COPASAH

EASTERN AND SOURTHERN AFRICA REGION FACILITATED LEARNING EXCHANGE VISIT

TO NAIROBI, KENYA

on 2nd – 4th December 2015

COPASAH

A REPORT ON THE COPASAH EASTERN AND SOURTHERN AFRICA REGION FACILITATED LEARNING EXCHANGE VISIT TO NAIROBI,KENYA ON 2ND TO 4TH DECEMBER 2015.

Organization profile

COPASAH is a global community of practitioners on accountability and social action in health. It has a **vision** of having communities actively engaging in promoting accountability and transforming health systems towards the realization of wellbeing dignity and social justice. Its **mission** is to nurture ,strengthen and promote collective knowledge, skills, capacity of community oriented organizations and health activists-primarily in Africa,, Asia and Latin America-working in the field of accountability and social action in health for promoting active citizenship to make health systems responsive, democratic, equitable and people centred. Currently the secretariat is in New Delhi, India and the secretariat is comprised of representatives from India, Uganda, Zimbabwe, U.S.A and Guatemala.

To achieve these, COPASAH have adopted several strategies, among them the Facilitated peer Learning Exchange (FLE) program. The FLE is a systemic exchange of knowledge, practice and resource sharing .The visits consist of three parts namely; an **introductory workshop,** a **field visit** and later a **debriefing session** to arrive at a way forward of implementing the learning. These visits are envisaged to facilitate the peer learning and to enable strengthening of the solidarity of shared practice among practitioners.

Day 1

Introduction

The regional facilitated learning exchange visit to Kenya was hosted by the National Taxpayers Association from 2nd to 4th December 2015 at Pride Inn Hotel, Nairobi. Those present were given an opportunity to introduce themselves and the organizations that they work for. Participants in this exchange visit were from Kenya, Uganda, Zambia and Zimbabwe and were warmly welcomed to Kenya.

LIST OF PARTICIPANTS

	NAME	ORGANIZATION	COUNTRY
1	Robinah Kaitiritimba	Uganda National Health Consumer Organization-UNHCO	UGANDA
2	Agaba Aziz	Uganda National Health Consumer Organization-UNHCO	UGANDA
3	Kirigwajjo Moses	Uganda National Health Consumer Organization-UNHCO	UGANDA
4	Odaro Jude	Uganda Debt Network(UDN)	UGANDA
5	Ojulong Patrick	Action Group for Health Human Rights and HIV/AIDS	UGANDA
6	Mwangala Mulundano	Ministry of Health-Zambia	ZAMBIA
7	Lorraine Mafunda	Zimbabwe Association of doctors for Human Rights-ZADHR-ZIMBABWE	ZIMBABWE
8	Wolde Wesa	National Taxpayers Association	KENYA
9	Annah Katuki	National Taxpayers Association	KENYA

10	Maryanne Mwangi	National Taxpayers Association	KENYA
11	Fransciscah Marabu	National Taxpayers Association	KENYA
12	Irene Otieno	National Taxpayers Association	KENYA
13	Reuben Chebii	National Taxpayers Association	KENYA

Robinah Kaitiritimba from UNHCO, Uganda, and member of the global steering committee graced the event.

Objectives of the FLE

i. To facilitate peer learning for regional COPASAH members
ii. To learn from National Taxpayers Association of Kenya and all participants as a way of strengthening the work of COPASAH members

About The National Taxpayers Association-Kenya

Irene Otieno, Nairobi Regional Officer and Project officer in charge of Health Project in NTA welcomed the COPASAH members and introduced NTA as follows;

The NTA is a national, independent, non-partisan organization focused on promoting good governance in Kenya. Since 2006, the NTA has been implementing programs focused on citizen demand for accountability through monitoring of the quality of public service delivery and the management of devolved funds. It has achieved this through the development of social accountability tools (Citizen Report Cards), civic awareness, and citizen capacity-building, partnerships with government agencies, service providers, private sector, and civil society and community action groups. NTA is fully independent of government; however, it is committed to working with the government to improve service delivery and the management of devolved funds.

NTA's vision is an accountable, citizen-responsive government delivering quality services to all. Its mission is to promote accountable, effective and efficient collection and utilization of public resources through citizen empowerment, enhancing public service delivery and partnership building. NTA has a governing council of 12 prominent civil society and religious organizations and eight active regional coordination offices covering the entire country that effectively support and enable operations at regional and constituency level. NTA has 8 regional offices so as to reach the marginalised sections of Kenya's society.

In addition to monitoring devolved funds NTA has project under the school report card project. This project aims at improving education indicators in Kenya. The community Health Monitoring project is aimed at working with health facility management committees (HFMCs) to improve the right to health and its indicators.

PRESENTATION ONE: PRESENT STATUS OF HEALTH CARE IN KENYA

Presented by Irene Otieno-health project &regional coordinator, Nairobi (**Appendix 1**)

Kenya has exhibited its interest in improving the health status of its people. Towards this end Kenya has signed international and regional instruments to move this agenda forward. The more significant step of domesticating these instruments has in a sense breathed life into the provisions.

The Government of Kenya is signatory to international and regional instruments whose import is to guarantee 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."

In the regional context Kenya is among the African Union countries that pledged to set a target of allocating at least 15% of their annual budget to improve the health sector.

The current government (Jubilee Government) has prioritized healthcare in their manifesto. They have specifically committed to achieve free primary healthcare for all Kenyans, starting with women, expectant and breastfeeding women and persons with disabilities by increasing health financing for healthcare from 6-15% among other commitments to healthcare. It is imperative for the communities to monitor whether this will be followed through including the waiver of user fees and the policy on free maternity services.

The 2010 Kenya constitution has afforded many gains to the Kenyan populace. Key among this is the enshrining of the social economic rights that were hitherto designated as third generation rights. Article 43 of the constitution provides that **(**1) every person has the right (*a*) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; therefore the government is duty bound to provide its citizens with the highest attainable standards of health as espoused in the constitution.

The guiding policy document is the health policy 2014-2030 which is anchored on two principles as follows: **Contribution to economic development as envisioned in vision 2030** and **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. 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.

Currently, provision of primary health care 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. This approach has however brought with it teething problems that have a negative impact on the enjoyment of the right to health. It is crucial that communities actively participate to ensure their rights are not overshadowed by politics of the day.

The Kenyan Government has initiated and continues to initiate drastic reforms geared at improving service delivery in the health sector. The introduction of direct funding to the tier 1, 2, and three, transforming Kenya Medical Supplies agency to an authority, the introduction of the community strategy and the introduction of the health committees in health facilities. The health facility management committees (HFMCs) are representatives of the community who are involved in the management and governance in the health centers. The HFMCs are mandated to ensure that the community accesses their right to health. However, there has been a disconnect between the HFMCs and the communities who they represent. There is need to build the capacity of the HFMCs so as to monitor provision of health care in their localities.

Further the economic blue print plan of Kenya the vision 2030 notes the indispensible place of a healthy workforce for the realization of economic growth. In deed economic growth has to go hand in hand with improved human development indicators. *The vision 2030 that details the long term national development agenda to make Kenya globally competitive by 2030 mentions health as 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.*

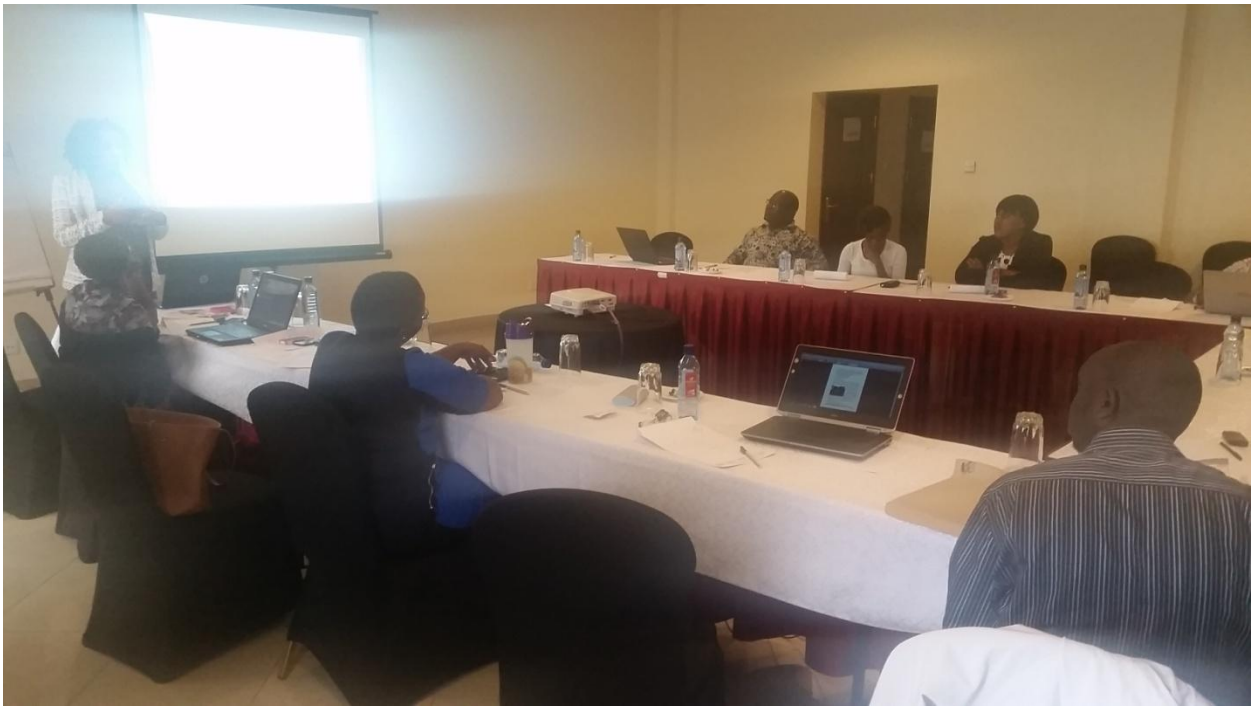
On the other hand the health sector still faces key challenges. There has been recurrent health sector strike by the health sector personnel. This has been attributed to the issues of poorly equipped facilities, staff salaries, and allowance, training and general welfare.

The state of health financing by the Government has also been static for years. This has a negative impact on health indicators as increased funding if efficiently managed will go a long way to resolve critical health bottlenecks.

PRESENTATION 2: OVERVIEW OF THE HEALTH PROJECT

NTA and the Community Health Monitoring Project

NTA in collaboration with the Ministry of Health (MOH) is implementing a second phase of community health monitoring project funded by Open Society Foundation (OSF) through Open Society Initiative for Eastern Africa (OSIEA) in eight randomly selected level 3 public health facilities in Kenya namely; **Keringet, Maiella, Chepkigen, Kiambara, Mweru, Kuinet, Kilala** and **Mukuyuni.** The project is as described below:



Maryanne Mwangi presenting on NTA's Community Monitoring Project during the Faciltated Learning Exchange Visit in Kenya in December 2015.

Project Objectives and Activities

Goal

To contribute to enhanced service deliver through improved governance in health institution by promoting democratic process in Health Facility Management Committees

To facilitate the attainment of the outlined project goal, several specific objectives and project activities will be implemented as follows:

Objective 1: To empower HFMC to demand for the right to health.

Activities under this objective include:

1. Training and capacity building for HFMCs. This entails human rights based approach, familiarization with the project, training on the tools for monitoring and research methodology.
2. Conducting monitoring activities. This entails development of tools that collect data on access to services, number of visits, waiting period, examination time and perceived quality, availability of medication, medicine stock outs, availability of healthcare providers, availability of equipment, general sanitation, availability of bed facilities, customer care and treatment and provision of medical or general information. Members of HFMCs and the community visit facilities randomly, conduct interviews and record data.

3.Development and dissemination of simple and easy to understand Information Education and Communication (IEC) materials including fliers and posters that contain information about citizen rights to quality healthcare and the need to participate to demand accountability.

Objective 2: Create linkages between Health Facility Committees (HFMCs) and government health service providers and communities to strengthen community voice in demanding quality health care though improved transparency and accountability.

Activities under this objective include:

1. Establishing a partnership with the Ministry of Health (MoH) through a formal invitation and holding consultative meetings to sell the project to MoH and

demonstrate its value in contributing to the achievement of its strategic plan. It is also hoped that this will secure MoH support through a working agreement or memorandum of understanding between NTA and MoH to provide a collaborative platform for project implementation thereby enhancing the chances of success.

2. Holding sensitization meetings/workshops with district healthcare service providers, community Ministry of Health (MoH) officials and HFMCs to explain the goals, objectives and expected outcomes of the project in order to create understanding and buy-in.

Objective 3: Improve the quality of health services at the county level through dissemination and advocacy for the implementation of Government commitments, policies and standards.

Activities under this objective include:

1. Development of a Health Community Score Card (HCSC) The HCSC shall be compiled from all the data collected during the monitoring activities towards the end of the project year.
2. Holding a national media launch event to disseminate the findings of the HCSCs to the wider public and exert pressure on the MoH to act on pertinent issues raised. It shall also provide a platform to review findings of monitoring activities, discuss progress on HCSC and challenges encountered, lessons learnt and way forward to enhance quality of health services.

Project Highlights

The health sector pyramid in Kenya is in six tiers;

i. Level 1 serves a population of about 5,000,
ii. Level 2/dispensaries-25000,
iii. Level 3/health centers -25,000
iv. Level 4/ county referral facilities-100,000-320,000
v. Level 5/regional referral facilities -1 million
vi. Level 6/national referral serves about 4 million

NTA implements this community health monitoring project in level 3 health facilities and focused on meeting the following objectives;

i. To empower HFMC by developing a manual and IEC materials to train the HFMC and communities on the human rights based approach to health care, the role of HFMC and community. This will facilitate them in demanding for the right to health.
ii. Create linkages between Health Facility Committees (HFMCs) and government health service providers and communities to strengthen community voice in demanding quality health care though improved transparency and accountability.
iii. Improve the quality of health services at the County level through dissemination and advocacy for the implementation of Government commitments, policies and standards.

This project focuses on working in the health centers and more specifically with the health facility management committee (H.F.M.C) in Kenya's health system. These 10 committee members comprise local community representatives, county administration and the facility management. The H.F.M.C is mandated will overall management of the facility. The committee as established by law should be democratically elected and carry out its mandate democratically with utmost transparency. The project seeks to work with health centers and the community to ensure that the H.F.M.C are democratically elected, hold office for the stipulated period, create and sustain linkages with the community and share with the community their mandate as per the establishing government document.

Challenges

Although the government has the put in place the right policies and legal framework, the same lacks effective implementation. Some of the challenges encountered in this project are;

- Low staffing levels have been a major issue across all level 3 health facilities in Kenya. In most facilities the numbers of trained health staff are less than 10 against a standard of 65 as stipulated in new health sector staffing norms 2014.

- HFMC are usually handpicked or the membership is influenced by local leaders and politicians thereby affecting the democratic right of the citizens to make their choices
- The HFMC members lack enough training especially on their mandate
- The government delays funding of the HFMC members since they are suppose to meet quarterly.
- The challenge of implementing the Abuja declaration since Health matters in Kenya was devolved in the advent of the Constitution 2010 and the uniqueness of challenges of the counties.
- In some, community members are not aware of their HFMC members
- Funding of the health sector has reduced since the government has majorly focused on infrastructural developments
- Sometimes there is lack of information/records given by the health facilities

NTA intervention areas

- NTA has engaged in sensitization and training of HFMC's on the gazette notice, their mandate, health norms and standards, budgets, project plans, and effective monitoring and evaluation.
- NTA has also supported the meetings of HFMC's by giving them monthly allowances in order to facilitate their meetings and activities.
- On engaging with the community, the project seeks to build the capacity of the communities in regard to the mandate of the H.F.M.C, build the capacity of the community on local governance structures and how they can utilize them and share with the community the government service delivery standards.
- Through this project NTA works with the health service providers so as to improve their appreciation of social accountability and democracy. It seeks to bring the service providers and the community to one understanding of increased democracy as an effective tool for improved service delivery.

FEEDBACK (comparative analysis)

Lorrainne from **Zimbabwe** also concurred with the Kenyan case on the issue of lack of information from the health practitioners citing the challenge of

bureaucracy. Most junior officers fear giving critical information on the basis that they must seek approval from their seniors. This challenge was cross cutting with all member countries alluding to it.

Zambia stated that there is less funding from their health facilities. Each of their 36 health facilities gets an approximate of 20 dollars that is insufficient for them to effectively discharge their mandate.

The Uganda team weighed in to point out that the community monitoring cannot be separated from politics: they are intrinsically interconnected. For them they used politics by mobilizing communities and the civil society to demand that the Ministry of Health employ more staff. This worked well and 7,000 additional staff was brought on board.

It was acknowledged that managing politics is a delicate matter but can be harnessed creatively as in the Uganda case since it has a bearing on the political incentive structure.

PLENARY DISCUSSIONS

An interesting discussion was prompted by a participants question on why the NTA project seeks to work with the official committee as opposed to working with an independent community unit. The discussion provoked by this question was very rich with participants from the different countries sharing how their health committees are elected and where it draws its composition. This was geared at analyzing whether the above would sufficiently insulate it from political interference and thus guarantee its independence to the extent of fostering trust, so that we as civil society work with it.

Responses

During the first grant by OSIEA, NTA formed an alternative oversight committee (community health action groups-CHAGs) for 2 years but it did not work properly since the issue of duplication of roles came up. Additionally, there is already public

funding by the Kenya government to form, train and fund operations of the HFMCs. NTA's thinking was that side stepping the HFMC would be a waste of taxpayers' money and found it more prudent to strengthen the existing structures.

NTA later resorted to use the legally constituted HFMCs but pushed for more community member's representation and worked towards strengthening it. NTA is working with HFMCs as these are community units that are recognized by law. The project will build their capacity since these are permanent institutions that will continue to exist even after NTA exits. The body of knowledge that will be generated from this project will be used to build the capacity of future HFMCs.

There was no consensus on this issue though most felt that this institution's political neutrality was not guaranteed and any engagement should be approached with due diligence.

Participants sought to know how HFMCs operates on a day to day basis. How to they also demand accountability? Do they share their reports?

The HFMCs are legally recognised committee.There is a gazette notice establishing them, with clear guidelines on their roles and responsibilities. They are to be elected democratically by the community members and other stakeholders. They meet quarterly and draw action plans on how to undertake oversight roles in the facility. The committee works with both local leaders through chief baraza's. The ward administrator also in some cases would write complimentary letters in support of the committee. The committees also channel their problems through the sub county administrators.

The visiting delegation wanted to know whether the health service charter is the same with client service charters. And how communities understand service charters and work towards accomplishing it.

In the Kenya case, Service charter is a twofold; Ministry service charter and health facility service charter. National Health policy document requires that service charters are publicly displayed. The service charters are put on the walls or facility

notice board. This helps direct the community on the Kind of services that are offered in specific facilities.

The service charter at Maille HCIII in Kenya

NTA had mentioned that they make use of the barazas as an avenue for community mobilization. Participants expressed interest on how often are they organized and who organizes them?

Baraza's are local community monthly meetings usually organized by the provincial administrators (chiefs).These meetings are vital avenues where government policies, programmes, budgets and activities are announced and discussed. The meetings are not usually well attended and those who attend partly understand and participate in the agendas for the respective meetings. With the coming of devolved governments there has arisen conflict duplication between the ward administrators and provincial administrators in convening such baraza's.

The visiting team was keen to have NTA highlight the unique work that it has done at local, county and National levels that could be borrowed as best practice

Apart from the Heath project, NTA has successfully implemented varied governance programmes and monitored devolved funds. Such as the School Monitoring Project, CDF, LATF among others.

By using the score card tool, NTA has used it to push for increased financing and accountability, staffing issues and quality service delivery.

NTA has been active on budget analysis broadly and health budget analysis more specifically. In this regard NTA obtains copies of the national budget, county budget and isolates the health budget component in these documents. Further, NTA works with the facility to scrutinize these budgets to establish if their facility is a beneficiary and how to follow this. More interesting is that even when the facility is a beneficiary then the scope of work is not specified. Hence NTA is working with the facility to effectively/constructively engage with constructors to share the Bill of Quantity among other project documents.

Participants wanted clarity on whether any country present had in place any policy reform platform of involving the citizenry in governance in health. Such a policy would safeguard community participation as opposed to ad hoc engagement with the community that was dependent on the good will of those in political office.

The Ugandan delegation provided their country approach as one of the progressive strategies. For Uganda there exist the quarterly and annual reviews meetings. In such issues are raised and an issue paper is written to inform service delivery. This has been majorly successful because of prior planning by CSOs to rally the community on upcoming meetings and help them well to highlight their issues.

In Kenya public participation in issues touching on policy and budget issues are guaranteed in the Constitution Article 118,196, County Government Act 2012 and Public Finance Management Act 2012.

HARNESSING CITIZEN EXPRESSION OF POWER

Presentation by Aziz Agaba, UNHCO (**Appendix 2**)

The objective of this presentation is to unbundle how to comprehend social accountability in Africa. How citizens express their citizenship when faced with different power laden interaction and how people express it as a form of agency and politics.

Strategic citizenship is citizens' action by powerful individuals whilst tactical citizenship is citizen's action by powerless citizens

How can different responsibility centres strengthen expressions of citizen power?

There are four categories of power;

i. Power within (individual empowerment &responsibility)
ii. Power with (ability to undertake collective action)
iii. Power to (Competency and ability)
iv. Power over

Group work exercise-Adopting the NTA case

Using the RICE (role, interest, contribution and effect);

i. Identify the responsibility centres that have effect on how citizens exercise their power?
ii. List down the RICE in strengthening citizens' power.

NTA STRATEGIES

Presented by Ann Katuki, RCO Eastern region, NTA

Media engagement

This is a very useful supporting mechanism for publicity, advocacy and sensitization of health matters.NTA has utilized community radio talk shows, television, radio and print media to publicize their activities.

Building partnerships and coalitions

NTA in seeking to enhance government accountability and transparency developed various tools including citizen report cards, service charters, and community scorecards to ensure that they are able to monitor, evaluate and access the quality, availability, adequacy, effectiveness of basic service delivery. To disseminate the information collected from these tools, NTA had to build partnerships with the media and state duty bearers to publicize their reports and activities in order to provide information to citizens.

Challenges

- The Social accountability tools do not take into account the political nature
- There are constant health workers strike affecting collecting of information
- There is also constant change of leadership and transfer of duty bearers necessitating rebuilding relationships
- The county governments have not been fully implemented the health functions
- Holding public officials and Political leaders accountable is always a delicate affair

DAY 2 FIELD VISIT

The field visit was held in Maiella health center that is a project site that NTA has been working in with funding from OSIEA. In attendance was the health facility management committee (HFMC), the health facility management, NTA staff and the Africa visiting delegation.

Participants were welcomed by the in charge of the facility Mr. Mwaura who gave an overview of Maiella health center. He discussed the history of the facility, the level of health care within the Kenya health system and the general data and statistics of the area.

Thereafter the participants introduced themselves with specific focus on which grouping they represent i.e. the youth, women, persons with disabilities and religious group.

The HFMC chair welcomed the participants and expressed his pleasure in hosting a team with representation from Africa. He pointed if there is anything to be taken home from the meeting is the different experiences that the African team would bring on board and transplant into their own health systems to strengthen them.

He enumerated the roles of the HFMCs and also discussed the partnership with NTA and how it has impacted positively on their working.

Feedback from field visit presentation:

Youth representation

A critical question was raised on the role of the youth representative in the committee. The youth representative clarified that the youth are used as a means of communicating with the nurses/doctor. He then brings the concerns of the community to such forums.

Additionally, it is a requirement that at the constitutive stage of the committee there has to be a youth representative. The youth representative highlighted the fact that Maiella health center does not have a youth friendly service contrary to the requirements at this level of care. The youth representative indicated that this is the one issue that he is working to change.

The team was interested on an explanation on the working of the Constituency Development Fund(CDF).The UHCO team requested for clarity on whether Community Development Fund(CDF) projects is a major source of funding to the facility

The HFMC stated that the CDF is a fund that is predominantly a discretionary fund that is managed by the local politicians. The structure of this fund has in most times been devoid of transparency. This is well depicted by the CDF project in the facility that has not been completed for 6 years now. The HFMC normally write a proposal to the local political leader to fund a project that they and the community have identified. If the leader agrees then it is funded. It was also pointed out that CDF only fund physical infrastructure projects.

Community representation:

The visiting team also voiced their concern that the community does not seem to be represented. It was noted that the HFMCs are representatives of the community but cannot usurp their roles and HFMCs are never a substitute of the community. This was duly noted by the HFMCs and they took up the challenge to work hand in hand with the community to have a robust community link.

Feedback Mechanism

The visiting team inquired on the existence of channels for the community and users to give their feedback. The HFMC pointed the team to the suggestion box, complaints and compliments register and the HFMC itself as feedback channel. Moreover, the community health volunteers and staff are another channel. The bigger issue was to establish who opens this box and whether the community actually gets responses to pertinent issues raised.

Mechanism of creating awareness on family planning use and its side effects

The HFMCs cited the fact that uptake of family planning is below the optimal level and this was attributed to myths propagated by the male members of the community. The team was interested to find out what the HFMC is doing to remedy this situation. The HFMC stated that they sensitize the community during outreaches and action days.

The contribution from the larger team was that the HFMC and facility in charge encourage the women to come for family planning with their spouses to dispel

the myth. This has worked well in Uganda safe for the fact that the women would hire “boda boda” riders to act as their spouses.

The issue of the reduction in uptake of the family planning was highlighted to be a result of negative perception of the community and men more specifically. It was shared that in Zambia, to go round this issue was encouraging the women to come with their husbands.

In Uganda and Zambia it was pointed out that they make use of the community radios. NTA was encouraged to explore the possibility of making use of community radio, to have male action groups and encourage testing and uptake of family planning. Give incentives to the men to accompany the women.

The Zimbabwe delegate added that in Zimbabwe particularly for communities that do not agree with immunization, forced immunization accompanied by police in the religious building of these sects is used.

Motivation of Community Health Volunteers (CHVs)

Motivation of the CHV was cited as a key issue in improving service delivery. It was pointed out by the Zambia team that in Zambia they have established projects for the CHVs such as fishponds and financial groups to raise funds and borrow among members to empower the CHVs economically. This was a best practice that the Kenya team could borrow and transplant in the Kenya system. As they have it in Maiella but this can be built on further.

Staffing

The understaffing at the Maiella health center was singled out as an issue as it made utilization of the available equipment and infrastructure less than optimal. The team discussed the possibility of the Maiella team coming up with strategies to push the duty bearers to address this glaring gap.

The committee helps in pushing for more staff when they meet the Ministry of Health (MOH) staff. The Maiella HFMC also reached out to the NTA team to explore the possibility of assisting them to reach the concerned stakeholders.

The Ugandan team proffered a way forward that has worked in their country. The medical institutions have partnered with health personnel training institutions so that their students carry out their internship there. However, the facility can look at the possibility of small allowance for toiletries and other small items.

To address the staff shortfall in Zambia, the casual workers and traditional midwifes are used to help to carry out deliveries in facilities. This approach was however not tenable in Kenya as this contributed to high maternal deaths. However, retired nurses and clinical officers are allowed to assist with deliveries but they report to the facilities.

Funding to the Health Centre

The visiting team was keen on carrying out an analysis on how much direct funds are send to the facility. The HFMC submitted that the Government gives them Kshs.239, 962 per quarter. Colleagues from Uganda indicated that this amount is what their facilities get in a whole financial year. This comparative analysis was useful to the extent that it provided the Ugandan team with the impetus to advocate with their Government for increased funding to facilities. This comparative analysis of countries within the East African Community is useful as the social economic climate is similar.

To break this down further, the team was interested to find out what budget lines are dedicated for these funds.

It was clarified that the medicine supplies vote head was only for emergency medication when the national medicine supplier Kenya Medical Supplies Authority (KEMSA) has delayed.

The Zambian team shared their experience in that their funding to the facility has a component strictly for community allocation that is deliberated and utilized according to the community preferences. Though the amount in question is

limited, the practice of subjecting these funds to community is quite progressive and needs to be applauded.

Outreach Services

The issue of outreach services was discussed as the participants were keen to establish how these are carried out by the Maiella facility. It was clarified that they carry out 3 outreaches per month in Ngondi, Narasha and Nkambani villages that are far flung. It was shared that in these outreaches it is mainly MCH services that are offered. However, the facility has been reduced to just offering one outreach as this services have ended up as outpatient services. It was pointed out that the outreaches for Narasha mainly serve the maasai that are not keen to use that outreach but prefer to use the far flung facility so as to get a little financial compensation by their spouses.

DAY 3:

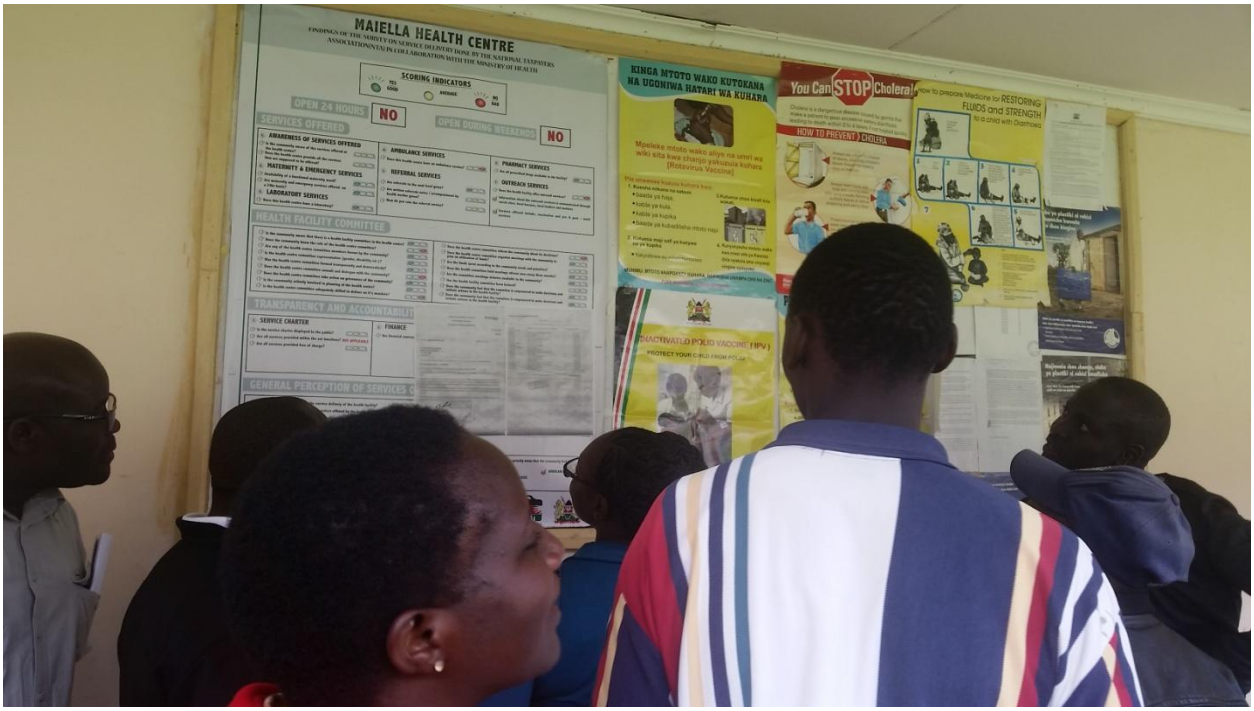
REVIEW OF THE FIELD VISIT

Day 3 was a half day meeting to reconvene and debrief on the field exercise. The visiting team having met the community and experienced NTA's approach first hand, they would be in a position to provide useful constructive critic. Below is an analysis of the strengths, gaps and suggested action for improvement that the team and NTA compiled:

STRENGHTS	GAPS	ACTIONS FOR IMPROVEMENT
Involvement of the community	Low staffing levels	More training and sensitizations
Good working relationship between HFMCs and staff	Low community level of advocacy	Health/client service charter to be translated to local languages
Presence of NTA	Overworking of staff	Establish a community radio
High level of commitment of the HFMC	Lack of incentives for staff	Multi-stakeholders action in advocating and advocating

		for change at higher levels
Public display of health service charter	County governments seem so detached from the HFMCs	Internship/attachment opportunities for trainee students
Accountability of public expenditures	Limited referral mechanism	Strengthen linkages for change
Good infrastructural developments	Wide area of coverage of facility	More community engagement
	Ignorance and illiteracy of some community members	Proper dissemination of information

Participants of the FLEV at Maille HCIII



Participants of the FLEV viewing the summary report on the community score card findings at Maiella HCIII

The NTA team found the above analysis extremely useful as in provided insight from an unbiased team of expert practitioners.

PARTICIPATORY BUDGET ANALYSIS

Presented By Odaro Jude Snr,programmeofficer Uganda Debt Network (Appendix 3)

Participatory budgeting literally means attending, listening to and contributing to budget making process. It is a democratic process in which community decide directly on how to raise and spend expenditure. It is not merely attendance but it is contribution in these meetings.

Factors determining participatory budgeting are;

- Political commitment
- Community support

- Right conditions

People tend not to participate because of lack of incentives and allowances

Relevancy of participatory budgeting

i. More civic engagement
ii. New community leaders and more active citizens
iii. Stronger relationships between government, organizations and community
iv. Fairer and effective spending
v. Political participation

BUDGET ANALYSIS

This is a comprehensive, systematic evaluation or assessment of a budget. An analysis examines the extent to which the revenue and expenditure measures to meet the set objectives. Practically though, most people who do budget analysis focus most on the budget expenditure and leaving out on the revenue.

Methods of budget analysis

i. Comparative budget analysis (central, local government and other sectors)
ii. Chronological budget analysis (overtime, period, and itemised)
iii. Zero budgeting (reviews wasteful /suppliers and does fresh reallocations).This more effective in smaller systems such as households
iv. Incremental system of budgeting (increase of percentages)

Budgets can be analysed in terms of the following;

- Social sector e.g education, health
- Population group e.g children, PWDs
- Government program e.g. IDPs resettlement
- Issue oriented e.g. HIV/AIDS

Techniques of analysing a budget

- Calculate the share allocation of the total budget (Ministry/department allocation)

- Calculate the sector priorities (e.g. what goes into administration, training and service delivery?)

These techniques should reflect the following attributes; Adequacy, priority, progress and equity.

CASE STUDY

In Uganda they have formed a civil society budget advocacy group which has been recognised by government ministries and departments as a focal point of CSOs involvement in budget matters. It has successfully lobbied for a simplified version of citizen budget. Furthermore it has been pivotal in trainings, sensitizations, coordination and even funding of budget public participation forums and activities.

This case study was particularly instructive for the NTA team as it is at the negotiating stage of forming a health budget advocacy group and the discussions had pointed out the merits and the pitfalls that NTA should look out for to optimize results from such an engagement.

Budget analysis in health care is a critical and the zero budgeting approach was an interesting discussion. Participants felt that this would be the answer to the wastage that is in most time exhibited by health Ministries amid calls for increased budgetary allocations for health. It was discussed that this approach would enable health departments and programs justify their line items.

Homework exercise*:*

- *Review your county budget for the years 2011-2015.*
- *Establish the health and education sector allocations*
- *Establish whether the budgets are increasing or decreasing and the reasons thereto*
- *Establish the relationship of the education and health budget to the total budget*

Debriefing the team after the field visit at Maiella HCIII

CONCLUSION

The facilitated learning exchange visit was concluded on a high note with excellent experience sharing.

These experiences if taken on board with the country context in mind will go a long way in ensuring robust health systems with the community taking the central stage. Some of the key recommendations are highlighted below

Recommendations and conclusion from the FLE:

- HFMC work more with the community to improve staffing
- The HFMC was commended on the fact that they are robust
- Partnership creation-NTA should do more-introduce some/more initiatives. Help community write reports and proposals.

- Participants discussed the importance of having the community at the center of all interventions. It was discussed that it should not be difficult to locate the community in any community monitoring project. The community should be the ones that own the project and should be in all stages of the project. NTA was challenged to re organize its project to ensure the community presence is strengthened. This suggestion came in at an opportune period as NTA is at the inception stage of the second year of project implementation and can thus take this on board.

Wolde Wesa of NTA officially closed the FLE on behalf of the Executive Director of NTA. He thanked COPASAH for allowing Kenya host the FLE.

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