National Taxpayers Association
pesa zetu, haki yetu

# Community Health Action Group

## Training Manual

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# LIST OF ABBREVIATIONS

| | |
|---|---|
| **WHO** | World Health organization |
| **SAP** | Structural Adjustment Program |
| **MOH** | Ministry of Health |
| **HCRC** | Health Community Report Card |
| **CSC** | Community Score Card |
| **GOK** | Government of Kenya |
| **MoPHS** | Ministry of Public Health and Sanitation |
| **MDGs** | Millennium Development Goals |
| **HIV/AIDS** | Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome |
| **KEPH** | Kenya Essential Package for Health |
| **USAID** | United States Agency International Development |
| **AMREF** | African Medical Research Foundation |
| **H.S.S.F** | Health Sector Services Fund |
| **C.E.O** | Chief Executive Officer |
| **NTA** | National Taxpayers Association |
| **NHSSP II** | National Health Sector Strategic Plan |
| **CHW** | Community Health Worker |
| **CHAGs** | Community Health Action Groups |

# ACKNOWLEDGEMENTS

Many individuals and institutions have participated in the development of this manual. National Taxpayers Association (NTA) is grateful to all of them for their concerted efforts in developing the manual.

Many thanks goes to the NTA implementing team for their useful input. The Executive Director of NTA for his oversight in the development of the manual and the National Advisor of NTA for their direction throughout the development of the manual.

The staff of the defunct Ministry of Health and Ministry of Public Health and Sanitation have been of great benefit to NTA in developing the manual. The facility in charges of the 8 health centres in focus have been key in providing data that went into developing the manual.

Appreciation goes to the Open Society Foundations (OSF) for their technical and financial support without which the implementation of this project would not have been a reality. To the International Budget partnership (IBP) and Health Rights Advocacy Forum(HERAF) for the use of their publications in the development of the manual.

# EXECUTIVE SUMMARY

## Training Manual

This is a training manual for community health action group members. Community health action group (CHAG) members are community resource persons. These are people in the community that have exhibited interest in the betterment of their communities. They are leaders in their communities and National Taxpayers Association has assisted in building their capacity to advocate for better health service delivery in their localities.

The CHAGs are affiliated to select health centres and work in collaboration with the facility managers and other duty bearers concerned with health service provision.

It is envisaged that the partnership between the CHAGs and the different duty bearers in the health sector will ultimately translate into better health care indicators in the health centres sampled in this project.

The trickledown effect is for the project to be up scaled to all health centres in Kenya.

## Introductions

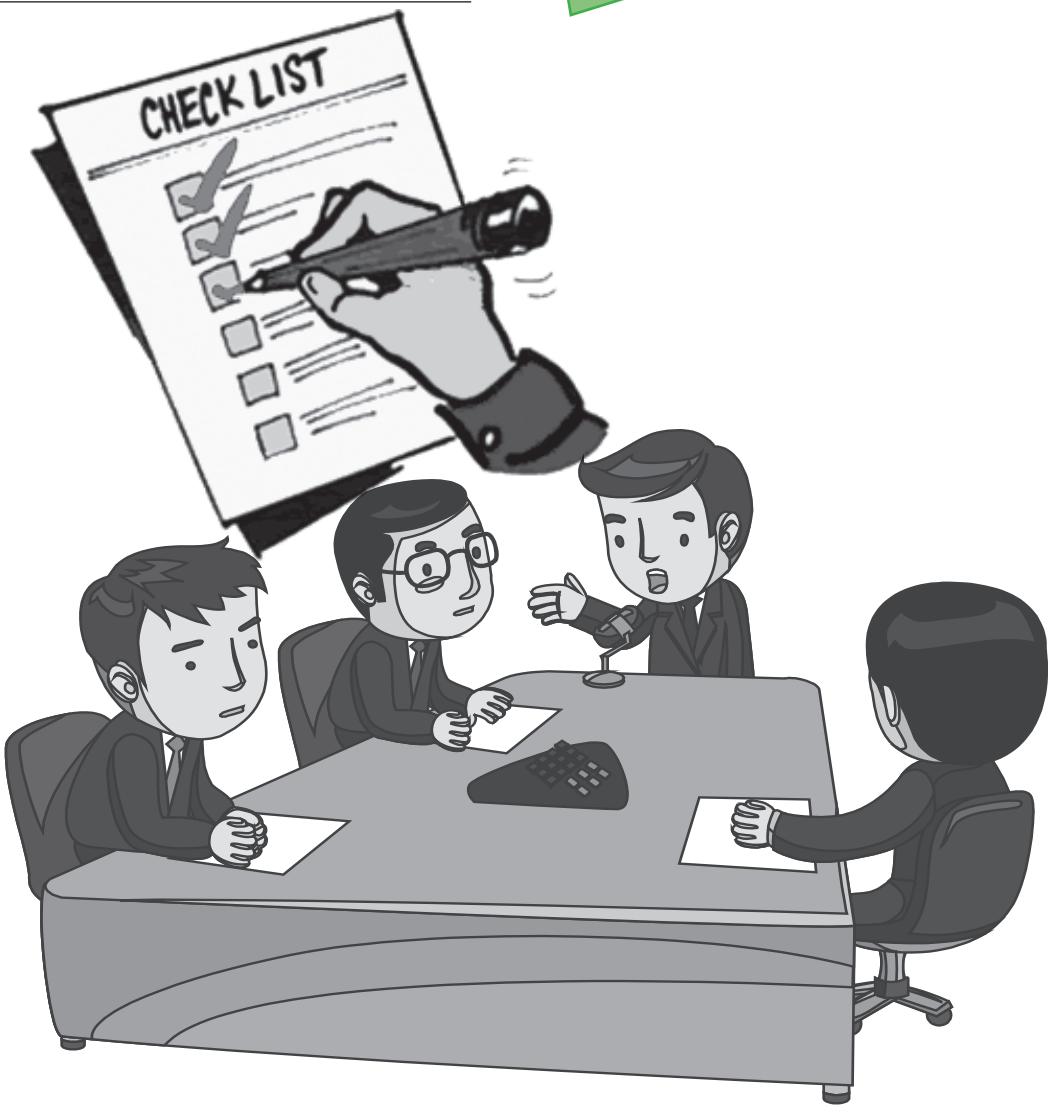
For the first time the right to health has been defined and enshrined in the Kenya constitution 2010. The right to health is in the category of the 3rd generation of rights and is in other words known as social economic rights. By the very virtue of its definition as 3rd generation rights it has not been given precedence. Governments have been providing it as and how they feel compelled to provide it. Consequently, the Kenyan citizenry has never known what to expect from each government as most have been issuing roadside declarations on matters touching on health.

Moreover, provision of health has been devolved and is a function of the county Government. The rationale for devolution is that service delivery will be efficiently and effectively provided at the local levels. It is thus important to monitor whether this assumption will hold true and translate into better health service delivery than previously provided to citizens.

The Kenyan citizen in most cases advocates for the Government to allocate more funds to the health sector. However, increased budgetary allocation does not always translate into better public services. Most challenges in the health sector are systemic and institutional that require more than increased budgetary allocation to improve it.

It is in view of this new avenue provided in the constitution that National Taxpayers Association seeks to build the capacity of local communities to demand for wholesome healthcare through the Community monitoring project as outlined below. The citizens have to add their voice, monitor and put pressure on the Government to improve health services.

# MODULE 1




# COMMUNITY HEALTH MONITORING

## 1.1 Project overview

***Project goal***

To contribute to improvement in the provision of quality healthcare services in public health facilities at the district level through enhanced transparency and accountability in the Republic of Kenya.

***Rationale for intervention***

- The Ministry of Public Health and Sanitation has committed "to reduce health inequalities and to reverse the downward trends in health related outcome and impact indicators" and also "scaling up the implementation of interventions aimed at enhancing the equitability of access to public health and sanitation services". However, in reality this commitment as laid out on paper is often not reflected at the local level.
- The Ministry of Public Health and Sanitation in its Second National Health Strategic Plan II (NHSSP II – 2005–2010), had committed "to reduce health inequalities and to reverse the downward trends in health related outcome and impact indicators".
- Through its Strategic Plan 2008-2012 the Ministry of Health (MoH) has also committed to scaling up the implementation of interventions aimed at enhancing the equitability of access to public health and sanitation services. It outlines the government's commitment to invest substantial resources in building the capacity of communities to take charge of their health care development and to manage resources for health.
- Health policy 2011-2030: ensures the implementation of healthcare policies as envisioned in the vision 2030

## 1.2 Situational analysis

- There exists a gap between community members and government health service providers especially at the district level. This lack of linkages and formal partnership between the health duty bearers and citizens on one hand and public interest groups like NTA on the other has laid bare any attempts at joint oversight mechanisms to enhance transparency and efficiency leading to deteriorating healthcare standards.
- Many communities do not have the capacity to influence provision of quality health care within their localities. Most NTA accountability programs have also demonstrated a poor linkage between citizens on one hand and government service providers on the other. The community in most cases is viewed as outsiders who do not have a direct mandate or capacity to monitor health facilities and service provision. There is therefore the need to mobilize citizens to actively get involved.

***Project objectives***

1. To empower citizens to demand accountability by providing information and building their capacity in an organized formal structure in order to effectively monitor delivery of health services at the district level.
2. Create linkages between the community and government health service providers to strengthen community voice in demanding quality health care though improved transparency and accountability.
3. Improve the quality of health services at the 8 health centres through collection of data that informs action by the Ministry of Health and other stakeholders both at the district and national policy level.

## 1.3 Activities under the community health monitoring project

### *1.3.1 Carrying out phase 1 and phase 2 monitoring activities*

The CHAGs will work together with the in charges of the health centres and other duty bearers to carry out monitoring activities.

These are monitoring activities and not supervision of the health service providers by citizens. The monitoring activities will be undertaken for the following key areas:

- Water and sanitation
- Infrastructure, electricity and communication-telephones
- Availability of commodities (drug stock-outs) and supplies
- Human resources
- Financial flows to the facility and budget accountability and transparency
- Wait time
- Community participation
- Referral system
- Impact of community health workers
- The working of the health committees

The monitoring will be carried out in 2 phases.

***Phase one*** is the initial monitoring phase that will be carried out at the health facility level. The monitoring will make use of different monitoring tools as follows:

- Focus group discussions
- Questionnaire
- Key informant interviews
- Observation
- Use of checklists

***Phase two*** monitoring activities shall be carried out 6 months after phase one. The purpose of the phase 2 is to establish whether the recommendations and issues arising from the phase one monitoring have been addressed. The data will then be collected and analysed before dissemination.

### *1.3.2 Development of a Health Community Score Card (HCSC)*

***Community Score Cards*** are participatory surveys that provide quantitative feedback on user perceptions on the quality, adequacy and efficiency of public services. They are used for local level monitoring and performance evaluation of services and projects. They go beyond just being a data collection exercise to being an instrument to exact public accountability through the extensive media coverage and civil society advocacy that accompanies the process.

The community score card (CSC) process is a hybrid of the techniques of social audit, community monitoring and citizen report cards. Like the citizen report card, the CSC process is an instrument to exact social and public ***accountability*** and responsiveness from service providers. However, by including an ***interface meeting*** between service providers and the community that allows for immediate feedback, the process is also a strong instrument for ***empowerment***.

The data collected from the 1st and 2nd monitoring activities shall be developed into a health citizen's report card.

There after sensitization meetings/workshops with district healthcare service providers, Ministry of Health (MoH) officials and CHAGs with all stakeholders will be organized to review findings from monitoring activities.

There will be a national media launch and advocacy activities as a result of the findings of the report.

#### *1.3.3 Holding of sensitization meetings/workshops with district healthcare service providers, Ministry of Health (MoH) officials and CHAGs.*

- This is the first order of business for the CHAGs
- The CHAGs will have a meeting with the facility in charge and the district health service providers
- The purpose of the meeting is to formally meet the in charges and agree on the ground rule for this engagement
- It should be taken into account by both the CHAGs and he service providers that the monitoring is not to find fault or expose service providers but rather to provide evidence based information that can be used for advocacy to change institutions and systems to be responsive to the needs of the users.

#### *1.3.4 Development of simple and easy to understand Information Education and Communication (IEC) materials including fliers*

- There are several policy documents and laws that give prominence to the right to health of citizens
- IEC materials will be prepared that highlight this rights in a creative way.
- These resources shall be used for advocacy purposes to both users and service providers

## 1.4 Envisaged outcomes of the project Outcomes

1. Set standards for community monitoring by establishing indicators for quality healthcare against which monitoring can be continually conducted.
2. Establish a critical mass of empowered citizens that can effectively demand accountability and monitor provision of health services through Community Health Action Groups.
3. A pool of credible researched data about the status of healthcare service provision and facility management to inform reforms both at the facility and national levels.
4. Inform citizens about their rights and obligations in demanding quality health service provision.
5. Strengthened community voice in demanding quality healthcare.
6. Enhanced Government/Citizen partnership in improving transparency and efficiency in the health sector at the district level.
7. Partnership between NTA and MOH for sustained monitoring of health services at a larger scale.
8. An established and reliable Health Citizen Report Card (HCRC) providing effective feedback mechanism about quality of health services.
9. Improved quality of health services at the district level as a result of an informed government and citizenry.

## 1.5 Attributes of community health action group members

To effectively carry out the tasks under this project the below attributes are key:

- Willingness to volunteer both time and skills
- Able to read and write
- Tact when dealing with duty bearers
- Continuous learning and community involvement

# MODULE 2

# RIGHT TO HEALTH AND THE KENYAN CONSTITUTION

## 2.1 The Right to health and the Kenya Constitution 2010

The Kenya constitution of 2010 has for the first time safeguarded the right to health by enshrining it in the constitution and has expanded this to include reproductive health care.

The right to health does not mean the right to be healthy. The WHO Constitution and other subsequent documents for example the International Covenant of Economic Social and Cultural Rights define health thus: "Health is 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'" (WHO1946).

Largely, health is influenced by the environments in which people live. Currently in Kenya, there exists gaps between those who enjoy higher standards of health and quality services and those who, for a mix of civil, political, economic, social or cultural reasons, are more vulnerable to ill-health and inadequate access to health related services. Health care services in the public health facilities are very poor and unaffordable by majority of citizens in Kenya especially with the introduction of the cost sharing effects of the Structural Adjustment Programmes (SAPs) of the 1980s.

The right to the highest attainable standard of physical and mental health is a fundamental human right protected under international and regional law. The right to information, education, housing and safe working conditions, and social security, for example are particularly relevant to the realisation of the right to health.

In essence, the right to health involves the following features:

- It is a right to enjoyment of variety of health facilities, goods and services and conditions necessary for the realisation of the highest attainable standard of health.
- It contains general freedoms and entitlements including freedom to control one's health and body, freedom from non-consensual medical treatment and experimentation among others.
- It is an inclusive right extending to the underlying determinants of health, such as access to safe and portable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.
- It includes specific entitlements, such as the right to health facilities, goods and services, prevention, treatment and control of diseases, maternal, child and reproductive health, and health natural and workplace environments.
- It provides for non-discrimination and equal treatment in access to health care and underlying determinants of health.
- The active and informed participation of individuals and communities in decision making that bears upon their health.
- Accountability and transparency are a vital element of the right to health. All duty bearers are to be held to account by the rights holders.

## 2.2 Why was it important to guarantee the right to health in the Constitution?

a. Kenya is a signatory to numerous treaties at the international and regional level that guarantee the right to health. Under Kenya's obligations to respect, protect, promote and fulfil the treaties, it is important to domesticate the treaties' provisions locally. The Constitution thus provides that the general rules of international law shall form part of the law in Kenya and that any treaty or convention ratified by Kenya shall form part of the law in Kenya (Article 2(5) (6).

In 1946, the WHO constitution first articulated the right to health and its preamble defines health as "a state of complete physical, mental and social well being and not merely the absence of diseases or infirmity."

## 2.3 International treaties safeguarding the right to health

The 1948 Universal Declaration of Human Rights also recognize the right to health and states that "Everyone has the right to a standard of living, adequate for health and well being of himself and of his family, including food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or lack of other livelihood in circumstances beyond his control."

Key among treaties ratified by Kenya which are binding and provide for the right to health include the:

- International Covenant on Economic Social and Cultural Rights (I1966ICESCR),
- International Covenant on Civil and Political Rights (ICCPR) (1966),
- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (1965),
- Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) (1979,
- Convention on the Rights of the Child, (CRC) (1989),
- Convention Against Torture and other Cruel, inhuman Degrading
- Treatment or Punishment (CAT) (1984),
- International Convention on the Protection of the Rights of All Migrant workers and members of their Family (MWC) (1990),
- Convention on the Rights of Persons with Disabilities (CRPD),

## 2.4 Right to health in the African Context

In the African system the following have been ratified the:

- African Charter on Human and Peoples Rights,
- African Charter on the Rights and Welfare of the Child and
- Protocol to the African Charter on Human and People's Rights of Women in Africa

## 2.5 Understanding the Right to Health In The Kenyan Constitution

The World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity. Effective promotion of health is highly dependent on the prevailing constitutional framework. The Kenyan Constitution affirms the importance of the right to health for ALL and thus provides:

- Article 43 1(a): Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care
- Article 43(2): A person shall not be denied emergency medical treatment
- The right to health is a fundamental human right that is associated with access to health care.

### *2.5.1 What entails the right to health care?*

The right to health care means that there must be an effective and integrated health system encompassing health care and the underlying determinants of health that is responsive to national and local priorities and accessible to all. Health care must be timely and appropriate. The right to health does not mean the right to be healthy. It means:

- Access to health facilities, goods and services on a non-discriminatory basis especially for the vulnerable and marginalized groups.

- Access to the underlying determinants of health discussed below.
- Equitable distribution of all health facilities, goods and services.
- Provision of essential drugs.

Human rights are interdependent, indivisible and interrelated. The underlying determinants of health are guaranteed in Article 43(1) (b)-(f) of the current Constitution and include:

- The right to accessible and adequate housing, and reasonable standards of sanitation;
- The right to be free from hunger, and to have adequate food of acceptable quality;
- The right to clean and safe water in adequate quantities;
- The right to social security and the
- The right to education.

### *2.5.2 Specific rights related to the right to health*

They are both freedoms and entitlements. This includes:

- The right to be free from non-consensual medical treatment, such as medical experiments and research.
- The right to be free from torture and other cruel, inhuman or degrading treatment or punishment.
- The right to a system of health protection forbidding any discrimination,
- The right to prevention, treatment and control of diseases.
- The right to access to essential drugs.
- The right of the population to participate in decision making.
- The right to equal and timely access to basic health services.
- The right to health education.
- The right to life.
- The right to dignity
- The right to be free from forced labour
- The right to privacy.
- Right to a clean environment.
- Children have a right to basic nutrition, shelter and health care.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have safe sex life and that they have the capability to reproduce and the freedom to decide, if, when and how often to do so.

## 2.6 Excerpts of constitutional and legislative framework Governing Health sector

- It is important for the CHAGs to understand which legal provisions, regulations and policies are in place that protect the right to health
- The Constitution is the supreme law that guarantees the right to health.
- However, it cannot legislate on everything.
- Other enabling and supportive laws draw from it and give effect to it. These laws clearly point out the modalities of realising this right for all citizens
- Below are listed several legislation, policies and regulations that attempt to expound on this right but the list is in no way exhaustive:

### *2.6.1 The constitution:*

Section 43(1) provides that every person has the right
(a)To the highest attainable standard of health, which includes the right to health care services, including reproductive healthcare
The above provision for the first time has provided for the right to health as a constitutional right. This means that the government has to provide it and in its absence a citizen can move to court for a declaration that their fundamental right has been deprived.

### *2.6.2 The Fourth schedule of the Kenya Constitution 2010 provides that:*

(2) County health services including in particular
(a) County health facilities and pharmacies
(b) Ambulance services
(c) Promotion of primary health care
(d) Licensing and control of undertakings that sell food in public
(c) Veterinary services (excluding regulation of the profession)

The above schedule indicates the functions that have been devolved to the county government in as far as the healthcare is concerned.

What this means is no citizen can demand for the county government to provide services that the county is not mandated by law to carry out. This is because provision of services requires financial resources that only follow functions.

### *2.6.3 The former Ministry of Health and Ministry of Public Health and Sanitation also developed their strategic plans.*

The key principles under this strategic plan are:

- Efficiency: Aimed at getting the best output from available resource input. To get optimum output with the least possible resource inputs
- Equity and human rights: Fairness in the use of available resources. The approach is a human rights based approach
- Quality: The ministry has committed to provide the highest feasible level of standards of care for the clients of its services. The service charter further articulates the quality that the ministry aspires to.
- Effectiveness: Interventions that are prioritized give the clients the best possible health outcomes. The priority is the one that can restore the health of the client to a as near a normal position as is feasible.

***Partnership and collaboration.***

### *2.6.4 Second National Health Strategic Plan II (NHSSP II – 2005–2010),*

The NHSSP II, 2005-2010, was launched in 2005 by the GOK/MoH. The NHSSP set out the agenda for the sector. The vision of "creating an efficient and high quality health system that is accessible, equitable and affordable for every Kenyan household". Its mission is to "promote and participate in the provision of integrated and high quality curative, preventive, promotive and rehabilitative health care services to all Kenyans". Further, the mandate of the health sector is to formulate policies, set standards, provide health services, create an enabling environment, and regulate the provision of health service delivery. The overall goal set out in the strategic plan is to reduce health inequalities and reverse the downward trends in health related indicators by pursuing six broad policy objectives that are directly linked to the Economic Recovery Strategy (ERS), Vision 2030, and the Millennium Development Goals (MDGs).

***Strategic objectives of the health sector***

The strategic objectives of the health sector as set out in the NHSSP II (2005-2010):

- Increase equitable access to health services
- Improve quality and the responsiveness of services in the sector
- Improve the efficiency and effectiveness of service delivery
- Enhance the regulatory capacity of the Ministries of Health
- Foster partnerships in improving health and delivering services
- Improve financing of the health sector
- The Ministries of Health have also developed strategic plans (2008-12) which are linked to NHSSP II and the Medium Term Plan of Vision 2030.

### *2.6.5 Health policy 2011-2030*

The policy is designed to be comprehensive and focused on two main objectives:

- Contribution to economic development as envisioned in vision 2030
- Realization of fundamental human right as in the Kenya constitution 2010
- It is centered on equity, people centeredness, participatory approach, efficiency, multi sectoral approach and social accountability in provision of health services. The focus is for the health system to be accessible to everyone
- It addresses the approach of "health in all policies" to ensure health sector interacts with influences design, implementation and monitoring of interventions in all sectors that have an impact on health.
- The goal of the policy is the attainment of the highest standard of health care in a manner responsive to the needs of the population
- The policy aims to achieve this through supporting provision of equitable, affordable and quality health beyond the current health approach to a focus on health, using a primary healthcare approach which remains the most efficient and effective way to organize a health system.

### *2.6.6 Vision 2030*

It details the long term national development agenda to make Kenya globally competitive by 2030. Health is one of the components of delivering the social pillar of vision 2030 given its role of maintaining a health workforce necessary to drive the economy. It makes reference to healthcare as follows below:

- Channelling funds direct to health centres
- Rehabilitate health facilities
- Strengthen the Kenya Medical Supplies Authority
- Equitable financing mechanism
- Community based information system
- Fast track community strategy by training community health workers
- Develop human resources strategy
- Revitalize efficacy of health information system
- Establish community based health information systems

### *2.6.7 Jubilee manifesto*

The jubilee manifesto contains the jubilee government's promises and pledges to the Kenyan people. On the health sector the manifesto pledges to:

- Achieve free primary healthcare for all Kenyans, starting with women, expectant and breastfeeding women and persons with disabilities by increasing health financing from 6-15%
- Increase the number of physical facilities at community level and increasing mobile health clinic services

- Reform NHIF to uproot corruption and bureaucracy and to ensure accountability and efficiency
- Guarantee that every familyhas access to a fully equipped health centre within 5 miles of their homes, wioth anatiuonal network and local community health workers promoting preventive health based at the centres.
- Upgrade and equip previous provincial hospitals to referral hospitalssupported bya network of county referral fracilities and community level public health centres
- Estabiuish fully fledged low cost diagnostic centres and provide adequate screening and treatment facilities for persons with chronic or terminal conditions, including cancer,diabetes and kidney failure in every county
- Ensure improved pay package for doctors and other health practioners
- Distribute fre mosquito nets to all families that need them
- Promote medical research, including indigenous mediocine
- Promote e-health as a strategy to reach remote and marginalized areas with health services

### *2.6.8 Free maternity policy by the jubilee government*

### *2.6.9 Report of the Taskforce constituted to address Health Sector issues raised by the Kenya Medical Practitioners, Pharmacists and Dental Union*

### *2.6.10 Policy on waiver of user fees in facilities*

The policy on waiver of user fees in health facilities will greatly improve access to healthcare especially for the urban and rural poor. The jubilee government has waivered off user fees. This action points to the challenges of accessing health care as was pointed out under the Economic recovery strategy for wealth and employment creation

***"The main challenge facing the poor in accessing health service is affordability. The second report on poverty revealed that 40%of the poor (39.5% of the urban poor and 43.8 %of the rural poor) did not seek health services when sick because of inability to cover the medical expense as per the economic recovery and wealth creation strategy."***

Measures advanced by the strategy to address health concerns are as follows:

- Enact legislation to convert NHIF into National Social Health Insurance Fund(NSHIF) which will cover both inpatient and outpatient medical needs, sharing of costs between the Exchequer, the Employer and Employees, informal sector and other productive sectors of the society
- Rehabilitate existing health facilities
- Overhaul the system of procurement and distribution of drugs for health facilities to reduce the cost and make them affordable and rationalize the distribution system to ensure that drugs are supplied to areas where they are most needed

### *2.6.11 Community strategy 2006*

The Ministry of Public Health and Sanitation (MoPHS) adopted the Community Health Strategy in the year 2006 to actively engage the communities in managing their own health. The strategy aims at improving health indicators by implementing some very critical interventions at the community level. The overall goal of the community strategy is to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, and child and maternal deaths, as well as improve education performance across all the stages of the life cycle and the government has achieved 7% coverage to date. Non-governmental and community based organizations (CBOs) have also been involved in the implementation of the strategy at grass-root levels.

### *2.6.12 2nd Edition Indicators and standard operating procedure manual, health information system: September 2012.*

### *2.6.13 The Millenium development goals also point to some health concerns as follows:*

- Reduce infant mortality
- Improve maternal health
- Combat HIV/AIDS, malaria and other diseases

### *2.6.14 Community health strategy*

### 2.*6.15 Ministry service charter*

### *2.6.16 National referral strategy 2006*

### *2.6.17 Public health Act Cap 242*

### *2.6.18 Kenya Essential Package for health (KEPH)*

The package elaborates the expected services the sector will deliver to Kenyans by life cycle cohorts and service delivery levels during the period of the NHSSP II

# MODULE 3


# APPROACHES TO DEMANDING RIGHTS TO HEALTH

## 3.1: Approaches to demanding for right to health:

### *3.1.1 Social audits:*

- These are audits carried out by the communities to gauge service delivery by different government departments.
- Their purpose is to involve the community in the development agenda.
- The approach is to build the capacity of the users of the services so as to demand what is entitled to them.
- The approach acknowledges that service provision is a multi faceted initiative-the users of the service need to collaborate with the providers and not collide with them.

**The approach targets:**

- Strengthening the voice of the beneficiaries and users of the service
- Prioritising the needs of the users and ensuring that funding follows priorities of the community
- In cases where implementing the priorities of the community are not feasible, a feedback with reasons should be provided to the community
- To build the capacity of the community to make informed decisions in light of limited resources

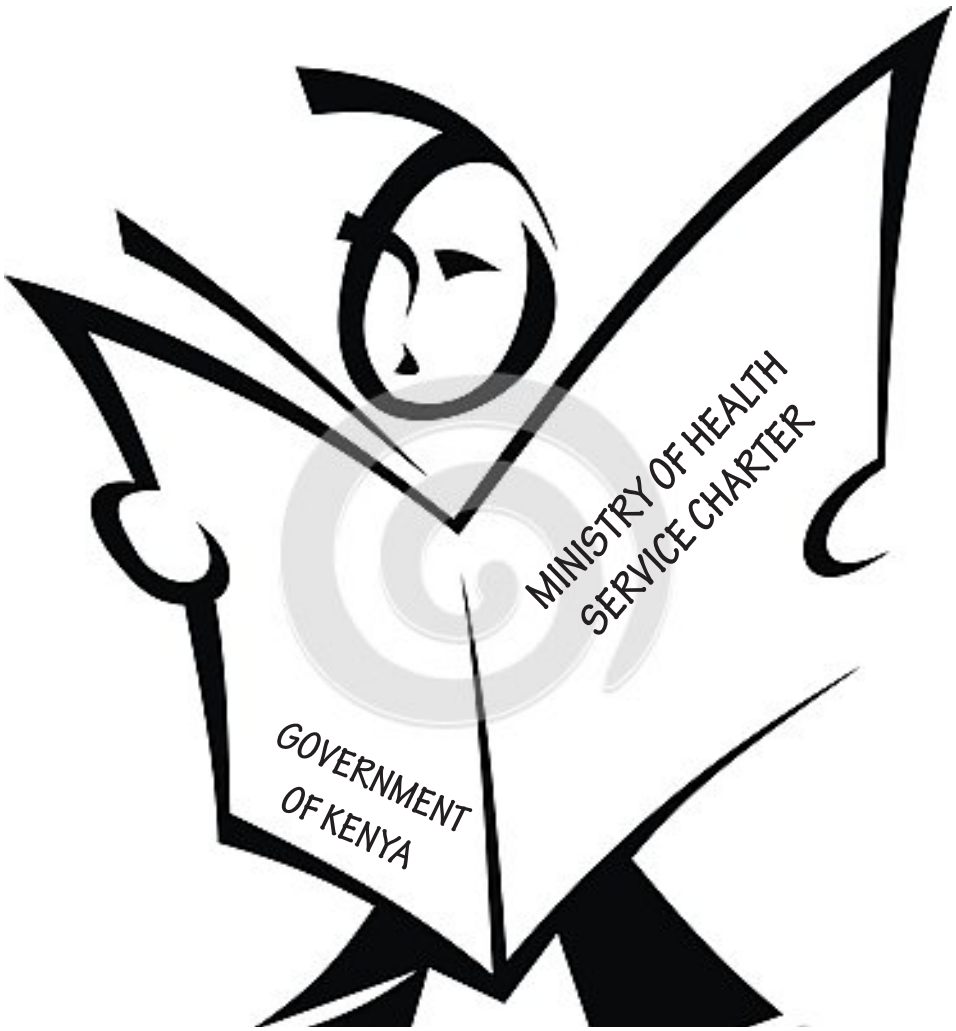
### *3.1.2 Budget analysis:*

- In this approach the national and county budgets are analysed to establish whether funds have been allocated to the health sector.
- It should be noted that there are heatlh functions that are duties of the national government and this should be analysed to establish budgetary allocations to this sector.
- This is because inadequate funding of any sector has a direct impact on service delivery.
- The same approach applies to analysis of the county budget. In this case the functions assigned to the county functions should be reflected by allocations in the county budgets.
- It should however be noted that increased budgetary allocation does not guarantee improved service delivery. Citizens have to monitor to ensure actual beneficiaries benefit from the allocations.

### *3.1.3 Building partnerships:*

- It is acknowledged that needs are always competing with limited resources.
- Consequently the government in most times inadequately funds some sectors and the health sector is no exception.
- The project thus approaches the demand to health with a multi-pronged approach; where transparent and prudent use of resource still reveals under funding of key sectors then the community can approach strategic partners to supplement that which the government has availed.
- World vision, concern worldwide, USAID and AMREF are among some key stakeholders in the sector that the CHAGs can partner with.

# MODULE 4




# STANDARDS AND NORMS

## 4.1 Background

The right to health is a fundamental human right. Kenya has this provision in the constitution. However, this provision can end up being a paper right that does not benefit the citizens. What the citizens do or not do can determine whether they enjoy this constitutional guarantee.

Citizens can only hold governments to account on what the Government has committed to do. This means that citizens have to know:

- What standards and norms are required at health centre levels
- Who are the duty bearers for effective engagement

## 4.2 Government standards and norms at tier 3

What is government standard and norm?

- This is the minimum and appropriate mix of human resources and infrastructure that is expected to serve the expected population at the different levels of the system with the defined health services.
- The health system should deliver the defined health services to the population in an efficient, equitable and sustainable manner
- The expected service standards for different activities to be delivered at the different levels to ensure comprehensive health service delivery
- The minimum human resources and infrastructure needed to ensure the different levels provide the expected service standards.

## 4.3 Services offered at Level 3

- Outpatient care
- Minor surgeries on outpatient basis
- Limited in patient services-emergency inpatient awaiting referrals, 12-hour observation
- Limited oral health services
- Maternity for normal delivery
- Specific lab tests-Malaria, TB. HIV tests

## 4.4 Staffing norms at level 3:

- Nursing staff
- Clinical officers
- Lab technicians
- Pharmaceutical technologists
- Community oral health officers

## 4.5 Inputs to be monitored by CHAGs

### *4.5.1 Public funding in health centres*

The government funds all government departments charged with provision of services and the health centres offer public services.

The project seeks to analyze the different funding streams that are at the health centre level e.g H.S.S.F,C.D.F projects and funds from the county government. This will enable the CHAG members to track the impact of the public funds.

It is acknowledged that in most instances there is no direct funding but that the support comes in terms of commodities and infrastructure

However, whatever funds come to the county health facilities it should be on a needs based approach that takes into account size of population, poverty levels, health status of the district and special health needs.

### *4.5.2 Availability of commodities*

Health centres as structures cannot work without commodities and supplies. This is therefore a critical input into the service delivery structure. The CHAGs will monitor and have discussions with the facility management to ensure that such supplies are available at all times, accessible and affordable.

Stock outs of critical medication will be a discussion that the CHAG s will have with the management The CHAGs will further establish whether commodities in the health facilities are provided on a PUSH or PULL system.

### *4.5.3 Community participation:*

Community participation has been enshrined in the constitution. It has been implemented before but in a manner that has not translated into constructive citizen participation. Ideal citizen participation has been expounded in the annexed publication: See annex 1

**Key areas for citizen participation:**

- The facility committee organizing meeting to meet with the larger community
- Facility committee meeting with the community to discuss findings of official monitoring results
- Meeting with community to discuss devolved funds such as the H.S.S.F and on the priority areas to dedicate the funds to

### *4.5.4 Equipment*

A health facility at whatever level should be well equipped. There is certain equipment that should be available at the health centre level.
There is lack of basic technical and administrative equipment to support service delivery including communication, ICT and transport. The CHAGs will be involved in establishing whether the said equipment is available, is in working condition and is put to use.

### *4.5.5 Water, waste disposal and sanitation*

Hygiene is important in any health facility. Consequently the CHAGs will work with the health facility to establish whether the facility has clean, piped water that is available most if not all the time. Further, the CHAGs will work at identifying whether the facility has alternative source of water, a facility that relies on only one source of water will experience challenges in service delivery.

There are certain set standards in waste disposal, the CHAGs will provide data on whether the requisite waste disposal system is in place. The number of toilets and pit latrines are a key factor. The project seeks to establish if these facilities exist. Are the toilets functional flush toilets or covered pit latrines with slab.

### *4.5.6 Staffing*

There are Government staffing norms that each health centre should have. The CHAG members shall seek establish what cadres of staff are available in their facility. In addition the number of each cadre shall be established. The presence or absence of subordinate staff shall also be taken into account.

### *4.5.7 Wait time*

The time it takes for users of the facilities to be attended, is a key issue that the project seeks to address. The project will seek to establish the underlying issues contributing to unacceptable wait time.

### *4.5.8 Infrastructure*

Infrastructure that is appropriate and functioning is crucial in delivery of health care. In health infrastructure consists of:

- Buildings-medical and non-medical including land on which it sits
- Equipment

Share of providers with thermometer, stethoscope, weighing scale-for child and adult patients,refrigerator and sterilization equipment.

- ICT
- General and ambulatory services transport
- Electricity

Having the electric power grid, a fuel operated generator, a battery operated generator or a solar powered system as their main source of electricity. This is particularly important for the storage of vaccines.

**Infrastructure norms for level 3:**

Medical service provision room with:

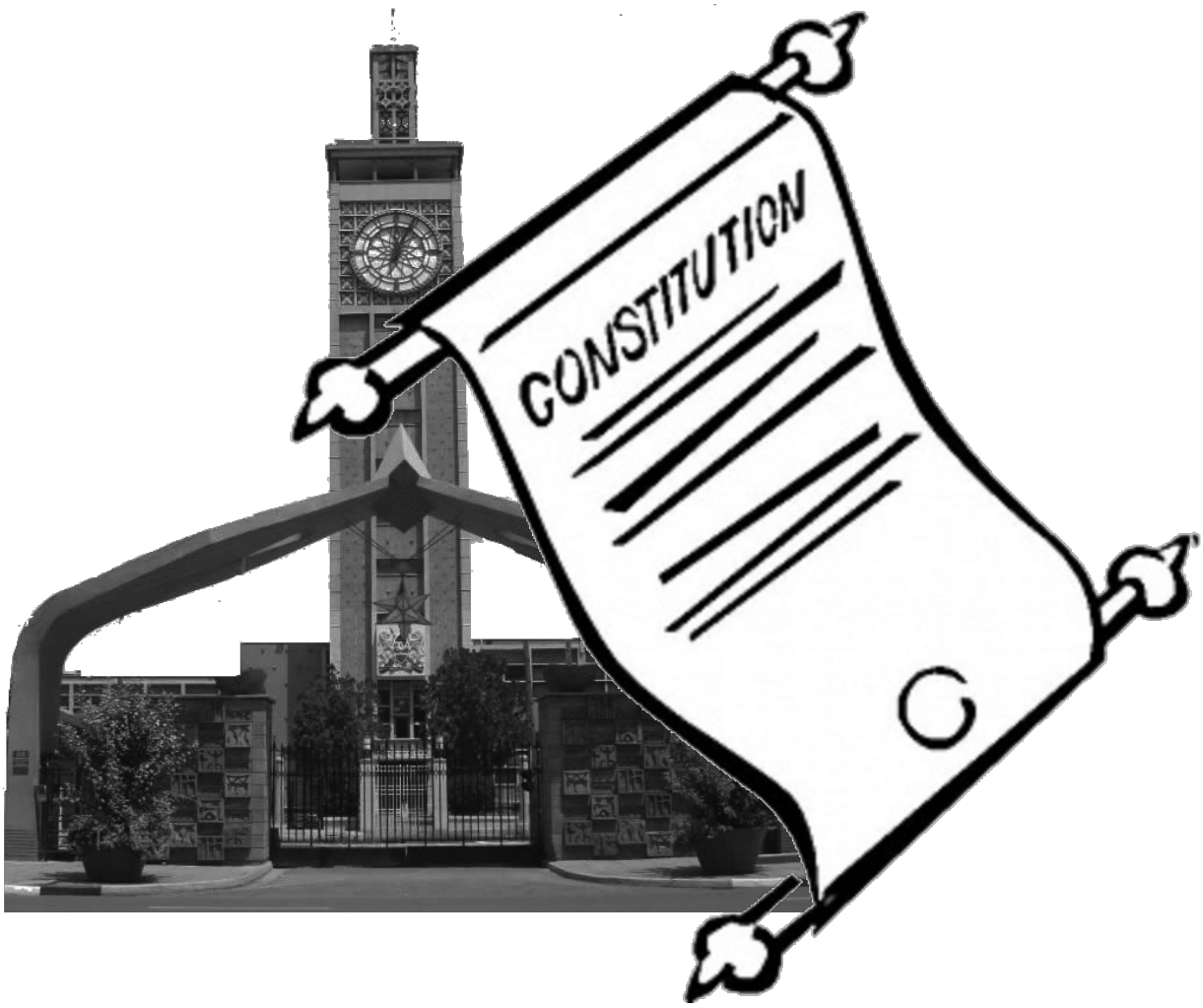
| | |
|---|---|
| • 3 consultation rooms<br>• 1 treatment room<br>• 1 minor theatre at outpatient<br>• 1 records room<br>• 2 rooms with total of 11 in patient beds<br>• 2 stores<br>• 1 for drugs, 1 general<br>• 1 laboratory room<br>• 1 labour ward for 2; and a delivery room<br>• 1 community services room<br>• Supply service unit with kitchen and laundry | • Staff housing for 2<br>• 4 stance pit latrine<br>• 1 simple incinerator<br>• 1 placenta pit<br>• 1 motorcycle<br>• Communication equipment<br>• Water storage for roof catchment<br>• Fence and gate<br>• Composite pit<br>• Minimum acreage of 2 acres |

### *4.5.9 Customer care and treatment*

Health centres should strive for patient cantered accountability. The national referral policy 2006 clearly states what is required for an effective referral system.

- Without an effective referral system, the lower level of service delivery will be underutilised while the higher level will be strained with high patient load.
- A good referral system will free limited resources both human and infrastructure for highly specialised care.
- There should be a means of transporting the patient to the next level and patients should not have to go back to their pockets
- The referring level should effectively communicate to the level that is to receive the patient

# MODULE 4




# MAPPING OUT DUTY BEARERS

For effective advocacy and intervention, the energy of the CHAG members has to be directed to the right duty bearer. It will not avail much for the CHAG members to engage the national government on functions that have been devolved to the counties. Consequently, this module attempts to map out different duty bearers and their roles.

## 5.1 The national Government:

The national Government under the 4th schedule has been mandated to take charge of:

i. National referral hospitals
ii. Capacity building and technical assistance to the counties

It should be noted that the bulk of primary healthcare provision has been given to the county. This is aimed at solving the below challenges that have continued to plague the health system under the centralised system of government:

- To address discrimination of the "low potential areas". Urban areas have had better health services than rural area
- To address problems of bureaucracy in matters of health service provision especially procurement related problems
- To promote efficiency in the delivery of health services
- Address problems of low quality of health services

With the function analysis of the national Government's role. The CHAGs can advocate with the central Government on budgetary allocation to the counties as this will have a direct impact on what the county Governments can dedicate to the health sector.

Moreover at the national level health functions there is need for the central government to increase budgetary allocations to the health sector.

iii. Training of medical practitioners

The quality of training of the different cadres of medical practitioners has a direct effect on the quality of healthcare availed to the public. There is need to ensure that the level of training is up to the required and acceptable standards. The national Government is tasked with training.

The CHAGs can consequently engage with the national government on the quality of health practitioners that are churned out of medical training colleges

## 5.2 Kenya Medical Practitioners and Dentists Board

The Medical Practitioners and Dentists Board is a statutory authority established under Cap 253 Laws of Kenya to regulate the practice of medicine and dentistry in the country. Its functions include:

- Maintaining standards and regulation of the profession
- Advise the cabinet secretary in charge of health on matters pertaining to health care and training
- Licensing of specialist and general practise
- To take a lead on ethics and standards
- Provide reliable data and information
- Provide technical expertise
- Tasked with handling disciplinary matters and should conduct preliminary inquiries on professional conduct and medical malpractice;

The CHAG members can engage with the Kenya Medical Practitioners and Dentists Board on issues of maintain standards and upholding ethics.

## 5.3 National Assembly

The national assembly is a useful avenue for the CHAGs to channel their advocacy messages to. They are in charge of laws touching on national health functions They have the power to redirect funds under the appropriation bill from other sectors to the health sector. This is an avenue that was previously not availed by the former constitution

### *5.3.1 Appropriation and budget committee in the National Assembly*

CHAG member should take up the public participation avenue that the budget and appropriation committee is mandate to carry out. In these public sessions the CHAGs should advocate for areas that are of concern to the actualization of the right to health.

The budget must be presented to the National Assembly by April 30. The budget committee of the assembly must seek public input before making its recommendations. This means that every year in early May the public has an opportunity to voice their concerns on National spending. The CHAGs can take this avenue to raise their concern on health priorities.

## 5.4 County Government

Health has been devolved and the county Government is the main player in this sector with very few exceptions. Therefore in the county the duty bearers to engage are as follows:

- The Governor as the CEO of the county
- The senators
- Represent the counties at the national level
- Protect the interests of the counties and the county government at the national level
- Debate and approve bills concerning counties

### *5.4.1 County assembly*

- The county has the power to make laws at the county-legislative power
- The assembly also has oversight over the county executive
- Receiving and approving plans and policies for:

### *5.4.2 County executive committee*

Administers functions of the county e.g ensuring the delivery of goods and services to the residents of the county. Other duty bearers include:

- Member of the county executive in charge of health
- Ward representatives
- Area member of parliament
- Members of the county assemblies
- Women representatives
- Village elders

## 5.5 Committee on health in the Senate

The senate has a committee that is charged with oversight on health matters
This committee is a useful resource for the CHAGs in as far as monitoring healthcare service provision is concerned.

## 5.6 HEALTH FACILITY MANAGEMENT COMMITTEE (HFMC)

Community accountability can be defined as listening to and responding to the views and inputs of the public, citizens, or users, and is increasingly being emphasized in health delivery in developing countries.A range of mechanisms have been introduced to strengthen community accountability at the facility level, including health facility committees (HFCs). The Kenyan Government officially established HFCs in 1998, although in some facilities similar community-based or NGO supported mechanisms existed before then.

The HFC gained more prominence at the onset of Health Sector Service Fund(H.S.S.F). The HSSF is an innovative finance initiative with the potential to strengthen community accountability and improve financing of the lower levels of the health system is the Health Sector Services Fund (HSSF). Under HSSF, the Government and development partners contribute to a central fund, which is used to credit funds directly into approved facilities' bank accounts. At the facility level, HSSF funds are managed by an Health Facility Mnagement Committee (HFMC) that includes community members from the facility catchment area. HSSF therefore provides HFMCs with budgets to manage.

H.S.S.F has a formal governance structure and is regulated by the legal notice "The Government Financial Management (HSSF) Regulations," 2007, Legislative Supplement No. 67, Gazetted on December 21, 2007, and subsequently updated in June 2009.

### Composition of the health centre management committee

The total membership of the Committees shall be at least seven and not more than nine members. The Committees shall consists of:

A representative from the provincial administration in the area of jurisdiction

- The person in charge of the health facility, who shall be the secretary
- The District Medical Officer of Health or his representative
- The person in charge of the local authority health facilities; and

The following persons, who shall be residents of the area of jurisdiction, appointed by the Minister or any other person authorized by him in writing

- One person who shall have knowledge and experience in finance and administration; and
- Four persons of whom two shall be women

The Committees shall meet four times in each financial year and shall maintain records of its deliberation. The elected members shall hold office for one term of three years and are eligible for re-election once.

### Mandate of the HFMC

The Health centers or dispensary management committee is mandated to:

1. Supervise and control the administration of the funds allocated to the facility. According to the Guidelines on Financial Management for Health Facilities through the Health Sector Services Fund of 2009, annual Work plans and budget should be prepared by each health facility technical team. The health facility technical team is headed by the facility in-charge who is also the secretary to the facility committee and its members includes heads of departments in each facility. Their workplans and budgets are tabled to the health facility committee for approval prior to onwards submission through the DMOH to the National HSSF Committee for approval. Monthly and quarterly financial and services reports are required to be submitted through the DMOH to the

National HSSF Committee.
2. Open and operate a bank account at a bank approved by the minister for finance
3. Prepare work plans based on estimated expenditures and cause to be kept books of accounts and records of accounts of the income, expenditure, asserts and liabilities of the facility as prescribed by the officer administering the fund
4. Prepare and submit periodic financial and periodic performance reports as prescribed
5. Cause to be kept a permanent record of all its deliberations

To strengthen HFMC financial oversight roles, and preparedness for national implementation of HSSF, the financial aspects of committee roles and functions were clarified in 2007 and 2009, emphasising HFMC responsibilities for planning, managing and accounting for facility expenditure. The required composition of HFMCs was also modified in 2009 by Government Gazette (an official notice required for all new legislation), reducing the number of community committee members from ten to five. It instructed that the five community members selected should include: one person who has knowledge and experience in finance and administration and three women . Representatives from the provincial administration and local authority were also added to the total number of committee members.

Given the important role of HFMCs in HSSF, it is essential for national implementation that the committees are in place, and that they have the training and role awareness that is key to their ability to manage budgets effectively. These factors comprised committee composition (selection, tenure, and constitution); operations of HFMCs (back accounts, training and meetings); HFMC links to the broader communities that they are expected to represent; awareness of HFMC roles among members, health workers managing facilities (in charges), and users; and HFMC members' motivation, job satisfaction, and relationships with in-charges.

# ANNEX 1

## 10 PRINCIPLES OF PUBLIC PARTICIPATION IN FINANCIAL MATTERS

The preceding sections on the functioning of the CBEF provide us with 10 key principles that should inform public participation more broadly in matters of public finance.

1. Public consultations should be open to the widest spectrum of citizens and taxpayers, without discrimination. The "public" refers to citizens and taxpayers who are not government officials.
2. Safeguards should be established to prevent consultative forums from being dominated by any one political group, organized interest, or politician. These safeguards should include open and transparent proceedings and competitively selected technical staff empowered to manage procedures. Where appropriate, there may be a need for vetting of participants.
3. Public consultations must have clear and specific purposes, and these purposes should generally be to seek feedback on government plans, budgets and budget implementation, to seek specific preferences over a defined set of priorities, such as prioritizing a list of capital investments, and to present and seek feedback on audit reports and queries raised by auditors. The purpose of the consultation should be made known in advance to the public, along with relevant documentation, so that they can prepare.
4. The timeline and venues for public consultations should be made known at least two weeks in advance of the consultation to ensure that people can prepare themselves to participate. The venue for consultations should be consistent, wherever possible, so people know where they need to be in advance. The venue selection should take into consideration citizen preferences for where they feel most comfortable expressing their views.
5. Public consultations must set aside dedicated time for public feedback and questions. A meeting at which officials simply present to the public without receiving any feedback or questions does not constitute public participation
6. Public participation in the planning and budget process should occur at all stages in this process, including formulation, enactment, implementation, and oversight/evaluation. This means that there must be consultations on at least a quarterly basis for any ongoing financial management processes.
7. The public must have access to all relevant plan and budget documents in a timely fashion, meaning at least two weeks before any decisions are taken about draft plans or budgets. Relevant documents include all strategic plans, budget proposals, enacted budgets, quarterly or monthly implementation reports, audit reports, supplementary budgets, project plans and implementation reports, and contract and tender documents.
8. All plan and budget documents should contain an executive summary and a narrative explanation of tables and figures. All of these documents should be written in a user-friendly, simple format, or should be accompanied by simplified versions that are readily accessible.
9. Citizens should be able to provide input into public consultations through direct participation, through representatives, and through written comments. It is not possible for every citizen to participate in every forum, and there must be other ways to provide input besides direct, physical participation.
10. Where the public is asked for input, there should be a feedback mechanism so that citizens know whether or not their inputs were received, and whether and why they were or were not incorporated into the relevant plans or budgets. This mechanism should take the form of a written document and, where possible a, public forum. The feedback must also be made available in a timely fashion so that citizens know before decisions are taken whether they have been heard or not.

# ANNEX 2

21st December, 2007

**LEGAL NOTICE NO. 401**

**THE GOVERNMENT FINANCIAL MANAGEMENT ACT (5 of 2004)**

IN EXERCISE of the powers conferred by section 26 of the Government Financial Management Act, 2004, the Minister for Finance makes the following Regulations:-

**THE GOVERNMENT FINANCIAL MANAGEMENT (HEALTH SECTOR SERVICES FUND) REGULATIONS, 2007**

***1. Citation.***
These Regulations may be cited ad the Government Financial Management (Health Sector Services Fund) Regulations,
2007.

***2. Interpretation.***
In these Regulations, unless the context otherwise requires-

"Committee" means the respective Committee established under

"financial year" means the period of twelve months ending on the 30th June in each year;

"Fund" means the Health Sector Services Fund established under regulation 3;

"health facility" means a hospital, health centre, dispensary or nursing home and includes registered faith based health institutions;

"Minister" means the Minister for the time being responsible for matters relating to health;

"National Committee" means the Committee established under regulation 6;

"officer administering the Fund" means the accounting officer of the Ministry for the time being responsible for matters
relating to health;

"user charges" means cost-sharing charges.

***3. Establishment of the Fund.***
(1) There is hereby established a Fund to be known as the Health Sector Services Fund.
(2) The Fund shall consist of-
(a) Monies appropriated by Parliament for that purpose; (b) Grants or donations made;
(c) Monies received as user charges;
(d) Income generated from the proceeds of the Fund.
(3) There shall be paid out of the Fund payments in respect of any expenses incurred in pursuance of the object and purpose for which the Fund is established.
(4) Any expenditure incurred by a health facility on the Fund shall be on the basis of, and limited to, the annual a llocation and the Authority to Incur Expenditure.
(5) The receipts, earnings, accruals and the balance of the Fund at the close of each financial year shall not be paid into the Consolidated Fund but shall be retained for the purpose for which the Fund is established.

***4. The objects and purposes of the Fund.***
The objects and purposes of the Fund are to-

(a) provide financial resources for medical supplies, rehabilitation and equipment of health facilities in the country ;

(b) Support capacity building in management of health facilities;

(c) Support and empower rural communities to take charge of improving their own health;

(d) Provide grants for strengthening of the faith based health facilities through their respective secretariats; and

(e) Improve the quality of health care services in the health facilities.

***5. Health Facilities Management Committees.***
(1) There are established Provincial Hospital Management Committees, District Hospital Management Committees, Sub- District Hospital Management Committees, Health Centre Management Committees and Dispensary Management Committees whose composition and functions are as specified in the Schedule.

(2) The Committees established under paragraph (1) shall exercise their specified functions in relation to s uch public health facilities as may, from time to time, be Gazetted by the Minister.

***6. National Health Services Committee.***
(1) There is hereby established a National Committee to be known as the National Health Services Committee.
(2) The National Committee shall consist of-
(a) a chairman, not being a public officer, appointed by the Minister;
(b) the Permanent Secretary in the Ministry for the time being responsible for matters relating to health or his representative duly nominated by him in writing;
(c) the Permanent Secretary in the Ministry for the time being responsible for finance or his representative duly nominated by him in writing;
(d) the Director of Medical Services, who shall be the Secretary; and
(e) three persons appointed by the Minister, of whom two shall be women and of whom-
(i) One who shall be appointed by virtue of his knowledge or ex¬perience in financial management; (ii) One who shall be appointed by virtue of his experience in health care delivery management; and (iii) One who shall be appointed by virtue of his expertise and experience as a medical practitioner. (f) A maximum of three other persons as the Committee may deem
(3) A person shall not be appointed as chairman under paragraph (2) (a) unless that person- (a) holds a university degree; and
(b) has at least five years experience in financial, business or economic management.
(4) The quorum at any meeting of the Committee shall be five members and the Committee shall meet four times in each financial year.

***7. The National Committee shall-***

(a) approve the work plans prepared by a health facility;
(b) ensure equitable distribution of resources to the health facilities; and
(c) review and approve annual expenditure statements of the health facilities.

***8. Fees.***
The fees payable as user charges under the cost-sharing programme, which shall be notified in the Gazette, shall be

reviewed from time to time by the Minister in consultation with the Treasury.

***9. Application of the financial and procurement regulations.***
The existing Government financial and procurement regulations and procedures shall apply in the administration of the Fund.

***10. Administration of the Fund. [No. 12 of 2003] The officer administering the Fund shall-***

(a) supervise and control the administration of the Fund;

(b) open and operate a bank account at a bank approved by the Minister for the time being responsible for finance; (c) develop a criteria for the allocation of funds for approval by the National Committee;
(d) prepare annual distribution of resources to facilities;

(e) if he thinks fit, in consultation with the National Committee, impose conditions on the use of the expenditure authorized by him or on his behalf and may impose any reasonable prohibition, restriction or other requirement concerning such use or expenditure;

(f) institute prudent measures for the proper utilization for monies deposited in the Fund using suitable internal controls and appropriate mechanisms for accountability including audit of accounts by internal auditors of the Ministry responsible for matters relating to finance.

(g) cause to be kept proper books of accounts and records relating to all receipts, payments, assets and liabilities of the
Fund and to any other activities and undertakings financed by the Fund;

(h) prepare, sign and transmit to the Controller and Auditor-General in respect of each financial year and within three months after the end thereof, a statement of account relating to the Fund specifying all contributions to the Fund and the expenditure incurred from the Fund, and such details as the Treasury may from time to time direct, in accordance with the provisions of the Public Audit Act;

(i) furnish such additional information as he may be required that is proper and sufficient for the purpose of examination and audit by the Controller and Auditor-General in accordance with the provisions of the Public Audit Act.

***11. Winding up of the Fund.***
In the event of winding up of the Fund, the cash balances shall be transferred to the Exchequer while other assets of the
Fund shall be transferred to the Ministry for the time being responsible for matters relating to health.

***12. Revocation of L.N. 268/1990***
(1) The Exchequer and Audit (Health Care Services Fund) Regulations, 1990 are revoked.

(2) On coming into operation of these Regulations, all the assets and liabilities of the Health Care Services Fund existing under the Exchequer and Audit (Health Care Services Fund) Regulations, 1990 shall be transferred to and vest in the Fund.

**SCHEDULE (r. 5)**
**COMPOSITION AND FUNCTIONS OF HEALTH FACILITIES MANAGEMENT COMMITTEES**

Provincial Hospital Management Committee
1. The total membership of the Committee shall be at least seven and not more than nine members.

2. (1) The Committee shall consist of-
(a) a chairman appointed by the Minister from the members of the Committee; (b) the area Provincial Commissioner or his representative;
(c) the Provincial Medical Officer of Health or his representative;
(d) the person in charge of the health facility;
(e) the person in charge of the municipal authority health facilities; and
(f) the following persons, who shall be residents of the area of jurisdiction, appointed by the Minister –
(i) one person who shall have knowledge and experience in finance and administration; (ii) one person nominated by women groups;
(iii) one person nominated by faith based organisations;

(iv) not more than two persons nominated by recognized community based development organisations, of whom one shall be a woman.

(2) A member of the Committee, apart from the ex-officio members, shall hold office for a period of three years and shall be eligible for re-appointment for one further term.
(3) The Committee may, if necessary, appoint sub-committees that shall carry out specific functions.
(4) The Committee shall meet four times in each financial year and shall maintain records of its deliberations
5) The quorum for the meeting of the Committee shall be five of all the members including the secretary.
(6) The committee shall be responsible to the officer administering the Fund.
(7) The hospital administration shall provide the necessary secretarial services to the Committee.

3. Functions of the Committee. The Committee shall-
(a) supervise and control the administration of the funds allocated to the facility;
(b) open and operate a bank account at a bank approved by the Minister for the time being responsible for finance; (c) prepare work plans based on estimated expenditures;
(d) cause to be kept basic books of accounts and records of accounts of the income, expenditure, assets and liabilities of the facility as prescribed by the officer administering the Fund;
(e) prepare and submit certified periodic financial and performance reports as prescribed; and
(f) cause to be kept a permanent record of all its deliberations.

**DISTRICT HOSPITAL MANAGEMENT COMMITTEE OR SUB-DISTRICT HOSPITAL MANAGEMENT COMMITTEE**

1. The total membership of the Committee shall be at least seven and not more than nine members.
2. (1) The Committee shall consist of-

(a) a chairman appointed by the Minister from the members of the Committee; (b) the area District Commissioner or his representative;
(c) the District Medical Officer of Health or his representative; (d) the person in charge of the health facility;
(e) the person in charge of the local authority health facilities; and
(f) the following persons, who shall be residents of the area of jurisdiction, appointed by the Minister - (i) one person who shall have knowledge and experience in finance and administration matters;
(ii) one person nominated by women groups;
(iii) one person nominated by the faith based organizations;
(iv) not more than two persons nominated by recognized community based development organizations of whom one shall be a woman.

(2) A member of the Committee, apart from the ex-officio member, shall hold office for a period of three years and shall be eligible for re-appointment for one further term.
(3) The Committee may, if necessary, appoint sub-committees that shall carry out specific functions.
(4) The Committee shall meet four times in each financial year and shall maintain records of its deliberations.
(5) The quorum for the meeting of the Committee shall be five of all the members including the secretary.
(6) The Committee shall be responsible to the officer administering the Fund.
(7) The hospital administration shall provide the necessary secretarial services to the Committee.

3. Functions of the committee. The Committee shall-
(a) supervise and control the administration of the funds allocated to the facility;
(b) open and operate a bank account at a bank approved by the Minister for the time being responsible for finance; (c) prepare work plans based on estimated expenditures;
(d) cause to be kept basic books of accounts and records of accounts of the income, expenditure, assets and liabilities of the facility as prescribed by the officer administering the Fund;
(e) prepare and submit certified periodic financial and performance reports as prescribed; and
(f) cause to be kept a permanent record of all its deliberations.

**HEALTH CENTRE MANAGEMENT COMMITTEE OR DISPENSARY MANAGEMENT COMMITTEES**

1. The total membership of the Committees shall be at least seven and not more than nine members.

2. (1) The Committees shall consists of-

(a) a representative from the provincial administration in the area of jurisdiction; (b) the person in charge of the health facility, who shall be the secretary;
(c) the District Medical Officer of Health or his representative;
(d) the person in charge of the local authority health facilities; and
(e) the following persons, who shall be residents of the area of jurisdiction, appointed by the Minister or any other person authorized by him in writing-
(i) one person who shall have knowledge and experience in finance and administration; and
(ii) four persons of whom two shall be women.

(2) The Committees shall appoint the chairman, who shall not be an ex-officio member, from any of the persons set out in sub-paragraph (1).
(3) A member of the Committees, apart from the ex-officio member, shall hold office for a period of three years and shall be eligible for re-appointment for one further term.
(4) The Committees may, if necessary, appoint sub-committees that shall carry out specific functions.
(5) The Committees shall meet four times in each financial year and shall maintain records of its deliberations.
(6) The quorum for the meeting of the Committees shall be five of all the members including the secretary.
(7) The Committee shall be responsible to the officer administering the Fund.

3. The Committee shall-
(a) supervise and control the administration of the funds allocated to the facilities;
(b) open and operate a bank account at a bank approved by the Minister for the time being responsible for finance; (c) prepare work plans based on estimated expenditures;
(d) cause to be kept basic books of accounts and records of accounts of the income, expenditure, assets and liabilities of the facility as prescribed by the officer administering the Fund;
(e) prepare and submit certified periodic financial and performance reports as prescribed; and
(f) cause to be kept a permanent record of all its deliberations.

Made on the 5th December, 2007

AMOS KIMUNYA
Minister for Finance

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15. International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (1965),
16. Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) (1979,
17. Convention on the Rights of the Child, (CRC) (1989),
18. Convention Against Torture and other Cruel, inhuman Degrading
19. Treatment or Punishment (CAT) (1984),
20. International Convention on the Protection of the Rights of All Migrant workers and members of their Family (MWC) (1990),
21. Convention on the Rights of Persons with Disabilities (CRPD)
22. In the African system the following have been ratified the:
23. African Charter on Human and Peoples Rights,
24. African Charter on the Rights and Welfare of the Child and
25. Protocol to the African Charter on Human and People's Rights of Women in Africa

# Community Health Action Group

## Training Manual

National Taxpayers Association
pesa zetu, haki yetu

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