29/4/26

PCA-LPCS
For tabling before House
29/4/26

**COUNTY GOVERNMENT OF BUNGOMA**

# COUNTY ASSEMBLY OF BUNGOMA

## OFFICE OF THE CLERK

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**BUNGOMA COUNTY**

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# COMMITTEE ON HEALTH

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**A REPORT**

**ON**

## IMPLEMENTATION STATUS OF THE SHA AND FIF ACTS IN THE COUNTY

Clerks Chambers
County Assembly Buildings
PO BOX 1886,
BUNGOMA, KENYA.

JANUARY, 2026

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## CHAPTER ONE

### 1.0 EXECUTIVE SUMMARY

**Hon. Speaker,**

Pursuant to the provisions of the Fourth Schedule,part-2 and Article 185(3) of the Constitution of Kenya,2010 read with Section 8 of the County Governments Act 2012,the Clerk to the County Assembly forwarded a letter dated 19th November,2025 under reference No.CAB/CC/SECT/5 VOL.111(73) to the CEC-Member, County department of Health and Sanitation Services requesting for the departmental submissions in respect to the departmental policy and operational guidelines that have been put in place by the department to facilitate implementation of SHA/SHIF and FIF Acts in Bungoma County.

The said request was necessitated by the fact that, the sector committee had noted pertinent issues related to the implementation of SHA/SHIF and FIF Acts at county and facility levels and resolved to assess the department's preparedness and progress in facilitating the implementation of SHA/SHIF and FIF Acts respectively, two years after their enactment.

Accordingly, the committee through the above mentioned letter invited the CEC-Member for Health and Sanitation services to appear before it on the 2nd December,2025 to provide information on the implementation status of the said Acts, and more specifically on the following issues;

1. The departmental policy guidelines established to support implementation of the SHA/SHIF and FIF Acts in the county

2. To provide information on the number of registered SHA/SHIF members in the county

3. The departmental registration plans for SHA/SHIF

4. To provide a breakdown of Health facilities currently implementing SHA/SHIF

5. To provide information on services offered under SHA/SHIF

6. To provide a breakdown of refunds processed under SHA/SHIF

7. To elaborate on the extent of implementation of the FIF Act

8. To state the challenges faced by the department in implementing the SHA/SHIF and FIF Acts

Consequently, vide a letter dated 27th November, 2025 under reference No.CG/BGM/MOH/CO/CA/REPORTS/VOL.V (7), the department forwarded a written response over the issues raised by the committee.

This report therefore is a comprehensive consideration of the departmental policy and operational guidelines established by the county department of health and sanitation to support or facilitate implementation of SHA/SHIF and the FIF acts in Bungoma County.

It is my pleasant duty to present the report on the implementation status of the SHA/SHIF and FIF acts, in respect to the department of Health and Sanitation for consideration by this House.

### 1.1 COMMITTEE MANDATE

**Hon. Speaker,**

The Sectoral Committee on Health Services was constituted on the 26th October, 2022 pursuant to the provisions of Standing Order No.179 and executes its mandate in accordance with Standing Order 217(5) which provides that the functions of a Sectoral committee shall be to-

a) Investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration, operations, coordination, control and monitoring of budget;

b) Consider quarterly reports of the assigned departments and report to the House within twenty-one (21) sitting days upon being laid;

c) Study the programme and policy objectives of departments and the effectiveness of the implementation;

d) Study and review all county legislation referred to it;

e) Study, access and analyze the relative success of the departments as measured by the results obtained as compared with their stated objectives;

f) Investigate and inquire into all matters relating to the assigned departments as they may deem necessary, and as may be referred to them by the County Assembly;

g) To vet and report on all appointments where the constitution or any law requires the House to approve, except those under *Standing Order 204* (Committee on Appointments); and

h) Make reports and recommendations to the House as often as possible, including recommendation of proposed legislation.

## 1.3 COMMITTEE MEMBERSHIP

**Hon. Speaker,**

The Committee on Health services as currently constituted comprises the following Members;

| | | | |
|---|---|---|---|
| 1. | Hon. George | Makari | Chairperson |
| 2. | Hon. Jerusa | Aleu | Vice – Chair |
| 3. | Hon. Meshack | Simiyu | Member |
| 4. | Hon. Joan | Kirong' | Member |
| 5. | Hon. Vitalis | Wangila | Member |
| 6. | Hon. Tony | Barasa | Member |
| 7. | Hon. Jackson | Wambulwa | Member |
| 8. | Hon. Orize | Kundu | Member |
| 9. | Hon. Wafula | Waiti | Member |
| 10. | Hon. Jeremiah | Kuloba | Member |
| 11. | Hon. Jacob | Psero | Member |
| 12. | Hon. Ali | Machani | Member |
| 13. | Hon. Dorcas | Ndasaba | Member |
| 14. | Hon. Milliah | Masungo | Member |
| 15. | Hon. Grace | Sundukwa | Member |

## 1.4 LEGAL FRAMEWORK

**Hon. Speaker sir,**

Pursuant to the provisions of Article 185(3) of the Constitution of Kenya 2010, the committee is mandated to exercise oversight over the County Executive Committee and any other County Executive organs.
Additionally, Article 43(1) of the Constitution of Kenya on economic and social rights provides that-

Every person has the right -

a) to the highest attainable standards of health, which includes the right to health care services, including reproductive health care;
b) to accessible and adequate housing, and to reasonable standards of sanitation;
c) to be free from hunger, and to have adequate food of acceptable quality;
d) to clean and safe water in adequate quantities;
e) to social security; and
f) to education.

Article 43(2) of the constitution provides that, a person shall not be denied emergency medical treatment.

## 1.5 ACKNOWLEDGEMENT

**Hon. Speaker, Sir,**

On behalf of the committee, I would like to extend my gratitude to the office of the Speaker and Clerk for providing a conducive environment that allowed the Committee to undertake the assignment seamlessly. Your unwavering support and logistical assistance have been instrumental in ensuring the success of this report. I express my sincere gratitude to the Honourable Members attached to this committee for their dedication and valuable contribution towards the compilation of this report. Equally, I acknowledge and commend the Secretariat for their tireless efforts in making this exercise a success. I further do confirm that the observations and recommendations of the Committee in this report were arrived at unanimously.

It is therefore my pleasant privilege and honour to present to this House the report of the Committee on the implementation status of the SHA/SHIF and FIF Acts in the County in respect to the department of Health and Sanitation.

**SIGNATURE..... DATE.....**

**HON. GEORGE MAKARI - MCA MUSIKOMA WARD.**
**CHAIRPERSON,HEALTH SERVICES COMMITTEE**

## CHAPTER TWO

## 2.0 OVERVIEW OF SHA/SHIF AND FIF ACTS

The Acts establishing the Social Health Authority (SHA), and the Social Health Insurance Fund (SHIF) were assented to on 19th October, 2023.

The SHIF is the replacement for the previous National Hospital Insurance Fund (NHIF), now defunct.

These acts were part of a set of four health related laws enacted to support Universal Health Coverage (UHC) in Kenya.

### 2.1 OVERVIEW OF THE SOCIAL HEALTH AUTHORITY ACT, 2023 (SHA)

The Social Health Authority (SHA) is a state corporation of the Government of Kenya that is responsible for the provision and management of public health insurance within the republic of Kenya.

### CORE MANDATE OF SHA

The core business and mandate of SHA therefore is to manage the Social Health Insurance Fund (SHIF), the Primary Health Care Fund (PHF), and the Emergency, Chronic and Critical illness Fund (ECCF).

The authority also implements income based contributions through collection of contributions based on income levels for formal and informal sector workers.

The authority is also mandated to provide accessible, affordable, sustainable and quality health services for all Kenyan citizens and foreigners, where applicable.

Health facilities in Counties are expected to utilize Social Health Authority (SHA) funds primarily for primary Health care services, as per the Social Health Insurance (General) Regulations, 2024.

These funds, channelled through the primary Healthcare Fund, are intended to support services at Levels 1, 2 and 3 and select Level 4 hospitals. The funds can be used to purchase services, pay facilities for providing quality health care based on prescribed tariffs, and establish a pool for managing these payments.

Additionally, higher level facilities i.e.,(Levels 4,5 and 6)can receive some funding from the Social Health Insurance Fund(SHIF) for specific services like Laboratory investigations for certain chronic diseases, with the patient then returning to a lower-Level facility for on-going care.

## 1. PRIMARY HEALTH CARE FUND (PHF)

### *Direct Funding*

The Kenyan government directly funds the PHF, which covers services at lower-level facilities (Levels 1-3 and some Level 4).

### *Purchasing Services*

The PHF is used to purchase primary Healthcare services from designated facilities.

### *Payment for services*

Facilities are compensated for providing quality primary healthcare based on established tariffs.

### *Fund Management*

The PHF also establishes a system for receiving and disbursing funds related to primary Healthcare

## 2.2. OVERVIEW OF THE SOCIAL HEALTH INSURANCE FUND (SHIF)

The social health insurance fund (SHIF), is Kenya's new national health insurance scheme, which officially replaced the National Hospital Insurance Fund (NHIF) on 1st October, 2024.

It is a key component of the government's strategy to achieve Universal Health Coverage (UHC), for all residents of Kenya.

## MANDATE OF SHIF

The primary objective of SHIF therefore is to ensure equitable and affordable access to comprehensive healthcare services for all Kenyans without them facing financial hardship. It aims to bridge the gap left by the previous system (NHIF), which primarily focused and covered majorly those in formal employment by bringing everyone, including the informal sector and vulnerable populations, into a mandatory and inclusive health insurance system.

SHIF operates under SHA, which is the governing body established by the social health insurance Act of 2023.

### *Member Contributions*

SHIF is funded by contributions from salaried and self-employed individuals.

### *Higher- Level Care*

SHIF primarily covers services at higher-level facilities (Levels 4, 5 and 6), including inpatient care, radiology, surgery, dialysis and oncology.

### *Specific Services*

SHIF may also fund specific services at lower-level facilities, like Laboratory tests for chronic diseases, with the patient returning to a lower-Level facility for ongoing management.

## GENERAL USAGE

### *Equipment and Supplies*

Funds can be used to purchase necessary equipment and medical supplies for the facility, ensuring it can provide adequate care.

### Staff Training

Training and capacity building for healthcare workers can also be supported by the funds.

### *Infrastructure*

In some cases, funds may be allocated to improve infrastructure at the facility to enhance service delivery.

### *Operational Costs*

Funds can be used to cover operational costs, including utilities and other essential expenses.

## ACCOUNTABILITY AND REPORTING

### *Financial Management Systems*

Facilities are expected to utilize integrated Financial Management systems (IFMIS) for accounting and record-keeping.

### *Expenditure Limits*

Expenditure is limited to the available funds in the facility's account and the authorized expenditure.

### *Returns and Accounts*

Facilities are required to file regular returns and accounts to the relevant authorities.

## KEY CONSIDERATIONS

### *Equipment availability*

Adequate equipment is crucial for facilities to effectively utilize the funds and deliver quality services.

***Referral System***

A robust referral system ensures patients receive the appropriate level of care.

***Transparency and Accountability***

Clear guidelines and transparent financial management are essential for the effective use of SHA funds

## 2.3. OVERVIEW OF THE FIF ACT AND ITS MANDATE

FIF, stands for Facilities Improvement Financing, a system that grants public health facilities financial autonomy to manage the revenue they collect from user fees, insurance payments, and other sources.

Its legal framework is established under the Facilities Improvement Financing Act of 2023.

**KEY OBJECTIVE AND MANDATE OF THE FIF**

The primary objective of FIF is to ensure that funds generated at the facility level remain available for immediate use to improve service delivery, rather than being consolidated into the general county revenue fund(CRF),established under Section 109 of the PFM Act and Article 207 of the constitution, which often caused delays and diversion of funds.

In essence, the FIF aims to empower local health facilities to address their immediate operational needs quickly, leading to improved quality of care and performance across the public health system.

FINANCIAL AUTONOMY

To provide an efficient, secure and accountable mechanism for public health facilities to collect, retain, and manage revenue.

IMPROVED SERVICE DELIVERY

To use the retained revenue to supplement county budgets for operations and facility quality health service delivery, including purchasing urgent goods and services, essential medicines and equipment.

ENHANCE ACCESSIBILITY AND PREDICTABILITY

To ensure that health facilities have readily available and predictable financial resources to sustain their daily operations and improve access to health services by all residents.

STRENGTHEN GOVERNANCE AND ACCOUNTABILITY

To establish a clear governance framework (involving facility management teams and committees), to plan, coordinate and oversee the use of funds in a transparent and accountable manner.

## CHAPTER THREE

## 3.0 DEPARTMENTAL SUBMISSIONS ON THE ISSUES HIGHLIGHTED BY THE COMMITTEE

**Hon. Speaker sir,**

The department of health and Sanitation submitted through written and oral submissions responded as follows to the issues highlighted by the sector committee on Health services;

### 3.1 ESTABLISHMENT OF POLICY GUIDELINES ESTABLISHED TO SUPPORT IMPLEMENTATION OF SHA/SHIF IN BUNGOMA COUNTY

Following the enactment of the Social Health Insurance Act NO.16 of 2023 and the establishment of the Social Health Authority (SHA), the Department of Health and Sanitation in Bungoma County has put in place a set of policy and operational guidelines to facilitate implementation of SHA/SHIF at county and facility level. These are summarized below:

1) **Governance and Coordination Mechanisms:**
   These are meant to strengthen county-level leadership and oversight of the Social Health Authority (SHA) reforms, that there is an established fully functional SHA Processes Team (SHA-PT). The team, formally chaired by the County Director of Health, comprises selected members of the County Health Management Team (CHMT.

The SHA-PT serves as the technical engine for county-wide implementation of SHA. Its mandate includes:

1. Steering implementation of all SHA processes across county health facilities.
2. Monitoring performance, including routine review of SHA indicators such as enrolment, service utilization, claims submitted, claims approved, rejection rates, and value of refunds received.
3. Identifying operational challenges affecting SHA processes at facility levels.
4. Mapping opportunities for improvement, including identifying high-performing facilities, scalable best practices, and areas requiring targeted support supervision or retraining.
5. Providing actionable recommendations to County Health Leadership to improve efficiency, accelerate refunds, enhance quality of documentation, and strengthen compliance with the Social Health Insurance Act.

The SHA-PT meets monthly and provides periodic briefings to the Chief Officer and CECM. Its work has significantly improved coordination, accountability, and responsiveness in the rollout of SHA reforms across all levels of care in the county.

**2) Directive to establish SHA Registration and Information Desks:**

The Department has issued a formal directive to all county health facilities requiring the establishment of SHA Registration and Information Desks. These desks are mandated to:

1. Support client registration including new enrolments, linkage to preferred facilities, and updating of details.
2. Provide accurate information and guidance to clients on SHA processes, benefit entitlements, referral pathways, and documentation requirements.
3. Ensure seamless client navigation within the facility by helping beneficiaries understand service points covered under SHA and any pre-authorization steps where required.
4. Serve as the first point of contact for addressing SHA-related queries, complaints, and community feedback at the facility level.
5. Strengthen documentation and claims readiness by ensuring that clients are properly registered before receiving services, thereby reducing claim rejections.

All facilities have been instructed to ensure these desks are:

- Clearly designated and visible,
- Staffed during all operating hours, and
- Equipped with the necessary tools and SHA informational materials.

This directive has standardized client flow, improved community awareness of SHA requirements, enhanced registration coverage, and supported smoother claims processing county-wide.

### 3) Directive on Monthly SHA Claims Data Capture and Reporting:

To strengthen transparency, accountability, and timely reconciliation of SHA reimbursements, the Department has issued a directive to all public health facilities requiring them to capture and report SHA claims data in a standardized format on a monthly basis.

Each facility is required to:

1. Capture all SHA-related service data using the approved Claims Data Capture Template, ensuring completeness of service category (outpatient, inpatient, maternity)
2. Track the full claims cycle, recording:
   - Claims submitted
   - Claims approved
   - Claims rejected (with reasons)
   - Claims under review
   - Claims paid / refunds received
   - Outstanding claims pending action
3. Reconcile monthly data against facility service registers and financial records to ensure accuracy before submission.
4. Submit the monthly facility claims report to the County Monitoring and Evaluation Coordinator.
5. Ensure that all claims are submitted within the stipulated SHA timelines and that any discrepancies or rejections are resolved promptly and documented.

This directive has enabled the Department to:

- Track facility performance on claims management

- Identify bottlenecks causing delays or rejections
- Monitor trends in SHA reimbursement
- Provide targeted supportive supervision
- Strengthen integration of SHA revenues into FIF planning and expenditure

Monthly reporting is now an obligatory compliance requirement for all facilities and forms part of routine performance monitoring at sub-county and county levels.

## COMMITTEE OBSERVATIONS

Observations from Oral Submissions Regarding Department Directives:

1. The department did not issue formal instructions to health facilities on how to set up SHA registration and information desks. As a result, each facility independently created their own desks based on their needs. This explains why the desks operate differently across various facilities.
2. The members of the SHA Processes Team (SHA-PT) have not been given official appointment letters. More importantly, this team lacks the authority and system access needed to perform their coordinating role effectively. Specifically, they had no direct decision-making power over SHA matters and cannot access the Taifa Care system. Health facilities at all levels send their reports to the national SHA coordinating team, but only three people in the county can view these reports: the County Executive Committee Member (CECM), the Governor, and the County Commissioner.
3. The health facilities are not provided with clear instructions on how to collect and report SHA claims data. The committee verified that there was no standard reporting format or monthly reporting requirement in place. Consequently, each facility developed its own method of submitting reports to headquarters, leading to inconsistency in how information is captured and shared.
4. It remained unclear who holds the technical responsibility for SHA matters at the county level. There is need to officially designate an officer as the SHA focal point at the county level who will coordinate with the facilities.

## 3.2 NUMBER OF REGISTERED SHA/SHIF MEMBERS IN THE COUNTY

As of 27th November 2025, Bungoma County had registered a total of **741,886** individuals into the Social Health Authority (SHA) scheme. This represents **44.4% coverage** against the county's target population of **1,670,413**, placing Bungoma **29th out of 47 counties** in terms of percentage registration.

A gender-disaggregated analysis shows that female registrants slightly outnumber males, with **386,504 females** enrolled compared to **348,328 males.** This indicates relatively balanced outreach efforts, with a notable edge in female enrollment—likely reflecting higher service-seeking behavior among women, particularly around maternal and child health needs.

Age-wise, the data reveals that children constitute **235,938** of the total registered population, while adults make up the larger proportion at **505,948.**

Overall, while Bungoma County has made commendable progress toward SHA enrollment, achieving nearly half of the target population, further efforts are required to accelerate uptake and move closer to universal coverage.

Table 1: SHA Registration by Employment Status – Bungoma County

| Employment Status | Percentage (%) | Number of People |
|---|---|---|
| Self Employed | 36.3% | 183,528 |
| Unemployed | 32.6% | 165,074 |
| Employed | 14.0% | 70,726 |
| Not Specified | 12.8% | 64,710 |
| Sponsored | 4.3% | 21,910 |

Registration continues daily through facilities, CHPs, and community outreach mechanisms.

## COMMITTEE OBSERVATIONS

It was established that most facilities rely on facility-based registration to get SHA membership. The department did demonstrate to the committee how it has plans to utilised digital optimization, and structured coordination across all sub-counties to enrol more members to SHA.

### 3.3 DEPARTMENTAL PLANS FOR SHA/SHIF REGISTRATION

To accelerate universal registration and ensure every household in Bungoma County is enrolled under the SHA/SHIF system, the Department has a multi-pronged, countywide SHA Registration Acceleration Plan. The plan focuses on community-level mobilization, facility-based registration, digital optimization, and structured coordination across all sub-counties.

a) **Community-Level Registration Through CHPs (Primary Strategy)**

The Department is leveraging the full network of **3,590 Community Health Promoters (CHPs)** to drive household-level registration. The specific actions are:

1. **Monthly Targets Per CHP**
   - Each CHP is assigned a monthly target of new or verified registrations, monitored by the sub county community strategy focal persons.

2. **Facility-Based Registration Desks (Second Major Strategy)**

All county facilities have established SHA Registration & Information Desks. The plan includes:

**Mandatory Staffing** to man the desks.

**Daily Registration Targets**

**Integration with Patient Flow**

- Registration to be conducted at:
  - Triage,
  - Waiting bays,
  - Pharmacy counters,
  - Maternity clinics,
  - CCC clinics.

3. **Coordination with National SHA Teams**

The Department will continue collaborating with:

- SHA Regional Office
- Digital Health Agency
- National Ministry of Health

Areas of collaboration include:

- Credentialing support,
- Training,
- Data cleaning,
- Troubleshooting portal challenges,
- Updating registration tools.

**Expected Outcomes of the Registration Plan**

The Department aims to achieve:

- Over 60% household registration coverage by June 2026
- Full facility linkage for all registrants
- Reduced claim rejections due to improved documentation
- Improved service uptake across primary care units
- Enhanced financial protection and reduced out-of-pocket (OOP) payments for households

**COMMITTEE OBSERVATIONS**

Observations on SHA Registration Strategies and Implementation:

1. The department presented a solid plan to achieve universal SHA/SHIF registration across Bungoma County, with the primary strategy being to deploy 3,590 Community Health Promoters (CHPs) to enroll households. However, the committee identified a critical concern: the department has been inconsistent in paying CHPs their stipends. Currently, CHPs are owed four months of payments (March, April, May, and June) from the previous financial year. These arrears have not been settled, nor has funding been allocated in the supplementary budget to clear them. This payment inconsistency risks demoralizing the CHPs and reducing their effectiveness, which could significantly slow down the registration targets.
2. The second strategy involves setting up registration desks at health facilities. However, the absence of clear departmental directives has

resulted in poor coordination of these desks across facilities. The committee also observed that permanent and pensionable hospital staff are rarely involved in the registration process, suggesting disconnect that could undermine the initiative. The original plan was to integrate SHA registration into patient flow at key service points such as triage areas, waiting bays, pharmacy counters, maternity clinics, and CCC clinics. Unfortunately, this integrated approach has not been successfully implemented.

3. The third strategy focuses on coordinating with national-level SHA teams, including the SHA regional office, the Ministry of Health, and the Digital Health Agency. A significant gap was identified here where health facilities have been forced to contact these coordinating teams on their own. As a result, facilities have to navigate through SHA-related challenges.
4. Problems continue regarding training, resolving system issues, and reporting processes. While CHPs and some facility ICT officers received SHA training, persistent system and network challenges have forced some facilities to revert to manual reporting methods instead of using the digital platform as intended.
5. Health facilities are experiencing difficulties using the system to submit supporting documentation for claims, such as doctors' notes. Most facilities have resorted to attaching hard copy evidence to their submissions. In other cases, it remains unclear whether facilities have found a way to submit such evidence digitally or are struggling with this requirement altogether.

### 3.4 BREAKDOWN OF HEALTH FACILITIES IMPLEMENTING SHA/SHIF IN BUNGOMA COUNTY

Bungoma County has a total of **190 health facilities** distributed across Levels 2, 3, 4 and 5. Out of these, a total of **160 health facilities** are actively transacting with SHA. The Department has continued to support the rollout of SHA/SHIF in all these facilities through credentialing, establishment of registration desks, digital support, and capacity building on claims processing.

Below is the breakdown of facilities by level.

**Table 2: Summary of Total Health Facilities by Level versus Transacting Health Facilities with SHA**

| Facility Level | Total Number of Facilities | **Transacting Health Facilities** |
|---|---|---|
| Level 5 | 1 | 1 |
| Level 4 | 10 | 10 |
| Level 3 | 58 | 55 |
| Level 2 | 121 | 94 |
| **TOTAL** | **190** | **160** |

The specific health facilities breakdown is as below:

**LEVEL 5 FACILITY (1 TOTAL)**

1. Bungoma County Referral Hospital (BCRH)

**LEVEL 4 FACILITIES (10 TOTAL)**

| | |
|---|---|
| 1. Chwele Sub-County Hospital | 7. Mt. Elgon Sub-County Hospital |
| 2. Sirisia Sub-County Hospital | 8. Webuye County Hospital |
| 3. Cheptais Sub-County Hospital | 9. Bumula Sub-County Hospital |
| 4. Naitiri Sub-County Hospital | 10. Bokoli Sub-County Hospital |
| 5. Sinoko Sub-County Hospital | |
| 6. Kimilili Sub-County Hospital | |

**LEVEL 3 FACILITIES (55 TOTAL)**

| | |
|---|---|
| 1. Malakisi Health Centre | 27. Lwanda Health Centre |
| 2. Kimaeti Health Centre | 28. Nasusi Health Centre |
| 3. Lwandanyi Health Centre | 29. Chesikaki Health Centre |
| 4. Kopsiro Model Health Centre | 30. Sikulu Health Centre |
| 5. Bulondo Health Centre | 31. Kimalewa Health Centre |
| 6. Kabula Health Centre | 32. Makutano Health Centre |
| 7. Ndalu Health Centre | 33. Nasianda Health Centre |
| 8. Miluki Health Centre | 34. Mukhe Health Centre |
| 9. Nalondo Model Hospital | 35. Bukembe Health Centre |
| 10. Korosiandet Health Centre | 36. Luuya Health Centre |
| 11. Tongaren Model Health Centre | 37. Kapkateny Dispensary |
| 12. Mechimeru Health Centre | 38. Sango Naitiri Dispensary |
| 13. Siboti Model Health Centre | 39. Chepkube Health Centre |
| 14. Chebukutumi Health Centre | 40. Webuye Health Centre |
| 15. Kabuchai Health Centre | 41. Kibuke Health Centre |
| 16. Makhonge Health Centre | 42. Miendo Health Centre |
| 17. Chemwaa Health Centre | 43. Sacha Health Centre |
| 18. Kaptanai Health Centre | 44. Kaptama Health Centre |
| 19. Mayanja Health Centre | 45. Musikoma Health Centre |
| 20. Tuikut Health Centre | 46. Mungore Health Centre |
| 21. Milo Health Centre | 47. Bahai Health Centre |
| 22. Ngalasia Dispensary | 48. Ndengelwa Health Centre |
| 23. Karima Dispensary – Bungoma | 49. Chepyuk Health Centre |
| 24. Mihuu Health Centre | 50. Myanga Health Centre |
| 25. Kamuneru Health Centre | 51. Siritanyi Health Centre |
| 26. Muanda Health Centre | 52. Mumbule Health Centre |
| | 53. Mukuyuni Health Centre |
| | 54. Kaboywo Health Centre |
| | 55. Lungai Dispensary |

**LEVEL 2 FACILITIES (94 TOTAL)**

1. Lukhome Dispensary
2. Khachonge Community Dispensary
3. Chepkurkur Dispensary
4. Sikusi Dispensary
5. Khalala Dispensary
6. Bisunu Dispensary
7. Lukusi Dispensary
8. Luucho Dispensary
9. Machakha Dispensary
10. Namwatikho Dispensary
11. Makhonge Dispensary
12. Kubura Dispensary
13. Kibingei Dispensary
14. Lunakwe Dispensary
15. Khaoya Dispensary
16. Bukokholo Dispensary
17. Tamlega Dispensary
18. Lukhuna Dispensary
19. Kapsambu Dispensary
20. Kituni Dispensary
21. Lurare Dispensary
22. Sitikho Dispensary
23. Chebukwabi Dispensary
24. Kamasielo Dispensary
25. Nasaka Dispensary
26. Talitia Dispensary
27. Ekitale Dispensary
28. Ruanda Dispensary
29. Chemoge Dispensary
30. Kang'ang'a Dispensary
31. Mulachi Dispensary
32. Daraja Mungu Dispensary
33. Kaborom Dispensary
34. Tulienge Dispensary
35. Marigo Dispensary
36. Kolani Dispensary
37. Matisi Dispensary
38. Butieli Dispensary
39. Kamusinde Dispensary
40. Kamukuywa Dispensary
41. Kapkota Dispensary
42. Maeni Dispensary
43. Misikhu Dispensary
44. Nabukhisa Dispensary
45. Kipsabula Dispensary
46. Kapkatelio Dispensary
47. Namatotoa Dispensary
48. Makololwe Dispensary
49. Kapchebon Dispensary
50. Kimobo Dispensary

1. Bituyu Dispensary
2. Kibisi Dispensary
3. ACK Soysambu Dispensary
4. Namarambe Dispensary
5. Kitabisi Dispensary
6. Kambini Dispensary
7. Matulo Dispensary
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16. Namirembe Dispensary
17. CBM Nalondo Dispensary
18. Kakimanyi Dispensary
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20. Lukhokhwe Dispensary
21. Kongit Dispensary
22. Mwomo Community Dispensary
23. Sirakaru Dispensary
24. Chemworemwo Dispensary
25. Koshok Dispensary
26. Lukhoba Dispensary
27. Kayaya Dispensary
28. Kaimugul Dispensary
29. Chepkerer Dispensary
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31. Fuchani Dispensary
32. Samoya Dispensary
33. Kamenjo Dispensary
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35. Kongoli Dispensary
36. Sulwe Dispensary
37. Mang'ana Dispensary
38. Savana Dispensary
39. Chebweek Dispensary
40. Ranje Dispensary
41. Malinda Dispensary
42. Mukhweya Dispensary
43. Kapkeke Dispensary
44. Misemwa Dispensary

## COMMITTEE OBSERVATIONS

Out of 190 health facilities in the county, 30 are not actively transacting with SHA. The committee learned that these non-participating facilities fall into two categories: newly established facilities that are still undergoing the registration process with the KMDC, and facilities that have been suspended by SHA due to misappropriation of funds or resources.

### 3.5 SERVICES OFFERED UNDER SHA/SHIF IN BUNGOMA COUNTY

It was submitted that under SHA/SHIF, Bungoma County facilities are providing services across the Primary Care Benefit (PCB), Essential Benefits Package (EBP), emergency care, inpatient care, maternal and newborn health, chronic disease management, advanced diagnostics, and specialized services. All Level 4 and Level 5 facilities offer the full SHA benefits package, while Level 2 and Level 3 facilities deliver comprehensive primary care and outpatient services as outlined by the Social Health Insurance Act.

### Primary Care Benefit (PCB) – Services at Level 2 and Level 3 Facilities

Most Level 2 (dispensaries) and Level 3 (health centers) facilities in Bungoma offer the full PCB package, which includes:

### A. Preventive and Promotive Services

- Vaccination and immunization
- Growth monitoring & nutrition services
- Health education and community health promotion
- Family planning counselling and services
- Screening for NCDs (BP, diabetes)
- Screening for cervical cancer and breast abnormalities
- HIV testing, counselling, ART follow-up
- TB screening and referral

### B. Outpatient Medical Services

- Consultation & diagnosis
- Laboratory investigations (basic labs)
- Pharmacy dispensing services
- Wound care and minor procedures
- Management of common illnesses (malaria, URTI, diarrheal diseases, skin infections)

### C. Maternal and Child Health Services

- Antenatal care (ANC)
- Postnatal care (PNC)
- Focused maternity counselling
- Newborn follow-up
- Growth monitoring

### D. Management of Chronic Conditions (stable cases)

- Hypertension
- Diabetes
- Asthma
- Epilepsy
- Follow-up for other NCDs with referral when needed

**E. Referral Services**

- Identification and referral of complicated cases
- Pre-referral stabilization

**Essential Benefits Package (EBP) – Services at Levels 3, 4 and 5**

Higher-level facilities (Sub-County Hospitals and the County Referral Hospital) provide advanced diagnostic and curative services, including:

**A. Inpatient Services**

- General medical ward
- Pediatric inpatient care
- Maternity inpatient care
- Surgical inpatient care
- Isolation wards (where applicable)

**B. Comprehensive Maternal & New-born Services**

- Labour and delivery
- Caesarean section (at L4–L5)
- Comprehensive emergency obstetric and new-born care (CEmONC)
- New-born resuscitation and neonatal care

**C. Advanced Diagnostics**

- Full laboratory diagnostics
- Imaging services:
  - X-ray
  - Ultrasound
- Specialist diagnostic tests (L4 & L5)

**D. Emergency Care**

- Triage and emergency stabilization
- Emergency resuscitation
- Trauma management
- First aid and pre-referral care

**E. Minor and Major Surgical Procedures**

- Basic surgical procedures (L3)
- Major surgeries (L4–L5) including:
  - Appendectomy
  - Hernia repair
  - C-sections
  - Orthopaedic procedures

- Laparotomy (BCRH & some L4s)

**Specialized Care Services (Mainly at Level 4 & Level 5)**

Some facilities in Bungoma County offer specialized and high-level services reimbursable under SHA:

**A. Chronic & Specialized Clinics**

- Diabetes/Hypertension clinics
- Renal clinics
- Oncology screening clinics
- ENT, ophthalmology, orthopaedic clinics

**B. Imaging & Radiology**

- Advanced imaging
- Ultrasound and X-ray at Level 4 facilities

**C. Specialist Consultations**

- General surgery
- Obstetrics/Gynaecology
- Paediatrics
- Orthopaedics
- Internal medicine

**D. Emergency Surgeries**

- Trauma care
- Management of road traffic injuries
- Exploratory surgeries
- Emergency obstetric surgeries

**Pharmacy and Health Products Services**

All implementing facilities offer:

- Essential medicines
- Chronic disease medications
- Maternity pharmaceuticals
- Emergency medications
- Basic medical supplies and consumables

SHA reimbursements support sustained commodity availability.

**Table 3: Summary of Service Coverage across Levels**

| Service Category | L2 | L3 | L4 | L5 |
|---|---|---|---|---|
| Primary care | ✓ | ✓ | ✓ | ✓ |
| Outpatient | ✓ | ✓ | ✓ | ✓ |
| Inpatient | X | Limited | ✓ | ✓ |

| | | | | |
|---|---|---|---|---|
| Maternity | Limited | Comprehensive | CEmONC | CEmONC |
| Emergency care | Limited | ✓ | ✓ | Advanced |
| Surgery | X | Minor | Major | Full |
| Imaging | X | Basic (some) | X-ray, US | X-ray, US, CT |
| Specialist services | X | X | Partial | Full |
| Renal services | X | X | X | ✓ |

**COMMITTEE OBSERVATIONS**

1. While SHA has established clear guidelines outlining the services each health facility level should provide (from Level 1 to Level 5), implementation faces several persistent challenges. Many lower-level facilities struggle to deliver the complete Primary Care Benefit (PCB) package due to inadequate infrastructure, including limited physical space, insufficient staffing levels, and shortages of essential medicines. These capacity gaps directly impact the quality of services patients receive.
2. Human resource constraints further compound these issues. Documentation and claims processing require trained health workers, yet most Level 2 and 3 facilities operate with only a single facility in-charge who manages an overwhelming workload. This makes it nearly impossible to effectively handle both patient care and administrative responsibilities.
3. Technology presents another significant barrier. The SHA Provider Portal frequently experiences downtime and slow connectivity, which disrupts the timely submission and verification of claims. These technical problems are especially severe in rural and remote facilities where internet infrastructure is poorest.
4. Finally, geographic barriers limit service reach in certain areas. The difficult terrain in Mt. Elgon and Cheptais makes it challenging for Community Health Promoters to access and serve populations in these remote locations. Together, these challenges create substantial gaps between SHA's well-intentioned service guidelines and the reality of healthcare delivery on the ground.

## 3.6 STATUS OF REFUNDS PROCESSED UNDER SHA/SHIF IN THE COUNTY

The Department reported to have been monitoring the processing of SHA/SHIF claims and issuing regular guidance to facilities to strengthen documentation, submission, and reconciliation. Below is a claims flow analysis versus payment status for the last one year for all county public health facilities:

**Table 4: Claim Flow Analysis vs payments Table**

| Claim Category | Count (#) | Count % | Amount (KES) | Amount % |
|---|---|---|---|---|
| **Total Submitted** | 65,083 | 100% | 1,030,304,550 | 100% |
| **Total Paid** | 36,429 | 55.97% | 559,034,669 | 54.26% |
| **Total Rejected** | 6,563 | 10.08% | 120,584,352 | 11.70% |
| **Total Returned** | 2,008 | 3.09% | 61,186,654 | 5.94% |
| **Total Under Review** | 20,083 | 30.86% | 289,498,875 | 28.10% |

**COMMITTEE OBSERVATIONS**

1. Only 54.26% (KES 559,034,669) of submitted claims totaling KES 1,030,304,550 has been paid. This creates a critical risk that health facilities will exhaust their supplies and become unable to deliver services.
2. The main challenges causing payment delays include rejected claims, returned claims requiring corrections, and claims pending review. Payments are not processed within expected timelines, resulting in cash flow gaps that affect procurement of commodities and operations.
3. Poor documentation quality is a significant issue. Incomplete or inadequate clinical records lead to high rejection rates. Staffing shortages increases the problem, with insufficient records officers and trained staff available. Level 2/3 facilities often operate with only one officer-in-charge managing overwhelming workloads.
4. Clinicians and nurses must balance patient care with documentation duties, which results in documentation errors and incomplete records. Processing backlogs further delay payments, with large volumes of returned claims awaiting corrections. These re-submission delays disrupt monthly revenue flows.
5. The committee notes that these issues must be addressed urgently to ensure seamless SHA (Social Health Authority) implementation and maintain uninterrupted health service delivery.

**3.7 EXTENT OF IMPLEMENTATION OF THE FIF ACT IN BUNGOMA COUNTY**
**Hon. Speaker.**

The Facility Improvement Financing (FIF) Act, 2023 empowers health facilities to retain and utilize revenues—including SHA refunds—to improve service delivery. The department has made significant progress in operationalizing the Act across all public health facilities.

The department reported that almost all health facilities have functional FIF accounts, SHA refunds are fully integrated as facility revenue, and facilities receive AIEs to support prioritized expenditures. Governance structures, financial reporting

mechanisms, and accountability measures have been strengthened to ensure efficiency, transparency, and compliance with the Act.

### Facility FIF Accounts and Operationalization

- 99% of County Public Health Facilities Have Functional FIF Accounts
- The health facilities (Levels 2–5) now operate designated FIF bank accounts in line with the FIF Act

### COMMITTEE OBSERVATIONS

1. The department has not yet customized the FIF Act, 2023 for local use. The draft version is still pending completion of the public participation process. This delay creates operational challenges for both the Hospital Management Committees and the County Health Management Team, as they lack clear guidelines for their work.
2. The committee noted that Level 1 and 2 health facilities continue to have problems with expenditure reporting. Audit reports suggest two main issues: facility accountants may lack adequate skills, and financial records are not being fully disclosed. This inconsistent or incomplete financial reports point to a need to for accountants training and capacity

### 3.8 CHALLENGES IN IMPLEMENTING SHA/SHIF AND FIF IN BUNGOMA COUNTY

The implementation of the Social Health Authority (SHA/SHIF) reforms and the Facility Improvement Financing (FIF) Act in Bungoma County has progressed well; however, a number of challenges at policy, operational, financial, human resource, digital, and community levels continue to affect full and smooth implementation.

The Department is working with the SHA and sub-county teams to address these gaps and ensure full compliance and optimal benefit to Bungoma residents.

These challenges are outlined below.

### Policy and Regulatory Challenges

Insufficient Clarity on Certain SHA Procedures

- Frequent updates to SHA tariffs, referral rules, and preauthorization requirements cause confusion at facility level.
- Lack of harmonized SOPs for claims documentation and service categorization.

### Operational and Service Delivery Challenges

Incomplete or Poor Clinical Documentation

- Leads to high rates of claim rejections or delays.

Inadequate Preparedness at Lower-Level Facilities

- Some Level 2 facilities lack capacity to provide the full PCB package.
- Limited space, low staffing, or missing essential medicines affect service quality.

Human Resource Constraints

Shortage of Records Officers and Trained Staff

- Documentation and claims require trained HRH but many Level 2/3 facilities have only one in-charge with heavy workload.

Limited Skills on Coding, Tariffs, and Claims Management

- Staff turnover leads to loss of trained personnel.
- Frequent need for re-training on SHA guidelines.

Competing Clinical Workload

- Clinicians and nurses often combine service provision with documentation, leading to errors or incomplete notes.

Digital and ICT Challenges

- SHA Provider Portal Downtime and Slow Connectivity
  - Affects claims submission and verification.
  - Particularly problematic for rural/remote facilities.

Inadequate Digital Devices

- Many Level 2 health facilities lack desktops, laptops, or tablets.
- Shared devices slow down registration and claims submission.

Weak Internet Connectivity

- Network outages hinder real-time registration and claims processing.
- Some facilities rely on personal hotspots which are unreliable.

Financial and Reimbursement Challenges

- Delayed/Partial Refunds from SHA
  - Not all claims are paid within expected timelines.
  - Facilities experience cash flow gaps, especially for commodities and operations.
- Rejected Claims and Verification Backlogs
  - High number of returned claims with requests for corrections.
  - Re-submission delays affect monthly revenue flows.

Community-Level Challenges

- Low Awareness and Misconceptions About SHA
  - Community confusion following transition from NHIF → SHA.
  - Some households believe SHA registration is optional.

Challenges in Household Registration

- Lack of national IDs among youth and migrants hinders registration process.
- Difficult terrain in Mt. Elgon and Cheptais affects reach of CHPs.

## CHAPTER FOUR

# 4.0 COMMITTEE OBSERVATIONS AND RECOMMENDATIONS

## 4.1 COMMITTEE OBSERVATIONS

1. The department failed to provide formal instructions for implementing SHA at the county level. Health facilities received no official guidance on setting up desks, collecting data, or reporting information. Coordination teams were never formally appointed and lacked the authority and system access to do their jobs. This lack of clear direction forced facilities to create their own systems, resulting in confusion, inconsistent operations, poor coordination, and unclear responsibility across the entire program.
2. While the department in conjunction with the national government has deployed 3,590 CHPs for household SHA registration, four months of unpaid stipends (March-June 2025) remain unaddressed with no funding allocated to clear arrears, threatening to demoralize CHPs and undermine registration targets.
3. Registration desks at health facilities lack clear departmental directives and staff engagement, the intended integration of SHA registration into patient service points has failed. Additionally, health facilities receive little departmental support when engaging national SHA coordination teams, this coupled with persistent system challenges have forced some facilities to abandon digital reporting for manual methods and hard-copy documentation submissions.
4. It was observed that 30 out of 190 health facilities (16%) are not transacting with SHA—either because they are newly established and awaiting KMDC registration, or because they have been suspended due to fund or resource misappropriation.
5. With only 54% of submitted claims paid and significant processing delays, health facilities face an acute liquidity problem that threatens their ability to procure essential supplies and maintain service delivery.
6. Understaffing, particularly at lower-level facilities operating with single officers, combined with poor documentation quality creates a vicious cycle of claim rejections, resubmissions, and payment backlogs that undermines the entire reimbursement system.
7. The delayed customization of the FIF Act, 2023 has left Hospital Management Committees and the County Health Management Team operating without clear guidelines, while Level 1 and 2 facilities struggle with expenditure reporting due to inadequate accounting skills and incomplete financial disclosure.

## 4.2 COMMITTEE RECOMMENDATIONS

**Hon. Speaker, the committee made the following recommendations;**

1. **THAT,** the department should immediately develop and distribute formal, written instructions to all health facilities detailing SHA desk setup procedures, data collection protocols, reporting requirements, and coordination team composition. These guidelines must include clear role descriptions, accountability frameworks, and system access authorization to eliminate operational confusion.
2. **THAT,** the County Secretary's office should endeavor to clear CHPs stipend arrears for the four months of outstanding CHP stipends (March-June 2025) and maintain a budget line with automatic monthly disbursements to prevent future arrears and maintain workforce motivation for achieving household registration targets.
3. **THAT,** the CECM-Health Services to issue mandatory directives requiring facility managers to staff SHA registration desks, assign the department's SHA coordination team as designated support contacts for facilities, and deploy technical teams to resolve persistent system issues driving facilities back to manual processes.
4. **THAT,** the department should fast-track facility credentialing and KMDC registration for the 30 non-transacting facilities while simultaneously conducting compliance audits and remediation plans for suspended facilities to restore their operational status within (60) days from the date of adoption of this report
5. **THAT,** where applicable, the department should deploy additional staff to single-officer facilities. In addition, it should conduct intensive training on proper claims documentation for all facility personnel, and assign dedicated claims support officers at sub-county level to review submissions before final lodging to reduce rejection rates.
6. **THAT,** the department to expedite on the formulation of the Bungoma County FIF Bill within (60) days after adoption of this report and ensure the approval by the County Assembly and distribution to streamline operational challenges.
7. **THAT,** the department to provide refresher accounting training and simplified reporting templates to Level 1 and 2 facilities to improve financial management and transparency.

## ADOPTION SCHEDULE

**Hon. Speaker,**

We the members of Health Services hereby append our signatures adopting this report with its recommendations

| No. | NAME | SIGNATURE |
|---|---|---|
| 1. | Hon. George Makari | |
| 2. | Hon. Jerusa Aleu | |
| 3. | Hon. Joan Kirong | |
| 4. | Hon. Meshack Simiyu | |
| 5. | Hon. Vitalis Wangila | |
| 6. | Hon. Ali Machani | |
| 7. | Hon. Miliah Masungo | |
| 8. | Hon Tony Barasa | |
| 9. | Hon. Jeremiah Kuloba | |
| 10. | Hon. Jack Wambulwa | |
| 11. | Hon. Grace Sundukwa | |
| 12. | Hon. Wafula Waiti | |
| 13. | Hon. Orize Kundu | |
| 14. | Hon. Jacob Psero | |
| 15. | Hon. Dorcas Ndasaba | |