



## Integrated Health Financing for Enhanced Service Delivery: Lessons from Kiwandani Dispensary, Kilifi County

County:	Kilifi		
Sector/s:	Health	Sub-sector/Theme:	Integrated Health Financing
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Target Audience:	County health officials, facility managers, health financiers, development partners, policymakers, County Government		
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### Context and Pre-Intervention Reality:

Kiwandani Dispensary is a Level 2 primary health care facility serving an estimated catchment population of approximately 30,327 people in a peri-urban setting of Kilifi County. The facility provides outpatient services, maternal and child health (MCH) services, including antenatal care (ANC), family planning (FP), immunisation and nutrition services, laboratory services, and community health programmes. The facility is supported by one Community Health Unit (CHU) comprising 30 active Community Health Promoters (CHPs), who play a critical role in linking households to facility-based services.

Prior to the adoption of an integrated health financing approach, Kiwandani Dispensary operated within a fragmented financing environment. Facility operations were supported through multiple funding streams, including County health allocations, Social Health Authority (SHA) reimbursements, the DANIDA Primary Health Care (PHC) Support Programme, and other development partner contributions. However, these funding sources were often uncoordinated, characterised by delayed disbursements, parallel planning, and limited flexibility in addressing immediate operational needs.

As a result, the facility faced persistent challenges in sustaining uninterrupted RMNCAH service delivery, supporting community engagement activities, and maintaining essential operational standards. Despite strong leadership and committed staff, the absence of harmonised planning and resource utilisation limited the facility's ability to translate available funds into consistent, high-quality health services.

### Implementation of the Practice

Implementation of the integrated health financing practice began with a shift from fragmented funding utilization to coordinated financial planning and execution. The facility leadership, together with departmental heads and community representatives, conducted annual and quarterly assessments to identify service delivery gaps, operational bottlenecks, and priority RMNCAH interventions.



*Figure 1 FY 2024/2025 Q1 facility work plan integrating all funding streams, including County allocations, SHA reimbursements, DANIDA PHC support, and partner contributions*

All available funding streams including County allocations, SHA reimbursements, DANIDA PHC support, and partner contributions were harmonised under a single, integrated facility work plan. This plan was reviewed and endorsed by the Health Facility Management Committee (HFMC) and subsequently submitted through the County system for issuance of Authority to Incur Expenditure (AIEs), ensuring compliance with public finance management requirements.

To strengthen financial accountability and continuity, Kiwandani Dispensary introduced a staff rotation system for financial reporting and budget tracking. This approach ensured that multiple staff members were equipped with financial management skills, reduced dependency on single officers, and enhanced institutional memory.

The facility embedded Continuous Quality Improvement (CQI) principles into financial and service delivery processes using the Plan-Do-Study-Act (PDSA) cycle. Monthly and quarterly reviews of expenditure patterns, service utilisation data, and stock status informed adaptive planning and ensured resources were directed to high-impact interventions.

### Contribution and Impact of DANIDA PHC Support

Within Kiwandani Dispensary's integrated health financing model, the DANIDA Primary Health Care (PHC) Support Programme provided crucial operational funding that allowed the facility to translate its plans into concrete actions. Supported by the Government of Denmark, the Programme aims to strengthen Kenya's primary health care system by addressing persistent operational and service delivery bottlenecks at both community and primary facility levels (Levels 1, 2 and 3). Its focus is on improving access, quality, continuity, and equity of essential health services, as well as other priority primary health care interventions.



Figure 2 Patient waiting bay at Tsangatsini Dispensary, constructed with support from the DANIDA PHC Programme to enhance patient care services

The Programme adopts a health systems strengthening approach rather than a vertical or disease-specific funding model, recognizing that many service delivery challenges at primary care level stem not from a lack of policy or infrastructure, but from gaps in operational financing, outreach capacity, community follow-up, availability of essential commodities, and routine use of data for decision-making.

During the reporting period (FY 23/24), Kiwandani Dispensary received an allocation of KES 117,359.00 through the DANIDA PHC Support Programme. These funds were channelled through County approved plans and implemented under the oversight of the Health Facility Management Committee (HFMC), ensuring transparency, accountability, and full alignment with public finance management requirements. By bridging operational gaps that could not easily be financed through other sources, DANIDA PHC support enabled the facility to strengthen service delivery, engage the community, and sustain impactful health interventions.

DANIDA PHC support was primarily applied to areas that directly affected service continuity, quality, and community access, including:

- **Operational continuity:** Payment of locum staff and casual workers during peak service periods, ensuring uninterrupted RMNCAH service delivery.
- **Community-facility linkage:** Facilitation of Community Health Promoters (CHPs) through transport allowances, airtime, and performance incentives to support referrals, defaulter tracing, and follow-up.
- **Community engagement:** Financing dialogue days, household registration activities, school health programmes, and targeted outreach to address sociocultural barriers to service uptake.

- **Facility functionality:** Minor infrastructure improvements, sanitation enhancements, waste management, and procurement of small but essential equipment that improved the care environment.
- **Quality and accountability:** Supporting Continuous Quality Improvement (CQI) processes, routine data reviews, and responsive adjustments to service delivery.

### Results of the practice

- The integrated health financing approach resulted in clear and measurable improvements in service delivery, facility functionality, and community health outcomes. Harmonised planning across funding sources reduced duplication and operational delays, enabling timely procurement of essential medicines, vaccines, and RMNCAH commodities and ensuring uninterrupted service delivery.



*Figure 3 Patient waiting bay equipped with a triage area to streamline patient assessment and care*

- Facility functionality improved significantly through targeted infrastructure upgrades, including the construction of patient waiting bays, improvements in sanitation and waste management systems, and the partitioning of service areas to enhance privacy and quality of care for clients.
- Community engagement and linkages were strengthened through regular dialogue days, school health programmes, and household registration activities, which increased community trust in facility services. Active involvement of CHPs enhanced client follow-up, reduced defaulter rates, and contributed to improved continuity of care.
- As a result of the community-level improvements, uptake of antenatal care services increased, both early ANC and 4<sup>th</sup> ANC attendance, while skilled delivery rates improved as confidence in facility-based services grew. At the same time, the motivation and performance of CHPs improved due to incentives, transport facilitation, and airtime support, enabling them to carry out referrals and defaulter tracing more effectively.
- The integration also strengthened governance and accountability at the facility level by improving financial management capacity, transparency, and oversight, reinforcing confidence among staff, community structures, and partners.

### Lessons learnt

- Integrating multiple funding streams under a single planning and accountability framework maximises the impact of limited resources.

- Flexible, facility-level financing such as DANIDA PHC support is critical for addressing day-to-day operational gaps that undermine service delivery.
- Building financial management capacity across multiple staff members enhances flexibility and accountability.
- Continuous quality improvement processes support adaptive decision-making and sustained performance improvements.
- Strong community-facility linkages, supported through adequately facilitated CHPs, are essential for improving RMNCAH outcomes.

### Recommendations

- Counties should institutionalise integrated health financing approaches to harmonise diverse funding sources at facility level.
- Flexible PHC support mechanisms, like DANIDA PHC funding, should be sustained and expanded to enable timely response to local service delivery needs.
- Facilities should continue rotating financial management responsibilities to strengthen institutional capacity and continuity.
- Routine use of service delivery and financial data should be strengthened to guide prioritisation and resource allocation.
- Investment in community engagement and CHP facilitation should be scaled to sustain demand for RMNCAH services and strengthen accountability.

### Photo Gallery

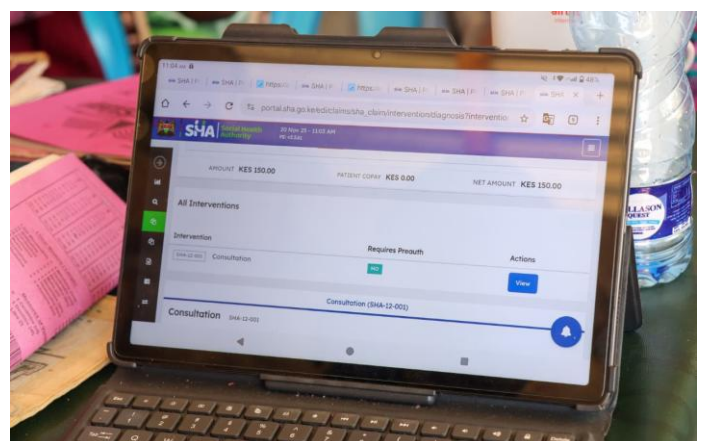


Figure 4 Dedicated desk office for SHA registration, with staff supported through DANIDA PHC Programme funding