UNIVERSITY OF NAIROBICOLLEGE OF HEALTH SCIENCES

UoN CAPACITY BUILDING FELLOWSHIP

PROJECT IMPLEMENTATION REPORTAT THE COUNTY GENERAL HOSPITAL (CGH) KAKAMEGA PARTICIPATING LOCAL PARTNER (PLP)

THE HOSPITALMANAGEMENT TEAM OF THE CGH KAKAMEGA 2017

PROJECT TITLE: TO DEVELOPA RESOURCE MOBILIZATION STRATEGY TO IMPROVETHE IN-PATIENT HIV TESTING SERVICES (HTS) FROM 60% AND SUSTAINIT AT 100%AT THE COUNTY GENERAL HOSPITAL KAKAMEGA 2016-2020

A PROJECT REPORT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS OF THE AWARD OF THE FELLOWSHIP DEGREE IN HIV PROGRAM OF THE UNIVERSITY OF NAIROBI

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AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Clinic
ANW	Ante Natal Ward
AP	Administration Police
ART	Anti-Retro Viral Therapy
ARV	Anti- Retro Viral
CCC	Comprehensive Care Clinic
CEC	County Executive Committee Member for Health Services
CGH	County General Hospital
CITC	Client Initiated Testing and Counseling
DHIS	District Health Information System
EEC	Executive Expenditure Committee
EMR	Electronic Medical Records
e- MTCT	Elimination of Mother to Child Transmission of HIV Infection
ENT	Ear Nose and Throat
EQA	External Quality Assessment
FGD	Focus Group Discussions
FIF	Facility Improvement Fund
FP	Family Planning
FSW	Female Sex Workers
FY	Financial Year
HCP	Health Care Provider
HDU	High Dependency Unit
HIV	Human Immune Deficiency Virus

HODs	Heads of Departments
HRIO	Health Records and Information Officer
HMC	Hospital Management Committee
HMT	Hospital Management Team
HOD	Head of Department
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
KII	Key Informant Interviews
ICU	Intensive Care Unit
IPD	In- Patient Department
KDHS	Kenya Demographic Health Survey
KMTC	Kenya Medical Training Centre
KNBS	Kenya National Bureau of Statistics
MMUST	Masinde Muliro University of Science and Technology
MOH	Ministry of Health
MSH	Management Sciences for Health
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission of HIV infection
NASCOP	National Aids and Sexually Transmitted Infections Control Programme
NBU	New Born Unit
OCA	Organizational Capacity Assessment
OJT	on the Job Training
OIs	Opportunistic Infections
PEPFAR	President's Emergency Plan for AIDS Relief

PLP Participating Local Partner

PMTCT Prevention of Mother to Child Transmission of HIV

PITC Provider Initiated Testing and Counseling

PRC Post Rape Care

PSSG Psycho Social Support Group

PT Proficiency Testing

PWID People Who Inject Drugs

QA Quality assurance

QIT Quality Improvement Team

RMS Resource Mobilization Strategy

SW Social Worker

SWOT Strengths Weakness Opportunities and Threats

SRH Sexual and Reproductive Health

STI Sexually Transmitted Infections

TB Tuberculosis

UHIV University of Nairobi HIV fellowship program

UoN University of Nairobi

VMMC Voluntary Medical Male Circumcision

WHO World Health Organization

WIT Work Improvement Teams

DEFINITION OF TERMS

Important highlights for HTS service delivery at the CGH Kakamega from the HTS 2015 Kenya Policy document.

The March 2015 HTS Policy guide gives a pointer to a reasonable way to health successes in the implementation of HTS programs. This is also on the same frame work of the Kenyan National Aids Strategic Program direction 2014-2019.

The HTS Policy Kenya document of 2015, considers the basic rights of individuals and families; the legal and ethical considerations were informed by the following legislative documents:

- The Constitution of Kenya, 2010
- The HIV and AIDS Prevention and Control Act, 2006
- The Sexual Offences Act, 2006
- The Children's Act, 2001
- The Gok Public Health Act (Cap 242)
- The Medical Laboratory Act, 1999
- The Science and Technology Act, 1980
- International Labor Law

Guiding principles

A public health and human rights-based approach is important to delivering HTS. A human rights-based approach gives priority to such concerns as universal health coverage, gender equality and health-related rights such as accessibility, availability, acceptability and quality of services. For all HTS, regardless of approach, the actual public health benefits must always outweigh the potential harm or risk. Moreover, the chief reason for testing must always be both to benefit the individuals tested and to improve health outcomes at the population level. HTS should be expanded not merely to achieve high testing uptake or to meet HIV testing targets, but primarily to provide access for all people in need to appropriate, quality HTS that are linked to prevention, treatment, care and support services. Thus, HIV testing for diagnosis must always be voluntary, consent must be informed by pre-test information, and testing must be linked to prevention, treatment and care and support services to maximize both individual and public health benefits.

The Kenya 2015 policy guidelines give a major shift from HIV Testing and Counseling(HTC) to HIV Testing Services (HTS) which brings in the perspective of the 5Cs of Consent, Confidentiality, Counseling, Correct results and Connection – linkage to care.

The 5 Cs are principles that apply to all HTS and in all circumstances

• Consent: People receiving HTS must give informed consent to be tested and counseled.

(Verbal consent is sufficient; written consent is not required.) They should be informed of the process for HIV testing and counseling and of their right to decline testing.
• Confidentiality: HTS must be confidential, meaning that what the HTS provider and the client discuss will not be disclosed to anyone else without the expressed consent of the person being tested. Confidentiality should be respected, but it should not be allowed to reinforce secrecy, stigma or shame. Counselors should discuss, among other issues, whom the person may wish to inform and how they would like this to be done.
Shared confidentiality with a partner or family members trusted others and a healthcare provider (HCP) is often highly beneficial.
• Counseling: Pre-test information can be provided in a group setting, but all people should have the opportunity to ask questions in a private setting if they request it. All HIV testing must be accompanied by appropriate and high-quality post-test counseling, based on the specific HIV test result and HIV status reported. Quality assurance (QA) mechanisms as well as supportive supervision and mentoring systems should be in place to ensure the provision of high-quality counseling.
• Correct: Providers of HIV testing should strive to provide high-quality testing services, and QA mechanisms should ensure that people receive a correct diagnosis. QA may include both internal and external measures and should receive support from the national reference laboratory. All people who receive a positive HIV diagnosis should be retested to verify their diagnosis before initiation of HIV care or treatment.
• Connection: Linkage to prevention, treatment and care services should include effective and appropriate follow-up, including long-term prevention and treatment support. Providing HTS where there is no access to care, or poor linkage to care, including ART, has limited benefit for those with HIV.

Approaches and settings

The two approved ways to under HTS in Kenya. These being the Client Initiated Testing and Counseling (CITC) and Provider Initiated Testing and Counseling (PITC). Both of these directions are premised on the need to expand options available to clients while seizing presenting opportunities to accelerate HIV testing coverage. These HTC services are done in two broad settings, namely community and facility based settings. Therefore I recommended that in the counties HTS is offered as a service mix of the above delivery models.

Who can provide HIV Testing and Counseling (HTC) Services?

a) Medical personnel qualified and trained to practice as HTS counselors must provide high quality testing and counseling services as per the policy guide from the NASCOP approved curricular.

b) Lay HTS providers undertaking HTS services in the community must have basic training using approved curricular and certified by NASCOP. The community lay counselors must help all their clients to be linked to care, adherence counseling and support group management.

Facility based HTS strategies

Kenya as a County with a mixed generalized and concentrated of the HIV epidemic has been given health facility HTS program guide. WHO expects for generalized HIV epidemics, that HTS services be availed to all patients attending all health facilities regardless of the reason of visit in the health facility? Regular opt out PITC should therefore be done in all service delivery points, including all the wards and special clinics in the health institutions.

According to WHO 2008 it is expected that all health workers practicing HTS need to be skilled to give integrated service delivery. This will ease the management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system.

Important reminders to all for quality HTS services:

Practicing HTC service providers need refresher trainings once a year and been given certificates for it.

The HTC program requires trained and cable counselor supervisors. These experienced officers have to undergone the counselor supervision training that is approved by NASCOP, before the serve as counselor support supervisors in health facilities.

Counselor self-assessment

During the HTS service it is expected that counselors use the standardized NASCOP approved self-examination forms to monitor the quality of their own service provision overtime. These can be done daily, weekly or monthly for monitoring to improve on their work.

Client satisfaction surveys

The Administration of client satisfaction surveys need to be carried out quarterly to gauge the quality of their service delivery from the client's perspective. It is very important to involve the community members on a voluntary basis to help administer the interviews, which may address various topics such as waiting time, cleanliness, counselor attitude, and overall satisfaction with the service. Survey feedback on client satisfaction should be shared with HTC service providers, and necessary changes made to improve the quality of HTC services accordingly.

Observed Practice

As part of the HTC service counselors need to be directly gauged from time to time as a routine in their practice of counseling. Plans for the sit-inn sessions with the clients

consent must be periodically done in all HTC settings by a trained and experienced counselor supervisors.

External quality assessment (EQA)

The EQA measures should be instituted and implemented to allow for quality check of all the service delivery points quality of services. A quick and appropriate check and achievement of the EQA can be done by these 3 ways;

Proficiency Testing (PT):

This type of testing exams the skill a service provider to withdraw blood samples from the clients.

Dry blood spot validation:

This involves the process issues to ascertain that clients do indeed receive true quality results and not false HIV positive or negative results. Blood samples from an agreed sample number of clients is transported and tested at the reference lab using the gold standard method e.g. ELISA for validation of results comparing testing sites and reference lab results. The validation is only limited to new HTC sites, HTS providers' with incorrect results to meet satisfactory quality and home ;

Other QA Approaches

Data quality management

- The data quality check is done to get a quick quality direction of HTS services. All data accuracy, completeness and timeliness are looked at to make informed decisions. Necessary training on data quality audits (DQA) should be carried out at all levels of service provision with the use of approved MOH tools.

Quality Improvement Teams (QIT)

- Improvement of services is an important part of HTC services. It has management from the national level, the NQIT led by NASCOP, which is tasked with formulating all coordination issues.

Coordination: This is a complex type of coordination of HTC services and has various levels of responsibilities from national, county and to all lower level structures. At each level, various stakeholders are responsible for various functions. This is a very important guide for CGH as a Health Facility to carry out its role in HTS service provision.

PROJECT SUMMARY

The HIV epidemic was declared as an emergency response by our 2nd President Daniel T. Moi in November 1999 to accelerate the care of HIV work in the Nation. This then gave the mission of the United States President's Emergency Plan for AIDS Relief (PEPFAR) has evolved from an emergency response to rapidly support sustainable HIV & AIDS programming in the Kenya. The new change involves a shift of funds from direct service delivery to technical assistance, capacity building, and systems strengthening. All stakeholders because of program sustainability and enhancement, donors and implementers are now supporting more Country-driven National HIV programs, rather than programs managed by implementing agencies. Due to this shift the resource mobilization strategy brings a sharp focus on the Hospital Management Team (HMT) to begin to drive the partners supported Comprehensive Care Clinic (CCC) and fully integrate the services. It will now be expected of County governments to plan and budget for the HIV services so that we all walk in the direction to end the HIV epidemic with the 90-90-90 strategy. Where 90% of the population get HIV testing, out of those HIV positive, 90% must be linked to care and 90% of those linked to care must achieve undetectable levels of viral load for successful programs.

The HMT will begin by paying more close attention, resource mobilizing and monitoring the provision of HIV Testing Services (HTS)in the in-patient to improve from the current 60% HIV in-patient testing and bring it to the policy stipulated 100% HIV in-patient HTS and sustain it for the next 4 years and beyond.

The SWOT analysis of the CGH has been an eye opener to the HMT; they will build on their strengths to improve on the diagnosis and treatment of HIV and TB.CGH will address their weakness especially in recruiting and training more staff on new skills for better service provision. Then consider all opportunities and guard the threats that can collapse health care like the strikes and better management of debts. The HMTs' retreat, the financial document and report reviews, the validation workshops and the bench mark trips have given us as a team an excellent insight. Objectives, action plans, way forward and recommendations have been made by the HMT to drive forward the core health business of CGH as an institution and to engage fully in the HIV program services to support, monitor and evaluate and also improve the HIV service indicators. Everyday bearing in mind that HIV incidence is on the increase in Kakamega County especially in the age segment of 15-24 years, therefore clients and patients must be tested linked to care and with a heavy hand promote the HIV prevention package by promoting in-patient HTS services. The dash board of NASCOP testing trends on the 25th April 2017 ranked the CGH the 2nd highest testing facility after Mukumu Mission Hospital among the 50 testing health facilities of Kakamega County. This is towards the 90-90-90 strategy as a means of achieving the end of the HIV Epidemic. This is the beginning of the end of the HIV Epidemic towards the last mile. An HTS in-patient service is the way to go combined with all the other HIV programs.

INTRODUCTION AND BACKGROUND OF THE COUNTY GENERAL HOSPITAL (CGH) KAKAMEGA RESOURCE MOBILIZATION STRATEGY (RMS) TO IMPROVE FROM 60% AND SUSTAIN AT 100% THE IN-PATIENT HTS SERVICES

Overview

The CGH Kakamega is a level5 hospital that has served generations of Kenyans since the early 1920's when it was turned from an army barrack. Currently it is the referral facility of Kakamega County, one of the most populous Counties in Kenya. The2015 Kenya National Bureau of Statistics (KNBS) population projection of Kakamega County is at 1,843,320with an HIV prevalence of 4%. The population of adults and children living with HIV are 46,939 and 3,905respectively. Mother to Child Transmission (MTCT) of HIV is at 5.5%.The HIV prevalence of women and men in Kakamega County is at 4.3% and 3% respectively. By 2015 a total number of people living with HIV was 50,844; with 14% being young people aged 15-24 years and 8% being children under the age of 15 years. Kenya HIV County Profiles 2016.

In the HIV epidemic women living in the Kenya and the county have been more vulnerable to HIV infection than the men. As a strategy, HTS services and linkage to care and treatment are important steps in reducing the sexual transmission of HIV. Advocacy and mobilization of the community on HIV testing is an important strategy to increase prevention and treatment services. This will boost the HTS services proportions as seen in KDHS 2014 which revealed that 19% of women and 34% of men in Kakamega County had never tested for HIV. The County such innovative strategies to improve on HIV testing and counseling to bridge the unmet gap. This strategy will scale up HIV testing in the county, to counsel and reduce the risk for those who test negative, and to link those who test positive to care and treatment programmes and also other important referral options for appropriate health services. The CGH data from the PMTCT program both at the in-patient and out –patient report improved HTS service performances; but even with this increase, 76% of HIV-positive pregnant women in Kakamega County do not deliver in a health facility. Only 44 per cent of pregnant women attend the recommended four antenatal visits in Kakamega County. The Mother to Child Transmission (MTCT) of HIV infection rate is at 5.5% which can be improved.

The CGH Kakamega admits about 1,700 patients every month. In the year 2015 and the year 2016 there were 24,039 and 18,221 admissions respectively. Due to the findings above with the referral hospital having about 20,000 patient admissions per year, I thought of focusing to improve the in-patient HTS services at the CGH and also engaging the HMT to monitor and evaluate the project for the next 4 years and beyond. The HMT will supervise constinous data review of timely HIV diagnosis, optimal linkage and retention to care for persons diagnosed with HIV, increased coverage of ART and viral suppression which are essential for improving the health outcomes and wellness of

people living with HIV. It is also government policy that all in-patients should undergo an HIV test if they are not aware of their HIV status from the HTS 2015 policy. The diagnosis of HIV infection is a life changing event, so close scrutiny must be employed before release of these results. The provider should keep in mind the 5Cs of HTS. All forms of HIV testing should adhere strictly to the WHO 5 Cs. These are; **C**onsent, **C**onfidentiality, **C**ounseling, **C**orrect test results and **C**onnection.

The RM strategy document is a 5 year strategic plan that will guide the CGH Kakamega Hospital Management Committee (HMC), that is the board and Hospital Management Team (HMT) who work daily in the facility, on their roles, responsibilities and importance of mobilization of required resources according to the vision and mission of the hospital. The mission of the CGH Kakamega states it, as an established teaching hospital which provides quality, affordable, specialized and sustainable promotive, preventive, curative and rehabilitative health care services.

We have worked together with the HMT and prioritized to focus and diversify on fund raising activities with an aim to improve the provision of quality health services. Along with this the HMT now have an urgent focus to fully integrate the partner supported Comprehensive Care Clinic (CCC) services, monitor and evaluate on a monthly basis how to improve from 60% to 100% and sustain the in-patient HTS services for the next 4 years and beyond. All the inpatient unit/ward in-charges have been sensitized as key focal persons in the project. They are responsible for the documentation of the daily in-patient admissions' HIV status and request for counselors to test those of unknown status and link those of known HIV status to other relevant referral sites. The CCC Medical Officer will support the process by doing ward reviews of patients living with HIV.
The resource mobilization document was informed by the review of key Ministry of Health (MOH) documents; the Kakamega County Health Sector Strategic and Investment Plan 2013- 2017,the lapsed strategic plan 2011 - 2014, the HMT retreat in 2016 and fellow daily interaction and working closely with the HMT at the PLP, the previous 3 financial reports 2013/14,2014/15, 2015/16 Financial Years (FY),conducting of a detailed SWOT analysis of the hospital by interviews of staff and stake holders, validation workshops and 2 bench mark trips which led to formulization of objectives, action plans, way forward and recommendations.

The importance of Resource Mobilization

Resource mobilization is a major sociological theory in the study of social movements which emerged in the 1970s. It stresses the ability of a movement's members to:

1) Acquire resources and to

2) Mobilize people towards accomplishing the movement's goals.

The need to conduct Resource mobilization:

Ensures continuity

Supports organizational sustainability

Allows for improvement and upscale of products and services

Organizations both public and private need to create new business to stay in business

The HMT of CGH Kakamega has to mobilize various resources to fully integrate the HIV program with the other health services and be able to support and sustain the in-patient HTS project. Joe Garecht wrote in an article; 5 quick ways to fund raise, where he noted that quick fundraising usually isn't good fundraising. It is important for hospitals and non-profit organizations to spend time getting to know their prospects and donors, cultivating them, and executing a well-written fundraising plan to raise the money they need to operate and provide health services.

Tables 1, 2, 3, 4and 5shows the Kakamega County HIV Indicators

Table 1: HIV burden in Kakamega County Rank* among other 46 Counties

		County Ranking
Total population 2017	1,843,320	45
HIV adult prevalence	4%	36
Population of adults living with HIV	46,939	40
Number of children living with HIV	3,905	41
Total population of people living with HIV	50,844	40

*In this HIV burden and indicator ranking (Table 2), the highest burden county is 47 while the lowest burden county is 1

Table 2: Kakamega County HIV indicators

Reducing Sexual Transmission of HIV			
	Annual	**County Ranking**	**National Estimates**
New adult HIV infections annually>15-19yrs		**35**	**3,971,034**
New Youth HIV infections annually 15-24yrs		**33**	**35,776**

Source: Kenya HIV County Profiles Report, 2016

Table 3: Kakamega County HIV indicators

Elimination of Mother to Child Transmission			
	Annual	**County Ranking**	**National Estimates**
New HIV infections annually among children 0-14	**11935**		**6,613**

Source: Kenya HIV County Profiles Report, 2016

Table 4: HIV Testing and Counseling, and Prevention in Kakamega County

Indicator in Percentage	% Change	County Ranking	National Estimate
Women who have never tested for HIV	19%	36	15%
Men who have never tested for HIV	34%	30	28%

Source: Kenya HIV County Profiles Report, 2016

KEY POPULATIONS IN KAKAMEGA COUNTY

Identified key populations are Female Sex Workers (FSW), Men who have Sex with Men (MSM), and People Who Inject Drugs (PWID). They have the highest risk of contracting and transmitting HIV, but have the least access to prevention, care, and treatment services because their behaviors are often stigmatized, and even criminalized. The County has programmes with FSW and MSM. A quarterly report April –June 2016, HIV testing among key populations is low among FSW at 7% and MSM at 26% against the national targets of 80% in Kakamega County.

Table 5: Key Population Programmes in Kakamega County

Key Population	County Key Population Size Estimate	Percent Tested for HIV against Target	National Key Population Size Estimate
FSW	3,405	7%	133,675
MSM	314	26%	13,019
PWID	230	-	18,327

Source: Kenya HIV County Profiles Report, 2016

Attitudes towards People Living with HIV

It is known that widespread stigma and discrimination against people living with HIV can adversely affect people's willingness to be tested and their adherence to antiretroviral therapy (Kenya Demographic Health Survey (KDHS) 2014). This survey has revealed that 25% of women and 44% of men in the age group 15-49 expressed accepting attitudes towards people living with HIV.

Table 6: Stigma and Discrimination

Indicator	Percent Change	National Estimate in 2015
Percentage expressing accepting attitudes towards people living with HIV-women	25%	26%
Percentage expressing accepting attitudes towards people living with HIV- Men	44%	44%

Source: KDHS 2014

PROJECT OBJECTIVES

- Goal: Resource mobilization by the HMT to improve the in- patient HIV Testing Services (HTS) from 60% to 100% and sustain this at the County General Hospital (CGH) Kakamega and plan to support the HIV Program in the Hospital for the next 4 years and beyond. To mobilize resources to create ownership in an enabling environment to sustain health provision.

SPECIFIC OBJECTIVES:

1. To work with the HMT on internal resource mobilization and to mitigate the gaps that will be revealed after conducting a SWOT analysis of CGH, its departments and the neighboring key academic institutions that use CGH for their student practical placement.
2. To conduct a desk review of the previous 3 year financial documents and reports from 2013/14, 2014/15, 2015/16 and bench mark with similar hospitals for a way forward to improve the quality of health services at the hospital.
3. To sensitize the HMT on HTS services as per the 2015 policy guidelines and focus them on their role to monitor and evaluate the in-patient HTS for the next 4 years and beyond. Along with this support the key focal persons to link all in-patients who tested to prevention services and HIV positive clients to Care and Treatment and other relevant referral services.
4. To review previous in-patient HTS performances and discuss the HTS data of the in-patient units 'monthly data an data in the year 2016 period of fellows attachment with HMT and ward in-charges. This review will continue monthly at the HMT meetings, quarterly in the M&E meetings and annually in the yearly HMT's retreat.
5. To review in-patient HTS individual unit or ward performances with the key focal persons/ ward in-charges and the challenges in the year 2016.
6. To agree on the terms of reference with the key focal persons and the way forward to improve performance; review their roles and responsibilities as per the new HTS guidelines October 2015. Print and laminate this roles guideline for each ward.
7. HMT to nominate a member (Deputy NO) to attend the Quality Improvement Team (QIT) meetings at the CCC with the unit in-charges to help in the mitigation of the in-patient HTS challenges and give feedback to the HMT.
8. To document the partner support at the CCC.
9. To identify the cost analysis of service components at the CCC.
10. To identify potential revenue streams at the CCC.
11. To identify future resource requirements to sustain the in-patient HTS services and the HIV Program
12. To document benefits to HTS in-patient services.

PROJECT IMPLEMENTATION METHODOLOGY

The project methodology followed was the life cycle of projects which defines the five project management phases or processes as defined. The management tips of how to do successful projects was learnt from the Project Management Body of Knowledge (PMBOK) Guide (Project Management Institute, A Guide to the Project Management Body of Knowledge – Fifth Edition, Project Management Institute Inc., 2013, Page 2.) There are 9 key areas of knowledge important for most projects.

1. Initiation and definition of project
2. Planning
3. Implementation (Execution)
4. Monitoring
5. Close. (Including Dissemination)

Each phase addresses a specific aspect of managing a project from definition through to closure.

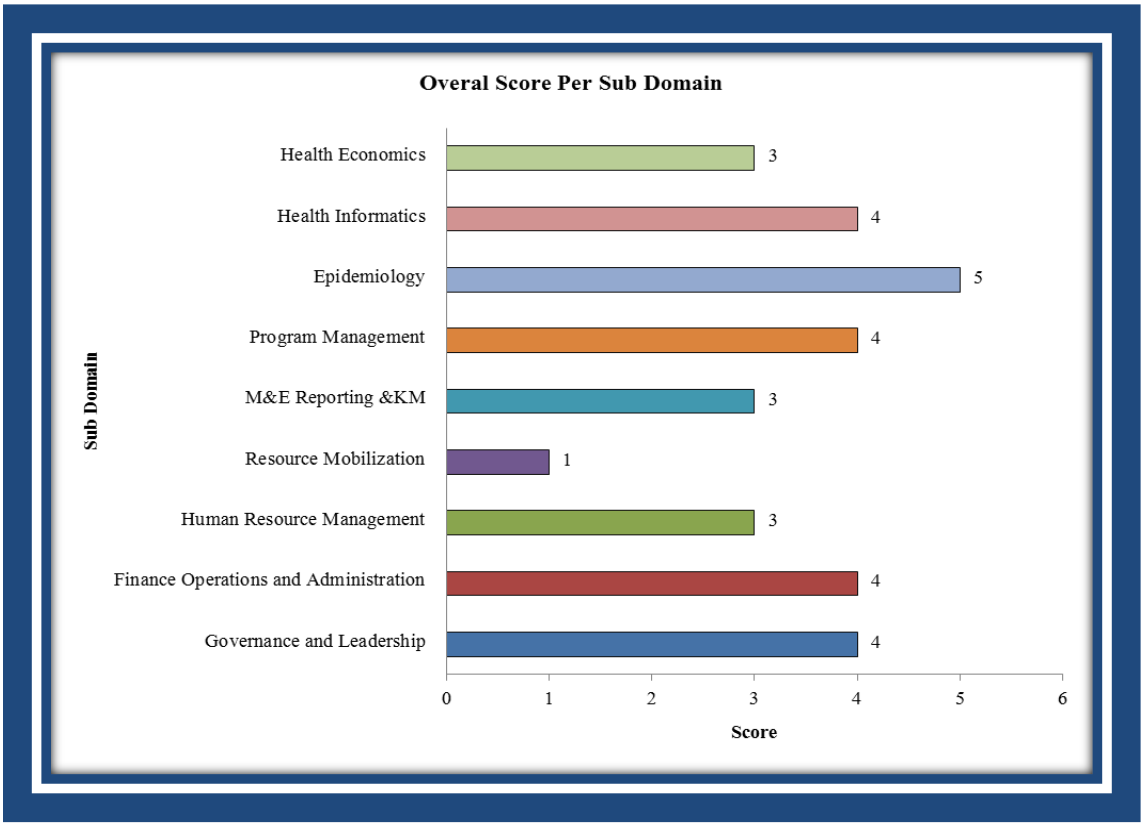
1. Project Initiation and definition
   This was a difficult part, but by the help of the Organizational Capacity Assessment (OCA) report of March 2015 done by the MSH, UoN and Washington University the Kakamega HMT and the Fellow came up with the project title by March 2016 during my attachment at the Kakamega CGH.
   - Fellow delivers' the initial introductory letter and signing of the MOU from the UoN by the Medical Superintendent
   - Fellow familiarization tour of the hospital to meet the departmental heads at the service points.
   - Fellow accepting the Advisor from the PLP and Supervisor from the UoN, and working together under their guidance
   - Bringing clarity of the project to the HMT and linking it with the OCA report after my introduction to them by my Advisor
   - Fellow gets to familiarize herself with the HMT
   - Fellow located an office space and starts to work closely with HMT and the CCC staff.
   - The Definition stage spells out clearly in the project, terms of Time, Scope and Costs, Location who will be involved.
2. Planning Phase
   Detailed planning was done which involved all tasks to be done for project to be executed, Questionnaires, FGDs, KII, workshops, desk reviews and all reports made available ready for launch or implementation
   - Developing the resource mobilization strategy with an inclination to the HIV program with the medium term fellows
   - Reference to the 6 months class work and field trips at the beginning of the program
   - Making arrangements to meet and enlist key senior HMT to support the project

- Frame simple questions around the title resource mobilization to use on the SWOT Tool to bring out the situational analysis of the CGH Kakamega
- Look on the internet for a free SWOT matrix to help us in documentation of the responses from the tool

3. Project Implementation (Execution)
   This was done in June 2016 when the project budget was approved for Implementation and the Kakamega CGH HMT and PLP advisor were informed and the project launch for implementation.
   - The use of the SWOT Tool to elicit strengths, weakness, opportunities and threats in all the CGH Kakamega from all departments and units,
   - Make appointments with key informant interviews (KII)for in-depth interviews of both senior HMT who work at the hospital and managers of institutions of higher learning who use CGH as a practical placement for their students
   - Use of the SWOT tool to do focus group discussions with the key focal persons / ward in-charges who will steer the improvement of in-patient HTS services and attend the QIT meetings to continue to understand the CGH core business and operations
   - Clearly spell out the roles and responsibilities of all the health staff towards a successful HTS service in the in-patient
   - Work closely with the HMT and attend all managerial meetings, HMC, HMT, EEC, FIF, Waiver committee, CME, QIT and WIT meetings and occasionally visit other sub counties.
   - Seek for approval and authority from the Advisor to review relevant financial reports and documents of the 3 previous years; financial year 2013/14, financial year 2014/15, financial year 2015/16
   - Conduct meetings, brainstorm sessions , discussions and validations workshop with the HMT, willing to work and learn from them
   - Go on retreat with the HMT as they reviewed departmental and hospital performances of previous year FY 2015/16
   - Plan and go for retreats with the HMT to learn from other level 5 hospitals and bring the necessary reforms for change to CGH.
   - Discuss agreed action points with the HMT
   - Come up with recommendations and conclusion of the resource mobilization strategy to steer ways to improve and sustain the inpatient HTS services
4. Monitoring and Control keep focus and track of tasks to be completed during execution, observations, lessons learnt, challenges, risks and expected outcome
5. Project review at the closure period what is pending what can be omitted and what needs to be concluded before closure
   - Launch or Dissemination of the resource mobilization document with the HMT in-charge of implementation, monitoring and evaluation along with all other services for the next 4 years and beyond. All stakeholders participated in the strategic document dissemination.

The project began after the fellow was posted by UHIV program for attachment at the CGH Kakamega for 18months. On arrival in September 2015; I meet the then Medical Superintendent Dr. Ajevi; who was to be my PLP Advisor and Mentor. He later introduced me to some members of the HMT and each team was to get familiar with the Organization Capacity Assessment (OCA) report of March 25th 2015. After a week we met again and discussed briefly about this report, as from it the fellow would write a project that would be implemented later by the HMT. The OCA report was done by the University of Nairobi (UoN), University of Washington and the Management Sciences for Health (MSH) as they assessed the then HMT. The University of Nairobi HIV (UHIV) Fellowship OCA utilized a participatory approach, where staff and other stakeholders were facilitated during focus group discussions to rank their organization's strengths on a scale of 1 (lowest) to 5 (highest).

The OCA is a participatory process that utilizes a triangulated approach consisting of a pre-assessment visit, desk review, and onsite system review. A team of two UHIV project staff, led by a team leader, conducted the assessment. The key findings are in figure 1 below: Figure1: Summary of scores for all domains



From the above key findings as shown in the above figure the domain of resource mobilization had the lowest score of 1. The fellow, the 2 medium term fellows and the HMT with the help of the Advisor and University of Nairobi Supervisor managed to

write a project proposal on resource mobilization strategy which was approved for funding by the project sponsors the CDC and we are now on the implementation phase.

The project was implemented in 3 phases, as indicated in the 3 budget estimates submitted to the CDC via the UHIV fellowship program accountant. During the initial phase my new Advisor Dr. Akoto, who I met in January 2016 on my return for attachment ,introduced me to the full HMT in one of their monthly meetings and asked them to support me as we began to do the SWOT in the over 50 hospital department's details in the annex section. He also wrote an introductory letter to other key stakeholders who I would interview as they too used the hospital as a practice and placement site for students of neighboring academic institutes of higher learning.

I gave copies of the SWOT tool to my advisor and the HMT. We had several in-depth sessions, discussions, and brain storm sessions, question and answer forums in which we used to share and explain the questionnaire so that when we would begin to visit the departments the HMT would also participate in the SWOT process. This process took about a period of 3 months to complete the data collection from all departments. We then in the same period began to book appointments to begin to conduct interviews with Key HMT and heads of other institutions that used the CGH for student placements. Some of the institutions visited included; Masinde Muliro University of Science and Technology (MMUST) where we visited about 6 departments and the Kenya Medical Training Centre (KMTC) which had 4 departments visited in Kakamega. Other institutions visited were; St Elizabeth School of Nursing in Mukumu, St Mary's School of Clinical Medicine in Mumias, the Aphia Plus who runs the HIV program at the CGH and one of the general suppliers of the CGH Kakamega. Over 15 HMT, 15 senior officers from Institutions of Higher Academic learning and 3 HMC members were interviewed as KII.

It was a real grueling process to do the SWOT and situational analysis in all the about 50 departments of the hospital. I had looked through the internet and identified a free SWOT tool analysis matrix from business balls.com which we used for the initial SWOT documentation, a sample copy is in the annex. After this initial documentation we had to again make several consultations with the departments if all we had captured was accurate or they needed to make amendments and corrections. This process of corrections took another one month. The full report of the situational analysis is ready but in this section I will give important highlights and a summary. The detailed report on the situational is in a separate report. The CGH Kakamega was founded in the 1920s from an army barrack which was turned to a hospital and has provided care to generations of Kenyans. The hospital has experienced growth in terms of Infrastructure, human resource and service variety. Though the hospital is committed to promoting the provision of equitable and affordable health care at the highest standards to its customers it has too many challenges that stifle the achievement of this goal. The costs of addressing these challenges remain high, thus the HMC and HMT have taken action, and the process towards a new strategic plan is underway. Here the resource mobilization strategy will find a home.

The hospital has old dilapidated buildings with inadequate working space especially the out-patient clinics, most of which leak during the rainy periods and the HMT had made renovation plans which were presented to the county health director in the FY 2015/16. The county health offices also prioritize to do renovations which did not match the requested list. As I do the write up some building have been renovated; namely the causality, pharmacy, the water tank, construction of the walk-way from pharmacy to out-patient and the road. A quick tour in the hospital reveals a miserable environment in some of the out-patient clinics. Dental clinic, Physiotherapy and Occupational Units, the Laboratory, special clinics are among clinics which leak and their floors need to be patched up to seal the cracks. Leaking in the Laboratory is a disaster as the equipment will fail and the working environment is wanting for many specimens. Construction of Amenity wards and renovation of the main theatre is ongoing.

In terms of the human resource when I reported here in January 2016 there was a total of over 500 personnel, today there are 13 Consultants, 42 Medical Officers (MO), 14 MO Interns, 3 Dental Officers, 1 COHO, 2 Dental Technologists, 7 Pharmacists , 36 Registered Clinical Officers (RCOs), 45 RCO Interns , 280 Nurses, 2 Health Administration Officers (HAO) ,1 Public Health Officer (PHO) , 18 Medical Laboratory Technologists, 2 Laboratory Technicians, 11 Health Records and Information officers,11 Radiographers , 2 Nutritionists, 11 Physiotherapists,7 Occupational Therapy staff , 5 Orthopedic Staff, 3 Plaster Technicians, 1 Social Worker (SW), 2 Accountants , 5 Clerical Officers, 2 Procurement Officers,2 Secretaries,2 House Keeping Officers, 13Support Staff,2 Cooks, 60 Casual Workers and 6 Mortuary Attendants. The number of nursing staff has reduced tremendously as those retired and those died or resigned have not been replaced. Details are at the Human Resource (HR) office. The major strengths of the facility are its recognition as a county referral hospital, a diagnostic and treatment centre for HIV and TB disease, an NHIF accredited hospital, daily excellent client flow to all departments and enjoys the community, partner and government support at the 2 levels.

CGH Kakamega admits an average of 1,700 patients per month and about 400 to 450 patients are seen daily at the out –patient. This kind of workload with the staffing numbers that we have, the SWOT tool picked staff shortage in all areas as a major weakness of CGH. Beside this staff with special skills are also inadequate for palliative care, renal, Intensive Care Unit (ICU), High Dependency Unit (HDU), Maternity, Psychiatry, CCC, Ear, Nose and Throat (ENT), EYE, New Born Unit (NBU) and even theatre staff. Others weaknesses are in the many loop holes in revenue collection by unskilled staff, inadequate supplies, as the hospital has large accumulated debts and the good suppliers now unwilling to supply unless their debts are paid. There are irregular reimbursements of hospital funds from the county health office; that are reported to harass the CGH staff, poor state of mortuary, documentation challenges in the in-patient files and inadequate funds to train the staff for special skills or allow them to attend scientific conferences.

The opportunities include making CGH a training hospital for the MMUST Medical School and also to attract donors and more health partners to recruit and train staff for special departments. CGH is in the verge of computerizing all the departments to improve in patient Records and Revenue collection and when they install a CCTV they can begin to seal most of the loop holes in revenue collections. Threats are the delays in financing the health programs being an impediment to health care, accumulated debts discourage quality suppliers, human resource strikes and inter cadre conflicts and finally the county political system has been quoted as being an impediment to the development of the hospital. The details of the CGH SWOT are found in the SWOT analysis report of the CGH Kakamega of March 2017. But below is a brief summary of the current CGH SWOT as at December 2016.

SWOT ANALYSIS TEMPLATE SUMMARY OF THE CGH KAKAMEGA
County General Hospital Kakamega April 2017

Strengths:

- Recognised as a County Hospital
- Excellent client flow
- Highly Skilled Health Staff
- Good cadre skills mix
- Diagnostic & treatment centre for HIV & TB
- Morden imagery equipment in X-ray department
- An NHIF Accredited Hospital
- Enjoys good partnership with regional Academic institutes
- Pivotal for registration of MMUST Medical School

Weaknesses:

- Unrecognised board by county health office
- Lack of dynamic Hospital Administrator to stamp Authority
- Old dilapidated buildings in need of urgent renovation
- Inadequate staff in all areas
- Inadequate staff houses
- Revenue collection has many loop holes
- Poor customer relations
- Too many waivers and exemptions
- Accumulated debts
- Lack hospital website

Opportunities:

- Partnership with international universities, NGO & community
- Use national & county government subsidiary to help community enrol for NHIF Scheme
- Lobby the County Government to legislate a law to increase hospital funds and let CGH be a Parastatel

- Computerize all units to improve revenue & records
- Install a CCTV
- Automate all collection points
- Improve amenity services
- Make CGH autonomous

Threats:

- County system a political interference to CGH
- Lack of a health commission
- Lack of staff promotions & trainings
- Improve- poor communication between CHMT & HMT
- Delay financial refunds from county health office
- Accumulated debts
- Human resource strikes

In the meantime I continued to consult with my 2 supervisors Dr. Elly Ochieng from the University and Dr. J. Akoto from the CGH Kakamega. As part of the initial phase I continued to work with the HMT and the staff at the CCC. We together with the medium term participants started to seek for necessary financial reports and documents of the 3 previous financial years (FY) thus financial year 2013/14, financial year 2014/15 and financial year 2015/16. This we did to prepare for the 3 day financial review of the CGH Kakamega. At this junction, though I had requested my project Advisor for these financial documents he gave me 100% support but I had a few hitches. This was mainly because of frequent transfers of key staff he had delegated to help me, in the administration department, the procurement and the Accountants offices. As I worked in the process the accountants, health administrators, and the procurement officers have since been replaced 3 times. This was difficult because you explain what you want to an officer and before you get the documents the officer is no longer available. A major set-back but we managed to do the financial review not as we had planned for 3 days but just for a day due to budget constraints as the hotels had revised their charges upwards, this being an election year 2017.

The summary of the financial documents and Accounts reports review was that the electronic system was introduced at the CGH in 2013/14 October. This meant that previous record may not be up to date, although this did not make financial sense to me. I later got a hard copy report with these details, that in the FY 2013/2014, income to the CGH was from the User Fee, Facility Improvement Fund (FIF) and NHIF at 79m, Free Maternity at 24.2 m and donations at 1m a total of 104.2 m which was all spent and liabilities totaled to 29.2 million. The amount that the hospital receives compared to the annual projected figures keep going down as the Accountant helped us to calculate in the Variance figures. In the FY 2014/15 the variance was at 11.5% while in the FY 2015/16 the variance was at 18%. There are irregularities at the NHIF hospital office and as a result most of the claims are not paid. The maternity data uploaded on the DHIS system is done in good time yet the free maternity reimbursements not done in good time. There

exists loop holes in revenue collections and the hospital has debts. The hospital is not able to meet its target collections, each month too much of the hospital bills are waived and exempted. The national government at some level should reimburse the hospital bills in terms of waivers and exemptions as per government policy; unfortunately this is not the case. A good gesture was done by the current County Executive Committee for Health, to waive in-patient bills to the tune of 2.1 million. Politically this may be acceptable but financially because there is no government subsidy, it has brought the hospital under debts, as nobody will repay the waivers yet bills must be paid. Medical treatment is not free someone must pay the bills. The issue with government hospitals is that patients are always admitted regardless of ability to pay or not. From all the above analysis the CGH is financially stagnated. Details of this are in the Financial and documents review report of April 2017.

1. Recommendations from the financial documents and reports review on the 9th March 2017

- The waiver report to include all the free services offered in the hospital, waivers and exemptions and including CCC programmes supported by donors so that we can have data to plan and sustain the services in case the donor support comes to an end – report by Social Worker, ICT & MO at CCC- By the Accountant to follow
- The amount of money waived and exempted by the hospital should be reimbursed back to the hospital by both levels of government. (Weekly waivers' are at least Ksh 100,000/, this happens to be the same amount of money made by the x-ray unit in a week.)
- HMT to seek address of the high tendency of exemptions and waivers and how to fill that gap- report to be generated by Social Worker every month for feedback to HMT meetings or urgently as need arises – By SHAO
- County Government way-forward on Exemptions, Waivers , Political waivers and lobby for a possible hospital grant / fund from county government- report by Medical Superintendent.- Quarterly
- The social worker to get some security to accompany her when carrying out some of her sensitive tasks like resettling psychiatric patients with the families. This happens where the relatives have abandoned and neglected a family member. Security and transport organized by the HAO
- Pharmacy department to give a report on waived drugs from CCC – Monthly report pharmacist in-charge (I/c)

- X-ray and Lab to also give reports on waived or denied investigations from CCC – Monthly report from the Lab I/c & X-ray I/c
- HMT to prepare the hospital to cushion itself during strikes on bill payments before patients are discharged- all departments to prepare for this- Report By the FIF Chair & HAO
- Create a Customer Care Desk to help clients on all issues – By the Matron/ SHAO
- Strengthen the NHIF Registration Desk at the OPD and Casualty- By the HRIO/HAO
- Train NHIF staff for maximum refunds no rejections from the NHIF office- By the HAO
- HAO to check or train another officer to check all the NHIF payment documents sent to for refund meet NHIF payment criteria
- The hospital to capitalize on all services that the expanded NHIF can offer and together help to create awareness to the population to register on the scheme.
- Full Automation of all the cash Collections- By ICT/ HAO/Accountant
- Installation of CCTV at all cash collection points and other strategic points in the hospital.- By ICT /HAO/Accountant
- Link all Data, Electronic Medical Records (EMR) from TB, CCC and Diabetes Clinic- By Health Records and Information Officer (HRIO
- Ward in-charges should be trained on how to fill the billing form so we can maximize the collection in that area and also improve on documentation.- By Matron/ HRIO/SHAO/ICT
- Employ or recruit casuals knowledgeable in ICT and professional for various under staffed departments- By Recruitment Committee
- Train Key departmental staff as champions for system use in their departments- By Training Committee
- A number of channels should be exploited that can possibly boast staff morale e.g. staff carrying out administrative functions should be able to get administrative allowance.
- Assessment, close supervision and support of areas in the hospital that could potentially increase hospital collection. Renal department, pharmacy, x-ray, laboratory and maternity unit are major areas of good revenue generation and must always be kept operational with supplies in stock for service provision.

- Separate the records management functions from accounting functions e.g. the registration of patients in the hospital Electronic Medical Records (EMR).By ICT/ HRIO/Accountant/SHAO
- The hospital new automation should be able to serve the needs of the various departments and sections of the hospital. The current EMR has failed to serve the hospital and the various sections satisfactorily e.g. the accounting module of the EMR should be integrated to the bank, the quality of health information should be improved to help Heads of Departments (HODs) and other stakeholders in optimal coordination of services.
- Monitor all special clinics collections- By Accountant
- Motivate staff by improved staff tea, Newspapers, Internet, relevant departmental trainings to upgrade skills, scientific conferences, promotions, CGH Kakamega Uniform T- Shirt and other welfare issues, Staff recognition day of good performers – By the Medical Superintendent.

Note during future HMT meetings HAO to follow up that all HMT given responsibility to give the various reports to review the financial exemptions, waivers and collections of all the departments. Emphasis should be put on the departments with poor collections and help given for improvement.

Members discussed on possible ways they could eventually increase the hospital collection, reduce wastage and maximize on the use of hospital resources. The chairman, my PLP Advisor, promised to support the above during the implementation of the findings to improve the health services.

After the SWOT analysis was documented and the financial review report of the 9th March were finalized it was time to plan and conduct the Stakeholders (SH) validation workshop for the 15th of March 2017 and share the findings with the HMT at the friends' hotel in Kakamega. This was the same venue where we had done the financial documents review on the 9th of March 2017. In the SH validation workshop it was another opportunity to share with them the SWOT again and challenge the HMT to openly with positive criticism give accurate analysis of the various departments and accept that the presentation before is a true reflection of the hospital. A copy of the SWOT analysis and questions put to the HMT for discussion in this meeting is in the annex.

This meeting like all other meetings we have held started with a word of prayer and deliberations as in the agenda and time table of the day. Once the chair of the meeting and secretary were established, I continued to share with the HMT various types of animated SWOT matrices to drive home the point of SWOT matrix analysis. This was to

further generate discussions and observations to allow more ideas to flow as we critically looked at and analyzed the current situation of the level 5 hospital. Action points and recommendations agreed on by the validation team are given below after the bench mark report. During this meeting the HMT did agree that the findings in the SWOT matrix were a true reflection of the current situation at the CGH Kakamega. Details are in the separate report of the stakeholders' validation workshop of 15th of March 2017 at the Friends Hotel in Kakamega.

2. Recommendations from the stakeholder's validation workshop of the SWOT on the 15th March 2017

- The wider HMT validated the SWOT analysis and the financial report as a true representation of the current situation of the CGH Kakamega. Details are in that report.
- Members discussed on possible ways they could eventually increase the hospital collection, reduce wastage and maximize on the use of hospital resources. The chairman promised to support even during the implementation of the findings.

At the validation workshop I had asked the Advisor to nominate 10 HMT members to go for the bench mark to learn more at a level 5 doing better overall than the CGH Kakamega. It had been conclusively decided that this bench mark site would be Nakuru level 5 and nominated members would travel on 29th of March and spend the whole day of 30th March to visit level 5 Nakuru. 3 of the nominated HMT members were given the task to look for a new vehicle to take the team to Nakuru. All the arrangements were made and the team travelled safely to Nakuru had a restful night and were ready for the visit to the level 5 Nakuru at 8am on the 30th of March. When the whole team was ready we left for level 5 hospital and arrived by 8.30am and we were taken to the Medical superintendents' boardroom where one of the senior Matrons welcomed us as we waited for the Medical Superintendent. We observed a lot of team work from all who welcomed us. After the hospital matron rang our host he was given the liberty to continue and give us a brief of the hospital. The Kakamega HMT introduced themselves to the host when he arrived. He then took over from the Matron who continued to sit in with us, as we interacted with each other asking questions, getting clarifications and just getting every detail that we required. After about an hour of in-depth details on level 5 Nakuru, the host asked the matron to take us to visit all areas of our interest.

The 10 member team from Kakamega led by the Medical Superintendent, Dr. Akoto were taken to areas that were relevant with our mission here on resource mobilization. We had divided ourselves into two teams of 5 members each for ease of reporting. The team visited one of the renal units, the billing and NHIF office which were managed by a senior nursing officer. From here we visited one of the payment points and observed the security and safety of this cash point, in-situ was a CCTV. The team was then taken to the stores, kitchen the Accountants' office after which we went for lunch and returned at

2pm to continue with the hospital tour. After lunch we again teamed up with the host matron who now took us to the admission centre before we visited the out-patient department (OPD). In the OPD all the work is organized with digital machines that register when each patient clocked in and when they visited the triage nurse and when they were finally seen by the clinical officer. All the patient history, investigations are done within the system, this is a paperless unit apart from the admissions which are done in files by the records personnel in a separate unit at the admission centre. From here we went to the Pharmacy. At the pharmacy were 5 windows that were operational. I was impressed by the under 5years window, ANC window, the adult window payment window but all patients report to a pharmacist who first reviews the online prescription and gives the patient details on how much they will pay and a prescription is generated in case some of the drugs are not available. There was order and all staff were at their work station. In Nakuru level 5 we observed what the medical superintendent had said, that if you don't perform than you had to leave for some other facility. This is a working hospital and the staffs are motivated and disciplined reporting on duty to serve.

The hospital was like a beehive full of activity no idealness. Every ward had a guard others had the Administration Police (AP) with their ammunition. We witnessed a security firm come for hospital collections taking the money to the bank. No jokes here. After a good round at the hospital we returned to the boardroom for a brief with our host before our appreciation and good byes. The full details of the visit and recommendations of the visit were done on a follow up meeting after the bench mark and are on the separate report. At the end of the visit it was concluded that a one day bench mark was not sufficient taking to account that we had to travel back at night which was un-safe.

3. Recommendations after the Bench Mark Trip of 30th March 2017

- Improve on security at the revenue collection points, the hospital gate and within the wards.- SHAO
- Release staff who are found practicing corruption after being warned- HMT
- Collection of all illegal stamps in the hospital - HMT
- Report to the authority whenever you see someone with an illegal rubberstamp- All staff
- Corruption committee should come up with some policies on corruption
- Patients should be having uniforms at least 3 pairs to avoid more losses in the wards - Matron
- Security officers should be inducted on what to be done before they start working- SHAO/ Matron/ Accountant
- Security officers should be charged for any in-patient absconders- SHAO

Refunds

- Patients should not be refunded, no money will be refunded because no money is allocated for refund - Accountant

- Hospital should set a policy for amenity clients in that if a patient even stays for one day they should be charged 3000/- HMT
- Service charter for all services being offered should be clear to avoid refunds, confirm service availability before payment is made -HMT
- Training will be done and all departments should present the list of all procedures to be included in the new system software – ICT/HMT
- All diagnosis should be updated. – ICT/HMT
- All requests for x-rays , laboratory and drugs must be seen by both the clinician and the pharmacist and patient directed to pay appropriately- ICT
- Hospital to employ cashiers for more than 3 months that can be trained and charged, in case of mischief. The 3 month period does not give them appropriate time to learn their work.- HMT
- Changing of cashiers every 3 months is affecting revenue collection in the hospital in that some of them double bill patients- HMT
- Cashiers should be denied some rights since they are removing some items- SHAO/ICT/Accountant
- Put focus on other areas like renal unit, dental department since they can generate more revenue than what we currently- SHAO/Matron/ Accountant
- The EMR system should be updated and be automatic so as children under 5 should not pay but the caretakers should be charged- ICT/ HRIO
- During admission the age of the patient should be specified if it's under 5 since it affects billing. ICT and health records department should have a meeting to ensure that some services are automatic and should be charged and if not charged the officer should be held to account for what was not charged. Supervision should be done regularly to ensure effective work is ongoing.- HRIO/SHAO/Accountant/ Matron
- All children under 5 years of age must have age verification document, clinic card and birth certificate for exemption of service fee.- HRIO/SW

Conclusion

The Resource Mobilization team learnt a lot from this visit. High on the list is team work, minimize corruption and find willing health workers to serve patients. This will require cultivation of a work environment that is conducive to both the clients and service providers. Dr. John Akoto also suggested CCC department to be included in the HMT and budgeting and participate fully but HMT will make final recommendations.

I have on several occasions also shared out on the resource mobilization highlights with the HMC. The chairman of the HMC has requested that I share with them the document as they are interested on the findings and resolutions that will go a long way to improve the hospital.

A follow up HMT meeting was held at the CGH Kakamega after the fellow returned from the final meeting in Nairobi KCB leadership Centre, where the fellow gave a full update on the progress of the resource mobilization strategy sharing some slight amendments. The amendments have required her to engage all the ward in-charges for a HTS in-patient project. Prior to this meeting on the 21st of April 2017, I had shared with my Advisor and the hospital matron who is the direct supervisor of the ward in-charges to allow us to have a meeting with them. In this meeting part of the senior management were in attendance at the focus group discussion with key focal persons and the in-patient ward in-charges. This very crucial meeting was to engage the ward in-charges, share with them that they are the drivers of the in-patient HTS project. We depend on them for the full success of the HTS in-patient project. I introduced them to the UoN and shared about the OCA report of March 2015 by the UoN, MSH and University of Washington, and how I was posted here to work with the HMT on the Resource Mobilization project.

STRATEGY TO IMPROVE IN-PATIENT DEPARTMENT (IPD) HTS

Dr. Diemo made a brief presentation on improving inpatient HTS from 60% to 100%

Key areas that were highlighted were:

- Appreciation for the good efforts made as we are at 60% now
- Units offering inpatient HTS services the 12 wards
- Yearly performance HTS data for each ward in the year 2016
- Monthly performance since Jan –Dec 2016
- Previous performances of late 2015 and early 2017
- Way Forward

I took time to present the data for the previous year 2016 which was the achievement from the wards. This has given us a good starting point we don't have to begin from zero. With this good launch pad we had to chart the way forward on how to improve the in-patient HTS from the current 60% to get to the desired 100%. Below are the 2016 data sets discussed at the FGD meeting of all the 12 in-patient wards where HTS project is on implementation.

Table 7: In- patient units individual HTS Data as percentages in 2016

UNITS IMPLEMENTING THE HTS SERVICES	ACHIEVMENTS OF HTS SERVICES IN PERCENTAGE IN 2016
WARD 1	60%
WARD 2	90%
WARD 3	55%

WARD 5A	75%
WARD 5B	40%
WARD 6	50%
WARD 7	48%
WARD 8	55%
WARD 9	0%
WARD 10	45%
AMENITY A	55%
AMENITY B	60%

Source: DHIS 2016

Note Ward 9 Psychiatry is at 0% due to legal issues with the patients admitted here.

Table 8: Monthly performance data of all the in-patient units in 2016

YEAR	MONTH	HTS DATA	PERCENTAGE
2016	JAN	547	15%
2016	FEB	291	20%
2016	MARCH	322	20%
2016	APRIL	325	20%
2016	MAY	829	25%

2016	JUNE	1076	40%
2016	JULY	1256	42%
2016	AUG	1235	44%
2016	SEP	845	33%
2016	OCT	1145	54%
2016	NOV	1476	60%
2016	DEC	426	40%

Source: District Health Information System (DHIS) 2016

The data of the previous year the last 3 months and the data of the 1st 3 months of 2017 was also presented and discussed. Below are the data sets that were presented for review.

Table 9: Display of HTS Data last three months of 2015 and 1st three months of 2017

MONTHLY PERFORMANCE OCT-DEC 2015&JAN –MARCH 2017

YEAR	MONTH	HTS DATA	PERFORMANCE %
2015	October	235	10%
2015	November	243	11%
2015	December	314	13%
2016	November	1476	60%
2017	January	0	0%
2017	February	0	0%
2017	March	0	0%

Source: District Health Information System 2015/2016/2017

In the year 2015 the last 3 months show the HTS data just begin to pick up and in the Quality Improvement Teams meeting, each ward in- charge was made to explain the reason for the low performances. Some of the challenges are written below. Mainly it was around the HTS staff, their organization and poor documentation of the results.

In the year 2017, the picture shows no work is done. This was during the Doctors' strike when all patients were discharged home and the wards were closed.

The full deliberations of the FGD with the ward in-charges are in the FGD report.

All ward in-charges present deliberated on key challenges that hinder the HTS work in their wards but from this engagement in the presence of the matron and medical superintendent that they accepted to work together to improve the in-patient HTS data. Details of the individual unit in-charges FGD deliberations from their wards were summarized on a SWOT matrix which depicted the current scenario of the HTS services at the in-patient. Each ward in-charge and all those who attended the FGD were given an opportunity to answer the questionnaire on SWOT at their wards. This is what the in-charges do daily it will only require them to strengthen the weak link of the HTS service in the wards. Table 10: Below is the summary of the current SWOT from the wards which will implement the HTS project.

SWOT Matrix Analysis Template FGD SUMMARY 2017 APRIL 21st as Agreed by Ward / Unit In-charges

	Helpful to achieving the objective	**Harmful** to achieving the objective
Internal origin (attributes of the system)	**Strengths** • Available Patients • Available trained staff in HTS • Motivation of Staff • Regular QIT meetings • Team work • Positive Attitude • Trained HTS Counselors • Availability of HTS Kits • HTS Counselors partner supported deployed in ward to test daily • Good leadership by unit In-charge • Regular feedback • Available HTS volunteers • Person is allocated to do HTS daily • Nurses are trained on HTS and are willing to do HTS •	**Weaknesses** • Staff /Nurses shortage • Negative Attitude of some Staff • Inadequate skilled personnel in HTS • High workload • Weekends and Public Holidays the HTS staff do not work • Lack of Privacy during HTS in the ward • No Space to do HTS • Incapacitated by Law of Mental Act • No Time to do HTS • Demotivation • Stigma & Discrimination

External origin
(attributes of the environment)

Opportunities	*Threats*
• Patients available • HTS Kits available • Referral to CCC • Exists good linkage between the CCC counselors and the in-patient • Capture all clients / relatives to ensure they are tested • Willingness to test • Use of free time to test one client • Patients tested at causality/ medical wards before admission to ward 9 • Available HSP who can be employed with skills & knowledge • Policy demands all in-patients must be tested • Partners who provide support train the Nursing staff • Updates CME for staff from the Partner • Support from partners	• Mental Act/ Law • Inter -cadre conflicts • Conflicting issues on HTS with Lab personnel • Legal threats • Stigma • Repercussions may emerge pertaining to legal Act • **HTS test kits out of stock on & off** • Untrained staff in HTS • Union leaders legal issues

During the FGD the ward in-charges deliberated on the issue of staff conflict in HTS services. The important issue that came up was how to handle the inter cadre conflict especially between the nursing staff and the Lab staff. A nurse manager brought the point that, laboratory staff had legal issues as concerns testing of patients. As I gave an overview the CGH Laboratory in-charge gave a truce statement on nurses testing of patients. She brought out the fact that each health cadre had a major role towards the accuracy of the HIV test results. With such a great point also confirmed accordingly in the Kenya 2015 HTS policy of the shared roles of all staff. To deal with this misplaced concern that would hinder the nurses from conducting the HIV test in the ward I also shared information on table 7below giving clear roles of all personnel involved in the HTS service. From the table below it is clear that HTS is not a one man show but involves everybody for quality performance. This table will be printed out, laminated and given to each ward in-patient in-charge for all to follow the guidelines.

Roles and responsibilities of staff within the CGH facility

There are various personnel involved in ensuring provision of high quality HTC services including but not limited to facility managers and in-charges. All HTC providers and other skilled personnel must clearly understand their roles in order for teams to deliver efficiently and effectively.

Table 11: Below summarizes the different roles and responsibilities of the personnel.

Staff/Cadre	Roles and responsibilities
HTC Providers	▪ They create need for HTS services through screening and health talks ▪ Responsible for high quality HTS services ▪ Do risk assessment and reduction counseling ▪ Provide HIV test and give accurate results ▪ Discharge appropriate referrals and linkages through patient escort and tracking of the referred clients ▪ Manage HTS commodities in accordance with the national guidelines ▪ Record the client and testing data using the nationally approved tools and report appropriately ▪ Within the community, coordinate post-test clubs and support groups ▪ Required to do HTS refresher trainings annually
Facility In-charges	To plan, conduct staff deployment, monitoring and evaluation of HTS services ▪ Provide and support and supervise HTS services in the facility ▪ Take stock of commodities for HTS ▪ Set HTS performance targets ▪ Avail space for providing HTS services ▪ Provide timely HTS reports
HTC Coordinators	▪ Responsible for day-to-day HTS activities in a facility ▪ Help HTC providers to create demand for services ▪ Provide mentorship to the HTS service providers ▪ Make sure adequate stocks of commodities for HTS reports. ▪ Team leader to ensure HTS services are of the highest quality ▪ Review referral and linkage mechanisms take place ▪ Give feedback to the facility management on performance of HTS ▪ Facilitate client surveys and feedback on quality of services ▪ Enroll HTS providers into a proficiency testing programs and corrective measures undertaken where necessary
Health records and information officers (HRIOs)	▪ Responsible for adequate and necessary data tools for all HTS service delivery points are available in the facility ▪ To train HTS providers on the tools utilization ▪ Updates on performance analysis ▪ Do regular data quality audits and support supervision
	▪ Check on quality assurance for HIV testing ▪ ▪ Follow up all SOPs are in place and adhered to

Laboratory in-charge	▪ Conduct and observed proficiency testing to ensure adherence to SOPs. ▪ Conduct QA audits and PT corrective actions ▪ Accountability of all HTS commodities (test kits, DBS commodities, PT panels etc.) management ▪ Do accurate stock projections and forecasting with timely reporting for commodities consumption ▪ Train and supervise on storage and management of testing commodities in accordance with the SOPs
Counselor mentors	▪ Supervise HTS providers to receive regular debrief sessions to mitigate burn out in order to maintain provision of high quality HTS services ▪ Give mentorship to HTS service providers through one to one or group sessions in the service delivery points ▪ Organize for observed sit in sessions to ensure adherence to HTS SOPs ▪ Give and review feedback to the HTS providers on their performance
Health workers	▪ To provide knowledge to patients on the benefits of HTS ▪ Advocate for and give HTS to all the patients ▪ Provide HTS or refer to the HTS provider ▪ Responsible for patient file/record the HIV status of the patient Provide appropriate referral and linkage for post-test services
Community	▪ Mobilized to demand for HTS services ▪ Consume HTS services ▪ Participate in feedback on the quality of services

Source: HTS Policy Kenya 2015

As we ended the FGD meeting I invited the ward in-charge of ward 2 to share on their individual achievements as a ward, since this was the best performing ward and had been awarded by the Aphia Plus partner on their good achievements in HTS Services. The ward in-charge from ward 2 gave us insights of the team work and motivation for the staff to do a test during free time. He also gave a wonderful way forward that what is before them is possible provided the team leaders are committed to give good leadership and do the follow up of the documentation they can all make achievements.

4. RECOMMENDATIONS AND WAY FORWARD TO IMPROVE THE IN-PATIENT HTS SERVICES AS AGREED WITH THE WARD INCHARGES AT THE FGDs

How do we improve from here?

- Supervision of HTS services and encouragement of inpatient testing- by Counselor Supervisor.
- Regular feedbacks meetings, weekly, monthly and quarterly – Hospital Matron and MO @ CCC in the WITs, QITs, HMT and Stakeholders meetings.
- Address shortage of staff especially during the weekends – Hospital Matron/Partner
- Attitude change of staff on HTS services- Matron
- Continue with spread of advocacy campaigns- All health Staff @ CMEs/ HMT/Partner
- Trainings and updates to staff on the HIV epidemic- HMT Training Committee / Partner
- The Ministry of health to address inter- cadre conflicts- HMT disciplinary Committee
- Ensure constant supplies- HMT- Commodity Nurse / Partner
- Frequent stakeholders meetings Medical Superintendent /HMT/ Partner

THE CCC AS THE LINK DEPARTMENT FROM THE HTS IN-PATIENT SERVICES

This is the unit that runs the HIV Program at the CGH Kakamega. This unit started its operations in the year 2008 supported then by Aphia 2.In the year 2009 the partner renovated the building where the clinic is situated and also furnished the CCC to what it is today, estimates of this work is not known . Currently the CCC has continued to enjoy support from Aphia Plus for close to 7years. Though the unit is within the hospital it has been run by partner support since its inception and most times forgotten in hospital budgets.

The CCC has a Medical Officer who is from the hospital and is in-charge of the unit. The majority of staff working here are mainly partner supported though the HMT have in the past posted 4 nurses to work here. These nurses are still on the normal rotation of hospital night shifts. The partner Aphia Plus has employed through the county government the following staff;7 RCOs, 6 Nurses, 4 HRIOs,3 Adherence Counselors, 2 Nutritionists, 4 Peer Educators, 1 Pharmaceutical Technologist, 3 Mentor Mothers, 8 HTC Counselors, and 2 Lab Technicians.
While on attachment here, I observed very committed staff with a call to serve clients. They work in shifts, the early group cloak-in at 6.30am-2pm the late group comes at 9am-6pm
This is one of the units where patients are not conned and money not asked from them. The main aim here is to prolong life to the HIV clients giving them free services, food supplements and Anti- Retro Viral Therapy (ART).
The services provided here include:

- HIV Counseling &Education to clients
- Linkage to the Prevention Program
- Admission to the wards for further management

- HIV Testing Services (HTS)
- Linkage to the Care Program
- Patient Registration to the ART Program
- Nutritional Counseling
- Adherence counseling
- Support Counseling
- Laboratory Investigations mainly CD4 and Viral load of all patients
- Cervical cancer screening
- Family Planning Services
- Distribute supplementary feeds to patients in need of them
- Clinical review of CCC patients
- Receive the prescribed drugs the ARVs and the OIs drugs
- Psycho Social Support Group (PSSG)meetings for all client segments for extended community awareness. The age segments include Adults, Adolescences and Pediatrics.
- Outreach services and follow up of clients who miss appointment
- Transfer in and out of clients from and to other ART sites for CCC clinic
- Encourage all CCC clients to go for TB screening
- Co infected clients can receive both ARVs and Anti – TB drugs
- Training sessions have in the past been organized by the partner to train mothers on how to take care of the children.
- Update the EMR of all clients attending the CCC
- Generate the updated hard copy report for all clients as they attend the CCC
- Generate EMR Reports of all services at CCC to Partner and the HMT

The partner says the government has left them the full ownership of the HIV program. They virtually support everything as concerns the HIV program at the CCC apart from the ARV (Anti – Retro-Viral) drugs and Nutritional Commodities which are purchased centrally by the National government. At times they have wanted to allow the HMT to support some areas but find that they have not prepared to do so. There is growing concern from the partner of what would happen should they no longer be able to support the program. She cried out that if only the HMT would start by owning the program. CGH has the majority of the CCC clients in Kakamega County. The partner Aphia Plus also comes in to support tools to help in service provision, buffer stock especially HTS Test Kits when they run out and all the stationary at the Clinic.

The cost analysis of the HIV program would roughly be estimated as follows:

- In terms of Staff salaries
- Staff Meetings
- PSSG Meetings
- CME's and Trainings
- Drugs from National Gok- Estimates at National level

Below are tables 7 and table 8 to give a rough guide and an estimation to help HMT in future plans to manage the CCC Unit.

Table 12: Estimate of Partner Staff Salaries @ CCC

Serial No.	Cadre	Number of Staff	Monthly Salary Ksh	Estimate per Month	Estimate per Year
1.	RCO	7	40,000	280,000	3,360,000
2.	Nurse	6	40,000	240,000	2,880,000
3.	Pharm- Tech	1	40,000	40,000	480,000
4.	Lab – Tech	2	40,000	80,000	960,000
5.	HRIO	4	40,000	160,000	1,920,000
6.	Nutritionist	2	30,000	60,000	720,000
7.	HTC Counselor	10	20,000	200,000	2,400,000
8.	Adherence Counselor	3	20,000	60,000	180,000
9.	Mentor Mothers	3	8,000	24,000	288,000
10.	Peer Educators	4	4,000	16,000	192,000
11.	TOTALS			**1,160,000**	**13,380,000**

Table 13: Estimates of Funds spent on Various Meetings @ CCC

No.	**Meeting /Type/Name**	**Frequency**	**Estimate**	**Monthly**	**Yearly**
1.	Work Improvement Teams (WITs)/ CME/ Staff Meeting	Weekly *4	10,000	10,000	120,000
2.	Quality Improvement Teams (QITs) Data Review	Once a month	3,000	3,000	36,000
3.	Quality Improvement Teams (QITs) Support to HTC Counselors	Once a month	3,000	3,000	36,000
4.	Multi -Disciplinary Team (MDT)/ Rx Failure	Once a month	10,000	10,000	120,000
5.	PSSG –Adult	2 times a month	3,000	6,000	72,000
6.	PSSG- Pediatric	3 times a month	3,000	9,000	108,000
7.	PSSG- Adolescents	Once a month	3,000	3,000	36,000
8.	PSSG- Adolescents	3 times a year during Holidays in	300,000	900,000	900,000

		April, August & December			
8.	Performance Based Funding on No. of HIV positive Clients initiated on Treatment	Quarterly	350,000	350,000	1,400,000
9.	Linkage Support Stipend				
10.	Stationary per Quarter Partner distributes 2000 files with all the required sheets in the client files				300,000
11.	Airtime for Tracing Clients who miss or come late for review appointments & LTF	4,000	4,000	4,000	48,000
12.	Internet Support for Reports	1,000	1,000	1,000	12,000
13.	Zonal Performance Review	Once a Month	1,250 for 5 staff from CCC	6,250	75,000
	TOTALS				3,263,000

In conclusion we can see that there is no free health service even at the CCC. Someone is paying for the service. Governments must come up with strategies to begin to support the CCC programs. Aphia plus uses over Ksh 16,643,000 per year to run the HIV Program at the CGH Kakamega for a year to manage 3,700 clients. A rough estimate of providing the CCC service to each client comes to about Ksh 4, 498/- per patient per year. The economist can tell us if this is cost effective or not. But look at all the services at the CCC this is pretty reasonable, @ about Ksh 5,000/- per patient in every year.

The Future funding streams for the CCC will be the expanded NHIF Social Security when the government stipulates in the NHIF that all HIV clients are enrolled and taken

care of within this health social security. The other funding stream is to lobby and convince the county government as health is a devolved function for its proper management and increased funding from the county system to cater for the elderly, the poor and the vulnerable groups of the society.

RESULTS

- Successful fellow attachment and training at the PLP in Kakamega CGH
- HMT now aware of the link between the PLP and the University of Nairobi
- SWOT situational analysis of the CGH Kakamega March 2017 report finalized
- HMT can now do their own departmental and hospital SWOT analysis
- Verified and validated SWOT documentation of each department and of CGH Kakamega and Financial and Bench mark reports finalized
- Financial position of the CGH as per the 3 previous FY 2013/14, 2014/15, 2015/16
- Agreed on Action points for implementation from the recommendations by the HMT
- Engaged the12 unit in-charges to drive the process to improve in-patient HTS

  Services from the current 60% to 100%
- Engaged CCC records officer to compile monthly and quarterly data for review in

the QIT meetings and MO at the CCC will give monthly reports to the HMT

- Recommendations and conclusions of the resource mobilization strategy
- Implementation Matrix Plan for the resource mobilization strategy
- Resource Mobilization Strategy (RMS) 2016- 2020
- HMT and HMC willing to implement the RMS
- Launch and dissemination of the Kakamega RMS 2016-2020 June 2017
- Kakamega CGH willing to train more fellowship students
- UoN is egger to post more fellowship students for experiential learning at this PLP
- Partner support documented at the CCC.
- The cost analysis of service components at the CCC identified and documented.
- The potential revenue streams at the CCC identified.
- The future resource requirements to sustain the in-patient HTS services and the HIV Program identified and benefits of HTS in-patient services documented.

PROJECTED IMPACT

- The in-patient HTS will improve from 60% to 100%
- Improved treatment and health outcomes with patients who know their HIV status
- The test if negative motivates the negative client to take-up prevention measures to maintain the negative HIV status
- In case of Sero-conversion, early diagnosis of HIV infection enables linkage to care and treatment and other support services such as e-MTCT to prevent further HIV transmission
- Re-testing may be offered as a prevention package for the negative partner and thus will facilitate better support to the partner living with HIV
- The Public health benefits to the client must outweigh the potential to cause harm or risk in terms of improving the health outcomes
- More linkage to both prevention and HIV program services
- More relatives of in-patients expected to be tested

-
- Expected more benefits of public health outcomes when more citizens know their HIV status and hopefully plan to reduce risk behavior
-
- Expected acceptability of HIV infection in the community
-
- Reduced stigma and discrimination in the community
-
- More demand for HTS not only in the hospital but also in the community
-
- Better acceptability to blood campaigns in schools
-
- More demand for HIV program services
-
- Health sector will walk towards the beginning of the end of the HIV Epidemic towards the last mile
-
- Gok already in a step in the right direction to give all CCC clients free NHIF cover to boost NHIF refunds to the hospital
-
- More citizens enrolled in NHIF and other Health insurances
-
- More citizens aware that quality health services are at a cost; and adequate plans for health care must be made at family , community and ward level
-
- More quality health provision from the citizens if plans for payment is made from the community and ward level
-
- More demand created on the provision of Health services
-
- County Government must respond to the health demand by good plans to improve the health infra-structure, recruit and train more skilled personnel, purchase modern equipment and deal with staff welfare issues to avert the human resource strikes
-
- County health director office to lobby the county assembly to pass a legislative law on health funding and appropriately accept to set aside funds for the provision of health to the vulnerable children and individuals, the elderly poor, abandoned widows, government waivers and exemptions and plan for disasters and health emergencies and outbreaks.
-
- Counties in future should start to develop along health specialties and focus on better quality of these services, recruit and train appropriate staff and buy the equipment to perform the special service.

-
- Engage the neighboring businesses and factories on their social cooperate responsibility to support the hospital provide special services to its citizens
-
- For the CGH engage the neighboring Academic Institutions, Sugar Factories and other prominent businesses to partner and fund CGH periodically
-
- The stakeholders need to have better MOUs so that all parties are satisfied with the agreement
- Health service provision must be an integral role of the county government and all partner support programs should eventually be taken over fully by the county health government only seeking technical support and input from other health partners from time to time.
- HMT will in future encourage most hospital clients enroll NHIF and on other social health security they are able to afford.

LESSONS LEARNT

- Team work is crucial all the way for good unit/ departmental performances and achievements

- There is still stigma of HIV infection among the populace

- Poor documentation of the patients' HIV status on admission
- Poor organization for in-patient HTS service after admission
- Few HTS counselors for in-patient HTS, only 3 HTCs available
- Poor HTS Services in-patient services
- Inadequate Counselor supervision & follow up of the HTC in-patient services
- Poor or late reports on in-patient HTS services

- Bench marking brings more insight to team members for better implementation of health services

- Everyone, all health and support staff are important in the hospital for improved service delivery

- Both the health staff and support staff require OJTs', CMEs', refresher trainings, recognition, awards, motivation for continued good performances in service delivery

- Welfare and respect to staff and improvement of work environment motivates all staff
- Staff promotions, skills training and general welfare meetings improve staff attitude towards their work
- Feedback is crucial from top to bottom and vice versa
- Patient exit interviews will from time to time indicate patient and client satisfaction of health services
- For any good change in the hospital service delivery it is important to involve all staff at all levels
- Leaders must always champion for the plight of their workers to both motivate the staff and improve staff attitude
- Human resource is a major building block in health services and must be treated with caution to avoid the strikes which is the worst threat to the health care services
- Visionary leadership is crucial in the management of health care services, more-over in resource limited settings

CONCLUSION

Kenya has a mixed generalized and concentrated epidemic. According to WHO in generalized HIV epidemics, HIV testing and counseling should be offered to all patients attending all health facilities, whether or not the patient has symptoms of HIV and regardless of the reason for attending the health facility. The future management of HIV programs lies on how good the coordination and management of the HTS services and reduction of stigma and discrimination among the populace.

The coordination of HTC services is multi-faceted and multi-level, with responsibilities spanning national, county and lower level structures. At each level, various bodies are responsible for various functions as listed below. Of importance to CGH as a Health Facility are the following;

- Provision of quality HTC services
- Performance monitoring and reporting
- Commodity management and reporting
- Human resource management
- Data quality audit
- Participate in External Quality Assessment(EQA)
- HTS promotion activities should be marketed with Sports and Athletics
- Other promotion activities can be endorsed with political and other celebrities.

If the HMT will follow the implementation matrix below and adhere to the above measures of quality HTS services there is no reason whatsoever why the in-patient HTS should not be sustained at 100%. The hospital will definitely also realize better resource collections to fund and support wanting departments like HIV program at the CCC and other needy units like the Renal unit. The term Resource mobilization must be demystified and all HMT/HMC trained so that all are engaged to do the mobilization agenda at their levels. Below are areas to be addressed as HMT/HMC is trained as shared by Andy Robinson (www.andyrobinsononline.com).Andy is the author of six books, including the brand new Train Your Board (and Everyone Else) to Raise Money .He provides training AR garden 200and consulting for nonprofits in fundraising and board development by:

• Redefining fundraising: It's not just asking for money
• Addressing myths and misconceptions about who has it and who gives it
• Building a board fundraising menu
• Helping board members take leadership and hold each other accountable

The other stream to follow is the NHIF expanded social scheme. It is the way to go for future funding and proper management of health programs at the county levels of devolved governments. The county governments must also legislate and set aside extra funding for health to sustain quality health for all at the county level. The county governments also need ownership of the health function at this level.

IMPLEMENTATION MATRIX OF THE RESOURCE MOBILIZATION STRATEGY AND THE IMPROVEMENT TO 100% OF IN-PATIENT HTS PROJECT AT THE COUNTY GENERAL HOSPITAL KAKAMEGA 2016-2020

No.	ACTIVITY	BY WHO	BY WHEN	RESULTS	REVIEW & ACTION BY HMT SEE Minutes
1A.	**Admission of Patient:** 1. Payment Mode Cash or NHIF/ other insurance 2. If Cash Pay Deposit/ If NHIF all relevant Documents given 3. Other record –Waiver/	5. HRIO to record all relevant issues and give in-patient No. 6. Clerks to take cash and issue appropriate	Immediately on admission	ICT help all departments to document appropriately Accountant and HAO to do follow up supervision	HRIO, HAO, ICT and Accountant give feedback on new NHIF clients recruited per month. M&E Committee to continue

	Exemption **4.** Recruit for NHIF	receipts 7. Nurse take patient to appropriate ward NHIF Clerk to recruit all patients with no health insurance			the monitoring work
1B.	Admission of Patient and assess patients' HIV status Note Screen all HIV positive patients for TB Other clients are referred for the prevention program	All the Ward In-charges Ward 1 Ward 9 Ward 2 Ward 10 Ward 3 Amenity A Ward 5A Amenity B Ward 5B Maternity Ward 6 Ward 7 Ward 8	Immediately on admission	All In-charges Refers patient appropriately for HTS and document results- No of patients with known HIV status / No. tested & Ref.	MO @ CCC in QIT meetings give monthly feedback to HMT on patients with known status, patients tested & linked to care
2.	MO at CCC review ARC patients on request of ward in-charge	All wards above	When patient is required for review in the wards	Ward in-charge documents the same for reporting	Ward in-charge to give feedback in QIT meeting
3.	QIT Meetings for HTS In-patient Data Review	Nurse @ CCC & Records Officer @ CCC for MO @CCC	Every 2 weeks	All ward in-patient in-charges submit data to CCC records officer	MO @CCC to give monthly feedback on HTS Data to HMT
4.	Counseling Supervision to HTS counselors in the ward	Counselor Supervisor	Once a month	Counselor Supervisor document results	MO @ CCC for HMT monthly feedback
5.	QIT Meetings for	Counselor	Every	Counselor	MO @

	HTS Counselor In-patient Support Supervision	Supervisor	Month	Supervisor document results	CCC for HMT monthly feedback
6.	Train Ward In-charges on Billing, Quarterly review on Billing and HTS data	Matron/ ICT/ HRIO/HAO/Accountant "	September 2017 December 2017	Documented by Matron HTS data documented by CCC HRIO	Monthly feedback of bills by Accountant and data by HRIO to HMT
7.	CCC Staff & health staff Updates and Trainings, CMEs and Visits	Partner to MO @ CCC HMT to Partner	As required to organize for CCC coverage & other departments /in-patients /out patients	Partner & MO @ CCC Document results	MO @ CCC feedback to Medical Superintendent
8.	Exemptions & Waivers Monitoring	Social Worker-SW	Daily , Weekly & Monthly	Documented by Social/W & ICT	Monthly Feedback to HMT- by SW
9.	CCC Exemptions	SW	Daily , Weekly & Monthly	Documented by Social/W & ICT	Monthly Feedback to HMT by S/W
10.	Political Waivers	HAO	As the need arises	HAO documents results	HAO feedback to Med. Supt /HMT
11.	Medical Superintendent to lobby County Assembly to legislate on extra funding to CGH to offset Large Waivers and Exemptions and pay for planned Medical/ Surgical camps and Renal Unit/ HIV Program	Chief /Med. Supt/ SHAO/ Board Chair	Immediately	Med Supt /SHAO to document results	Med. Supt to give feedback to HMT and the HMC of progress

	Support				
12.	Drug Waivers / Exemptions include CCC patients	Pharmacist In-charge	Monthly	Pharmacist documents all results	Monthly Feedback to HMT By Pharmacist
13.	X-ray Waivers/ Exemptions include CCC patients	Radiographer In-charge	Monthly	Radiographer documents all results	Monthly Feedback to HMT by Radiographer I/C
14.	Laboratory Waivers/ Exemptions include CCC patients	Lab Technologist In-charge	Monthly	Lab Technologist In-charge documents results	Monthly feedback to HMT by Lab I/C
15.	Accountant to Monitor Bills / Payments	Accountant In-charge	Daily, weekly & Monthly	Accountant document results	Monthly feedback to HMT by Accountant
16.	CCTV & Automation of Cash Points	Chief Officer – Med Supt. /ICT, HAO & Accountant	December 2017	Documented by Accountant	ICT/ HAO Accountant report progress to HMT
17.	Establish Customer Care Desk	Hospital Matron/ SHAO	October 2017	Documented by Matron	Monthly Feedback to HMT
18.	NHIF recruitment	HAO/HRIO	Continuous Activity	Documented by HRIO	Monthly feedback to HMT
19.	Documentation of other Insurance Schemes	HAO/HRIO	Continuous Activity	Documentation by HRIO	Monthly feedback to HMT
20.	ICT Training of Departmental Heads/ Champions to boost revenue	RCO in-charge/ HRIO/ Matron/ ICT/ HAO/ Accountant	July 2017	Documentation by Matron /Depart Heads and HAO	Monthly feedback by All Departments
21.	Train the RM team to start engaging external stake holders in RM. Appoint RM manager of CGH	Medical Superintendent / SHAO/ Board Chair- RM Committee of the HMC	As soon as the funds are available – latest by December 2017	Documentation SHAO	Feedback by SHAO to both the HMT and HMC after training and next

					steps to Fund raise for CGH plan
22.	HMT Support to CCC	HAO/Matron/ Accountant	Immediately	Documentation by HAO	Monthly feedback by MO @ CCC
23.	Quarterly Review of In-patient HTS by Casco and midterm fellows	Casco and Nutrition Officer/ HRIO @ CCC	July 2017	Documentation by MO @ CCC	Quarterly feedback & progress by MO @ CCC to HMT & Casco
24.	Human Resource issues /work @ weekend especially nurses/ attitude/ conflicts on HTS	Hospital Matron	As soon as possible	Hospital Matron	Matron gives monthly feedback to HMT
25.	Advocacy on HTS	CME chair at all Hospital meetings and Departmental Heads at all Hospital departments	Continuous Activity	CME Chair and all Departmental Heads	All monthly feedback to HMT
26.	Supplies for HTS & others	Supply Chain Manager/ Commodity Nurse	Continuous Activity	Documentation by Commodity Nurse	Monthly Feedback to HMT by Commodity Nurse
27.	Stakeholders Quarterly meeting	Medical Superintendent	Quarterly Meetings	SHAO/ Matron/ RCO In-charge	Quarterly feedback to HMT by RCO
28.	M& E of all the above Activities	M&E Chairperson	Quarterly M&E Meetings	M&E chair document progress	M& E give Quarterly reports to HMT
29.	Review progress of the Activities of the Resource Mobilization Document and engage external	Appointed chair / manager of the RM team after training the RM team	Plan for Quarterly external Stake holders meeting by	Secretary of the RM team to document the proceedings	RM chair to give report to both the HMT and the HMC

	Stake Holders to start raising funds for CGH Kakamega		identifying of all potential SH and giving a good report of the internal environment of CGH Kakamega		

N/B: HRIO as the Chair of M&E to keep track of all indicators for monitoring and give HMT feedback for Action.

By Dr. Diemo for the CGH Kakamega HMT to improve on HTS Services of in-patient and build up on resource mobilization activities. This template will feed the monthly, quarterly and annual progress reviews of both the HTS in-patient project and improvement of the collections as the action points of the recommendations are implemented. When the resource management team has been trained and a manager appointed program diversity can be encouraged especially in areas that will improve on all types of required resources. Plan to recruit more skilled staff for quality health services.

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ANNEX

1. CGH Hospital Departments:

1. The Administration Block which houses several offices

- Office of the Medical Superintendent- Meeting place
- Office of the Medical Superintendent – small place
- Office of the Hospital Matron
- Office of Deputy Hospital Matron
- Office of the Senior Hospital Administrator
- Office of the Registered Clinical Officer In-charge
- Office of the Health Records and Information Officer (HRIO)
- Office of the Public Health Officer
- Office of the Accountants
- The NHIF Office
- The Data Centre
- The Human Resource (HR) Office
- The Billing Office
- The Hospital Library
- The Computer room
- The Rest rooms

2. The Blood bank
3. The Afya Sacco Bank
4. The KEPI Office
5. The Hospital Generator

6. The Causality
7. The Central Medical Records
8. The Pharmacy
9. The Out Patient Department (OPD):
    - The Central Registry
    - KCB Mtaani
    - The Clinical Officers' consultation rooms
    - The MCH/FP- PMTCT- Oparanya Care
    - Several Nursing Staff Offices
    - Injection room/ minor procedure room
    - Patient Waiting Bay
10. The Dental Unit
11. Special Consultant Clinics and Patient Toilets
12. Eye Unit and Ward 10
13. Physiotherapy and Occupational Therapy (OT) Units
14. X-ray Unit
15. MRI Centre
16. Bio-Medical Engineering
17. Orthopedic Unit
18. Maternity Unit- Ante Natal Ward (ANW), Post Natal Ward (PNW), Labor Ward, New Baby Unit
19. CCC
20. ICU
21. HDU
22. Laundry , Tailoring
23. Incinerator
24. Kitchen
25. Stores
26. Theatre

Social Workers' Office

27. Amenity A&B
28. All Wards:
    - Psychiatry Ward 9
    - Ward 5A
    - Ward 5B
    - Gynecological Ward 8
    - Ward 1
    - Ward 2
    - Ward 3
    - Ward 6
    - Ward 7
29. Mortuary
30. Stakeholders of CGH Kakamega:
    - KMTC – Kakamega- 4 Departments
    - St Elizabeth's School of Nursing – Mukumu

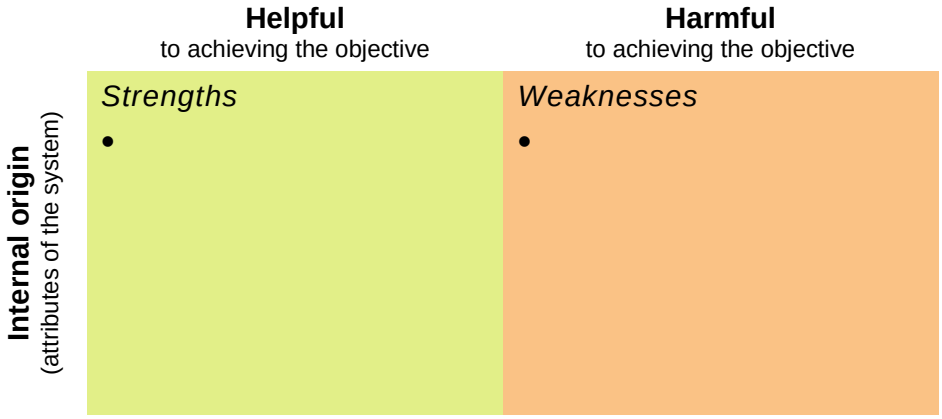
- St Mary's School of Clinical Medicine- Mumias
- Masinde Muliro University of Science and Technology- 6 Departments
- 3 Members of the HMC- Board
- Suppliers to the Hospital- 1
- Contracted Hospital Service

13. SWOT TOOL- Questionnaire and below the SWOT Analysis Template

Questionnaire for Key Informant Interviews (KII) and Focus Group Discussions (FGDs)

1. What are the strengths of the County Hospital?
2. What are the weaknesses of the County Hospital?
3. What are the opportunities of the County Hospital?
4. What are the threats faced by the County Hospital?
5. Is there any other discussion you would like to contribute about the county hospital?

SWOT Matrix Analysis Template



111. SWOT QUESTIONS TO HMT AS SWOT ANALYSIS IS VALIDATED

Date: 15th March 2017

Venue: Friends Hotel Kakamega Limited

Strengths

These are positive, internal factors that affect how your business performs. Although they may be difficult to change, they should be within your control:

- What are we good at?
- What do we do better than anyone else?
- What is our competitive advantage?
- What do we do that no one else does?
- What resources do we have at our disposal?
- What are our company's advantages?
- What advantages do our team and employees have?
- What valuable assets does our company have?
- What do our customers like about our business?

Weaknesses

These are negative, internal factors that affect the performance of your business. They may be difficult to change, but they should be in your control:

- What are we bad at?
- What do our competitors do better than us?
- What do our customers complain about?
- What disadvantages does our team carry?
- What is holding us back?
- Which resources are we lacking?
- What could we improve?

Opportunities

These are external factors could affect your business in a positive way. Use strengths to take advantage of opportunities. They may be largely out of your control but you can choose to leverage them:

- What potential regulation changes could help our business?
- Is the market changing in a favorable way?
- Is the current economy going to affect us in a positive way?
- What opportunities have we not pursued yet?
- What new opportunities are becoming available?
- Are our costs of goods going down?
- Is there a way for us to acquire useful resources that we do not already have?

Threats

These are external factors that could affect your business in a negative way. They are likely out of our control but you can create a contingency plan to minimize the damage:

- Who are our existing competitors?
- What new entrants to the market could threaten our business?
- Is our market size declining?
- Is the industry changing in a way that could negatively impact our business?
- Are our costs of goods increasing?
- Is a supply we rely on becoming scarce?
- Are regulations changing in a way that could hurt our business?
- Is our manufacturer unreliable?

What to Do With Your SWOT Analysis?

As business owners, we constantly have to prioritize what gets our attention. **Tough decisions about resource allocation are unavoidable.** No matter how successful you become you'll always have to pick and choose **where** to direct your attention. SWOT analysis helps you determine strategic areas to focus your energy and resources.