REPUBLIC OF KENYA

GOVERNMENT OF MAKUENI COUNTY

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MUTULACARE

THE MAKUENI UNIVERSAL HEALTHCARE IMPLEMENTATION GUIDELINES

AUGUST 2025

Accelerated Achievement of HealthCare for All

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

CHP - Community Health Promoter

CRP - Community Resource Person

HPT - Health Products & Technologies

KIHBS – Kenya Integrated Household budget Survey

PHCF – Primary Health Care Fund

SHA - Social Health Authority

SHIF – Social Health Insurance Fund

UHC- Universal Health Coverage

YSSS – Youth, Sports and Social Services

1.0 INTRODUCTION

The Makueni Universal Healthcare Coverage(UHC) is a County health financing initiative, designed to provide access to quality healthcare services for Makueni County residents while protecting them from financial hardships arising from out-of-pocket health expenditures.

The Makueni Universal Healthcare commonly known as *MutulaCare,* is a new scheme aligned to the national Social Health Authority (SHA) framework and which will provide Universal Health Coverage for vulnerable and indigent households in Makueni County. Beneficiaries will receive comprehensive care, including inpatient and outpatient services, dental and optical care, chronic illness management, and emergency treatment. Under the *MutulaCare* program, all other residents in the County will be mobilised to register into SHA and pay for Social Health Insurance Fund (SHIF). By doing so, *MutulaCare* will ensure that no resident is left behind in the journey towards UHC thereby enhancing sustainability, equity and improved health and economic outcomes.

Under the existing national framework, SHA has not rolled out social protection for vulnerable and indigents thereby worsening their access to healthcare, even though they are the cohort that needs health services the most. The *MutulaCare* program will issue a Mutula card, which will be portable to facilitate services to both private and public facilities and also outside the county. This will enable beneficiaries to enjoy high quality services from an array of providers empanelled by *MutulaCare* framework.

1 OVERVIEW OF THE MAKUENI UHC AND HEALTH STATUS

1.1.1 The Pilot Makueni Universal Health Care

In May 2016, the Government of Makueni County launched a pilot universal healthcare program targeting residents aged 65 years and above. The six-month pilot informed the design of a countywide scheme, which was officially rolled out on 1st October 2016. Under the scheme, households headed by individuals below 65 years paid an annual registration fee of Kshs. 500, while those aged 65 and above registered for free. The program aimed to enhance equitable access to healthcare, ensure financial protection, and deliver high-quality services to Makueni residents.

The County provided a package of essential curative, promotive, and rehabilitative healthcare services at no cost to registered members across all hospitals within the county. The hospitals under the program invoiced the County government monthly for reimbursement of incurred costs.

Between 2019 and 2022, two independent evaluations were conducted on the scheme. While the reports highlighted notable successes, several challenges emerged. From inception, the scheme suffered from adverse selection, as many members enrolled only when seeking care, undermining the principle of risk pooling. The renewal rate for annual registration fees remained low resulting in insufficient premium collections to sustain the scheme. Additionally, specialized services remained uncovered, often forcing residents to pay out-of-pocket. By the end of the 2020/21 financial year, pending hospital reimbursements had

reached Kshs. 203,395,239.20. Budgetary allocations to the scheme also declined significantly, from Kshs. 250 million in FY 2017/18 to Kshs. 70 million in FY 2024/25.

Many facilities relied on the scheme reimbursements to hire contract staff, procure essential supplies and improve facilities infrastructure. The scheme's instability therefore negatively impacted service delivery and quality of care.

The hospitals faced raising debts and waivers for vulnerable and indigent persons unable to pay their medical bills. Last financial year, registered waivers was Kshs. 46,000,000, making it unsustainable for an already stretched county revenue.

The MakueniCare scheme was thus bedevilled with a financially unsustainable health benefit package making it difficult to maintain the program's intended impact due to a high operational cost leading to debt accumulation. While the scheme was strong secondary care, it had a weak referral system thereby weakening primary health care which is the linchpin of accelerating achievement of the UHC.

1.1.2 The National Universal Health Coverage

Administered by the Social Health Authority (SHA), the national universal health coverage comprises of three funds namely; the Primary Healthcare Fund, the Social Health Insurance Fund (SHIF) and the Emergency, Chronic & Critical Illness Fund. While the Primary Healthcare Fund is financed by national government. The other two funds are financed by user fees, grants, county or national government and donations. There is mandatory registration for all Kenyans and long-stay non-Kenyans. Salaried workers pay via payroll deductions; others contribute through means-tested annual payments while the government is expected to pay for vulnerable and indigent members. It is worth noting however that enrolment is still low at an estimated 40% nationally while standing at 31% for Makueni County. Further, the National government has not yet rolled out the enrolment for the vulnerable and indigent members.

1.1.2.1 Primary Healthcare Fund

The fund covers primary and preventive services in Levels 1–3 and is accessible to all registered members of SHA. Benefits include outpatient and inpatient care, screening, and optical services. Outpatient services cover management of acute and chronic conditions, mental health, ANC and PNC services. Optical services include eye tests and treatment for refractive errors. Inpatient care includes consultation, bed and nursing charges, lab tests, medication, and physiotherapy.

1.1.2.2 Social Health Insurance Fund

Accessible to paid-up SHIF members at higher-level facilities (Levels 4–6). Benefits include outpatient and inpatient care, maternity and child health, renal care, mental wellness, surgical and oncology services, diagnostics and overseas treatment.

1.1.2.3 Emergency, Chronic, and Critical Illness Fund

The fund offers financial protection for emergencies and chronic conditions once SHIF coverage is expended. Benefits include ambulance evacuation, accident and emergency services, chronic illness care, assistive devices, Critical illness care, and Palliative care.

1.2 Makueni County Health status

The burden of non-communicable diseases (such as diabetes, hypertension and cancer) and communicable diseases remain a priority given that they contribute significant morbidity and mortality within the County.

1.2.1.1 Trends and disease burden

The trends and disease burden is as summarised below;

Table 1: Top five conditions -under fives

Dataname	2021	2022	2023	2024
Upper Respiratory Tract Infections	166,879	136,168	151,923	151,186
Disease of the skin	28,553	27,955	30,839	32,507
Diarrhoea with no dehydration	26,448	26,798	31,015	26,732
Pneumonia	17,462	14,855	16,702	18,059
Tonsilitis	11,676	10,713	10,984	10,815

Table 2: Top five conditions - over fives

Dataname	**2021**	**2022**	**2023**	**2024**
Upper Respiratory Tract Infections	353,554	292,277	350,708	333,595
Urinary Tract Infection	98,052	90,097	96,529	160,583
Hypertension	76,681	87,697	93,043	76,180
Disease of the skin	97,281	86,154	97,409	92,676
Arthritis, Joint pains etc	86,178	74,319	79,697	70,558

Table 3: Non-Communicable Diseases

Dataname	**2021**	**2022**	**2023**	**2024**
Hypertension	76,681	87,697	93,043	76,180
Arthritis, Joint pains etc.	86,178	74,319	79,697	70,558
Diabetes	23,469	25,562	24,577	25,021
Neoplasms	337	478	545	514

Table 4: Other Health indicators

	Indicator	KDHS 2022		2024
		County	National	
Child Health	Under five mortality rate (per 1,000 live births)	38	41	41
	Children 12-23 months old fully immunized	82%	80%	77
	Neonatal Mortality rate (per 1,000 live births)	26	21	21
Maternal Health	Maternal mortality rate (per 100, 000 live births)	355	479	479
	Births delivered by a skilled provider	92%	89%	70
	Mothers having more than 4 ANC visits	76%	66%	51
	Use of modern method of FP	64%	57%	42
Public Health	Household population with basic sanitation service	46%	41%	49
	Household population with access to at least basic drinking water service	46%	68%	64
Nutrition	Children under 5 who are stunted (%)	20%	18%	20
	Children under 5 who are underweight (%)	9%	10%	8.7
	Children under 5 who are wasted (%)	4%	5%	4
	Children under 5 who are overweight (%)	3%	3%	5

This health status underscores the urgent need to design and implement a county universal health coverage to ensure that all residents can access high-quality health services without facing financial hardship.

1.3 Problem Statement

Makueni County continues to face significant challenges in achieving universal access to quality and affordable healthcare. The county bears a high burden of both communicable and non-communicable diseases, including respiratory infections, diarrheal diseases, hypertension, diabetes and maternal health complications. These health issues disproportionately affect vulnerable populations in rural and remote areas where access to timely and adequate healthcare remains limited.

With Makueni's poverty index at 39.2% (Kenya Economic Survey, 2024), residents are at risk of impoverishment and catastrophic health expenditures. Many households cannot therefore afford out-of-pocket healthcare expenses. Despite the rollout of the national Social Health Authority (SHA) and its promise to deliver comprehensive health coverage, Makueni's registration to the SHA remains critically low at just 31%, far below the national target. This low uptake is particularly evident among indigent and vulnerable households who

either lack information, digital access, or means to contribute under the current means-testing model.

SHA has not rolled out social protection for vulnerable and indigents thereby worsening their access to healthcare, even though they are the cohort that needs health services the most. This has created a protection gap that leaves a large portion of the county's most vulnerable citizens without financial risk protection or access to essential healthcare services.

The above challenges necessitate a county-led universal health coverage program to complement and bridge the gaps in the national SHA framework. A localized initiative will enable Makueni to directly identify and cover vulnerable households through community structures, ensure targeted subsidies, and leverage the county's experience from the MakueniCare model to accelerate UHC outcomes. This program is critical not only for improving health outcomes but also for reducing poverty-related vulnerabilities and ensuring equity in access to healthcare.

2 OVERVIEW OF THE *MUTULACARE* UHC SCHEME

The *MutulaCare* is designed to advance the realization of Universal Health Coverage (UHC) for residents of Makueni County by paying SHIF for over 18,000 indigent and vulnerable households and also mobilisation of the whole population to register to SHA while educating residents on the benefits of SHIF. As at July 2025, SHA registration coverage in Makueni County stands at 31%. Through the implementation of *MutulaCare*, the County Government aims to achieve over 50% SHA enrolment.

2.1 Legal Framework

The *MutulaCare* program is supported by a comprehensive legal and policy framework at both national and county levels, ensuring equitable access to healthcare for marginalized populations. It is grounded in the Constitution of Kenya, 2010, which guarantees the right to health and social protection, and is further reinforced by the Social Health Insurance Act, 2023, which mandates universal health coverage with provisions for subsidizing indigent individuals. The County Governments Act, 2012, and the Makueni County Health Services Act, 2018, provide the administrative and legal basis for county-led health initiatives, including the establishment of a County Health Fund. Additionally, the Makueni Health Policy, 2020, and the Social Protection Policy, 2024, requires the county to implement social health protection mechanisms and strengthening health and nutrition programs. Together, these instruments ensure that the program is not only legally compliant but also aligned with the broader vision of inclusive, rights-based healthcare.

2.2 Goals and Objectives

Goal: To ensure all residents of Makueni County have equitable access to quality and affordable healthcare without suffering financial hardship. The specific objectives are;

a) To achieve over 50% SHA registration in Makueni County.
b) To strategically pool and mobilize resources for sustainability of health programs.
c) To improve health outcomes by expanding access to quality healthcare.
d) To align with national healthcare financing reforms.

2.3 Scope

MutulaCare initiative will be implemented across all 30 wards in Makueni County and will focus on the following key areas:

1. **Identification and Enrolment of vulnerable and indigent households**: The activity will include Mapping, identifying, and registering indigent and vulnerable persons to SHA and SHIF supported by the County Government.
2. **Community Mobilization for SHA Registration**: Countywide mass registration and sensitization campaigns to increase SHA uptake to more than 50%
3. **Health Facility Integration**: Public health facilities will identify indigent and vulnerable persons for enrolment to *MutulaCare*.

3 IMPLEMENTATION PLAN

3.1 Financing and Resource Mobilization Strategy

The projected indigent households in Makueni County are over 100,000 based on the Kenya Integrated Household Survey (KIHBS 2015/16). There are two options available for SHIF payment for indigents and vulnerable households. These include; **Kes 880** monthly per household for fully sponsored households while the other option is means testing approach at a base rate of **Kes. 600.** The estimated resources required to register all indigent households under the *MutulaCare* Program is **Kshs. 1.056 billion**, based on a fully sponsored option of Kshs. 880 per household. Alternatively, if a means-testing approach is applied to determine eligibility at an average base rate of Kes.**600,** the projected cost reduces to **Kshs. 720 million.** Given the two options the county government will pursue the option of means testing at average the base rate of kes. 600.

Due to prevailing economic constraints and the need to uphold fiscal responsibility, phase one of the program has been allocated a budget of Kshs. 90 million under the wards (kes. 3 million per ward) and another Ksh. 5 million at the department. From the total budget of Ksh.95 million, **Kshs. 15 million** will be allocated for capacity building of Community Health Promoters (CHPs) and Community Resource Persons (CRPs), identification of indigent and vulnerable households for SHA registration, mass mobilisation of Makueni residents and development of an online system for indigents and vulnerable households registration. The balance of Kshs. 80 million will be directed to paying SHIF for indigent and vulnerable persons' households. Under the means-testing with an average base rate of kes. 600, a total of **11,100** indigent households in the county will be registered translating to **370** households' heads per ward. Under phase 1 of Mutulacare, the county plans to cover **18,000** indigents and vulnerable households at **the** average base rate of Kes.600, with a projected cost is **Kshs. 129.6 million.** The county Assembly will therefore require to allocate an additional estimated **kes. 49.6 million** to ensure that all the 18,000 indigents and vulnerable households are covered under SHIF. Each ward will therefore be required an additional kes. 1,653,333million to cover the budget deficit.

3.1.1 Sources of Funds

a. Funds appropriated by the County Assembly for *MutulaCare*.
b. Ring fence at least 10% of Health Facilities' SHA reimbursement to *MutulaCare*.
c. Funds received from development partners, donations, and public-private partnerships.

3.1.2 Makueni County and Social Health Authority Agreement:

The Government of Makueni county will enter into an agreement with SHA for the provision services to vulnerable and indigent persons enlisted for SHIF by Makueni County through the *MutulaCare*.

3.2 Registration of general population and Indigents to SHA

Using social mobilization plan, combinations of interventions; radio talk shows, Market activations, Church announcements and community education strategy will be used to reach

all the residents of Makueni for uptake of the program. All residents will be enrolled to SHA either for PHCF which is free or & SHIF if the residents are able to pay.

3.2.1 Registration of Makueni Residents for SHA and SHIF

3.2.1.1 General Criteria for Residents Registration to SHA

a) Must be a Kenyan Citizen
b) Must be a Makueni County resident.
c) Non-residents must provide proof of continuous residency for a minimum of three (3) years (official confirmation from the area chief and ward administrator).
d) Must provide a Mobile phone number for the household head.

3.2.1.2 Indigents and Vulnerable Households Identification and mass registration

a) Community Health Promoters and Community Resource Persons will carry out mass registration targeting at least 30 residents per CHP or CRP out of which at least 6 will be indigents or vulnerable households
b) During the mass registration, the community will be given an opportunity to propose indigents and vulnerable households for county sponsorship to SHIF.
c) Health facilities will be requested to provide list of residents who have been seeking waivers due to inability to afford the out- of –pocket expenses
d) The county will also consider the list of vulnerable households in Makueni County on *Inua Jamii* by national government
e) The whole list of identified vulnerable and indigent will be submitted to the e-platform dubbed *MutulaCare* information management system which will generate and prioritise the list of indigents and vulnerable households.

3.2.1.3 Validation of indigents

a) The selection will be done by proxy means test (PMT) where a score of 0 is richest while a score of 10 is poorest, this will enable ranking where a score of above or equal to 5.0 is a cut off for qualification to be an indigent and vulnerable
b) Preliminary lists of beneficiaries as generated by the PMT tool for each ward will be submitted to the ward vetting committees for validation.
c) Cases of disputed names shall be communicated to the County coordination committee.

3.2.1.4 Enrolment of indigents into SHA

a) The validated list of indigents will be submitted to SHA for approval and registration
b) The approved list will be send back to the county government for the payment of premiums.
c) In collaboration with the County, SHA will create a sponsor code within their system and support the County Government in generating a payroll reference number (PRN) to facilitate premium payments
d) Indigents and vulnerable persons whose SHIF premiums have been successfully paid will be issued with a *MutulaCare* Card.

3.3 Health Benefits Package

MutulaCare will provide access to an essential healthcare benefits package to beneficiaries in line with the Social Health Insurance Act and its implementing regulations.

Beneficiaries will be entitled to services under the Primary Healthcare Fund, the Social Health Insurance Fund, and the Emergency, Chronic, and Critical Illness Fund, as outlined in the Second, Third, and Fourth Schedules of the Social Health Insurance Regulations.

3.4 Service Delivery Model

Services will be accessible through all SHA-contracted facilities from the primary to county and national referral levels, giving priority to public health facilities. Primary healthcare (PHC) will serve as the foundation, offering promotive and preventive services and acting as a gatekeeper to secondary and tertiary care. This approach will reduce unnecessary referrals and manage costs while ensuring people-centered care. Facilities will follow national clinical guidelines and referral protocols. Beneficiaries for *MutulaCare* will also have access to services beyond Makueni County.

3.5 Monitoring and Updating the Register

The beneficiary register will be reviewed and updated annually to reflect changes such as residence, deaths, or insurance status, ensuring accurate and up-to-date records.

7.0 Risk Pooling and Sustainability Strategy

a) Mass SHA registration and means testing.
b) Adopt guidelines and regulations to ensure only genuine indigents and vulnerable households
c) Allocate at least 40% of SHA reimbursements for Health Products and Technologies (HPTs).
d) Allocate at least 10% of Health Facilities' SHA reimbursement to *MutulaCare*.
e) Allocate at least 50% of SHA reimbursements for operations and equipment
f) Progressive ward budgetary allocation to the program.
g) Develop/review the existing legal framework to embed *MutulaCare*.
h) Enhance partnership collaborations towards the support of the *MutulaCare program.*

3.6 Institutional framework

3.6.1 Composition of *MutulaCare* Committees

The roll out and implementation of the program shall be undertaken under the framework of the following committees with the composition as below:

3.6.1.1 Steering Committee

a) CECM Health Services- Chairperson
b) Chief Officer Health Human Resource Management and Administration - Secretary
c) CECM Finance, Planning, Budget and Revenue
d) CECM Gender, Children, Youth, Sports and Social Services
e) CECM ICT, Education and Internship

f) CECM Devolution, public participation, county administration and Special programs
g) County Attorney

3.6.1.2 County Coordination Committee

a) Chief Officer Health Human Resource Management and Administration- Chairperson
b) Director Health Services-Secretariat
c) Chief Officer Health Services-Member
d) Chief Officer Gender, Children & Youth, Sports & social services
e) Chief officer Social Economic Planning, Budgeting, Monitoring &Evaluation-Member
f) Chief Officer Financial Services-Member
g) Director Gender and Social Services-Member
h) Director ICT-Member
i) Director Administration-Member
j) Office of the County Solicitor-Member
k) County Commissioner Representative-Member

3.6.1.3 Sub-County Coordination Committee

a) Sub-County Administrator-Chairperson
b) Sub-County Medical Officer of Health-Secretary
c) Sub-county Social Development Officer- Member
d) Sub-County Civic Coordinator-Member
e) A representative of the County Commissioner in the Sub-County

3.6.1.4 Ward Vetting Committee

a) Ward Administrator-Chairperson
b) Ward Development Officer-Secretary
c) Social Development Officer-Member
d) Village administrators-(2)-Members
e) Community Health Assistants (2)-Members
f) Representative of NGAO

3.6.1.5 Service delivery Committee

To ensure quality service delivery for all residents in the county registered under the Mutulacare program, a service delivery committee has been established. The committee will ensure that beneficiaries are linked to suitable health facilities in the county and beyond an need arises. The service delivery committee will comprise the following members;

Designation	Role
Chief Officer Health Services County Director of Health Services	Chairperson
Head, County SHA Coordinator	Secretary
Director Health Products and Technologies	Member
Rep Department of Finance	Member
Monitoring & Evaluation Officer	Member
Rep from Governor's Delivery Unit	Member
Rep Medical Superintend	Member
Rep Medical Officer of Health	Advisory
Rep ICT	Data verification
Rep from SHA	Co-opted
Rep Development Partners	Co-opted

3.7 Implementation Approach

The county coordination committee will develop the *MutulaCare* implementation guidelines under the guidance of the county steering committee. After the guidelines and training materials are approved, the county coordination committee will divide themselves into groups of 2- 3 members, with each team being allocated to a sub county for the training on the *MutulaCare* program. The trainings will be conducted concurrently coordination committee in all the six Sub-Counties, with supervision from the county steering committee. After the sub county coordination committee are trained, they will divide themselves into groups of 2-3 and proceed to train the ward vetting committees. The ward vetting committees will also divide into groups of 2- 3 and proceed to train an estimated CRPs and CHPs. Trainings for CHPs and CRPs will be undertaken at the zone level with each ward being divided into 4 zones to ensure a fair regional representation in program outreach.

After the CHPs and CRPs are trained, the will be mapped to villages and households to ensure full coverage. The CHPs and CRPs will have one day for massive registration targeting to register an estimated 60,000 households with each CHP/CRP having a target of 10 households registered out of which at least 4 will be vulnerable or indigents households. After the one-day massive registration, the CHPs will continue to register residents to SHA.

Households will be enrolled to the *MutulaCare* program and SHA by CHPs & CRPs and supervised by the ward vetting committees. This will be superintended by Subcounty implementation committee at the Sub-County level. For seamless operation, there will be a coordination committee at the county level reporting to the steering committee which will provide overall direction to the rollout of *MutulaCare* program. The table below shows the

stepwise approach to the Indigents identification and community mobilization for SHA registration.

3.8 Risk Management

The program has inherent risks that require mitigation to improve risk tolerance and enhance sustainability. The established risk profile is as below:

	Risk description	Impact	Risk Level	Mitigation measures	Risk owner
A. Financial					
1	Delayed exchequer disbursements	Debt accumulation	High	- Piloting in phase 1 - External resource mobilization - GovT-to-govT procurement - Framework contracts	Chief Officer HHR & Admn
2	Delayed SHA reimbursements	Debt accumulation	High	- County budget supplementation - Timely claim processing - External resource mobilization - Continuous SHA engagement	CO HHR & Admn
3	Referral of patients to private clinics from public	Loss of revenue	Medium	- Revamp healthcare supply side	CO HHR & Admn
4	Fraudulent claims	Revenue loss	Medium	- Enforcing SHA regulations - Public awareness	CECM Health
B. Operational					
1	Sub optimal quality of care	Unsustainability (Higher utilization in private health facilities)	High	- Revamping healthcare supply side - Operationalize committee on service delivery	CO HHR & Admn
2	Appeals for inclusion	Low uptake	Medium	- Public disclosure of the beneficiary list/ Community - Vetting at the sub ward level	CECM Health
3	Violating data protection rights	Delayed roll out	High	- Seeking consent for sharing personal data on the ICT	CECM Health
4	Lack of ID	Low program uptake	Medium	- National ID issuance campaigns	CECM Health
5	Induced demand	Low program impact	Low	- Enforcing SHA regulations - Community sensitization	CECM Health

C. Strategic					
1	Political interference	Low uptake	Medium	- Community sensitization/public participation - Stakeholder engagement	CECM Health
2	SHA exclusions	Low uptake	Medium	- County budget supplementation - External resource mobilization	Chief Officer HHR & Admn
3	Poor healthcare utilization by indigents	Low program impact	Low	- Health promotion - Advocacy	CECM Health
4	Low SHA registration	Program unsustainability	High	- Mass registration drives - County budget supplementation - Buy-in by the political class - Facilitating CHPs	CECM Health
5	Delayed ICT integration into HMIS (Tiberbu)	Low real-time monitoring and validation	High	- Requesting technical support from DHA	CECM Health
6	Introduction of SHA registration waiting period	Low uptake	Low	- County budget supplementation - Community sensitization - Fast track program implementation	CECM Health
7	Change of political administration	Collapse of the program	Medium	- Policy reviews for continuity	CECM Health
8	Delayed communication	Low uptake	High	- Defining & executing proper communication channel	CECM Health
9	Low Stakeholder support	Low program uptake	Medium	- Continuous stakeholder engagement - Political buy-in	CECM Health
10	Inequitable indigent enrolment	Sub optimal impact	Medium	- Stringent indigent identification criteria - Reviewing and updating indigents register - Political support	CECM Health

11	Nonresident indigents	Sub optimal impact	Mediu m	- Health facility supported enrollment	CECM Health

Table 5: TOR's/ Responsibilities				
Key Activity	Sub Activity	Where	Participants	Outputs
Planning phase	implementatio n Framework	County Level	Steering Committee	Harmonise county and national legal framework on UHC implementation Provide strategic direction to the implementation of the program Oversight the implementation of the program Approve training materials Advocate resource allocation to the program Recommend approval/amendment of guidelines to cabinet Sensitize stakeholders including County Assembly Committee on Health Publicise the program to community
	County Planning meeting	County *Level*	County Coordination Committee	Develop guidelines for identification of indigents, vulnerable households and general community mobilization strategy to SHA registration -Develop training content for various Implementation teams - Divide into groups (2-3) for concurrent training in each of the 6 sub counties
	Sub county Planning Rollout	Sub county level	Sub-County committee	Training from county coordination committee on *MutulaCare* implementation plan Divide into groups (2-3) for ward level

Table 5: TOR's/ Responsibilities				
Key Activity	Sub Activity	Where	Participants	Outputs
				trainings Schedules for ward level trainings Steering committee supervises
	Stakeholder sensitization	County Level	Steering Committee	Create awareness on the *MutulaCare* program to County Assembly Committee on Health and partners Radio talk shows to publicise the program-
	Ward planning	Ward level	Ward vetting committee	Training from Subcounty committees on the *MutulaCare* implementation - including SHA program, means testing approach, indigents and vulnerable households' identification. Divide into groups (2-3) for CRPs and CHPs trainings Identify 4 zones per ward where trainings will be conducted Mapping of suitable CRPs and CHPs County coordination committee supervises
	Training of CRPs and CHPs	Zone level	Ward vetting committee	training to understanding of; SHA registration, Means testing, Identification of indigents and vulnerable HHDs, Reporting mechanism Mapping of the CRPs and CHPs to villages and HHs for program implementation Mobilise villages to identified venues for registration Target of 30 per CRP/CHP of which at least 6 will be indigents of vulnerable HHs Subcounty teams supervise
Registration	Mass	Village	CRPs and	Register at least 30 per CRP/CHPs to SHA

Table 5: TOR's/ Responsibilities				
Key Activity	Sub Activity	Where	Participants	Outputs
to SHA	registration	and Household Level	CHPs	of which at least 6 will be indigents of vulnerable hhds in one (1) day Identified Indigents forwarded to both SHA and County portal Select indigents based on PMT and regional representation per ward Share report of residents registered and identified indigents NGAO makes application for residents without IDs
	Facility registration	Health facilities	Health Facility managers	Submits list of indigents/ vulnerable households based on waivers
	Registration to SHA	Household level	CHPs	Continuous registration of residents to SHA for 10 days
Registration to SHIF	Selection of indigents	County level	Coordination Committee/ICT	Selects indigents and Vulnerable households for submission to SHA depending on CHP/CRP and health facility registration
	Verification	Ward Level		Ward vetting committee confirms identified indigents and vulnerable households are from the ward and ensures regional representation
	Cabinet approval	County	Steering Committee	CECM presents list of identified indigents and vulnerable hhds to Steering Committee and Cabinet
	SHA approval	SHA	Coordination Committee	List of identified indigents submitted to SHA for approval
	registration to SHIF	County	-Finance - ICT	Payment for indigents Printing of cards
Launch	Launch of program	County	Steering Committee	Launch of the *MutulaCare* program Issue cards to some beneficiaries

Table 5: TOR's/ Responsibilities				
Key Activity	Sub Activity	Where	Participants	Outputs
Rollout	Quality of service delivery	County	Service delivery implementation committee	Ensure quality, timely and people centred health services to all Mutulacare beneficiaries Monitor and report on service delivery at public health facilities serving SHA beneficiaries Provide technical and policy advise to the CECM Health services and implementation and improvements Monitor and track progress on coverage targets for the over 50% SHA registered households and service utilization by beneficiaries

3.9 ICT Integration Process for *MutulaCare* Implementation

The objective is to leverage ICT to enhance *MutulaCare* beneficiary management, data-driven decision-making, and financial accountability.

3.9.1 Key ICT Integration Components

3.9.1.1 Digital Beneficiary Registration System

- **Function**: Enable secure capture, validation, and storage of indigent beneficiaries' details.
- **Features**:
  - Mobile-friendly interface for field use at ward and facility levels.
  - Geolocation tagging and ward mapping.
  - Generate *MutulaCare* card.

3.9.1.2 Real-Time Monitoring Dashboard

- **Function**: Provide real-time insights into program coverage, usage, and financial flows.
- **Key Indicators**:
  - Total number of indigent households registered both at facility and community levels (daily, weekly, cumulative).
  - Registrations by sub-county, ward, gender, age group, vulnerability category.
  - Claims raised per facility
  - Claims paid per facility.
  - Out-of-Pocket Spending
  - Facility-specific waiver approvals and rejection rates.

- Heat maps for underserved areas.

3.9.1.3 Facility-Level ICT Tools

- **Function**: Streamline waiver approvals and claims processing.
- **Tools to Deploy**:
  - *Waiver/Vetting module* embedded in facility HIS (Hospital Information System).
  - *Claims Submission Portal* with audit trail capability.

3.9.2 ICT Integration Process – Step-by-Step

Phase	Activity	Responsible
Phase 1: System Design & Architecture	Define technical architecture, system requirements	Directorate of ICT
	Develop and customize the enrollment module for *MutulaCare*	ICT Technical Team
Phase 2: Platform Development	Develop the beneficiary registration portal and dashboard backend	ICT Development Team
	Design and embed vetting/waiver workflows at the facility level	ICT + Health Facility Leads
Phase 3: Testing	Conduct user testing with gender officers and facility clerks	ICT + Dept. of Health
Phase 4: Countywide Deployment	Train ward-level registration teams and health facilities	ICT + Health
	Go-live for Mutula Care Registration & Dashboard	ICT Directorate
Phase 5: Post-Go live Support & Monitoring	Continuous system monitoring, bug fixes, data quality assurance	ICT Support Desk

3.9.3 Digital Inclusion Measures

- Provide USSD access for basic services like verification and complaint submission (this will be a post-launch consideration)
- Deploy devices (tablets/smartphones) to underserved wards.

3.9.4 Data Protection & Governance

- Ensure all ICT tools comply with the **Data Protection Act, 2019**.
- [Post-Launch] Conduct Data Protection Impact Assessment (DPIA).
- Define roles for data access, storage, and audit.
- Enforce end-to-end encryption and secure hosting on county-approved cloud or data center.

3.9.5 ICT Budget and Resource Requirement

- Development
- Testing, training, devices, and user support

4