system—were chosen for their ability to improve continuity of care at different touchpoints in the pregnancy journey.
  - ✓ Wanda Health was deployed to support AI-driven risk stratification using colour codes.
  - ✓ Safe-Mama Tech was introduced to strengthen adherence to ANC/PNC visit schedules through reminders and visit tracking.
  - ✓ Jacaranda Health was integrated to deliver personalised health messages and behaviour-change prompts.

Together, the platforms addressed clinical risk identification, service uptake, and informational support.

- **Capacity Building for Health Workers and CHPs:** Health care workers and CHPs across the five wards were trained on each digital platform, including data entry, interpretation of risk categories, and follow-up protocols. This ensured that the tools complemented, rather than replaced, existing workflows. CHPs played a critical role as the link between households and the health facilities.
- **Enrolment of Expectant and Postnatal Women:** Facilities and CHPs jointly enrolled mothers into the platforms during ANC visits, community outreach sessions, and household follow-ups. Women received orientation on the purpose of the platforms, the benefits of digital prompts, and how to engage with messages and referrals.
- **Synchronisation and Alignment of Workflows:** A key part of Kisumu's solution path was harmonising workflows across the three platforms.
  - ✓ Risk categorisation from Wanda informed follow-up intensity.
  - ✓ Safe-Mama reminders reinforced attendance for those flagged as high-risk.

- ✓ Jacaranda messages supported education and early detection of danger signs.

This synchronisation ensured seamless support from early pregnancy to postpartum.

- **Monitoring, Feedback and Iterative Improvement:** Sub-county teams in Kolwa East conducted regular reviews of utilisation data, risk categorisation trends, clinic attendance, and community follow-up outcomes. Feedback loops with digital partners helped refine algorithms, update message content, and adjust implementation strategies.
- **Strengthening Partnerships for Sustainability:** The County facilitated collaboration between the digital health partners, RH coordinators, CHAs, and community structures to ensure shared ownership. Development partners supported training, infrastructure strengthening, and periodic technical review meetings to sustain momentum.

Results of the practice:

The coordinated approach created a supportive ecosystem where expectant women received continuous, personalised, and timely care across multiple platforms—leading to improved ANC attendance, earlier detection of risks, stronger linkages to care, and enhanced responsiveness from health teams.

Lessons learnt:

- Digital tools strengthen PHC by improving early identification and follow-up of high-risk mothers.
- Reminder systems, such as "PROMPTS" help increase timely ANC and PNC visits at PHC facilities.
- CHPs are critical PHC actors, linking households to facilities and reinforcing digital messages.
- PHC teams make better decisions when they have access to real-time maternal data.
- Continuous mentorship of PHC staff improves accuracy, use, and ownership of digital tools.
- Coordinating partners at PHC level reduces duplication and improves continuity of care.
- Strong leadership at PHC and sub-county levels ensures smoother integration of digital solutions.

Recommendations:

- Encourage facilities and CHUs to discuss digital trends (missed visits, late ANC initiation, danger signs) during routine PHC review meetings to guide actions at facility and community levels.
- Use dashboard and KHIS trends to guide targeted mentorship visits—especially in facilities consistently showing gaps in ANC uptake, PNC coverage, or late referrals.
- Continue enhancing coordination between partners operating in the same PHC units
- Maximize on system data to identify specific villages or CHUs with low ANC attendance, high missed visits, or low early initiation—and plan targeted PHC outreach accordingly.
- While risk categorisation exists, strengthen the feedback from receiving facilities back to the PHC or CHP who initiated the referral to ensure continuity and reduce loss-to-follow-up.

Expanding Access to Sickle Cell Disease Care through a Primary Healthcare Model: Mwembe Tayari Dispensary Experience in Mombasa County

Introduction:

Sickle Cell Disease (SCD) is the most common inherited blood disorder in Kenya, representing a significant public health challenge with an estimated 4,000 children born with the condition every year. The prevalence and burden of the disease are not evenly distributed across the Country but are markedly higher in malaria-endemic areas, particularly along the Coastal belt, as well as in the Western and Nyanza regions. In these areas, the interplay between SCD and malaria further worsens health outcomes, contributing to increased morbidity and mortality rates among affected children.

Despite the growing burden, access to routine and specialized care for individuals living with SCD remains limited and unevenly distributed. Patients in underserved urban and peri-urban communities often face the greatest barriers. Many are forced to rely on overstretched high-level referral facilities where healthcare workers manage overwhelming patient volumes. This leads to long waiting times, overcrowded clinics, and reduced consultation periods, which can discourage patients and caregivers from maintaining regular follow-up visits that are essential for disease monitoring and management.

The challenges are compounded by the frequent unavailability of essential medications such as hydroxyurea, folic acid, and prophylactic antibiotics, as well as the scarcity of diagnostic services like haemoglobin electrophoresis. The lack of consistent supply chains and limited laboratory capacity hinder both early diagnosis and effective long-term management. For many families, financial constraints, inadequate health education, and social stigma surrounding the disease further limit their ability to access and adhere to care.

These systemic barriers highlight the urgent need for a decentralized, patient-centered approach that brings care closer to communities. Strengthening primary healthcare systems, training frontline health workers, and integrating SCD services into existing maternal and child health programs could significantly improve outcomes. By reducing reliance on overburdened referral hospitals and expanding access to essential drugs, counselling, and diagnostic services at the community level, Kenya can begin to address the inequities in care and improve the quality of life for individuals living with SCD.

Implementation of the practice

In recognition of the persistent barriers to quality Sickle Cell Disease (SCD) care, the Mombasa County Department of Health Services initiated a progressive intervention in 2022. This initiative was anchored on three foundational pillars: data-driven planning, capacity building, and service decentralization. The goal was to shift SCD management from overburdened referral facilities to more accessible community-level health centres, while ensuring that the model remained sustainable and responsive to patient needs.

Key steps taken included:

1. *Baseline mapping and community engagement*

A County-wide baseline study was conducted to generate accurate data on SCD prevalence, service gaps, and patterns of care-seeking behavior. The findings informed resource allocation and intervention design. Simultaneously, the County invested in community engagement by training Community Health Promoters (CHPs) to play a frontline role. They were equipped with knowledge and tools to:

- ✓ Identify common symptoms of SCD at the household level;
- ✓ Facilitate timely referrals to health facilities; and

- ✓ Provide continuous follow-up and psychosocial support for families.
- ✓ This approach strengthened the linkage between the community and the health system, ensuring early detection and reducing delays in care.

2. Strategic facility selection

Mwembe Tayari Dispensary was identified as the most suitable pilot site for the intervention. The facility's central location in Mombasa town, its accessibility by public and private transport, and its existing health infrastructure positioned it as a hub for SCD care. Its proximity to markets and residential areas further ensured that patients from both urban and peri-urban communities could access services conveniently, making it an ideal model clinic for decentralization.

3. Capacity building and benchmarking

To ensure clinical readiness, the facility's healthcare providers received targeted training in SCD management, counseling, and laboratory diagnostics. In addition, a benchmarking visit was organized to a leading SCD center in Nairobi, where staff observed best practices in patient management, multidisciplinary teamwork, and data systems. This exposure not only improved their technical capacity but also enhanced their confidence to manage SCD cases locally, reducing dependence on referral hospitals.

4. Service rollout (March 2023)

With systems and staff in place, the Mwembe Tayari SCD Clinic was officially launched in March 2023. The County Government publicized the SCD through public barazas and in mosques and churches across the County. The clinic began providing a comprehensive package of services tailored to the needs of patients and families. These included:

- ✓ Free health education sessions and psychosocial support, focusing on awareness, stigma reduction, and coping strategies for patients and caregivers.
- ✓ Routine laboratory tests such as haemoglobin levels and reticulocyte counts, which are essential for monitoring disease progression and treatment effectiveness.
- ✓ Provision of basic medications, including infection-prevention drugs, folic acid supplementation, and pain management therapies, ensuring continuity of care at no cost to patients.
- ✓ Specialized consultations and scheduled reviews, where complex cases were managed collaboratively with visiting haematologists and referral specialists.

This phased and structured rollout created a patient-centered care model that balanced accessibility with quality, laying the groundwork for replication across other facilities in the County.

Results of the practice

Metric	Value
Total Patients Enrolled	127
Female Patients	53%
Previously Diagnosed but Not on Care	88%
Transferred from Level 5 Facility	8%
Newly Diagnosed at Facility	4%
Stable Patients Seeking Routine Care	89%
Patients with Complications	6%
Patients on Interrupted Hydroxyurea	46%
Patients on Uninterrupted Hydroxyurea	39%
Patients Never on Hydroxyurea	15%
Enrolled in SHA (Social Health Insurance)	100%

The clinic has demonstrated strong uptake and impact within its first operational year:

Geographic reach

- ✓ Likoni Sub-county: 40%
- ✓ Kisauni/Nyali: 27%
- ✓ Changamwe/Jomvu: 20%
- ✓ Mvita: 10%
- ✓ Kilifi: 2%
- ✓ Kwale: 1%

(Source: Mombasa County Department of public health)

Uptake at the Mwembe Tayari Dispensary has been high with a total of 127 patients enrolled with 53% being female. 88% of the patients had been previously diagnosed but not on continued care while 8% were on continued care at a level 5 health facility but opted to continue with the care at this level while 4% are new patients diagnosed at the facility. 89% are stable patients seeking routine examination and refill of medications while 5% are not stable but with no complications while 6% have complications having scheduled consultant reviews at the facility. (Source: Mombasa County Department of public health)

46% are on interrupted Hyroxyurea, 39% on uninterrupted Hyroxyurea while 15% have never used Hyroxyurea. 40% come from Likoni sub-county, 27% from Kisauni/Nyali sub-counties, 20% from Changamwe/Jomvu sub-counties, 10% from Mvita sub-county, 2% from Kilifi County and 1% from Kwale County. 100% have been enrolled to SHA. (Source: Mombasa County Department of public health)

Lessons learnt:

- ✓ **Decentralized care works:** Locating SCD services within a primary healthcare facility significantly improves access, especially for financially constrained patients. The Sickle Cell Disease clinic has provided an easy access to care for patients with the condition.
- ✓ CHPs play a key role in identification and referral which is very instrumental in early diagnosis, referrals and continuity of care.
- ✓ Hydration and supplementation matter in managing sickle cell disease. This is because even patients not on daily Hydroxyurea have shown reduced crisis episodes when supported with proper hydration and nutritional supplements.
- ✓ Likoni Sub-county needs targeted expansion: The high patient concentration from Likoni signals a need for localized replication.

Recommendations:

- ✓ It is necessary to expand diagnostic capacity at the clinic by equipping it with comprehensive laboratory tools for full SCD profiling.
- ✓ There is need to ensure drug availability at the clinic. It is important to maintain a consistent supply of essential medications, including Hydroxyurea and pain management drugs.
- ✓ Strengthening referral pathways by developing clear protocols for escalating cases to higher-level facilities when inpatient care is needed is very important.
- ✓ It is important to establish a digital County registry for SCD patients to support continuity of care, data-driven planning, and national integration.
- ✓ Replication of the model is highly recommended. Rolling out similar clinics in other Level 2 facilities, prioritizing Likoni and other underserved sub-counties will go a long way in ensuring routine care of SCD patients in Mombasa County and other neighboring Counties like Kwale that seek these services from Mombasa County.

In conclusion, this initiative by Mombasa County Government department of public health aligns with Kenya's Universal Health Coverage (UHC) goals by decentralizing specialized care and reducing the burden on tertiary hospitals. It also offers a replicable model for other Counties seeking to integrate NCD care into primary health systems.

SECTION

2

COMMUNITY ENGAGEMENT AND PEOPLE-CENTRED PRIMARY HEALTH CARE

Integrating Risk Communication and Community Engagement into Primary Health Care: The Case of Mpox in Busia County

Introduction

Busia County is one of the busiest cross-border trade hubs in East Africa. It shares a long border with Uganda and has two official entry points (Busia and Malaba) as well as over 20 informal crossing points used daily by traders, travelers, and communities on both sides. The towns of Busia and Malaba host thousands of long-distance truck drivers, traders, travelers, and business operators who interact closely with residents in markets, restaurants, and social spaces. While this vibrancy drives economic growth, it also increases the County's vulnerability to cross-border transmission of infectious diseases.

The porous nature of the border, combined with high human mobility and weak community-level surveillance, has made Busia a high-risk hotspot for the introduction and spread of Mpox. Recognizing these risks, Busia County prioritized strengthening its public health response through Risk Communication and Community Engagement (RCCE), aimed at equipping communities with the knowledge and tools to prevent and contain the spread of the disease.

Background

Mpox, formerly known as Monkeypox, is a viral zoonotic disease caused by the Monkeypox virus, belonging to the Ortho poxvirus genus. The disease is primarily transmitted through direct contact with infected individuals, contaminated materials, or infected animals. Human-to-human transmission occurs via close physical interaction, including skin-to-skin contact, respiratory droplets, or contact with body fluids. Pregnant women can also transmit the virus to their unborn children, and newborns may be infected during or after birth.

Typical symptoms include fever, muscle aches, swollen lymph nodes, headaches, fatigue, and a distinctive skin rash or lesions that may last 2–4 weeks. While most patients recover, severe cases and deaths can occur, especially among immuno-compromised individuals. Globally, Mpox has been designated as a public health emergency of international concern due to its rapid cross-border spread.

In Kenya, the first confirmed Mpox case was reported on 22nd July 2024, involving a 42-year-old truck driver at the Taveta One-Stop Border Point who had travelled from Uganda. Following this, the Ministry of Health (MoH) declared a national outbreak on 31st July 2024. Given Busia's heavy cross-border movement and high-risk groups, including truck drivers, sex workers, traders, and hospitality workers, the County was identified as a potential hotspot for rapid local transmission.

Aggravating the risk was low public awareness and widespread myths and misconceptions about Mpox, which led to stigma, misinformation, and reluctance to seek healthcare. Many community members lacked accurate knowledge on how Mpox spreads, its symptoms, or how to protect themselves and their families. This knowledge gap threatened to undermine prevention and control measures, creating an urgent need for structured RCCE interventions that could bridge information gaps, build trust, and promote behavior change at the community level.

Implementing Risk Communication and Community Engagement (RCCE) for Mpox Prevention and Control:

Busia County Government adopted a phased and inclusive approach to Mpox Risk Communication and Community Engagement (RCCE), ensuring that both technical teams and communities were actively involved from the start. The process ran from December 2024 to March 2025 and covered all eight sub-counties.

Picture 1: Training of Healthcare workers on Mpox Risk Communication and Community Engagement (RCCE)

The first step was to strengthen the skills of frontline teams. Health workers, Community Health Promoters (CHPs), and County RCCE staff were trained on Mpox symptoms, transmission, case management, and effective communication strategies. These trainings equipped them not only with clinical knowledge but also with skills to counter misinformation, address community fears, and build trust. For instance, CHPs were guided on how to deliver Mpox messages during household visits in a culturally sensitive manner.

Recognizing that disease control requires collective effort, Busia County organized multi-level stakeholder forums. Meetings were held at the County, sub-county, and ward levels, bringing together National Government administrators (chiefs, assistant chiefs, and village elders), religious leaders from churches and mosques, representatives of youth and women groups, Civil Society Organizations and high-risk populations, including truck drivers and sex workers. These forums helped to build ownership, align messages, and create a common understanding of the Mpox threat. Religious leaders, for instance, became trusted champions who shared prevention messages with their congregations, while administrators integrated Mpox awareness into barazas and community meetings. The County has further developed an MPOX Emergency and response plan which is being implemented and tracked on a regular basis.

A RCCE plan was developed to guide community interventions. Activities were tailored to reach different audiences through multiple communication channels:

- Radio talk shows: Local radio stations such as Busia Border Radio and Western Nyota Radio hosted interactive talk shows where health experts responded to live questions from listeners. This created an open space for dialogue and allowed myths and misconceptions to be addressed in real time.
- Peer education: Given their high exposure risk, truck drivers and sex workers were trained as peer educators. These peer champions used their social networks to spread accurate information, identify suspected cases, and encourage timely referrals.
- Community dialogues: Dialogue forums were held with boda boda operators, market traders, and women leaders, creating safe spaces to discuss fears and co-develop prevention strategies.
- Household visits: CHPs reached thousands of homes, engaging families directly in conversations about Mpox prevention, early signs, and the importance of seeking care. This approach personalized the messages and ensured they reached even those without access to mass media.

Alongside information campaigns, RCCE activities strengthened community-based surveillance. CHPs and peer educators were trained to recognize symptoms, report suspected cases, and work with the County Rapid Response Team for follow-up. This integration of RCCE with surveillance ensured that communities were not just informed but actively participated in identifying and reporting cases.

Results of Implementing RCCE Interventions:

The RCCE campaign in Busia County led to significant reach and community engagement across different groups and platforms. The key achievements are summarized below:

Table 1 Data on RCCE campaigns conducted by the County Department of Health

	RCCE activities conducted	Number reached
1	Healthcare workers trained	286
2	County Mpox stakeholders reached	30
3	Sub County stakeholders reached	240
4	Radio talk shows conducted	10
5	CHPs trained	2190
6	Ward level stakeholders reached	875
7	High-risk group members reached	720
8	Active surveillance and contact tracing	168
9	Households reached with Mpox messages	16,307
10	Peer educators trained	40

Lessons Learnt

- Increased knowledge on Mpox signs and symptoms empowered community members, peer educators, and CHPs to identify and refer suspected cases early.
- Active participation of local leaders, peer educators, and households strengthened trust in the health system, reduced misinformation, and promoted behaviour change.
- With proper information, communities became effective "eyes and ears" on the ground, supporting surveillance and reporting mechanisms.
- As awareness campaigns intensified, more cases were identified and referred, proving that RCCE is not just about information sharing but a vital disease-control tool.

County Mpox statistics as of 6th June 2025

	Indicator	Value
1	Total cases detected	44
2	Total deaths	1
3	Recovered	37
4	Total tests done	82
5	Positivity rate	54%
6	Total admitted	1
7	Home based isolation	5
8	Total active contacts	0
9	Total contacts traced	186

Recommendations

- Adopting RCCE as a frontline strategy in responding to outbreaks and public health emergencies is essential for strengthening both prevention and control efforts.
- There is need for continuous community awareness initiatives to improve case search, promote early detection, and sustain positive behaviour change and practices aimed at preventing Mpox transmission.
- There is need to integrate sustainability strategies for RCCE, including community feedback mechanisms, to ensure long-term effectiveness beyond the outbreak period.
- Utilization of both visual and culturally relevant communication materials that keep prevention messages alive and accessible to all segments of the community enhances prevention and control of Mpox.
- Sustainability of RCCE activities even during the inter-epidemic periods supports early case identification and builds resilience against future outbreaks

Photo Gallery

Picture 3: Stakeholders meeting held in Teso North

Picture 2: Community engagement session on Mpox awareness

Picture 3: Busia Border Radio talk show on Mpox awareness

Picture 6: Radio talk show on Western Nyota Radio

Community Scorecards Transform Health Service Delivery in Kisumu County

Introduction:

St. Marks Lela dispensary, located in Kisumu County, began as a Level 2 health facility and has since been upgraded to a Level 3 health facility (health centre). It serves a catchment population of approximately 12,000 people. The health facility has three Community Health Units (CHUs) linked to it, i.e. Lower Korando, Upper Korando, and Otonglo. The facility offers a range of health services, including Outpatient Services (OPD), special clinics, laboratory services, maternal, newborn and child healthcare services and pharmacy services.

The facility is overseen by a Health Facility Management Committee, which represents the broader community. This committee is involved in the budgeting process, approves expenditure, and acts as a bridge between the facility and the community.

Previously, the lack of structured feedback channels posed a significant challenge, and communities had no formal mechanism to voice their concerns, while health providers received little meaningful data on patient experiences. This created a cycle that frustrated residents who avoided clinics, leading to worsening health outcomes and further strain on the health system.

To address this, the County Government of Kisumu, through the Health Facility Management Committee led efforts to conduct community dialogue sessions to provide a platform for community, service providers and local stakeholders to express their health concerns, and collaboratively develop solutions geared to improve health services within the facility. During these discussions, the health facility identified widespread dissatisfaction with some of the services provided. Key challenges included understaffing which left health workers overburdened and demotivated, persistent medicine stock-outs due to weak supply chain management, and limited infrastructure budgets that left the health facility without basic security measures such as perimeter fencing.

These findings highlighted the need to conduct a Community Scorecard (CSC) assessment to enhance service delivery. The CSC is a structured tool that enables community members to evaluate health services, similar to a "report card", and facilitates joint planning for improvements. Similar approaches have yielded positive results in other Counties, such as improved clinic cleanliness in Makueni and reduced maternal mortality in Nakuru. However, common challenges remain, including resistance to feedback from health workers, fear of victimization and sustaining community engagement over time.

Implementation of the practice

The initiative was rolled out by the County Government of Kisumu in 2020. However, it faced challenges due to the lack of national guidelines with a common set of performance indicators. The Community Scorecard (CSC) guidelines were thereafter developed in 2021 to provide standard operating procedures for promoting transparency, action, and accountability in the collection, interpretation, and use of information from service users in the health and related sectors.

During the Financial Year 2022/2023, the DANIDA PHC program supported the facility through training, organizing community dialogue meetings, and implementing preventive and promotive interventions. Other activities supported by the program included dialogue days, action days, integrated outreaches, payment of incentives to Community Health Promoters (CHPs), household visits, and data review meetings. During these meetings, the top diseases affecting the community, such as skin infections, upper respiratory tract infections (URTIs), malaria, and diarrhea, were reviewed. The program also supported Reproductive, Maternal, New-born, Child, and Adolescent Health (RMNCAH) trainings and referrals from the community to the facility.

Picture 1: Targeted dialogue on ANCs and immunization of U5s held in Jan 2025

At the facility level, the process began with a 3-days training of Community Health Committees (CHCs) on how to use the Community Scorecard. The training enabled them to guide discussions and collect feedback from community members about health services provided at St. Marks Lela Health Centre.

During the community scorecard session, the community members openly shared their perspectives and experiences concerning the quality and accessibility of health services. Health workers from the facility, along with representatives from the Sub-County Health Management Team, and other partners, actively participated in the discussions, listening to community concerns, responding to questions, and collaboratively working toward practical solutions.

The CHCs then led scoring sessions where community members rated the health services based on things like the quality of healthcare services, availability of drugs and diagnostics, responsiveness to community needs, and assessment of health insurance among other 9 indicators scored. This gave a clear picture of the main issues and strengths in the health system.

A feedback meeting followed up at the facility to review the results of the scorecard where it includes the HFMC, the facility staff and some members of SCHMT were present and scores were given with explanations of the on the scoring by the community members.

Thereafter, a community scorecard interface session was conducted which brought stakeholders, including health workers, community members, CHCs, and partners who worked together, to develop an action plan. They agreed on what needed to be done, who would do it, and when. This would be then monitored on a quarterly basis.

Community Health Promoters (CHPs) played a key role in follow-up activities, including:

- Weekly household visits to offer health education and minor treatment;
- Tracing children and pregnant women who missed vaccines or check-ups (defaulter tracing); and
- Referring people to the facility for further care.

This approach brought the community and health providers closer together. It encouraged open conversations, joint problem-solving, and stronger ownership of health services. Today, the CHCs continue to lead quarterly meetings to check on progress and keep the community involved in improving healthcare.

Results of the practice

- Outpatient visits at the facility rose significantly from 100 to 450 clients per month indicating growing community trust in the health facilities and its services. Antenatal care (ANC) attendance and community referrals also increased. To improve service delivery, the health facility introduced a Service Charter and reduced waiting times by involving Community Health Promoters in a revolving manner in triage at the registration desk.

Picture 4: An immunization outreach held at Kateng' village.

- Facility staff now actively participate in community meetings, action days, and dialogues, listening to concerns and co-creating solutions. Community members feel empowered to give feedback, which is taken seriously. Quarterly community scorecard follow up sessions are held, followed by updating the joint action planning between CHCs and health workers. Support groups formed during these sessions continue meeting for up to a year, sharing health information and promoting community-led solutions.
- To ensure safety and better service delivery, the health facility constructed a secure perimeter fence. A dedicated CHP desk was also established to support client registration and track community referrals.
- Trained CHCs now lead scorecard sessions, facilitate community dialogues, and help address local health challenges. CHPs conduct household visits, provide health education, offer minor treatment, and trace defaulters, especially among children and pregnant women. Their increased visibility and effectiveness have earned them greater recognition and trust within the community.
- Quarterly dialogue and scorecard follow up sessions are now institutionalized and supported by trained CHCs. The model has been successfully replicated in other wards, using existing local structures such as schools and village leadership. This approach ensures sustainability and minimizes costs.

Lessons learnt:

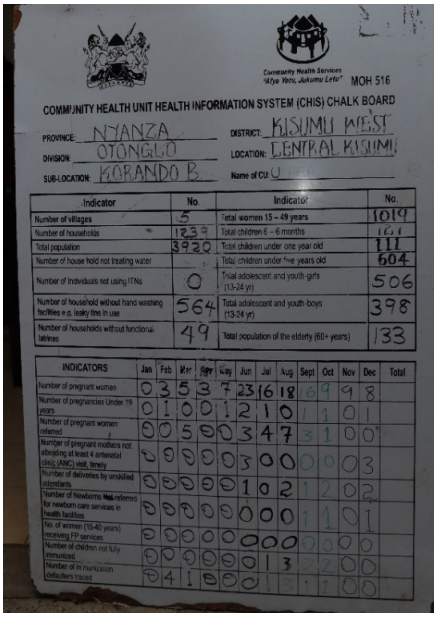
- Community meetings proved to be an affordable yet a powerful tool for raising awareness and driving behaviour change.
- Integrating services like treatment, immunization, and health education during outreach activities is effective in improving access and utilization of these services efficiently.
- As trust in health services increased, more people began seeking care early, leading to better maternal and child health outcomes.
- Active community participation in healthcare decisions has fostered a sense of ownership and accountability.
- Developing shared work plans between health facilities and communities has improved service delivery, strengthened partnerships, and changed health-seeking behaviour.
- Well-trained CHPs significantly improve service delivery and positively impacted key health indicators.
- When equipped with essential supplies, CHPs effectively manage minor ailments at the community level, reducing the burden on health facilities.
- CHCs, supported by Health Facility Management Committees (HFMCs), can effectively lead scorecard sessions and provide feedback that helps facilities respond to the community needs.
- Sustainable health interventions require continuous, meaningful engagement and ownership from the community.
- Tools like the Community Scorecard enable communities to assess service quality, identify gaps, and hold providers accountable.

Building lasting relationships with local health authorities and communities is key to sustaining progress and scaling impact.

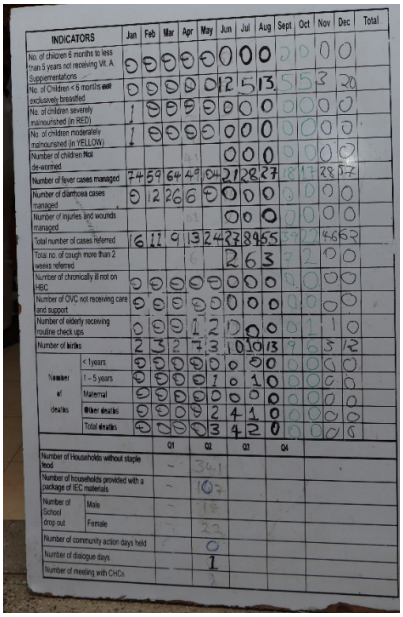
Recommendations:

- Increased allocation of resources to scale up the initiative and ensure additional Community Health Units (CHUs) benefit from similar support.
- Deepen community participation by enhancing dialogue forums, empowering Community Health Committees (CHCs), and maintaining continuous feedback mechanisms.
- Provide ongoing training, incentives, and a supportive work environment to motivate Community Health Promoters (CHPs) and ensure long-term commitment. Expand supportive supervision structures.
- Conduct more integrated outreach activities and health education programs to address diverse community health needs and improve service reach.
- Collaborate with local NGOs, women's groups, and faith-based organizations to mobilize communities and promote inclusive health initiatives.
- Organize exchange programs with other Counties to share best practices, enhance skills, and promote innovative community health solutions.
- Improve funding mechanisms to enhance service delivery and boost CHP motivation and performance.
- Create forums for Counties to share evidence-based interventions and lessons learned, fostering innovation and collaboration.
- Broaden the scope of DANIDA PHC Level 1 support to cover more community units and improve access to basic care.
- Implement targeted initiatives to increase male participation in community health and family support.
- Work towards universal registration of community members under the Social Health Authority (SHA) to ensure access to essential health services.

Photo Gallery


Community Health Services
"Afya Yetu Jukumu Letu"
MOH 516
COMMUNITY HEALTH UNIT HEALTH INFORMATION SYSTEM (CHIS) CHALK BOARD
PROVINCE: NYANZA
DISTRICT: KISUMU WEST
DIVISION: OTONGLO
LOCATION: CENTRAL KISUMU
SUB-LOCATION: KORANDO B
Name of CU: U
Indicator | No. | Indicator | No.
Number of villages | 5 | Total women 15 – 49 years | 1019
Number of households | 1239 | Total children 6 – 6 months | 161
Total population | 3920 | Total children under one year old | 111
Number of house hold not treating water | | Total children under five years old | 604
Number of individuals not using ITNs | 0 | Total adolescent and youth girls (13-24 yr) | 506
Number of household without hand washing facilities e.g. leaky tins in use | 564 | Total adolescent and youth boys (13-24 yr) | 398
Number of households without functional latrines | 49 | Total population of the elderly (60+ years) | 133
INDICATORS | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Total
Number of pregnant women | 0 | 3 | 5 | 3 | 7 | 23 | 16 | 18 | 6 | 9 | 9 | 8 |
Number of pregnancies Under 19 years | 0 | 1 | 0 | 0 | 1 | 2 | 1 | 0 | 1 | 1 | 0 | 1 |
Number of pregnant women referred | 0 | 0 | 5 | 0 | 0 | 3 | 4 | 7 | 3 | 1 | 0 | 0 |
Number of pregnant mothers not attending at least 4 antenatal clinic (ANC) visit, timely | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 3 |
Number of deliveries by unskilled attendants | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 1 | 2 | 0 | 2 |
Number of Newborns Not-referred for newborn care services in health facilities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 |
No. of women (15-40 years) receiving FP services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
Number of children not fully immunized | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 3 | 1 | 2 | 0 | 0 |
Number of in Immunization defaulters traced | 0 | 4 | 1 | 0 | 0 | 0 | 1 | 3 | 1 | 2 | 0 | 0 |

Picture 5: A photo of the Community Health Unit Health Information System (CHIS) Chalk Board


INDICATORS | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Total
No. of children 6 months to less than 5 years not receiving Vit. A Supplementations | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
No. of Children < 6 months old exclusively breastfed | 0 | 0 | 0 | 0 | 0 | 12 | 5 | 13 | 5 | 15 | 3 | 20 |
No. of children severely malnourished (in RED) | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
No. of children moderately malnourished (in YELLOW) | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
Number of children Not de-wormed | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
Number of fever cases managed | 74 | 59 | 64 | 49 | 104 | 21 | 28 | 27 | 18 | 11 | 28 | 12 |
Number of diarrhoea cases managed | 0 | 12 | 26 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
Number of injuries and wounds managed | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
Total number of cases Referred | 6 | 11 | 9 | 13 | 24 | 37 | 8 | 5 | 5 | | 4 | 6 |
Total no. of cough more than 2 weeks referred | | | | | | 2 | 6 | 3 | | 2 | 1 | 0 |
Number of chronically ill not on HBC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
Number of OVC not receiving care and support | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
Number of elderly receiving routine check ups | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 1 | 1 | 0 |
Number of births | 2 | 3 | 2 | 1 | 3 | 1 | 0 | 0 | 13 | 9 | 6 | 5 | 12
Number of deaths: < 1 years | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
Number of deaths: 1 - 5 years | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
Number of deaths: Maternal | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
Number of deaths: Other deaths | 0 | 0 | 0 | 0 | 2 | 4 | 1 | 0 | 0 | 0 | 0 | 0 |
Number of deaths: Total deaths | 0 | 0 | 0 | 0 | 3 | 4 | 2 | 0 | 0 | 0 | 0 | 0 |
Q1 | Q2 | Q3 | Q4
Number of Households without staple food | | 341 | | |
Number of households provided with a package of IEC materials | | 07 | | |
Number of School drop out: Male | | | | |
Number of School drop out: Female | | 23 | | |
Number of community action days held | | 0 | | |
Number of dialogue days | | 1 | | |
Number of meeting with CHCs | | | | |

picture 6: A photo of the Community Health Unit Health Information System (CHIS) Chalk Board

Picture 6: Facility staffs participating in dialogue

Use of Health Information Point (HIP) in Increasing Demand and Utilization of Primary Healthcare Services: The Experience of Bomani Dispensary in Kilifi County.

Introduction:

Kilifi County is among the seven counties in the coastal region of Kenya. It was established in 2010 following the merger of the former Kilifi and Malindi Districts. The county has a population of 1,725,900 (2019 census) and is served by 419 health facilities, of which 156 are public. In addition, 328 community health units with 4,049 Community Health Promoters (CHPs) support community-level health promotion and linkages to care.

Despite this infrastructure, primary health indicators remain low, particularly in Kilifi South. Contributing factors include poor healthseeking behaviour among communities living in Kilifi South, limited access to reliable health information inconsistent community health education & weak linkages between communities and health facilities.

Bomani Dispensary, serving a predominantly rural population, has long struggled with low uptake of essential primary healthcare services such as antenatal care (ANC), immunization, family planning, nutrition counselling, and screening for NCDs. Health education sessions were irregular, materials outdated, and misconceptions widespread.

To address these challenges, the Department of Health Services—working with North Coast Medical Training College under the Community Health Promotion Fund—introduced Health Information Points (HIPs) in the Bomani catchment area.

Implementation of the practice

A Health Information Point (HIP) is a community-based education and wellness station strategically established within local primary schools for easy access by school populations and community members.

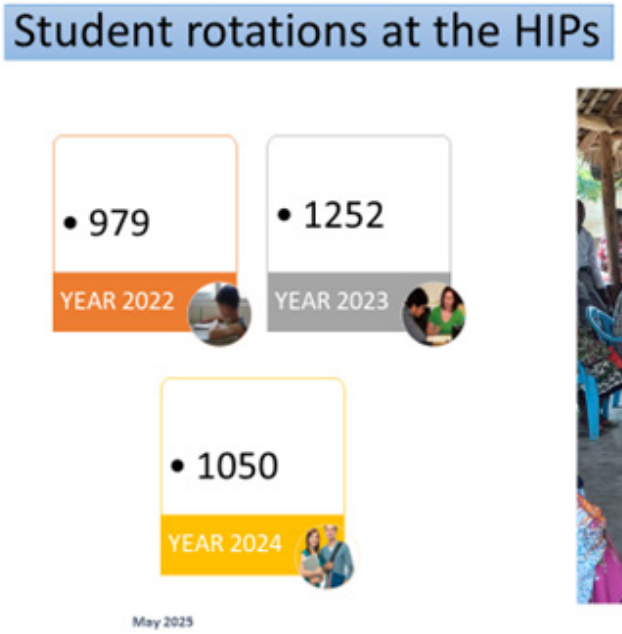
Picture 1: Services offered at the HIPs

Key challenges informing the establishment of HIPs

- Low awareness of available primary healthcare services
- Limited provider–client health education time
- High default rates for ANC and immunization
- Prevalence of myths and misinformation about healthcare
- Inconsistent health messages due to lack of standardized IEC materials
- Need for expanded communitybased clinical learning areas for medical trainees in Kilifi County

In early 2024, the Kilifi County Directorate of Health conducted a community scoping exercise that identified four schools for HIP establishment: Chidongo, Bodoi, Mirima Mine, and Kireme.

A multidisciplinary team was constituted and sensitized. The team comprised:




GD Kilifi Project

- Community clinician
- Community Health Promoters
- Nutritionist
- HIP Coordinator
- Social worker
- Child protection officer
- Physiotherapist
- Lecturers and students from North Coast Medical Training College.

The HIP activities are publicized through CHPs, school assemblies, community announcements, and CHEW-led engagements. Children also act as information carriers back to their households. HIP stations are operational daily during school days, with CHPs, students, and the HIP coordinator present. Targeted home visits also occur weekly.

HIP Set-up: Each HIP contains:

- Illustrated IEC posters and brochures (maternal health, immunization, nutrition, WASH, HIV, NCDs)
- A TV screen with rotating health education videos
- A CHP-managed desk for triage, guidance, and referral
- A service menu outlining facility services
- A suggestion box for feedback

The HIP team provides the following services:

- Health education
- Basic screening (BP, MUAC, blood sugar)
- Pregnancy tracking and referral
- Home visits for highneed cases
- Mentorship for MTC students supported by Bomani Dispensary staff

Results of the practice

Since implementation, Bomani Dispensary has documented significant improvements:

- Increased Service Uptake
  - ✓ ANC attendance increased by 32% within six months.
  - ✓ Immunization defaulter rates reduced due to improved caregiver knowledge.
  - ✓ Family planning uptake increased by 21%.
  - ✓ Early identification and referral of individuals with hypertension and diabetes improved.
  - ✓ Annual HIP workload increased from 4,869 (2023) to 7,915 (2024).

Source of data: Bomani Dispensary OPD registers, ANC/immunization registers, and HIP service statistics (2023–2024).

- Improved Health Literacy

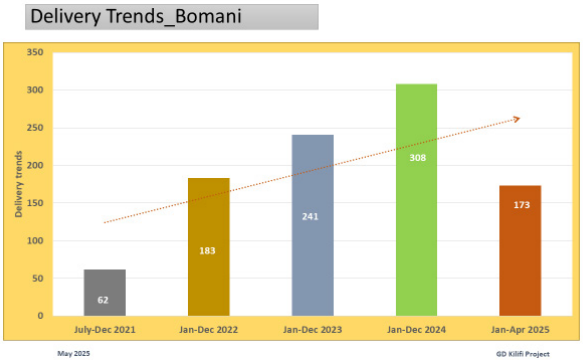
  Clients now arrive at the facility with better understanding of available services, leading to shorter consultations and improved clinic flow.

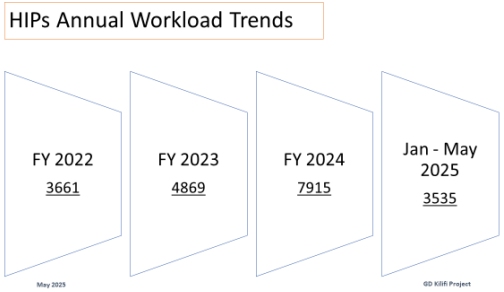
- Enhanced CHP Engagement

  CHPs now use standardized IEC materials, improving message accuracy and referral practices.

- Better Client Experience

  The HIP keeps clients engaged as they wait for services, reducing anxiety and complaints. The suggestion box has enhanced facility feedback and service improvement.





Lessons learned:

- Low-cost innovations can significantly strengthen primary healthcare demand when paired with community engagement. The success of HIP activities depends on meaningful community involvement in the scoping stage.
- Partnership and collaboration between the health facilities and Medical Training Colleges is key in rolling out key PHC initiatives.
- Continuous, self-directed learning empowers clients (patients) to make informed decisions.
- Integration of CHPs into facility-based education creates consistency in community messaging.
- Multimedia tools (IEC) (videos, posters, flip charts) help to address literacy barriers.
- Locating the HIP in schools ensures maximum visibility and utilization. School-going children are a good avenue for sustaining positive behavior in health.
- Sustainable financing for PHC is key for the continuity of rolling out key PHC initiatives

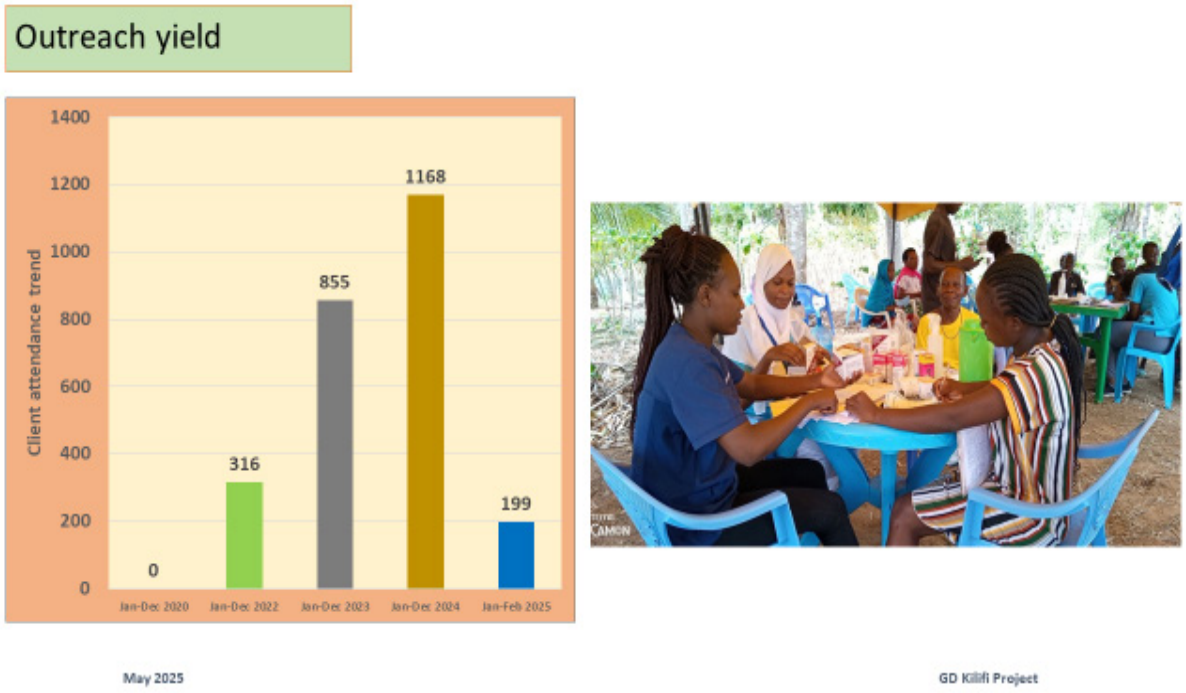
Recommendations:

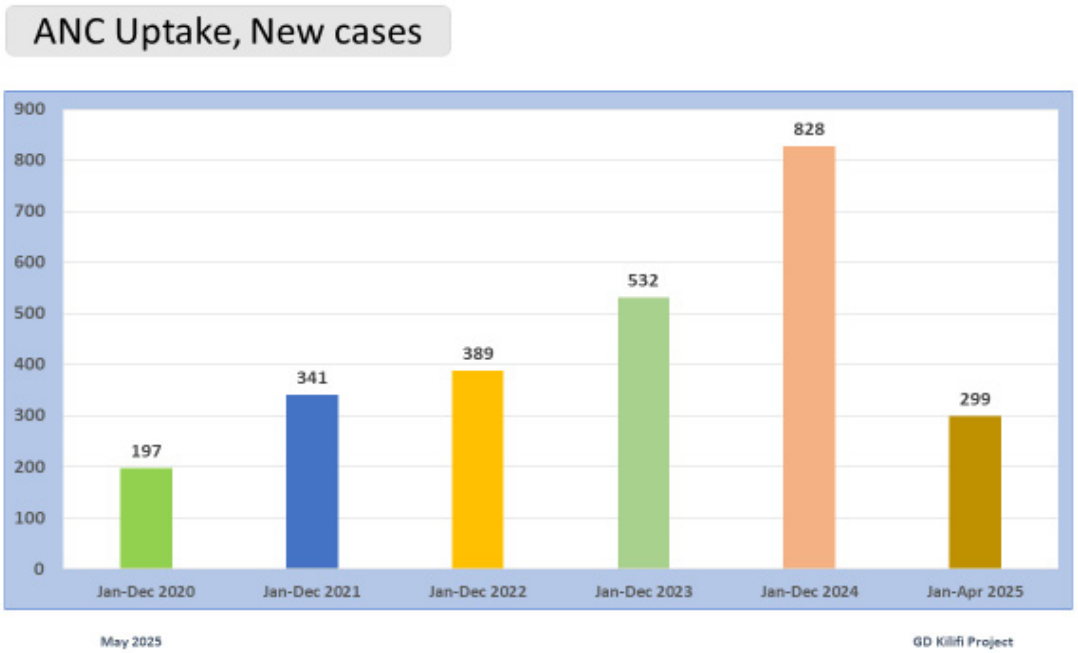
- It is recommended for County Governments to foster partnership and collaboration between the Department of Health and Sanitation Services and medical training colleges in strengthening PHC.
- The support from County Governments departments of health through domestic funding for PHC initiatives is very vital in the success of the HIP and similar programs.
- The HIP should be replicated in other health facilities as a low-cost-high impact initiative.
- Integrate the health promotion services and the HIPs with high-impact low-cost preventive health interventions like vaccination, deworming, and vitamin A supplementation services.

In conclusion, the Health Information Point has transformed the way Bomani Dispensary engages with its community. By making health education continuous, accessible, and client-driven, the facility has successfully increased the utilization of primary healthcare services and strengthened the link between the community and the health system.

Bomani's experience demonstrates that simple, low-cost innovations can meaningfully enhance health-seeking behaviour and improve outcomes—an approach that other primary healthcare facilities across Kilifi County and beyond can adopt.

Pictorial





Father-to-Father Support Groups: A Game-Changer for Primary Care Networks (PCNS) Strengthening in Tana River County

Introduction:

Tana River County, like many pastoralist regions in Kenya, faces persistent challenges in maternal and child health. Long distances to health facilities (only 22% of population within 5km of a facility), low literacy levels, cultural norms that limit women's decision-making power, and minimal male involvement in reproductive health contribute to low antenatal care (ANC) attendance, delayed referrals, and home deliveries. According to Tana River County health records (2022–2023), only 42% of expectant women completed the recommended four ANC visits with facility-based deliveries remaining below 50% in certain pastoralist communities, including parts of Dhalo.

In many households, men are the primary decision-makers and resource controllers, yet traditionally, health services have focused almost exclusively on women and children. Male involvement in maternal and child health activities was below 10%, with most clinic records indicating women attended ANC visits and child immunizations alone. As a result, mothers often lacked support to attend clinics, buy essential supplies, or seek emergency care. This disconnect weakened the effectiveness of Primary Care Networks (PCNs), as health workers could only partially influence household-level decisions.

Recognizing that maternal and child health cannot improve without engaging fathers, Community Health Promoters (CHPs), religious leaders, and local administrators in Dhalo Community Unit began mobilizing men to participate more actively in health discussions. Rather than approaching health as a "women's issue," they reframed it as a shared family responsibility — led and protected by men.

This shift laid the foundation for the creation of Father-to-Father Support Groups, now one of the most impactful strategies in strengthening PCNs across the area.

Implementation of the practice:

To strengthen household-level decision-making and improve maternal health outcomes, Community Health Promoters (CHPs) in Dhalo Community Unit with support from Tana River County Government department of health services initiated a structured Father-to-Father Support Group Model, implemented through the following steps:

- **Community Sensitization and Recruitment of Male Participants:** CHPs, in collaboration with village elders, Imams, and chiefs, began by conducting barazas and mosque-based dialogues targeting men. Instead of framing maternal health as a "women's matter," they positioned it as a family responsibility and a mark of responsible fatherhood. Men who had previously escorted their wives to delivery or supported child immunization were identified as early adopters and recruited as role models to help mobilize others.
- **Formation of Structured Father-to-Father Support Groups:** Once mobilized, men were organized into support groups of 10–20 members per village cluster. Each group selected: A Chairperson, responsible for coordination, a treasurer, to manage group savings, health Liaison, usually a CHP or CHA, to deliver health guidance. Meetings were scheduled every two weeks, initially hosted outside mosques, under trees, or at local social spaces to encourage open participation.
- In Tana-Delta Subcounty, Shirikisho Location, Garsen Constituency, formed a father-to-father support group called Dhidhaade 1 village father-to-father-support group with 11 members comprising men with wives who are of reproductive age.
- **Health Education Integrated with Economic Empowerment:** To maintain consistent attendance and sustainability, the groups were not designed as lecture

sessions but as hybrid health–economic platforms. Each session included short interactive discussions on topics such as: ANC timelines, danger signs during pregnancy, birth preparedness, newborn care, immunization schedules, malnutrition and family planning.

- **Income-Generating Activities That Reinforce Health Goals:** Tana River County Government department of health services in partnership with World Vision also trained the father-to father-support groups on savings and income-generating activities, including: a "Health Emergency Savings" kitty where each member contributes KSh. 50–200 per meeting, used to support transport or medical needs for group members' families; Table Banking or Rotational Funds — Members pooled money for livestock purchases or small business capital.

To ensure the sustainability of the Father-to-Father Support Groups and deepen their role beyond discussion forums, members initiated joint income-generating activities that also aligned with health outcomes. Some groups invested collectively in goats, poultry, or communal farms, agreeing that a portion of the profits would be set aside to support emergency maternal referrals, such as transport costs or hospital supplies for group members' families. This created a self-funded social protection system, reducing dependence on external aid during health crises.

A notable example is the Dhidhaade 1 Village Father-to-Father Support Group. After receiving training on nutrition and dietetics, they recognized that malnutrition was a persistent issue in the largely pastoralist Garsen area, where diets are heavily reliant on meat and milk with minimal vegetable intake. Instead of discussing the problem in theory, the group took practical action and collectively established kitchen gardens next to their homes.

These gardens now provide: Fresh vegetables (mchicha, tomatoes, sweet potatoes, maize etc.) for household consumption, improving dietary diversity. Surplus produce sold to support group savings and referral emergency funds.

By linking economic empowerment with nutrition and maternal health advocacy, the group transformed from health spectators into solution-makers, proving that fatherhood can be both protective and productive. This economic component created ownership, making the group both a social safety net and a health mobilization platform.

4. Linking Male Champions to Health Facilities and PCN Systems ; CHPs worked with nearby health facilities to register active male participants and track the number of men escorting their wives to ANC or delivery. Facilities began: Recording "Male Attendance at ANC" in reporting tools & fast-tracking couples who arrive together publicly recognizing "Model Fathers" during Mother & Child Health Days. This honor-based recognition system further strengthened participation.

5. Peer Accountability and Follow-Up: Members created WhatsApp groups or phone chains to, remind each other of ANC appointments, raise emergency transport funds instantly and escort fellow members to health facilities when needed. The men groups also acted as peer learning and information sharing groups on maternal and reproductive health issues. Men not adhering to responsibilities were followed up by peers, turning health-seeking behaviour into a collective expectation rather than individual choice.

Results of the practice

The introduction of Father-to-Father Support Groups in Dhalo, particularly the Dhidhaade 1 group, has significantly improved the performance of the Primary Care Network (PCN) by bridging the gap between households and health facilities. The model shifted men from being passive observers to active facilitators of maternal and child health. The impact can be observed across several key areas:

1. **Increased male participation in maternal and child health services:** Before the initiative, less than 10% of men accompanied their wives to ANC or delivery facilities. Within six months of group activation, over 60% of Dhidhaade 1 members consistently escorted their spouses to ANC visits, with several personally transporting wives of fellow group members during emergencies. Health facility records now indicate a growing trend of "couple attendance", improving client-provider communication and shared birth preparedness
2. **Improved ANC completion and facility deliveries:** CHPs and CHAs reported that ANC dropout rates reduced drastically, as men actively reminded and mobilized their wives for scheduled visits. With men now participating in birth planning, more households saved early to prepare for transport or delivery supplies. Facility staff in the PCN observed a visible rise in facility-based deliveries, especially among group-affiliated households.
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Picture 2: Dhidhaade 1 Village Father-to-Father Support Group in their kitchen garden at Shirikisho Location, Garsen sub-county Tana river County

2. **Enhanced nutrition and household food security through group-led agriculture:** The Dhidhaade 1 group's kitchen garden initiative has not only improved dietary diversity in member households especially the breastfeeding mothers and the young children but also shifted male perceptions of nutrition from a "women's topic" to a shared parental duty. Women now report less resistance when preparing vegetable-based meals, as men have been sensitized on the health value of balanced diets.

Lessons learnt:

- Male engagement significantly accelerates health-seeking behavior. Especially in patriarchal communities. Once fathers were directly involved in antenatal and delivery planning, ANC attendance became more consistent and referrals happened faster, reducing delays common in households where women had to seek permission or wait for finances.
- Peer-to-peer influence is more effective than top-down health messaging. Health workers alone could not shift household decision-making. However, when men heard testimonies from fellow fathers; such as how escorting their wives saved lives; the message became relatable and convincing.
- Economic solidarity strengthens sustained participation. Dhidhaade 1's joint savings and group projects (like goat rearing and kitchen gardens) ensured that health commitments were backed by financial readiness, especially for emergency transport or hospital costs. This model proved that health behaviour change is easier when supported by economic capacity.
- Recognition and dignity motivate more than cash incentives. Members valued public acknowledgment during mosque gatherings or community meetings more than monetary rewards. Being seen as a "responsible father" or "protector of mothers" elevated their status and encouraged continued engagement.
- Male involvement transforms not only maternal care but broader household health culture. As men became more aware of danger signs and prevention measures, they also took initiative in ensuring child immunization, nutrition improvements, and sanitation practices — turning them into full health ambassadors in the PCN ecosystem.

Recommendations:

- It is important to formalize Father-to-Father Support Groups as a core PCN strategy. Rather than relying on ad-hoc volunteerism, Counties should institutionalize these groups within Community Health Unit structures, giving CHPs and CHAs official responsibility to coordinate and monitor them.
- Training and mentoring more 'Male Champions' from within communities is recommended. Use graduation models where the most active participants, such as Dhidhaade 1 leaders, are trained to mentor new groups, ensuring scalable and sustainable replication.
- Integrate livelihood initiatives into male engagement programs. Linking health promotion with income-generating activities, such as livestock projects, savings groups, or kitchen gardens. Such initiatives encourage self-reliance and longer-term commitment.
- Track and report male attendance as a key maternal health indicator. Health facilities should record "Male-Accompanied ANC Visits" and "Joint Birth Plan Adoption" as performance metrics, reinforcing accountability for male participation.
- Engage cultural and religious leaders as custodians of the messaging. Use Imams, elders, and clan leaders to preach male responsibility in maternal care as a moral and religious duty, ensuring alignment with cultural values rather than appearing externally imposed.
- Expand beyond maternal health to full household wellness. Once groups are strong, integrate immunization follow-up, nutrition support, and WASH promotion, turning father groups into full-scale health enablers across the PCN.

Transforming Maternal Health and Child Health Outcomes in Primary Health Care Networks (PHCNS) Through Community Led Initiatives: The Garissa County Experience

Introduction:

Garissa County, located in Kenya's arid North Eastern region, has for a long time faced challenges in access to maternal, newborn and child health care services. A number of factors have contributed to this including the nomadic pastoralist population with low health-seeking behaviour, vast distances between households and health facilities, shortages of skilled health workers and medical supplies, social cultural barriers, low immunization rates and weak community-facility linkages. Further to this, facilities in Garissa County lacked resources to respond effectively, and appropriately. According to KDHS 2022 report, Garissa County led the Country in facility-based maternal mortality at 271 per 100,000 live births during the 2019-2011 period.

To address these challenges, Garissa County Government through the Department of health services sort innovative, integrated solutions to reduce the 'three delays' in maternal health: delay in seeking care, delay in reaching care, and delay in receiving adequate care. The County Government also sought innovative approaches to deal with the challenge of financing within the health facilities.

Implementation of the practice

Garissa County has emerged as a beacon of innovation in advancing Kenya's Universal Health Coverage agenda through the strategic implementation of Primary Health Care Networks (PCHNs). With a deep commitment to maternal and child health, Garissa County Government rolled out a suite of community-driven, equity-focused interventions that are transforming health outcomes across its sub-counties. The following solutions have been implemented to enhance the maternal and child health outcomes.

1. Mama Kits: Incentivizing Skilled Deliveries

To encourage expectant mothers to seek skilled care, Garissa County Government through the Directorate of health services introduced the issuance of Mama Kits; essential delivery supplies provided to mothers who deliver in public health facilities. The mama kit package comes with essential delivery items such as sanitary pads, a basin, mosquito net, baati (traditional loose-fitting comfortable dress for Somali women), sandals, soap, brush & toothpaste. These kits not only reduce the financial burden on families but also serve as a powerful incentive for facility-based deliveries. The initiative has led to a marked increase in skilled birth attendance, contributing to safer deliveries and reduced maternal and neonatal complications.

Picture 1:A mother receiving a mama kit package after delivery at Medina sub-county hospital in Garissa County

2. Mama Taxis: Bridging the last mile

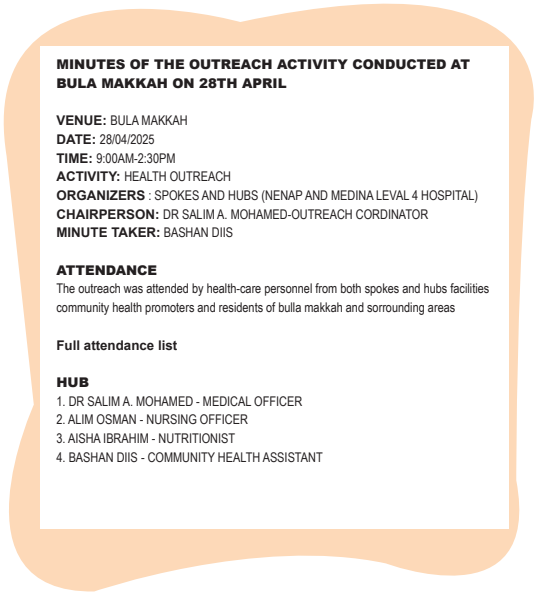
Recognizing the transportation barriers that hinder timely access to care, the sub-county health management team rolled out the Mama Taxi initiative by identifying and procured taxi services from operators within the County. These dedicated vehicles are stationed at strategic locations to ferry expectant mothers to health facilities, especially during emergencies or labour onset. Upon delivery, the mama taxis are available to transport the mothers back home. The program has significantly reduced delays in reaching care, particularly in remote and underserved areas.

3. Strengthening primary health care at the community level through the community health promoters

Garissa County's Community Health Promoters (CHPs) serve as the backbone of the County's Primary Health Care (PHC) network, bridging the gap between communities and health facilities. Through regular household visits, CHPs play a critical role in ensuring early detection of health risks, providing essential health education, and facilitating timely referrals to nearby health facilities. During community outreach activities, CHPs deliver a wide range of preventive and promotive health services, including Immunization, Antenatal care (ANC), Family planning services, HIV testing and counselling, Nutritional assessment and supplementation, Social Health Authority (SHA) registration.

To enhance maternal and child health outcomes, each expectant mother in Garissa County is paired with a designated CHP who provides continuous follow-up and ensures adherence to ANC visits from early pregnancy through delivery and the postnatal period.

CHPs receive a token of KES. 1,000 for every expectant mother they successfully support to deliver in a health facility. This performance-based incentive motivates CHPs to actively track pregnancies and promote skilled deliveries.
To further strengthen continuity of care, health facilities retain the birth notification until the newborn returns for the second immunization, and birth certificates are released once all immunization visits are completed. This approach ensures full immunization coverage and sustained follow-up of newborns.



MINUTES OF THE OUTREACH ACTIVITY CONDUCTED AT BULA MAKKAH ON 28TH APRIL

VENUE: BULA MAKKAH
DATE: 28/04/2025
TIME: 9:00AM-2:30PM
ACTIVITY: HEALTH OUTREACH
ORGANIZERS : SPOKES AND HUBS (NENAP AND MEDINA LEVAL 4 HOSPITAL)
CHAIRPERSON: DR SALIM A. MOHAMED-OUTREACH CORDINATOR
MINUTE TAKER: BASHAN DIIS

ATTENDANCE
The outreach was attended by health-care personnel from both spokes and hubs facilities community health promoters and residents of bulla makkah and sorrounding areas

Full attendance list

HUB
1. DR SALIM A. MOHAMED - MEDICAL OFFICER
2. ALIM OSMAN - NURSING OFFICER
3. AISHA IBRAHIM - NUTRITIONIST
4. BASHAN DIIS - COMMUNITY HEALTH ASSISTANT

Picture 2: Minutes of an outreach activity conducted at Bula Makkah on 28th April 2025

The outreach efforts of CHPs have significantly improved early detection of pregnancy complications, increased ANC attendance, and enhanced community trust in the formal health system. Beyond service delivery, CHPs continue to play a vital role in health education, behaviour change promotion, and follow-up of defaulters, reinforcing Garissa County Government's commitment to achieving universal health coverage through community-centered primary care.

4. Financing health at the source: the impact of the Facility Improvement Fund (FIF)

In a landmark policy move, Garissa County Government enacted the Facility Improvement Fund (FIF) regulations that allow health facilities to retain and utilize locally generated revenue at the facility level. This has empowered facility managers to address immediate needs, such as purchasing equipment, hiring support staff, and improving infrastructure, without waiting for central disbursements. The result is more responsive, better-equipped health centers that reflect community priorities.

5. Embracing the traditional birthing/ delivery stool setup in maternal units/ delivery wards.

As part of its ongoing maternal health improvement initiatives, the Garissa County Government, through the Directorate of Health, introduced innovative traditional birthing stool setups in health facilities to create more comfortable, dignified, and culturally acceptable delivery spaces for mothers. These birthing stools are designed to support upright or semi-upright labor positions, allowing women to give birth in squatting or forward-leaning postures that are culturally familiar and widely accepted among pastoralist and rural communities in Garissa County. This initiative bridges traditional birthing practices with modern obstetric care, promoting safer deliveries and greater community trust in health services.

Picture 3: traditional birthing/ delivery stool setup at Iftin Sub-County hospital Garissa County

Key benefits of the traditional birthing stool setup include:

- Encouragement of upright birthing positions: The stool's design allows women to sit or lean against a padded backrest in a squatting or semi-seated posture. This position utilizes gravity to assist with pushing, often shortening the second stage of labour.
- Enhancement of comfort and dignity: Many women in Garissa and other ASAL regions prefer non-lithotomy positions for cultural and personal reasons. By accommodating these preferences, the birthing stool promotes dignity and encourages women to deliver in health facilities rather than at home.
- Improved support for birth attendants: A smaller accompanying stool enables the midwife or sbaa (traditional birth companion) to assist comfortably and safely, maintaining optimal visibility and access during delivery.
- Reduction of obstructed labour risks: Upright birthing positions facilitate better pelvic opening and circulation, which can help prevent complications such as prolonged or obstructed labour.
- Strengthening of community–facility linkages: Incorporating culturally appropriate birthing tools builds trust between communities and health facilities, encouraging more women to seek skilled delivery services and contributing to a reduction in maternal and neonatal mortality.

6. ANC Cohorts-Grouping of pregnant women according to their antenatal care (ANC) stage and pairing them with Community Health Assistants (CHAs)

In many remote communities across Garissa County, expectant mothers face persistent challenges in maintaining regular ANC visits. Long distances to health facilities, limited awareness of ANC importance, and various social or cultural barriers often result in missed appointments, increasing the risk of complications during pregnancy and childbirth.

To address this challenge, the Garissa County Government, through its Primary Care Network (PCN) strategy, introduced a simple yet highly effective innovation: grouping pregnant women according to their ANC stage and linking them to specific Community Health Assistants (CHAs) for personalized follow-up and support.

Under this approach:

- Expectant women are grouped based on their ANC visit stage (e.g., ANC 1, ANC 2, ANC 3, or ANC 4).
- Each group is assigned a unique colour of baati —a traditional Somali dress — which fosters a sense of identity, unity, and recognition within the community.
- Each group is paired with a dedicated CHA, who becomes responsible for continuous follow-up, health education, and timely referrals. CHAs maintain both digital and paper-based tracking tools to monitor attendance, identify defaulters, and conduct home follow-ups as needed.
- Peer support networks naturally form within each group, as mothers encourage one another to attend ANC visits, share experiences, and adopt healthy maternal practices.

This community-based system has enhanced accountability and continuity of care, improved ANC attendance rates, and strengthened the link between households and health facilities. By leveraging culturally familiar symbols like the baati and fostering peer solidarity, the initiative effectively combines tradition, technology, and community health systems to improve maternal outcomes across Garissa County.

7. Involvement of spouses as male birth champions

In many communities across Garissa County, maternal health has long been considered a "women's affair." Decisions about ANC, delivery locations, or referral during complications were often left to expectant mothers; even when they lacked the authority or support to act on them. This led to delays in seeking care, especially when cultural or financial approval from husbands was required.

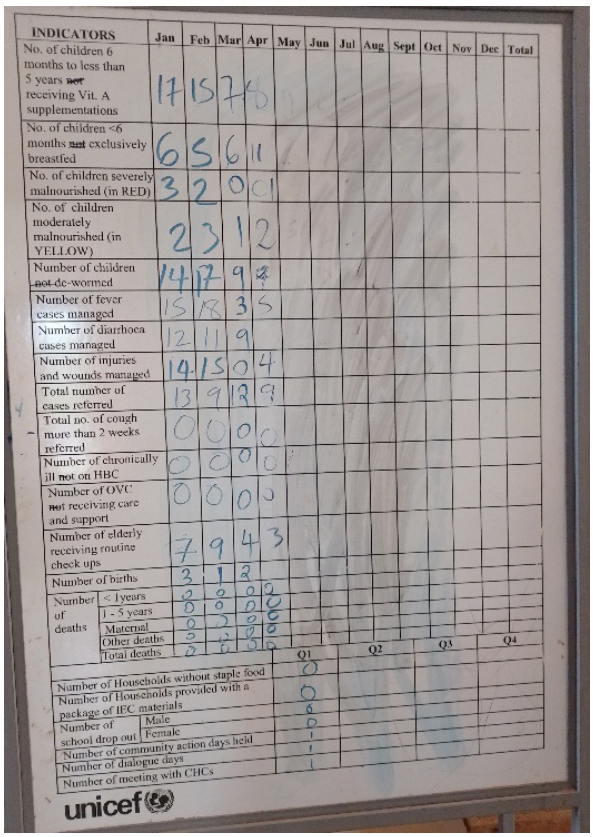
To shift this dynamic, Garissa County Government through the department of health services introduced an innovative approach within its PCNs: engaging and incentivizing husbands as "Male Champions" who accompany their wives to ANC visits and delivery facilities. Spouses are encouraged and, in some areas, incentivized to physically accompany their wives to ANC visits and delivery as a demonstration of support and leadership. The incentives include free wellness checks, free health services as well as recognition in mosque gatherings and chief barazas.

Results of the Practice

Between January and April 2025, Garissa County recorded significant improvements in maternal and child health outcomes, demonstrating the success of its integrated Primary Health Care (PHC) interventions.

Key achievements include:

- Improved nutrition outcomes: Data shows a sharp decline in cases of severe malnutrition, reflecting the effectiveness of ongoing nutrition interventions and community outreach programs.



Picture 4: Data chart showing ANC indicators at Medina Hospital, Garissa County

- Zero maternal deaths: No maternal deaths were reported during this period — a strong indicator of enhanced service delivery, early detection, and preventive health measures.
- Increased skilled births: The number of facility-based deliveries rose markedly, from 11 skilled births in March 2025 to 52 skilled deliveries in May 2025 underscoring growing trust in health facilities and improved access to skilled care.

Community and system-level impacts:

- The involvement of traditional birth attendants (TBAs) — now encouraged to accompany expectant mothers to health facilities — has greatly strengthened trust and collaboration between communities and healthcare providers.
- The Mama Taxis initiative, which provides reliable transport for expectant women, has reduced maternal delays by improving emergency referrals and access to services.
- Health facilities have seen improved readiness and responsiveness through decentralized financing and greater autonomy and accountability under the Facility Improvement Fund (FIF)

Enhanced antenatal care (ANC) outcomes:

Before the introduction of the grouping of expectant women by ANC stage and pairing them with Community Health Assistants (CHAs), many women attended only their first ANC visit and failed to return. The absence of systematic tracking meant high-risk pregnancies were often identified too late. Today, no woman in Garissa County is left behind. As of June 2025:

- 80% of mothers had completed all four ANC visits — a dramatic improvement from previous inconsistent rates;
- ANC clinic attendance stands at 99%; and
- Referral of high-risk pregnancies has reached 98%, directly contributing to safer pregnancies and better birth outcomes.

Social and behavioural transformation:

Male involvement has been a key driver of success. The active participation of male spouses has helped shift community perceptions that previously viewed maternal clinics as "women-only" spaces. This inclusive approach has normalized and celebrated male engagement in maternal health, positioning men as protectors, decision-makers, and caregivers. By working within existing cultural structures rather than against them, the initiative has fostered genuine community ownership and sustainability.

A replicable model for health systems strengthening: Garissa County's integrated approach — combining strong leadership, sound governance, policy reforms, community engagement, and service delivery innovation — presents a replicable model for other counties aiming to strengthen their PHC systems and improve maternal and child health outcomes.

Lessons learnt:

- Understanding the community needs and involving the community enhances ownership and sustainability of innovations. It is therefore key to involve village elders, traditional birth attendants, elders and religious leaders to improve health-seeking behaviour.
- Building community trust by allowing the mothers to choose their preferred health facility and who they want to help them deliver ins very important in the success of primary health care especially in the conservative communities like Garissa.
- Sustaining incentive-based strategies like Mama Kits is key to increasing skilled birth attendance in rural and underserved areas.
- Addressing transport barriers through initiatives such as Mama Taxis is essential for improving access to maternal healthcare in remote and hard-to-reach areas therefore ensuring that no woman is left behind due to distance or lack of mobility.
- Strong community–facility linkages facilitated by Community Health Promoters (CHPs) are critical for ensuring continuity of care across all

service delivery levels. By investing in CHPs to strengthen community–facility linkages is one of the most cost-effective ways to sustain preventive and follow-up care.

- Empowering facilities to manage and utilize their own resources through mechanisms like the FIF is key to sustaining service delivery improvements. When facilities control their own funds, they respond faster to community needs and sustain progress without waiting for external approval.
- The most effective health interventions are those that align policy with cultural contexts, empower communities and secure adequate financing simultaneously. Multi-pronged approaches that integrate policy reform, community engagement, and sustainable financing consistently deliver the most impactful outcomes.
- Male involvement significantly improves decision-making speed. When husbands are sensitized and engaged, delays related to seeking care or approving referrals are drastically reduced. Couples attending ANC together improves not only attendance but quality of care. Health providers report better communication and shared understanding when both partners are present.

Recommendations:

Building on the demonstrated successes of Garissa County's Primary Health Care (PHC) and maternal health interventions, the following recommendations aim to consolidate gains, enhance sustainability, and expand impact across all sub-counties:

- **Scale Up the Mama Taxi Initiative Countywide**

  Expand the Mama Taxi program to all sub-counties to strengthen emergency referral systems and eliminate transportation barriers for expectant women. Scaling up this initiative across all health facilities will ensure that no woman is left behind simply because she cannot reach care in time. Reliable, community-based transport systems are critical in reducing the first and second delays that often contribute to maternal and newborn deaths.

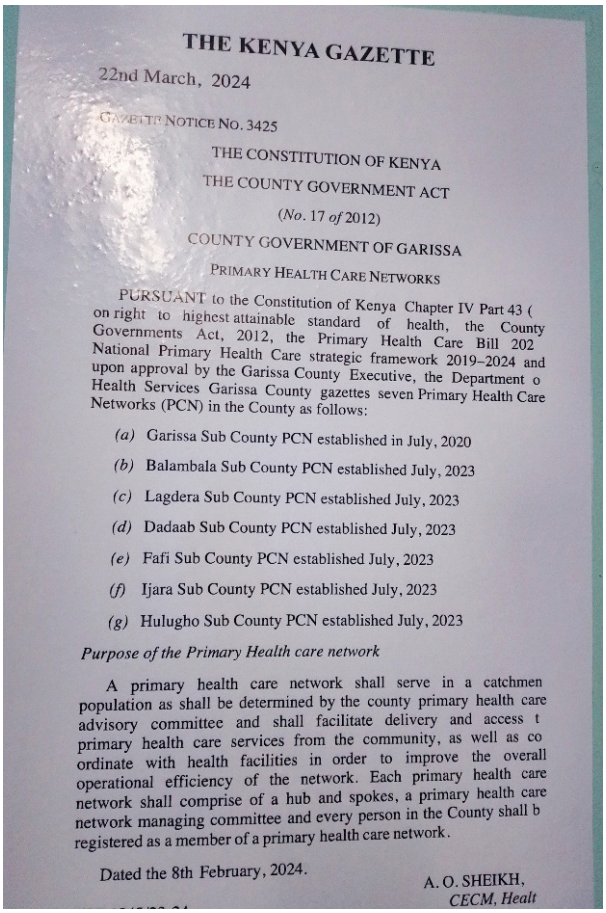
- **Strengthen Capacity Building and Incentive Structures for Community Health Promoters (CHPs)** Continuous training, mentorship, and motivation of CHPs are vital to maintaining their effectiveness as frontline health workers. Sustained investment in their capacity building—through refresher trainings, supportive supervision, and peer learning—will enhance their ability to deliver quality services at the household level. Additionally, providing consistent and predictable incentives will reinforce accountability, reduce attrition, and sustain community trust.
- **Formalize Male Champion Programs within Primary Care Networks (PCNs)** Institutionalize structured male champion programs within the PCN framework to promote inclusive, family-centered maternal and child health care. Assign CHPs and Community Health Assistants (CHAs) to register, track, and mentor active male participants, encouraging shared responsibility between spouses. This approach will foster stronger household engagement, reduce gender-related barriers to care, and enhance male appreciation of their roles in supporting antenatal, delivery, and postnatal services.Institutionalize Best Practices and Knowledge Sharing
  Document and disseminate Garissa County's successful PHC innovations—such as ANC grouping, traditional birthing stool adoption, and CHP-led follow-up—to guide replication in other Counties. Establish learning exchange forums and integrate these best practices into County health policies and training curricula to promote sustainability and scale.
- **Enhance Monitoring, Data Use, and Accountability Mechanisms**

  Strengthen community-level data collection and feedback systems to track progress on ANC attendance, skilled deliveries, and child immunizations. Regular performance reviews and the use of digital dashboards will improve transparency, enable data-driven decision-making, and reinforce accountability within the PHC network.

PICTORIAL

Picture 5: Mama Kit issued to mothers upon delivery at a health facility in Garissa County

Picture 6: Mama Taxi Contacts displayed at Iftin Su-County Hospital, Garissa County



THE KENYA GAZETTE

22nd March, 2024

GAZETTE NOTICE NO. 3425

THE CONSTITUTION OF KENYA

THE COUNTY GOVERNMENT ACT

(*No.* 17 *of* 2012)

COUNTY GOVERNMENT OF GARISSA

PRIMARY HEALTH CARE NETWORKS

PURSUANT to the Constitution of Kenya Chapter IV Part 43 (on right to highest attainable standard of health, the County Governments Act, 2012, the Primary Health Care Bill 202 National Primary Health Care strategic framework 2019–2024 and upon approval by the Garissa County Executive, the Department o Health Services Garissa County gazettes seven Primary Health Care Networks (PCN) in the County as follows:

(a) Garissa Sub County PCN established in July, 2020

(b) Balambala Sub County PCN established July, 2023

(c) Lagdera Sub County PCN established July, 2023

(d) Dadaab Sub County PCN established July, 2023

(e) Fafi Sub County PCN established July, 2023

(f) Ijara Sub County PCN established July, 2023

(g) Hulugho Sub County PCN established July, 2023

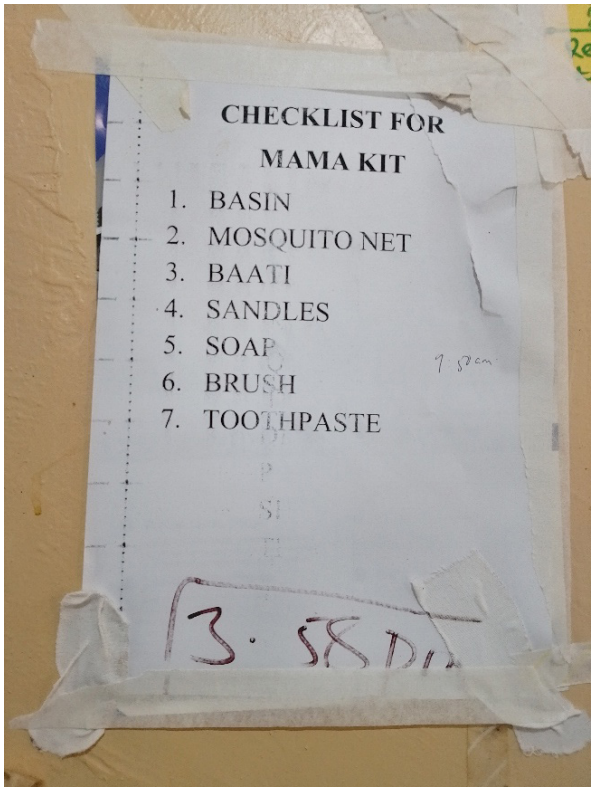
Purpose of the Primary Health care network

A primary health care network shall serve in a catchmen population as shall be determined by the county primary health care advisory committee and shall facilitate delivery and access t primary health care services from the community, as well as co ordinate with health facilities in order to improve the overall operational efficiency of the network. Each primary health care network shall comprise of a hub and spokes, a primary health care network managing committee and every person in the County shall b registered as a member of a primary health care network.

Dated the 8th February, 2024.

A. O. SHEIKH,
CECM, Healt

Picture 7:Mama kit Checklist at Iftin Sub-county hospital in Garissa County



Picture 6: Gazette notice on the gazettement of Primary Care Networks (PCNs) in Garissa County

Strengthening Routine Immunization through the 'My Village, My Home' Tool in Burundu Community Unit, Kakamega County

Introduction:

Immunization is recognized as one of the most effective and affordable public health interventions in the world, preventing millions of deaths every year. Globally, vaccines have eradicated smallpox, nearly eliminated polio, and drastically reduced cases of measles, diphtheria, and tetanus. In Kenya, routine immunization continues to be a cornerstone of child survival and is integrated within the broader Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) strategy.

Despite this progress, a significant number of children still miss vital vaccines. The gaps arise from weak follow-up systems, limited community awareness, geographical barriers, and inconsistent quality of health data. When vaccinations are missed or delayed, children remain exposed to preventable illnesses and entire communities risk outbreaks that undermine the gains made in disease control.

Kakamega County, like many others in Kenya, has faced these very challenges. Coverage rates in some areas lagged behind national targets, and health workers struggled with incomplete household records that made it difficult to track children who had defaulted. Community Health Promoters (CHPs) lacked simple tools to monitor immunization status at household level, and families often relied solely on clinic visits, which were sometimes irregular. These realities highlighted the urgent need for a locally adapted, community-owned solution that could bridge the gap between health facilities and households.

In response to these challenges, Kakamega County, in partnership with its communities embraced innovative, community-driven solutions to strengthen routine immunization. One of the most impactful of these innovations is the "My Village My Home" (MVMH) tool. The tool is a simple design that allows communities to monitor the vaccination status of every child at household level.

Implementation of the practice:

In 2022, Burundu Community Unit in Malava Sub-County, Kamuchisu Dispensary initiated the use of the "My Village My Home" (MVMH) tool in Kakamega County. The idea was introduced by the Assistant Community Health Officer, who, after reviewing evidence on its effectiveness and gauging community receptivity from previous engagements, presented the idea to CHPs, CHAs, link health facilities, and local leaders, all of whom endorsed it to improve immunization timeliness and coverage.

The tool is a large, poster-sized register that records every child under two years in a village, capturing key details such as the child's name, sex, date of birth, age, and birth weight, alongside caregiver information, contact, and vaccination history as verified through the Mother & Child Health (MCH) booklet. It also includes space for recording the date of household visits and remarks from CHPs based on the outcome of each follow-up.

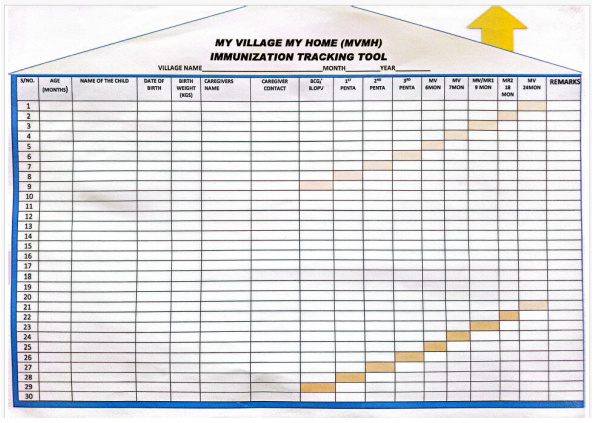
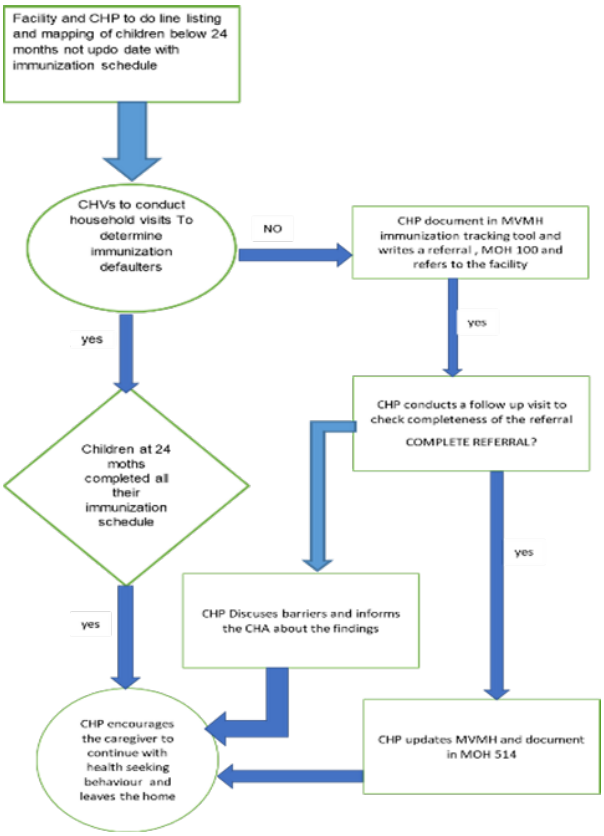


Figure 7"My Village My Home" (MVMH) tool used at Burundu Community Unit in West Kabaras Ward, Malava Sub-County

Once trained by the National Division of Community Health Services (NDCHS), CHPs began by mapping all infants within their villages, listing them in age order on the poster, and updating vaccination progress during home visits or outreach sessions. Newborns were



Picture 2: Immunization Defaulter Tracing and Follow-Up Flowchart

added shortly after birth to ensure no child was left out. Copies of the posters were also placed at link health facilities, enabling parents to confirm their children's immunization status during clinic visits and ensuring that facility and community actors worked with synchronized information.

This transparency fostered accountability, while routine reviews by CHAs and Work Improvement Teams (WITs) provided supervision, technical support, and follow-up on challenges such as missed opportunities for vaccination.

Community engagement was central to the process, with CHPs mobilizing families through home visits, dialogue days, and outreach sessions. Fathers were encouraged to support mothers by reminding them of immunization dates or taking on household responsibilities so mothers could attend clinics. The poster also served as a defaulter tracing tool, allowing CHPs to easily identify children who had missed doses and conduct targeted follow-up visits for catch up.

Results of the practice:

- Routine community monitoring and DHIS2 data indicate that immunization coverage in Burundu increased from 68% in October 2022 to 91% by March 2023 (Ministry of Health [MoH], 2023; Burundu Community Health Unit, 2023). Household verification across eight villages showed that only 1.6% of infants had not commenced vaccination (Burundu Community Health Unit, 2023).
- Sub-county immunization performance reviews show that villages in Burundu Community Unit consistently achieved vaccination coverage of 80% or higher, outperforming neighbouring community units during the same period (Kakamega County Department of Health, 2024).
- CHPs expressed pride and responsibility in ensuring no child was left behind in immunization.
- Mothers gained awareness of the importance, benefits, and limitations of immunization, while fathers became more involved in supporting routine vaccination.
- Reports from CHPs and mothers indicated a decline in measles and other vaccine-preventable diseases, showing improved timeliness and completeness of vaccinations.
- Community health records further indicate a 20% increase in mothers counselled and referred for family planning services following the introduction of the tool (Burundu Community Health Unit, 2023).
- Community nutrition screening records show that the proportion of children below 24 months screened for malnutrition increased from 30% to 70%, leading to the early identification of nine malnutrition cases, including eight cases of severe acute malnutrition and one case of moderate acute malnutrition (Burundu Community Health Unit, 2023, Endline Survey on BFCI report).
- The tool revealed gaps in service delivery such as undocumented birth weights, missing growth monitoring records, and unrecorded Vitamin A supplementation

and deworming in mother and child health booklets. Monthly review meetings used the findings from the tool to discuss these delivery gaps and take corrective measures.

- Motivation and recognition grew among CHPs, whose success in immunization follow-up and malnutrition referrals led to the selection of Burundu CHU for Baby-Friendly Community Initiative (BFCI) training.
- As a result of their outstanding performance in immunization coverage, data utilization, and community engagement, Burundu CHU and its CHPs received several awards, including being the overall winner during the Kakamega County Learning Forum 2024, as well as Best Innovation, Best Organized WIT, and Cycle Completion Award.

Lessons learnt:

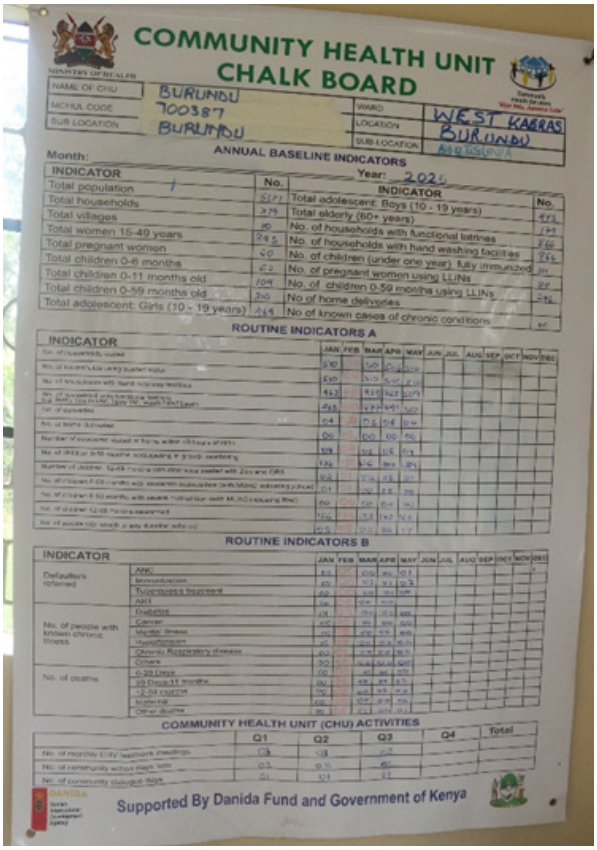
- Community-led tracking tools such as "My Village My Home" improve accountability and significantly boost immunization coverage as they enable real-time monitoring of every child and empower CHPs to take immediate action.
- Household involvement, particularly when fathers actively participate, strengthens demand and turns immunization into a family priority.
- Capacity building for CHPs and CHAs ensures consistent follow-up, accurate data collection, and sustained quality of service delivery.
- Community pride and ownership act as powerful motivators. When CHPs and caregivers see the direct results of their efforts, they become more committed to sustaining child health gains.
- Collaboration between Community Health Units, health facilities, and local administration provides the institutional support needed to scale up and sustain community-based immunization initiatives.
- There is need for continuous engagement and tailored messaging to overcome misconceptions from some community members due to religious beliefs.
- Adolescent and youth health services that target young people must be strengthened to improve access and use maternal and child health care by young mothers. This can address challenges of teenage pregnancies and related health complications due to unsafe abortions.
- Over-reliance on cash crops demonstrated that household economic activities can compete with health priorities, highlighting the importance of flexible service delivery models that accommodate community realities.

Recommendations:

- To build on the gains, nurturing passion among CHPs and CHAs should be prioritized, as their commitment is important to achieve success.
- There is need to enhance continuous research, learning, and skill growth within community health systems.
- To sustain community gains, it is important we encourage sacrifice and commitment among health workers and volunteers.
- There is need to strengthen collaboration between CHPs, CHUs, and facility in-charges to reinforce accountability.

Photo Gallery

Picture 3: Burundu CHU team displaying awards earned for excellence in immunization and community health performance.



Picture 5: Community Health Unit chalkboard at Burundu Health Facility

How a Community in Nakuru County is Boosting Nutrition through Kitchen Gardens

Introduction:

Poverty, food insecurity, and limited awareness of proper nutrition leave many families struggling, particularly children, who face severe malnutrition challenges. Malnutrition manifests in various forms, including undernutrition (wasting, stunting, underweight), micronutrient deficiencies, and overweight or obesity. According to the World Health Organization (WHO) in its 2024 fact sheet "Malnutrition", globally in 2022: 149 million children under 5 were stunted, 45 million were wasted, 37 million were overweight or obese and nearly half of under-5 deaths in low and middle-income countries are linked to undernutrition.

Women, infants, children, and adolescents are especially vulnerable. Proper nutrition during the first 1,000 days (from conception to a child's second birthday) is essential for long-term health and development. This critical window lays the foundation for a child's cognitive, physical, and emotional growth. Proper nutrition includes:

- For pregnant women: Adequate intake of calories, protein, iron, folic acid, iodine, calcium, and other essential micronutrients to support fetal development and maternal health.
- For infants (0–6 months): Exclusive breastfeeding, which provides all the necessary nutrients, antibodies, and enzymes for optimal growth and immunity.
- For young children (6–24 months): Continued breastfeeding along with the introduction of safe, age-appropriate, and complementary foods rich in nutrients, including fruits, vegetables, grains, and foods sourced from animals.

Poverty aggravates malnutrition, while malnutrition, in turn, perpetuates poverty by increasing healthcare costs, reducing productivity, and slowing economic growth.

In Ogilgei community in Nakuru County, challenges such as food insecurity, poor child-feeding practices, parental alcoholism, and inconsistent exclusive breastfeeding have worsened malnutrition. In 2023, the local health facility recorded two malnutrition cases (one severe, one moderate) and one malnutrition-related death. Most affected families were transient renters, highlighting the need for community-based interventions to improve nutrition awareness and household food production.

Figure 8: A photo of Community Health Committee members together with Community Health Promoters who train and educate the community on kitchen gardening and nutrition

Implementation of the practice (Solution Path):

To address this challenge, the Community Health Committee (CHC), supported by the DANIDA PHC Support Program, introduced kitchen gardening as a sustainable solution. A kitchen garden, also known as a home garden or a vegetable garden, is a small garden grown at home to produce fresh vegetables, herbs, and fruits for household use.

Key steps included:

1. Capacity building and leadership
    - CHC members received training in leadership and resource mobilization to better support Community Health Promoters (CHPs).
    - Regular feedback and monthly CHP meetings facilitated knowledge-sharing and adaptive planning.
2. CHCs and CHPs conducted sessions in five villages (Kamungei, Kapchorua, Kaptembwa, Kerma, Kapkoros), demonstrating how to grow vegetables in reused sacks and containers, ideal for households with limited space.

Setting up a Sack Garden

The sack garden is an affordable and accessible option for cultivating leafy greens. It utilizes vertical space by hanging or stacking sacks filled with a well-balanced soil mix.

The process begins by:

- Gathering your materials: a sack, healthy soil (preferably loamy soil), compost, and plants.
- Cutting holes with a diameter measuring about 3cm in the bag.
- Filling the bag with healthy soil.
- Planting your seedlings into the holes on the sack and watering them from the midrib.

This method maximizes vertical space, conserves water, and is easily movable. It's suitable for leafy greens like spinach, kale, and radishes.

Figure 9: A proud beneficiary showcases her thriving managu crop, grown in recycled cement bags with support from CHPs

3. **Community demonstration garden**

- A 0.25-acre unused plot at the health facility was repurposed into a communal garden.
- CHCs and CHPs contributed seeds, tools (jembes, pangas, slashers), and KES 150 each from funds received after implementing activities facilitated by the DANIDA PHC Level 1 support, totaling to KES 2,250 to plant fruit trees along the garden borders.
- Members managed assigned plots in a bid to foster ownership and teamwork.

4. **Direct impact on nutrition and health services**

- Harvests supplemented diets of malnourished children identified during household visits.
- Over 40 households adopted kitchen gardening.

Results of the practice

1. Families consumed fresh produce and sold surplus, boosting food security and earnings.
2. Increased Health Service Utilization:
   - ANC visits rose from 357 in 2023 to 464 in 2024.
   - Immunizations increased from 1,113 to 1,669.
   - Deliveries grew from 39 to 45 by February 2025.
3. Community benefits:
   - Access to affordable, chemical-free food.
   - Reduced malnutrition risks.
   - Enhanced social cohesion and knowledge-sharing.
4. Collaboration among CHCs, health facility staff, and County officials drove success.

Lessons learnt:

- The use of vegetables as a reward increased the number of mothers attending ANC.
- Simple innovations like planting vegetables in empty sacks or containers helped overcome the challenge of limited space.
- Community ownership, local resource mobilization, and teamwork were the driving forces behind the success of the kitchen garden initiative.

Recommendations:

- Continued support from DANIDA and other partners is needed to sustainably fund community health services.
- Information, Education, and Communication (IEC) materials should be provided for use during community dialogue and action days.
- CHCs and CHPs need support to transport chalkboards (MOH 516), materials and tools during action days.
- Provision of water tanks for irrigation will help maintain the CHP demonstration gardens throughout the year.

Photo Gallery – Kitchen gardens with variety of nutritious foods

Expanding Access to Essential Healthcare Through Community-Level Interventions in Gaceuni Dispensary, Tharaka Nithi County

Picture 1: Gaceuni health facility management team during a knowledge exchange program with COG

Gaceuni Dispensary, a key primary healthcare facility in Tharaka North, has transformed how underserved and hardtoreach communities access essential health services. In a region where some villages lie more than 10 km from the nearest health facility—and where cultural and religious barriers continue to discourage healthseeking behavior—the introduction of targeted community interventions has significantly improved service uptake and community wellbeing.

The initiative focused on three core activities: integrated community outreaches, community dialogues, and community action days. These efforts aimed to reduce barriers to healthcare, promote sanitation, increase immunization coverage, and strengthen trust between the community and the health system.

Gaceuni's catchment area faced multiple obstacles:

- Long distances to health facilities in villages such as Kiamiramba, Kamutuando, and Kamajuria.
- A local religious sect that advocates for the avoidance of modern healthcare, leading to low immunization and ANC uptake.
- Low latrine coverage (60%), contributing to disease outbreaks including Kala-azar and bilharzia.
- High poverty and low literacy levels that limited positive healthseeking behavior.

These complex challenges required a community-driven model that would bring healthcare directly to the people who needed it most. Community dialogue sessions, where residents identified their key barriers to health access, were commenced. The findings therein were then integrated into action plans through the Health Facility Management Committee (HFMC) and the SubCounty Health Management Team (SCHMT).

The teams then implemented several initiatives:

- Regular integrated outreaches delivering immunization, ANC, family planning, Kalaazar screening, and health education.
- Household visits by Community Health Promoters (CHPs) to promote sanitation, monitor defaulters, and support highrisk households.
- Community action days to promote hygiene, latrine construction, and maternal health.

- Health education sessions on handwashing, hygiene, immunization, nutrition, and school health.
- Mobilization through local leaders to increase participation and encourage male involvement.

Source of data: Gaceuni Dispensary Health Facility Management Committee (HFMC)

These activities were funded primarily through DANIDA PHC funds, which supported logistics, supplies, and community mobilization. The initiative has delivered transformative and measurable results:

- Improved Health Service Utilization: The facility maintained an average immunization coverage of 76% despite challenges such as coldchain breakdown and cultural resistance. The facility also reported increased ANC uptake and reduction in home deliveries. Facility workload also increased due to improved healthseeking behaviour.
- Strengthened Sanitation and Disease Prevention: Latrine coverage increased from 60% to 85%. Households embraced hygiene practices introduced during action days.
- Shift in Cultural Norms: Members of previously resistant religious sects increasingly accepted modern healthcare, including child immunization.
- Enhanced Equity in Access: Populations living more than 10 km from the facility now receive regular, reliable care through outreach services.

Sustainability and Replicability

The model is highly sustainable because:

- Outreaches are aligned with routine health facility operations.
- CHPs and HFMC members have been empowered to maintain community engagement.
- Costs remain low, and community ownership is strong.

Its simplicity, efficiency, and demonstrated impact make it easily replicable in other regions facing similar challenges—especially those with hardtoreach populations and cultural barriers.

Conclusion

The Gaceuni Dispensary initiative shows how community-centered primary healthcare can break long-standing barriers to health access. By engaging residents, empowering CHPs, and strategically using PHC funds, Tharaka North is strengthening essential care delivery—even in the most remote areas.

This success story demonstrates the power of localized, collaborative action in achieving equity in health and moving Kenya closer to universal health coverage.

SECTION

3

DRIVING RMNCAH AND ESSENTIAL SERVICE PERFORMANCE THROUGH FUNCTIONAL PCNS

Busia County's Transformation of Maternal Health through Zero Home Deliveries

Introduction:

Busia County, a vibrant borderland region serving as Kenya's gateway to the East African Community, has demonstrated remarkable resilience in transforming its healthcare system. However, healthcare in border Counties like Busia faces numerous challenges. Poor road networks, difficult terrain, and lack of identification documentation create significant physical barriers. Financial hurdles, such as the high cost of cross-border healthcare, the need for foreign currency, and the non-transferability of health insurance policies, further complicate access. The County has also borne the brunt of epidemics, including mpox, red eye disease, Ebola scares, and COVID-19, due to international travel, further straining the health system. These issues are compounded by shortages of quality healthcare infrastructure and skilled personnel, as well as language barriers that hinder patient-provider communication. Underlying these challenges are disparities in national legal and institutional frameworks, which dictate healthcare entitlements and create inconsistencies in service delivery protocols across borders.

Despite these obstacles, Busia County has made significant strides in improving maternal health outcomes. One of its most notable achievements is the elimination of unskilled home deliveries in Kamuriai Location, Malaba North Ward, a community previously overwhelmed by high rates of childbirth conducted by untrained Traditional Birth Attendants (TBAs).

Kamuriai Location, comprising Korisai and Osasame sub-locations, had long struggled with unsafe home deliveries. Poverty, lack of awareness, cultural preferences, and logistical barriers, such as long distances to health facilities and fears of mistreatment by medical staff drove mothers to seek delivery services from TBAs. These practices posed severe risks, including postpartum hemorrhage, retained placenta, and neonatal complications. Additionally, cross-border dynamics, such as intermarriages and lack of identification documents, further complicated access to formal healthcare services.

Implementation of the practice

Recognizing the maternal health challenges faced by women in the community, the County initiated a partnership with local actors including chiefs, Nyumba Kumi members, village elders, Community Health Promoters (CHPs), and Traditional Birth Attendants (TBAs). This partnership began with sensitization and training sessions aimed at equipping stakeholders with the knowledge and skills to address unsafe delivery practices.

TBAs, who were key actors in home deliveries, often provided their services for a small fee, as low as KES 20, or in exchange for foodstuffs when clients could not afford to pay. Most TBAs had inherited their skills from grandparents or acquired them informally while working in hospitals as subordinate staff. Besides conducting deliveries, many offered traditional massage services, which some mothers continue to request to date.

Acknowledging that their livelihood was at stake, TBAs were trained separately on the dangers of home deliveries, the importance of skilled attendance during childbirth, and safe maternal care practices. Some TBAs gave heartfelt testimonials about traumatic experiences during deliveries that resulted in maternal deaths due to their lack of medical training. These stories reinforced the urgency for change.

Picture 10: Inception sensitization and training sessions between the chiefs, Nyumba kumi members, village elders, Community Health Promoters (CHPs), and Traditional Birth Attendants (TBAs)

To ease the transition, TBAs were offered an alternative role as birth companions. In this role, they accompany expectant mothers to health facilities for antenatal care and delivery. This strategy was effective because many women felt safer with TBAs, whom they trusted more than nurses due to prior experiences of mistreatment.

The sensitization campaign extended to the community level, beginning with village-by-village visits led by chiefs and CHPs. These efforts included dialogue days, community barazas, and forums designed to openly discuss the risks of unskilled deliveries and promote facility-based births. Chiefs played a central role by initiating health talks and involving CHPs in engaging men and husbands, helping them understand their role in supporting their spouses throughout pregnancy and ensuring clinic attendance.

To enhance impact, community stakeholder meetings were organized involving the National Government Administrative Officers (NGAO), CHPs, Community Health Committees (CHCs), TBAs, religious leaders, and Community-Owned Resource Persons (CORPs). These sessions aimed to sensitize key opinion leaders and collectively condemn unskilled deliveries. The resulting framework, developed with guidance from the Sub-County Community Health Strategy Focal Person (SCCHSFP), fostered strong multi- The County Government supported this initiative by funding community outreach programs, providing incentives for health workers, and covering transportation and referral logistics. Training was also extended to CHPs and community members to strengthen the health system at all levels.

As a result, CHPs now conduct early mapping of pregnant women within their communities, ensuring timely follow-up and linkage to health services. The engagement of community leaders, especially chiefs, has played a crucial role in sustaining awareness and reinforcing behavior change, sectoral collaboration and promoted social accountability.

Picture 11: CHPs engaging the community members on the dangers of unsafe delivery practices

Results of the practice

- The shift from home to skilled deliveries was achieved by retaining TBAs as birth companions. They now build trust, escort mothers to health facilities, monitor hesitant cases, and facilitate referrals, strengthening community confidence in healthcare.
- Local chiefs and religious leaders drove change through regular meetings, barazas (public forums), and awareness campaigns.

- The initiative was supported by a well-structured resource mobilization strategy. Funding from DANIDA enabled the development of educational materials, provision of transport for emergency referrals, and financial incentives for health workers to enhance motivation and retention. Partnerships with local stakeholders further reinforced the initiative, ensuring sustained momentum and preventing a return to unskilled deliveries.

Lessons learnt:

- Strong leadership from chiefs and local health officials proved critical for driving behavior change, as they provided consistent guidance and mobilized community participation.
- Engaging TBAs rather than sidelining them successfully built trust within the community while bridging cultural practices with modern medicine, making the transition to facility-based deliveries more acceptable.
- Community-driven solutions demonstrated greater effectiveness and sustainability compared to top-down approaches, as they incorporated local perspectives and fostered ownership of health initiatives.
- Involving men and entire family units in maternal health decisions led to better outcomes by addressing household-level barriers and creating a support system for expectant mothers.
- Consistent training and open dialogue maintained accountability among stakeholders while keeping community members invested in sustaining positive health practices.
- The availability of skilled healthcare workers and adequate facilities was necessary to handle increased referrals and maintain the zero home delivery record over time.
- Collaboration among diverse stakeholders, including health workers, local leaders, and community groups, strengthened both implementation and long-term sustainability of interventions.

Recommendations:

- Continued integration of TBAs as maternal health champions through ongoing training and small incentives to maintain their vital role in promoting facility deliveries.
- The model should be expanded to other regions and Counties facing similar challenges, ensuring that adaptation aligns with local contexts while preserving core principles.
- Establishing partnerships to provide transport vouchers or delivery care packs, further incentivizing hospital births and reducing financial barriers.
- Maintain regular community dialogues to ensure continuous improvement, address emerging challenges, and preserve the community's sense of ownership over maternal health outcomes.

Photo Gallery – Community barazas and forums to discuss the risks of unskilled deliveries and promote facility-based births

Increasing Antenatal Care Visits At Kasemeni Dispensary Using The Roving Lab Model In Kwale County

Introduction:

Access to comprehensive and timely maternal health services remains a challenge for pregnant women in Kasemeni, a rural area in Kinango SubCounty, Kwale County. Long distances to facilities offering laboratory services—combined with the unavailability of essential ANC diagnostic tests (Hb, urinalysis, HIV testing)—resulted in low ANC attendance. Many women skipped scheduled visits because referrals to distant hospitals increased costs and travel time.

This gap increased the risk of missed early detection of pregnancy complications such as anaemia, infections, and highrisk pregnancies.

Implementation of the practice:

To address this, the County Government of Kwale, through the Department of Health Services, introduced the Roving Laboratory Model—a mobile service where SubCounty laboratory technologists rotate across remote facilities to offer essential diagnostic tests.

- **Geographic Coverage and Rotation Schedule:** The rotation serves select hardtoreach facilities within Kinango SubCounty, including Kasemeni, Mshanga, Kibandaongo, and Ndavaya. Kwale County operates three roving lab units, each allocated to a different cluster of peripheral facilities.
- **Frequency:** At Kasemeni Dispensary; the roving lab team visits once every week aligned with ANC clinic days. In other peripheral facilities, visits occur monthly depending on patient volumes.
- **Partners and Funding:** The model is implemented by the County Department of Health, with technical support from:
  - ✓ KWTRP (KEMRIWellcome Trust Research Programme) – supported digital tracking tools
  - ✓ Nutrition International – supported IEC materials for ANC
  - ✓ County Government – funds personnel, fuel, and part of the reagents

The mobile lab units were assembled and equipped by the County Government, using:

A refurbished County van

- ✓ Loaned portable diagnostic kits from subcounty labs
- ✓ Additional supplies purchased through the County health budget

Picture 1: Community members awaiting roving lab services

➢ **Service Package**

During the weekly roving lab days, services offered include:

- ✓ Haemoglobin (Hb) testing
- ✓ HIV testing (including partner testing)
- ✓ Urinalysis
- ✓ Syphilis screening
- ✓ Random blood sugar
- ✓ Malaria testing
- ✓ Recording results directly in ANC booklets and facility registers

➢ **Community Engagement and Publicity**

To ensure optimal attendance, the County uses:

- ✓ CHPs conducting doortodoor mobilization
- ✓ Community dialogues involving men
- ✓ Announcements in chief's barazas
- ✓ WhatsApp groups managed by CHEWs

➢ **Technology Integration**

Supported by KWTRP, the dispensary uses:

- ✓ A digital ANC register
- ✓ Automated reminder SMS
- ✓ A dashboard to flag missed appointments and highrisk pregnancies

This system enables timely followup and supports real-time monitoring.

Picture 2: Community members receiving lab services at the mobile laboratory in Kwale

Picture 3: Medical officer offering lab services at the roving lab in Kwale County

Results of the practice

Since the Roving Laboratory Model began in 2024, Kasemeni Dispensary has documented remarkable improvements:

1. **Improved ANC Uptake**
   - ✓ **ANC 1 attendance increased from 62% in 2023 to 88% in 2025. ANC 4 completion rose from 41% to 70%** in the same period.
   - ✓ Mothers tested for HIV, syphilis, and anaemia increased by over 40%.
2. **Increased HighRisk Pregnancy Detection**
   - ✓ The number of highrisk pregnancies identified and referred to Kinango SubCounty Hospital doubled between 2024 and 2025.

3. Enhanced Community Trust

Women reported that they:

- ✓ Trust services more since tests are available onsite
- ✓ Prefer attending ANC at Kasemeni due to reduced transport costs
- ✓ Feel safer knowing complications can be detected early

Health workers also reported improved client satisfaction.

Source of data: Kasemeni ANC Register (2023–2025), Roving Laboratory Logbook 2024–2025, DHIS2 maternal health trends for Kinango SubCounty.

Kwale County has outlined a sustainability roadmap:

1. Integrating the model into annual County health budgets covering fuel, maintenance, and laboratory reagents.
2. Capacitybuilding for additional laboratory technicians to expand rotation clusters.
3. Procurement of two additional portable lab kits in FY 2026/27 to reduce service interruptions.
4. Gradual transition away from partnersupported digital tools the County ICT unit will host and manage the ANC digital system.

Lessons learnt:

- ➢ Bringing services closer to the community increases access and encourages consistent ANC attendance. Bringing services closer to communities significantly improves uptake, especially in hard-to-reach areas.
- ➢ Inter-departmental collaboration between clinical, laboratory, and community units is crucial for efficiency and sustainability.
- ➢ Planned outreach and communication through community health promoters enhances turnout during Roving Lab days.
- ➢ Community ownership is also critical. Engaging local leaders, men and CHPs ensured acceptance and sustainability of the initiative.
- ➢ Data-driven approaches work. Real-time tracking and reminders helped retain women in the ANC continuum.

Recommendations:

- ➢ Conduct needs assessments to prioritize underserved facilities.
- ➢ Integrate roving lab services into existing subcounty structures to minimize cost.
- ➢ Enhance community mobilization through CHPs and local radio stations.
- ➢ Use digital tools for tracking ANC attendance and follow-up.
- ➢ Combine roving lab visits with other health outreaches for efficiency.
- ➢ Strengthen County ownership through dedicated budgeting.

How Community Linkages are Transforming Maternal and Child Health At Malava Sub-County Hospital, Kakamega County

Introduction:

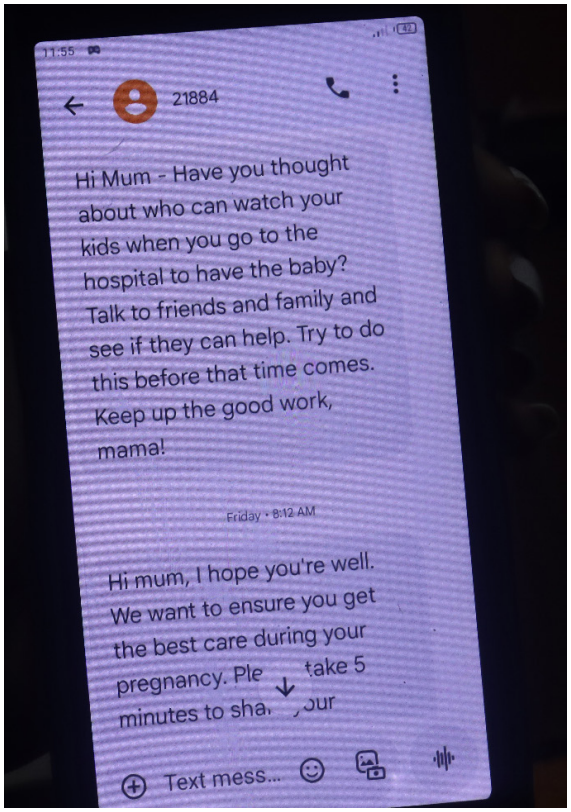
Maternal and child health remains a national priority in Kenya, with Counties at the frontline of implementing strategies that advance Universal Health Coverage (UHC). Despite improvements, challenges such as low Antenatal Care (ANC) attendance, limited male involvement, and the persistence of traditional home deliveries continue to undermine progress. County Governments, therefore, have sought to strengthen service delivery by building stronger community facility linkages, engaging local structures, and introducing innovations that make care more inclusive and accessible.

Malava Sub-County Hospital in Kakamega County stands out as a leading example of how community linkages can strengthen maternal and child health. The hospital has successfully demonstrated that maternal and newborn outcomes improve significantly when the community is fully involved in the continuum of care. By leveraging Community Health Promoters (CHPs), community dialogue platforms, and even engaging Traditional Birth Attendants (TBAs), Malava has redefined family engagement in health care service provision for outcomes.

Implementation of the practice

The transformation at Malava Sub-County Hospital is anchored on deliberate steps that place communities at the center of maternal and newborn care.

The process begins at the household level, where Community Health Promoters (CHPs) identify expectant women early enough, sometimes as soon as four weeks into pregnancy, and encourage them to start ANC. CHPs not only mobilize mothers but also accompany them to the hospital, maintain detailed follow-up records, and provide consistent after-visit care. Their close proximity to households ensures no mother is left behind.



Picture 1: Hospital SMS to an expectant mother providing reminders and guidance for clinic visits, pregnancy care, and family support.

To complement this, the hospital conducts outreaches and dedicated clinic days that bring services closer to communities, reducing the distance barrier that often discourages mothers from attending ANC. Coordination is further supported by Maternal and Neonatal Committees and Community Health Assistants (CHAs), who ensure quality and continuity of care.

Within the facility, investment has been made towards a specialized Newborn Care Unit, which provides interminable support for infants until the time of discharge. The hospital also receives referrals from neighbouring facilities, underscoring its role as a critical facility for neonatal and maternal care in the Sub-County. The Nurse-in-Charge plays a visible leadership role, personally checking on mothers in the wards and ensuring quality care. Expectant

mothers are also given opportunities to tour the wards, interact with nurses and doctors, and familiarize themselves with delivery processes, which helps build confidence and preparedness.

Technology has been integrated into service delivery through a prompt Short Message Service (SMS) reminder system. Once a mother is registered at ANC, she begins receiving regular text messages reminding her of clinic visits, health talks, and follow-up appointments after delivery. Importantly, these messages are also sent to CHPs, creating a dual accountability system where both the mother and the health promoter stay engaged.

Beyond clinical care, the hospital has invested in inclusive community engagement mechanisms. Dialogue days bring together men, women, and families to openly discuss maternal health, ANC, and safe deliveries. To encourage male involvement, men who accompany their partners to the hospital are given priority services, particularly during Point of Care Ultrasound (POCUS) sessions. This approach has significantly boosted male participation in maternal care, which was previously limited.

To promote equity in access, the hospital introduced a ticketing system that ensures clients are served on a first-come-first-served basis, eliminating discrimination and building trust. Meanwhile, Traditional Birth Attendants (TBAs), once seen as competitors to formal health facilities, have been sensitized and integrated into the health system as birth companions and advocates, actively mobilizing women to deliver at the health facilities and further supporting them throughout the journey.

Managing maternal complications, particularly Postpartum Haemorrhage (PPH), has been another focus area. The facility records an average of one to two PPH cases per week. To address this, staff have been trained in emergency response, and the hospital laboratory ensures the constant availability of at least two units of blood. While this has helped curb complications to some extent, shortage in blood supply remains a challenge in the County.

Results of the practice

- The number of women completing at least four ANC visits rose from 42% in 2019 to 71% in 2024. Facility-based deliveries also increased, from 58% in 2019 to 82% in 2024. These gains demonstrate how early mobilization by CHPs, together with community dialogue and consistent follow-up, has directly translated into higher service uptake.
- Every 2–3 months, the hospital convenes open days where experienced mothers share testimonies, tour maternity wards with expectant mothers, and offer peer guidance. First-time mothers have particularly benefitted, with many reporting that these sessions helped them overcome fears and better prepare for delivery.
- Early ANC attendance has enabled the hospital to identify at least 68% of cases of Rhesus incompatibility and HPV during the first two trimesters, compared to previous years when most cases were only discovered late in pregnancy or at childbirth. Early detection has allowed timely interventions which have seen a reduction in complications and improved maternal and newborn survival rates.
- Male partners' participation grew from 15% in 2019 to 39% in 2024. This involvement is particularly evident during ultrasound sessions, where men witness fetal development firsthand. These experiences have made men more interested, supportive, and excited about the pregnancy journey, helping foster stronger family-centered care.
- Over 30 TBAs have been sensitized and integrated into hospital outreach efforts. They now mobilize women for ANC and deliveries, accompany them to the facility as birth companions, and provide supportive health talks.
- Through continuous health education, peer testimonies, and supportive follow-up, mothers have expressed feeling more confident about facility care. Many first-time mothers say the support reduced anxiety and encouraged them to adhere to clinical advice.

- The introduction of a ticketing system has replaced the previous culture of favouritism, where some patients were attended to ahead of others regardless of their arrival time. By instituting a first-come, first-served approach, the hospital has enhanced fairness, strengthened community trust, and significantly reduced complaints of discrimination.

Lessons learnt:

- Strong and deliberate community linkages are important in improving maternal and child health outcomes.
- Simple communication tools such as SMS reminders can significantly improve compliance and follow-up.
- Male involvement creates stronger family support systems, improving both maternal and newborn outcomes.
- Effective engagement of TBAs in the health care system as allies make them become powerful partners rather than competitors and a threat to the health system.
- Transparent, fair, and inclusive practices between communities and link health facilities strengthen trust between facilities and the communities they serve thus enhancing outcomes.

Recommendations:

- There is need to strengthen continuous communication and feedback loops with communities through CHPs to ensure sustained demand for services.
- It is important to institutionalize maternity open days as a regular feature to promote awareness, build trust, and facilitate peer learning.
- Counties should scale up training for health workers, particularly in the management of Postpartum Haemorrhage (PPH), one of the leading causes of maternal deaths.
- There is need to strengthen the supply chain for essential MNCH commodities including blood supply to guarantee timely response to PPH and related emergencies.
- It is important to continue engaging TBAs as trusted community influencers and birth companions to sustain gains in facility-based deliveries.

Bringing Diagnostic Services Closer: How Portable Ultrasound is Transforming Maternal Health Care in Mwatate Sub-County Hospital – Taita Taveta County

Picture 1:Portable Point-of-Care Ultrasound (POCUS)

Mwatate Sub-County Hospital, located in Taita Taveta County, serves a predominantly rural population where access to specialized diagnostic services has historically been limited. Expectant mothers often had to travel long distances; sometimes over 50 kilometres to access ultrasound scans at the County referral hospital in Voi increasing the referral burden for basic ultrasound scans. Access to imaging services was also limited often leading to delayed or missed diagnoses especially for high-risk pregnancies. High maternal and neonatal complications were also reported due to lack of timely obstetric assessments. These challenges highlighted the urgent need for innovative, low-cost diagnostic tools that could function effectively in rural, resource-limited settings.

To bridge this gap, Mwatate Sub-County Hospital through the Taita Taveta County Health Department introduced a **Point-of-Care Ultrasound (POCUS);** a portable, battery-powered ultrasound device that enables clinicians to perform real-time imaging at the patient's bedside. The portable machine is also used during periodical community outreaches especially in the extensive nearby sisal plantations. The good practice aligns with Taita Taveta's County Government efforts to strengthen primary health care (PHC) and advance Universal Health Coverage (UHC) through affordable, accessible, and timely diagnostic services.

Since the introduction of the portable ultrasound the Mwatate Sub-county referral hospital:

- **Over 1,200 women** have received antenatal ultrasound scans within the facility and outside especially during the outreaches in the extensive neighbouring sisal estate.
- **Early detection** of complications such as ectopic pregnancies, multiple gestations, and fetal distress has improved management and outcomes.
- **Increased antenatal attendance** as women are more motivated to attend clinics knowing they can receive comprehensive care locally.
- **Improved clinical decision-making,** as clinicians can make prompt and accurate diagnoses in emergency cases (e.g., abdominal pain, trauma, and suspected internal bleeding).

Form this initiative, it is very clear that decentralizing diagnostics through portable technologies significantly improved access to quality healthcare at the primary level. The use of the Point-of-Care Ultrasound in Mwatate Sub-County Hospital has proven to be a game-changer in maternal and general healthcare delivery. It demonstrates how simple, low-cost technologies can dramatically improve outcomes and bring essential services closer to communities.

Strengthening Routine Immunization in Ilula Central: A Community-Driven Approach in Uasin Gishu County

Introduction:

Routine immunization uptake in Ilula Central, a rural community within the Cheboin sub-location of Kapsoya Ward, Uasin Gishu County, had persistently lagged behind national targets, creating a dangerous immunity gap among children under five. For years, the community faced ongoing challenges in achieving adequate vaccination coverage, often falling below the County's average of 70.1% for DPT3 coverage, as reported in the 2022 Kenya Demographic and Health Survey (KDHS). A combination of factors has contributed to this situation, including widespread misinformation about vaccine safety, logistical barriers to accessing health services, and resistance from certain religious groups that express skepticism toward modern medical practices.

In early 2023, public health surveillance systems detected three confirmed cases of measles in Ilula Central, along with 26 zero-dose cases identified within a single month. Subsequent epidemiological investigations revealed troubling trends, including gaps in childhood immunization coverage and limited caregiver awareness of vaccine-preventable diseases. Community surveys further underscored the need for enhanced public health education and improved access to routine immunization services. Focus group discussions with local mothers uncovered deeply rooted myths, such as fears that vaccines cause infertility or contain forbidden animal products.

These findings exposed weaknesses in the area's primary healthcare infrastructure. Although the community is nominally served by 13 Community Health Promoters (CHPs) under the Kogilgei Community Unit, their efforts have been hindered by cultural barriers and a lack of trust. Religious leaders from minority sects have actively discouraged followers from attending vaccination drives, while some traditional herbalists continue to promote harmful practices, such as treating ailments with herbal enemas instead of referring cases to health facilities. With the threat of further outbreaks looming, urgent action was needed to address these gaps and protect the community's children.

Implementation of the practice:

In response to the measles outbreak, a coordinated and community-driven intervention was launched to control the spread of the disease and improve immunization coverage. The initiative brought together multiple sectors and stakeholders, leveraging local leadership, health systems, and community structures to ensure an effective and sustainable response. The process was marked by strategic planning, targeted outreach, and continuous monitoring, all aimed at protecting vulnerable populations, particularly children under five years old.

Figure 14: An award given to Cheboin CHU for the Best Performing Community Health Unit

The response was implemented through the following steps:

1. A consultative meeting was held involving key stakeholders, including the local administration (NGAO), education officers, healthcare workers, security personnel, and religious leaders. This multi-sectoral engagement laid the foundation for coordinated planning, enhanced outbreak awareness, and a harmonized approach to implementation.
2. A significant entry point was the involvement of the Assistant Chief, a former Community Health Promoter (CHP), who led community mobilization efforts. Supported by Community Health Committees (CHCs) and CHPs, the team organized community barazas and dialogue days to educate residents on the importance of immunization. Household visits were conducted to identify children who had missed routine vaccinations.
3. With support from DANIDA, the program facilitated training for Community Health Assistants (CHAs) and provided resources for outreach services. This included funding for transportation, communication, and referral systems, ensuring that operational needs were met.

Figure 18: Community Health Promoters (CHPs) and the Community Health Committees (CHCs) working who provide their services at Cheboin sub-location of Kapsoya Ward

4. Special outreach days were organized to provide catch-up immunizations for children under five. Some sessions were conducted in schools, targeting preschool children under three. Immunization cards were used to screen and identify defaulters.
5. County and Sub-County Health Management Teams (CHMT and SCHMT) offered technical support and oversight throughout the implementation. Community leaders, including village elders and religious figures, played a key role in mobilization and addressing vaccine hesitancy, particularly among religious sects initially opposed to immunization.
6. To ensure long-term impact, a requirement was introduced requiring all children enrolling in preschool to present a valid immunization card. Monthly CHP meetings were held to monitor progress and follow up on the 26 zero-dose cases identified during household visits.
7. The initiative leveraged local resources, with CHPs and healthcare workers conducting health education and administering vaccines. Information, Education, and Communication (IEC) materials and posters were used to reinforce key messages. The Chama cha Mama Toto initiative, which supports maternal and child health at community level, complemented these efforts by promoting maternal and child health, and encouraging service uptake.

Results of the practice

Children who had previously missed routine immunizations were successfully identified through household visits and promptly vaccinated.

- The community demonstrated increased acceptance of routine health services, reflecting a shift in health-seeking behavior.
- Religious leaders who had initially opposed immunization changed their attitude and began actively supporting the initiative, encouraging their followers to participate.

- There was a notable increase in attendance at maternal and child health services, contributing to a reduction in immunization defaulters.
- Community members became more engaged in healthcare decision-making which encouraged a stronger sense of ownership and responsibility for health outcomes.
- Health facilities reported improved uptake across all immunization and child health services, indicating broader community trust and participation.
- Community Health Promoters (CHPs) were involved in tracing defaulters and registering households. They used immunization cards and household registers to identify zero-dose children and follow up with caregivers, ensuring no child was left behind.
- Effective collaboration among all stakeholders, including local administration, health workers, educators, and religious leaders led to the success of the initiative.
- Routine immunization coverage increased significantly, and the number of zero-dose cases declined as a result of targeted outreach and follow-up.

Lessons learnt:

- Continuous community engagement through dialogue days and feedback meetings promotes health ownership and trust.
- Monitoring and evaluation by healthcare providers and CHPs ensures timely identification of gaps and progress tracking.
- Community-led solutions, especially when supported by local leaders and CHPs, are sustainable and cost-effective.
- CHPs' contributions to health education, household registration, and defaulter tracing are essential for strong community health systems.
- County-level support, including the provision of stipends for CHPs and the enactment of health laws like Facility Improvement Fund (FIF), enhances program sustainability.
- It is important to engage all relevant stakeholders, including religious and traditional leaders, in order to overcome social and cultural barriers.

Recommendations:

- This model of collaborative response and community engagement should be scaled up and adapted in other regions with similar challenges.
- Continued support from National and County Governments, development partners, and local leaders is important for sustainability.
- Strengthening stakeholder involvement and ensuring regular community dialogue will help maintain high immunization coverage.

SECTION

4

SUSTAINABLE HEALTH FINANCING AND STRATEGIC PARTNERSHIPS FOR PCNS

Sustainable Health Financing for Primary Healthcare: The Rukala Model Health Centre Experience, Busia County

Introduction:

The Constitution of Kenya (2010) enshrines health as a right, entitling every citizen to the highest attainable standard of healthcare. It also assigns health as a devolved function, placing the responsibility for service delivery primarily on County Governments. Counties are therefore mandated to plan, finance, and deliver health services, while the National Government plays a policy and regulatory role. To realize this constitutional obligation, Counties must deliberately invest in health financing, human resources, service delivery, health products and technologies, digitization of health data, and strong leadership and governance structures.

Busia County has operationalized these principles through key legislation: the Busia Community Health Services Act (2023) and the Busia Facility Improvement Financing (FIF) Act (2024), which empower health facilities to mobilize, retain, and utilize revenues directly at the point of service delivery.

In 2024, Kenya launched the Social Health Authority (SHA) to replace the NHIF as the national health insurance framework. SHA ensures access to a defined package of health services and reimburses accredited facilities for care provided. In line with this national requirement, Rukala Model Health Centre proactively implemented SHA, integrating it with the FIF framework to strengthen service delivery and improve financial sustainability.

The facility serves a catchment population of 6,226 people, supported by two satellite facilities (Osieko and Bulwani) and four community health units (Namabusi, Mabinju, Rukala A, and Rukala B). It provides outpatient, inpatient, maternity, and chronic disease management services delivered by a multidisciplinary team of clinical officers, nurses, lab technicians, public health staff, and community health promoters. For a long time, the facility relied on declining DANIDA grants, which created challenges in stock management, service continuity, and financial autonomy.

Implementation of the practice:

The implementation at Rukala Model Health Centre focused on operationalizing the Social Health Authority (SHA), in conjunction with the Busia Facility Improvement Financing (FIF) framework to ensure sustainable primary healthcare financing. The facility proactively embraced SHA registration and used the FIF Act to retain and reinvest revenues directly at the facility level, strengthening service delivery and community trust.

The process began with intensive community mobilization to raise awareness about SHA, its benefits, and the registration requirements. Health workers and Community Health Promoters (CHPs) conducted outreach through chiefs' barazas, community dialogue days, markets, schools, and churches, supported by four targeted monthly outreaches to cover every village in the catchment area.

On-site registration desks were set up to enable immediate enrolment and address common challenges such as misinformation, digital literacy gaps, and resistance from community members. During registration, the facility encountered operational barriers:

- Some residents had lost identification documents or birth certificates during floods.
- Others, particularly border residents from Uganda, lacked valid national documents.
- Many had outdated or inactive mobile numbers, preventing receipt of SHA one-time passwords (OTPs).

Through collaboration with the County Health Department, SHA support teams, and mobile service providers, these issues were resolved efficiently. Tasks that previously took up to 24 hours were now addressed within minutes, ensuring residents could access SHA registration and services without delays.

Picture 1: Maternity wing at Rukala Model Health Centre, fully equipped to provide safe and quality delivery services.

To improve maternal and child health service utilization, the facility introduced incentive-based strategies where CHPs received KES 500 stipends for early referrals of pregnant women and families supporting antenatal care attendance and child immunizations received small incentives such as bar soap, basins, and cotton wool. These measures increased early ANC attendance, immunization coverage, and monthly deliveries, with 16 deliveries per month, surpassing the facility target of 15. The approach also strengthened community trust in the SHA system, as residents experienced tangible improvements in service quality.

- As SHA enrolment and service utilization increased, SHA reimbursements, managed under the FIF framework, were reinvested directly into the facility to address service gaps. Key investments included: Procurement of essential medicines, laboratory reagents, and maternal-child health commodities, reducing stock-outs.
- Rehabilitation of four rainwater harvesting tanks, ensuring a reliable water supply.
- Provision of meals and welfare support for staff, enhancing morale and productivity.
- Deployment of a dedicated SHA registration officer and training of all staff on SHA guidelines, claims documentation, and ICT tools to reduce claim rejections and improve registration efficiency.

Picture 2: Vaccine fridge donated by UNICEF for safe vaccine storage

Support from development partners complemented SHA–FIF integration:

- UNICEF provided solar panels to reduce electricity dependence and donated a vaccine fridge for immunization services.
- Kenya Red Cross renovated water tanks, addressing water scarcity and improving hygiene standards.

Results of the practice /Intervention:

Table 2:SHA claims and reimbursements (July 2024 – Present)

Item	Amount
Claims submitted	KES 5,940,449
Claims reimbursed	KES 1,690,327
Claims pending	KES 4,250,122
Amount withdrawn for facility use	KES 886,000

These figures demonstrate that Rukala Health Centre has begun generating substantial revenue through SHA reimbursements, managed and reinvested under the FIF framework. Although only 28% of claims have been reimbursed to date, nearly KES 900,000 has already been withdrawn and directly reinvested in improving service delivery. The large volume of pending claims highlights the need for stronger documentation and faster processing to ensure consistent cash flow.

Key outcomes:

- Patients now access all essential services without out-of-pocket payments, improving equity in healthcare.
- Staff motivation has increased significantly, supported by FIF-funded meals, welfare provisions, and stipends for casual workers.
- Four previously broken water tanks were rehabilitated, ensuring reliable rainwater harvesting for staff and patients.
- Procurement of essential medicines, laboratory reagents, and non-pharmaceutical supplies is now regular, minimizing stock-outs.

Community health-seeking behavior has improved, with higher ANC attendance and completion of child immunization schedules.

Lessons learnt:

- Persistence and resilience by health workers ensured uninterrupted services, even when the facility was cut off by flooding during rainy seasons.
- Embedding business principles in facility operations improved revenue generation and sustainability.
- Providing meals to health workers acted as a motivation that boosted staff morale, saved time, and improved productivity.
- Linking incentives to antenatal visits and child immunization increased service uptake and changed community health-seeking behaviour.
- Assigning a dedicated SHA registration officer and ICT tools increased enrolment numbers and improved claims processing.
- Revenue generated through SHA and FIF can be reinvested directly to address facility needs and improve service delivery.

FIF is complementary to national equalization funds, ensuring flexibility at the facility level while national resources support broader County priorities.

Recommendations:

- Facilities should be granted full autonomy to utilize all revenues generated for the benefit of the facility and the community, with strict accountability measures in place.
- Health facilities should organize integrated outreaches that bring on board other sectors, such as civil registration, to facilitate the issuance of birth certificates and national identification cards, prerequisites for SHA registration.
- The National Assembly and Senate should develop a position paper and legislate amendments to the SHA Act to allow more flexible SHIF premium payment schedules (monthly, quarterly, semi-annual, or annual), as most citizens cannot afford lump-sum annual payments.
- There is need to finalize and operationalize Busia FIF regulations to ensure consistency in facility-level implementation.
- Encourage pooling of FIF resources at sub-county level to support larger projects, while safeguarding individual facility priorities.
- There is need for continued support towards portable desks for registration, stipends for CHPs, and incorporation of school health talks to reinforce community engagement and service uptake.

Figure 6: Designated office space for patient registration and processing of SHA claims

From Savings to Stronger Care: How Community Health Promoters in Makueni are Financing Better Health Outcomes

Introduction:

In many Kenyan communities, the first interaction with the health system happens not in hospitals, but at the doorstep—through trusted Community Health Promoters (CHPs). These frontline workers play a critical role in health education, disease surveillance, maternal and child health follow-up, immunization support, and timely referrals. Their work underscores a fundamental truth: health begins at the community level.

In Makueni County, strengthening community health systems has been central to advancing Primary Health Care (PHC) and Universal Health Coverage (UHC). With a population of 1,067,845 (2019 Census), the County comprises six sub-counties, 18 hospitals, and 279 Level 2 and 3 health facilities across government, private, and faith-based providers. Although the County's health facility density stands at 2—below the national target of 2.5—Makueni has compensated through deliberate investment in a robust community health workforce.

The County has fully established and operationalized all 240 Community Health Units (CHUs), supported by 3,660 CHPs who form the backbone of household-level service delivery. At Kimeeni Dispensary, 36 CHPs linked to four CHUs exemplify how strong community–facility linkages can improve early detection of health risks, increase service uptake, and enhance overall health outcomes.

Implementation of the practice

Picture 1 1: Kimeeni C.U - A village savings and lending group during an engegement session with CoG

CHPs attached to Kimeeni Dispensary routinely conduct household visits, often traversing long distances—on foot or by motorcycle—to reach hard-to-access households. While stipends are jointly financed by the County and National Governments on a 50:50 basis, delays in disbursement have historically disrupted their ability to meet both personal and professional needs.

To cushion themselves against these financial challenges, the CHPs formed a savings group in 2013. Initially, members contributed KES. 20 weekly, later adjusting to KES. 100 monthly as the group matured. In 2016, World Vision introduced table banking in Kathulumbi Sub-County, training community members through a Training of Trainers (ToT) model. This approach enabled scale-up across community units by 2020.

Kimeeni Dispensary's savings group benefited from this initiative when its chairperson received formal training in early 2022 and subsequently cascaded the knowledge to fellow CHPs. The group established a structured savings mechanism, starting with basic tools such as a lockable metal box, ledgers, passbooks, and money bags, and later formalized operations through a constitution.

Each member holds five shares valued at KES. 50, contributes KES. 20 to a social fund upon joining, and saves a minimum of KES. 50 weekly, with a maximum share purchase of KES. 250. In 2022, with support from World Vision, the group transitioned to a digital platform—Dream Save—to improve transparency, accountability, and efficiency. The application tracks individual savings, loans, social funds, and overall group performance, overseen by three designated signatories.

To date, the group has successfully completed three savings cycles—mobilizing KES. 180,000, KES. 220,000, and KES. 287,000 respectively—with a fourth cycle currently underway.

Results of the practice

- **Improved Livelihoods and Personal Well-being**
  - ✓ CHPs are now able to pay school fees for their children without financial strain.
  - ✓ Several members have invested in small businesses, including hospitality ventures, increasing household incomes.
  - ✓ Overall living standards among CHPs have significantly improved.
- **Enhanced Service Delivery**
  - ✓ Financial stability has boosted morale and motivation among CHPs.
  - ✓ Household visits have increased due to improved access to transport.
  - ✓ Referrals are timelier, as CHPs can now support patients with transport costs.
  - ✓ Data availability and reporting have improved through E-CHIS, strengthening decision-making and accountability.

Lessons learnt:

- **Financial empowerment drives performance:** Supporting CHPs' economic resilience directly enhances service delivery and consistency.
- **Community-led solutions are sustainable:** Savings groups managed by CHPs themselves foster ownership, accountability, and long-term viability.
- Capacity building enables scale: The Training of Trainers model accelerated adoption of table banking across multiple CHUs.
- **Digital tools enhance transparency:** Platforms like Dream Save simplify financial management and build trust among members.
- **Partnerships matter:** Collaboration with partners such as World Vision strengthened skills, systems, and innovation at community level.
- **Small investments yield big returns:** Modest contributions and simple tools have translated into meaningful improvements in health outcomes.
- **Workforce welfare is critical:** Strengthening the personal well-being of CHPs is as important as investing in infrastructure and supplies.

Recommendations:

- Fast-track timely disbursement of CHP stipends to reduce financial vulnerability.
- Scale up community savings initiatives across all CHUs to strengthen financial resilience.
- Promote adoption of digital financial management tools for transparency and accountability.
- Enhance continuous training in financial literacy, table banking, and group governance.
- Strengthen County–partner collaboration to provide technical and resource support.
- Integrate economic empowerment initiatives into broader community health strategies.

Strengthening Primary Health Care Delivery through Community Health Promoter Livelihood Initiatives in Kitui County

Introduction:

Located in the Eastern region of Kenya, Kitui County has a total of 505 health facilities serving a total population of 1.259 million residents, distributed across its 8 sub-counties. Despite this network, gaps in service delivery have persisted, particularly at the community level where Community Health Promoters (CHPs) are the backbone of Kenya's primary health care system.

CHPs provide the first line of contact for households, linking them with formal health services. However, for years, their effectiveness was undermined by financial insecurity. With a monthly stipend of just KES 3,000, many CHPs faced economic hardships, leading to high attrition and disrupted service continuity.

Recognizing this challenge, the County Government of Kitui, through its Department of Health services and sanitation, initiated a bold and structured economic empowerment model. The goal of the initiative was to enhance CHP motivation, retention, and performance by embedding livelihood support directly into the health delivery ecosystem.

Implementation of the practice:

Kitui County has 2,470 Community Health Promoters (CHPs) organized into 247 Community Health Units (CHUs). To operationalize the empowerment model, the County Government further organized the CHPs into 247 savings and investment groups, each comprising 10 members. One such initiative is the Kitungati Community Health Unit cluster, which brings together two CHUs—Ngagani and Kitungani—located in Kitui Rural Sub-county. These two CHUs formed a joint cluster known as the Ngatunga Community Health Group in July 2023.

Operationalizing economic empowerment for community health promoters in Kitui County

To strengthen the delivery of primary health care while enhancing the livelihoods of frontline health workers, Kitui County Government through the department of health services, adopted a structured economic empowerment model targeting its 2,470 CHPs. This initiative is anchored in the belief that financially secure CHPs are more motivated, consistent, and impactful in their service to communities.

Group structuring and institutional anchoring

The first step in operationalizing the model involved organizing CHPs into 247 savings and investment groups, each comprising 10 members. This group-based approach fosters peer accountability, shared learning, and collective decision-making. To formalize their operations, each group was:

- ✓ Registered with the Department of Social Services, ensuring legal recognition and access to government support services.
- ✓ Facilitated to open bank accounts, enabling secure financial transactions and access to formal financial systems.
- ✓ Assigned Community Health Assistants (CHAs) as co-signatories to the accounts, reinforcing oversight and promoting financial discipline.

This institutional anchoring ensures that the groups operate transparently and are positioned to engage with external partners, including financial institutions and development agencies.

Stipend allocation and financial pooling

Each CHP receives a monthly stipend of KES 1,000, provided by the County Government as part of its commitment to incentivize and retain health workers which goes directly into savings. This translates to KES 120,000 per group annually and KES 29.64 million Countywide per year. Rather than disbursing stipends individually, the funds are pooled within each group's account. This collective pooling serves as the foundation for savings accumulation and future investment in income-generating activities (IGAs).

Year 1: Savings and capacity building

The first year of implementation was deliberately focused on building financial literacy, group cohesion, and entrepreneurial capacity. Activities include:

- ✓ Training in entrepreneurship, covering business planning, market analysis, and risk management.
- ✓ Workshops on group dynamics, leadership, and conflict resolution.
- ✓ Financial literacy sessions, including budgeting, record-keeping, and savings culture.

Picture 1: Display showing all products made during the training of Ngatunga CHP Group at Kitungati Dispensary

Through the partnership with the Ministry of Health and Sanitation, Kitui County FINISH INK supported the training and capacity building of the Ngatunga Community Health Group on the implementation of market-based sanitation activities such as making selling sanitation products, innovative e-ledger system for saving and loaning for sanitation improvement and table banking.

This phase was critical for laying a strong foundation. It ensured that CHPs not only understand the principles of economic empowerment but are also equipped to manage group resources responsibly.

Year 2 Onward: Economic activation and sustainability

From the second year, groups begin to access their pooled savings to launch IGAs tailored to local market opportunities and member interests. Common ventures chosen by various CHP groups include:

- ✓ Poultry farming
- ✓ Soap and detergent production
- ✓ Small-scale retail kiosks
- ✓ Value-added agricultural processing

To ensure sustainability, groups are required to continue saving biannually, maintaining a revolving fund that supports reinvestment, expansion, and financial resilience.

Transparency and accountability mechanisms

To safeguard group assets and promote trust, several governance measures are embedded into the model:

- ✓ Dual signatory system involving CHAs and group leaders
- ✓ Regular financial audits and reporting to the County Health Department
- ✓ Experience-sharing forums where groups showcase progress, challenges, and innovations
- ✓ Mentorship by CHAs, who provide technical guidance and monitor group performance

These mechanisms not only prevent misuse of funds but also foster a culture of integrity and shared responsibility. The Ngatunga Community Health Group for example was also trained on the use of the ala Data App; a financial accountability tool for managing their sales and finances. This model is already yielding positive outcomes improved CHP motivation, reduced attrition, and enhanced service delivery at the community level. It stands as a replicable framework for other Counties seeking to integrate health service delivery with economic empowerment.

Results of the Economic Empowerment Model for CHPs in Kitui County

The implementation of Kitui County's economic empowerment model for CHPs has yielded a range of impactful results, both immediate and long-term, across financial, operational, and service delivery dimensions.

Key Outputs

- ✓ Formation of 247 savings and investment groups, each comprising 10 CHPs, fully registered and operational with formal bank accounts.
- ✓ KES 29.64 million disbursed annually in stipends, pooled into group accounts to support collective savings and future investments.
- ✓ Comprehensive training delivered to all groups in entrepreneurship, financial literacy, and group dynamics during the first year.
- ✓ Initiation of income-generating activities (IGAs) by several groups in Year 2, including poultry farming, soap production, and small-scale retail ventures.

The Ngatunga Community health group had saved 30,000Kshs between Jan-June 2025, 50,000 from sale of Safe Toilet (SATO) stools, soaps and detergents. With each group member contributing 100 KES every month as savings, the group had further contributed 100,000KES in annual savings (2024) from the Gala data App.

Strategic Outcomes

- ➢ **Strengthened financial literacy and entrepreneurial capacity**

  From trainings and capacity building sessions offered by the Kitui County Government, the CHPs have acquired practical skills in budgeting, savings planning, and business development. This has enabled them to manage pooled resources with discipline and foresight, evaluate and launch viable IGAs tailored to local market needs while also building personal and group financial resilience.

- ➢ **Improved motivation, cohesion, and service delivery**

  The group-based model has fostered a sense of belonging and shared purpose among CHPs. The model has fostered teamwork and improved peer support; CHPs are more consistent in household visits and health promotion activities as a result communities have reported increased trust and engagement with CHPs.

- ➢ **Enhanced accountability and governance**

  The involvement of CHAs as co-signatories and mentors reinforced financial transparency and minimized misuse of funds while strengthening oversight and reporting mechanisms hence building a culture of integrity and shared responsibility.

  - ✓ Reduced dependency on external support
  - ✓ By generating their own income and reinvesting in group ventures, CHPs are:
  - ✓ Less reliant on donor stipends or ad hoc incentives;
  - ✓ More empowered to sustain their roles independently; and
  - ✓ Positioned to scale their ventures beyond subsistence level.
  - ✓
  - ✓ Boosted retention and effectiveness
  - ✓ The model has significantly improved CHP retention rates, with fewer dropouts and greater continuity in service delivery. This has led to:
  - ✓ More stable and reliable community-level health coverage;
  - ✓ Better tracking of health indicators and follow-up care; and
  - ✓ Stronger linkages between households and formal health systems.

Picture 2: SATO stool, sold by the Ngatunga Community Health Group to improve WASH in the communities in Kitui Rural Sub-county

More specifically, the Ngatunga Community Group Initiative has had a significant impact on improving hygiene and sanitation standards in Kitui Rural Sub-county and beyond. For instance, the introduction of the SATO stool has not only enhanced sanitation by upgrading traditional pit latrines but also provided comfort and accessibility for the elderly, particularly those living with arthritis who often struggle with conventional latrines.

Additionally, the production of soaps, detergents, and lotions has greatly improved household hygiene while promoting better skincare. These products have helped control skin-related conditions such as ringworms (mashilingi), especially among children, thereby complementing the efforts of CHPs in advancing community health and wellbeing.

This initiative stands as a replicable model for other Counties seeking to integrate economic empowerment into health systems strengthening. It demonstrates that when CHPs are supported not just as volunteers but as economic actors, the ripple effects extend far beyond health—into livelihoods, governance, and community resilience.

Lessons learnt:

The implementation of Kitui County's economic empowerment initiative for CHPs has surfaced several critical insights that can inform replication, scale-up, and continuous improvement across Counties:

- **Capacity building is foundational to success:** Early investment in training and mentorship is essential. Equipping CHPs with knowledge in entrepreneurship, savings culture, financial literacy, and group dynamics lays the groundwork for sustainable IGAs. This foundational phase builds confidence of the CHPs in managing pooled resources, enhances decision-making and risk assessment while also fostering group cohesion and leadership capacity. Without this preparatory stage, IGAs risk failure due to poor planning, mismanagement, or internal conflict.
- **Financial empowerment drives health outcomes**

  Economic stability directly influences service delivery. CHPs who are financially empowered; exhibit higher levels of motivation and consistency, are more committed to household visits and health promotion, experience reduced attrition, ensuring continuity in community-level care. This link between livelihood support and health system performance underscores the value of integrating economic empowerment into health workforce strategies.

- **Phased implementation enables learning and adaptation**

  A gradual rollout, starting with savings and training before transitioning to IGAs creates space for capacity development at a manageable pace, peer learning and troubleshooting (as groups share experiences and refine approaches) as well as continuous improvement, with feedback loops informing policy and operational adjustments. This phased approach therefore reduces risk, builds institutional memory, and ensures that groups are truly ready before taking on financial ventures.

These lessons affirm that economic empowerment is not just a welfare intervention; it's a strategic lever for strengthening primary health care systems. Kitui County's model demonstrates that when CHPs are supported holistically, the ripple effects benefit households, communities, and the health system at large.

Recommendations:

Drawing from Kitui County's experience, the following recommendations can guide Counties and stakeholders seeking to replicate or enhance the economic empowerment of CHPs:

- **Scale and replicate the model across Counties:** Counties with active CHP networks should consider adopting and adapting Kitui's group-based empowerment approach. By organizing CHPs into savings and investment groups, Counties can:
  - ✓ Improve motivation, retention, and performance of frontline health workers
  - ✓ Foster peer accountability and teamwork
  - ✓ Enhance the integration of livelihood support into health systems strengthening
  - ✓ Customization to local contexts, such as climate, market dynamics, and cultural norms, is essential for successful replication.
- **Strengthen monitoring, mentorship, and technical support:** Sustained success depends on robust oversight and capacity reinforcement. Counties should:
  - ✓ Institutionalize regular follow-up visits by CHAs
  - ✓ Provide ongoing mentorship and refresher training in financial management, entrepreneurship, and group governance
  - ✓ Engage other departments (e.g., Social Services, Trade, Cooperatives) to offer cross-sectoral support

This multi-level engagement ensures that groups remain accountable, resilient, and responsive to emerging challenges.

- **Integrate digital tools for efficiency and transparency:** Leveraging on digital platforms such as the Data Gala App can significantly enhance the model's scalability and impact. Counties should explore:
  - ✓ Mobile savings and banking platforms to streamline financial transactions
  - ✓ Digital reporting tools (e.g., ODK, dashboards) for real-time monitoring of group performance and health service delivery
  - ✓ E-learning modules for remote training and peer exchanges among CHP groups as well as CHP groups in other Counties

Digital integration reduces administrative burdens, improves data accuracy, and fosters transparency especially as the model expands across regions.

These recommendations position the CHP empowerment model not just as a health intervention to promote provision of PHC, but as a strategic lever for inclusive development, financial resilience, and community-driven transformation.

Picture 3: Members of Ngatunga CHP during a knowledge sharing session with COG

APPENDICES

Appendix 1: References

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Appendix 3: County Logos

Bungoma County

Busia County

Garissa County

Kakamega County

Kilifi County

Kisumu County

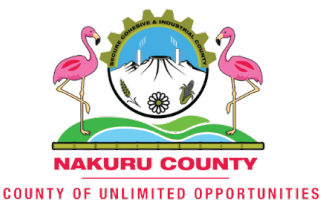
Kitui County

Kwale County

Machakos County

Makueni County

Mombasa County



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Tana River County

Tharaka Nithi County

Vihiga County

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