Strengthening and Sustaining County Performance Management Processes for Primary Health Care

3RD Bi-Annual PHC Peer-Learning Workshop

Nakuru County and Trans Nzoia County, Kenya
Victoria Comfort Inn, Kisumu County | 5–6 August 2026

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Acronyms

CEC	County Executive Committee
CECM	County Executive Committee Member
CDH	County Director of Health
CHMT	County Health Management Team
CHP	Community Health Promoter
DHIS2	District Health Information System 2
EMR	Electronic Medical Record
EmOC	Emergency Obstetric and Newborn Care
FIF	Facility Improvement Fund
HDU	Health Delivery Unit
HPT	Health Products and Technologies
HRH	Human Resources for Health
HRIO	Health Records and Information Officer
ICCM	Integrated Community Case Management
MDT	Multidisciplinary Team
MNCH	Maternal, Newborn and Child Health
PCN	Primary Care Network
PHC	Primary Health Care
SHA	Social Health Authority
UHC	Universal Health Coverage

Executive Summary

The 3rd Bi-Annual Primary Health Care (PHC) Peer-Learning Workshop was convened by the county health departments of Nakuru and Trans Nzoia, in collaboration with Hecta Consulting and with the support of the Gates Foundation. It brought together county health leadership, facility managers, community representatives and implementing partners for two days of reflection on PHC Performance Management (PHC PM). Hosted in Kisumu County, the workshop marked the close of the current phase of the Hecta-supported engagement, examining what county teams have achieved, what should be sustained, and how.
The workshop opened with remarks from Kisumu's CECM for Health, the Gates Foundation, and the CECMs for Health of both participating counties. Day 1 then moved through the project's endline evaluation findings, panel discussions on outputs and outcomes, and a community-voices plenary. Day 2 turned to sustainability with a structured reflection on what each county intends to keep, adapt or trade off as the project transitions towards its close.

Key Themes and Insights

1. **Overall improvement in PHC performance capacity.**

- Composite PHC performance capacity across both counties rose from 67.3% at baseline (February 2025) to 78.6% at endline (June–July 2026); the largest gains were in health financing (+25.7 points), Electronic Medical Record (EMR) functionality (+18.9 points) and MDT functionality (+15.9 points).
- Facility-level financial autonomy, individual facility budgets, Social Health Authority (SHA) claims management and Facility Improvement Fund (FIF) utilisation were repeatedly named as a catalytic lever for service delivery in both counties.

2. **Dashboard as a catalyst for accountability**. Both counties described the dashboard the same way: not a driver of change on its own, but a catalyst that works once paired with regular leadership review and clear escalation pathways to county executive committees and governors.
3. **Domestic financing shift toward PHC.** Trans Nzoia's SHA facility contracting rose from roughly 14% to 40%, and Nakuru's health budget allocation rose from roughly 26% to over 30%.
4. **The human stakes behind the data.** A community-voices session grounded the data in lived experience, firsthand testimony from a mother navigating severe financial and access barriers to maternal and child care, a young mother's experience of teenage pregnancy and a Community Health Promoter’s (CHP's) role in keeping her in school, and the session moderator's own reflection on loss.
5. **Partner coordination.** Partners, including AMPATH, AMREF, Jacaranda and Deloitte, flagged the need for closer coordination among themselves to avoid duplicated dashboards and competing demands on county teams' time.

Commitments and Next Steps

Both counties committed to keeping their internal data review meetings on the standing agenda of existing county health management structures. They also committed to retaining the clear escalation pathway and to formalise the small cross-departmental core team that coordinates both, rather than treating any of this as dependent on Hecta's continued involvement. For their part, the Gates Foundation and other partners signalled they intend to remain engaged with both counties, though the shape of that support is likely to change as the project transitions to its next phase.

Opening and Keynote Addresses

The workshop opened with introductions from the Trans Nzoia and Nakuru county teams, led by Bernard Lugah (County Health Multisectoral Coordinator, Nakuru County). Followed by welcome remarks from Kisumu's CECM for Health, the Gates Foundation and the leadership in both participating counties.

Hecta Consulting. As project lead, Mike Mulongo traced the project to a founding question: could data inform decision-making in Primary Healthcare (PHC) from the facility level up to the Governor's office, with accountability flowing back from the community? The project had deliberately departed from how most donor-funded work is structured. Rather than arriving with fixed indicators, Hecta and the Gates Foundation let counties decide what to track themselves, a decision he described as an uncomfortable one for a funder to accept, thanking the foundation for taking the risk. He read the room itself, with three CECs, chief officers, county directors and PHC coordinators all present together, as evidence of genuine county ownership. He set three goals for the two days: 1.) assessing whether data has genuinely improved primary health care without financial hardship to patients, 2.) enabling cross-county learning and 3.) distilling lessons for wider publication.

Gates Foundation. Yabi Marcos, Senior Programme Officer for Health, thanked Kisumu for hosting and credited Nakuru and Trans Nzoia's CECMs with having "really lived and led" the work. She restated the Foundation's premise for the engagement: that county teams with reliable data and the autonomy to act on it would strengthen PHC "not because of any external efforts that we brought, but because counties themselves would be actively strengthening the muscle that already exists", tying this to the Foundation's goals of preventing maternal and child deaths and protecting the next generation from infectious disease.

CECM Health, Kisumu County , Hon. Dr Gregory Ganda. Welcoming delegates on the Governor's behalf, Dr Ganda compared Kenya's and Rwanda's health insurance trajectories. Rwanda's coverage stands at roughly 90% against Kenya's 18% , attributing the gap to Rwanda building up from community-level prevention before layering on curative cover, while Kenya, he argued, funds catastrophic care generously but gives "zero shillings" to the Community Health Worker (CHW) taking blood pressure in someone's home. Kisumu's own primary care funding, he noted, has grown from around KSh 15 million to over KSh 100 million in five to six years. He closed with a line that captured the spirit of the two days:

*"Innovation does not belong to you once you innovate; it belongs to the people. When we see something good, we copy it and improve on it, because our aim is not to compete but to grow together.." — **CECM Health, Kisumu County , Hon. Dr Gregory Ganda.***

Trans Nzoia County leadership. Chief Officer Dr Judith Simiyu introduced the county's team, thanking Hecta for giving the county an external feedback mechanism and framing the engagement as a structured opportunity for self-evaluation and correction. CECM Hon. Christopher Lorot followed, describing data as "the next goldmine" for proactive decision-making and crediting Hecta with identifying primary health care, not higher-level facilities, as the area most worth strengthening. He acknowledged candidly that Trans Nzoia's indicators had trailed Nakuru's at the outset, confirmed the county had since redirected resources toward its weaker areas, and closed by asking Hecta to consider extending the engagement.

CECM Health, Nakuru County, Hon. Roselyn Mungai. Hon. Mungai described the partnership as transformative for how her department organises around data, cautioning against treating any one county's model as one-size-fits-all. As a concrete example, she described recalling all 16 of Nakuru's Primary Care Networks (PCNs) for joint work-planning after data revealed a coordination gap with facility-based Multidisciplinary Teams, citing one case where road-network data secured a resourcing request from county leadership. She also confirmed Nakuru now requires 40% of sub-county PHC funds to go toward Health Products and Technologies, above national allocations.

Endline Findings: Project Effectiveness

Moderator: Dr. Mike Mulongo (HECTA)
Presenters

- Marvin Mmasi (Monitoring and Evaluation Officer)
- Benard Bowen (Deputy County Health Records and Information Officer)

Marvin Mmasi and Bowen presented the project's quantitative endline findings, comparing PHC performance capacity across four points: baseline (February 2025), midline (August 2025), a further assessment (March 2026), and endline (June–July 2026), drawn from sampled level 2–5 facilities across both counties.

- Composite PHC performance capacity rose from 67.3% at baseline to 78.6% at endline, a gain of 11.3 points across the life of the project.
- Health financing showed the largest improvement of any domain, rising by 25.7 points; EMR functionality improved by 18.9 points and MDT functionality by 15.9 points.
- Infrastructure, medical products and equipment showed smaller gains, attributed to a ceiling effect; these domains were already performing well at baseline.
- Kuresoi and Endebess recorded the strongest sub-county gains; Gilgil and Naivasha showed slight declines from an already high baseline, again read as a ceiling effect, not a decline in care quality.
- Maternal and child health commodity availability improved markedly (oxytocin, magnesium sulphate, tranexamic acid, emergency trays), and maternal and perinatal death audits rose 20–80% depending on sub-county.

Discussion raised two cautions. First, some top-performing baseline facilities showed marginal declines at endline ,a reminder not to leave strong performers unsupported. Second, a partner representative noted that gains in commodity and service availability were not always matched by service-delivery outcomes like skilled birth attendance, and asked that any continuation of the project examine access and quality of care ,not only availability, including how well services reach adolescents and other vulnerable groups.

Take-home message: Progress in what's available doesn't yet guarantee progress in who's actually being reached.

Panel Discussion: What Outputs and Outcomes Have Been Achieved?

Moderator: Mike Mulongo (HECTA)
Panellists

- **Dr.** Kevin Awere- CDMS Nakuru
- Dr. Zaietuni Akajoroit Mulaa- Primary healthcare coordinator, Transnzoia County
- Dr. Isaac Babu Kisiang'ani- County Director of Health Services and Sanitation, Trans Nzoia
- Dr. Simiyu Judith- County Chief Officer ,Transnzoia
- Roselyn Mungai- CECM, Nakuru County

Mike Mulongo structured the panel around four questions, tracing the arc from resource allocation to community accountability.

1. ***How have resources shifted toward PHC, and what evidence drove the shift?***
Nakuru pointed to SHA reimbursements as the most significant lever strengthening facility-level finances, alongside redistributing commodities and equipment from level 4–5 facilities toward level 2–3 to reduce stock-outs at the primary care tier. Human resource strain at dispensary level is easing but continues; the dashboard has helped the county use existing resources more efficiently rather than always needing bigger budgets.
Trans Nzoia gave a more granular account. The county set a specific 2026/27 recruitment budget line, resulting in over 200 staff recruited in the final quarter of the prior year alone (roughly 75% nurses). It also adopted a continuous replacement policy, retiring or exiting officers are automatically replaced the following month, rather than through periodic cycles. Other commitments included continued dispensary construction with equipping budgets, dedicated financing for PCN coordination and supervision, and a higher CHP stipend. Asked what made this level of budget specificity possible, the team credited Hecta's two years of engagement directly. Findings were shared with the County Health Management Team, which triggered a facility-assessment committee and CHP consultation. This process culminated in a Governor-chaired meeting with County Assembly health committee members, which fed directly into the 2026/27 budget.

2. What informed prioritisation, and what enabled follow-through?
Both counties started from baseline gap analysis. Nakuru added that prioritisation explicitly excluded areas already covered by other active partners, to avoid duplication, meaning choices reflected both Hecta's data and the existing partner landscape.

3. What is the actual escalation pathway to the County Assembly and Governor?
Nakuru's Director of Medical Services described a triage process: routine issues are resolved at his desk; cross-departmental matters go to an inter-departmental advisory committee; and politically sensitive or high-value issues escalate further still. He cited a County Assembly member who had for years blocked removal of non-functional equipment as an example of how ward-level politics can stall operational decisions. Treasury-level financing gaps requiring pooled resources form a separate escalation category.
Trans Nzoia described a calendar-driven structure: a standing Monday leadership meeting between the Chief Officer and Director of Health reconciles ground-level reports with County Assembly Health Committee feedback before issues are tabled to Cabinet or the Committee chair directly. MCAs themselves

often act as an informal escalation channel, personally flagging under-resourced facilities in their wards, and the Governor's own accessibility serves as a further, less formal feedback loop.

4. How is community feedback captured, with a concrete example?

Trans Nzoia described community dialogue days and PCN-structured engagement on access, quality and financing, alongside newer channels like WhatsApp-based feedback. Nakuru offered the panel's clearest example of a closed feedback loop: referral data showed mothers bypassing their nearest area facility to deliver elsewhere. Investigation traced this to which clinician mothers trusted, not distance or cost. The county deployed a well-regarded clinician to the local facility in response; within two weeks, referral data showed mothers returning to deliver at their nearest facility, which the team cited as proof that acting on data, not just collecting it, changes outcomes.

Panellists closed by reiterating the case for preventive over curative investment; one Trans Nzoia panellist noted bluntly that Kenya's system tends to "wait for you to get cancer" before responding generously, when many of the same conditions are cheaply screenable at the primary care level and confirmed mental health integration is now standard across every PCN in the county, delivered in part through CHPs. Both counties closed by thanking Hecta and other partners for engagement; they described it as instrumental and asked that it continue.

Emerging highlights:

1. SHA reimbursements and the redistribution of commodities and equipment toward level 2-3 facilities were the most significant financing levers named in both counties
2. Trans Nzoia's shift to continuous staff replacement was a directly traceable result of Hecta's data reaching county budget processes.
3. Both counties run a two-track escalation pathway with routine issues resolved administratively and politically sensitive or high-cost issues escalated to the County Assembly or Governor
4. Preventive, community-level care was repeatedly favoured over curative investment, with mental health now integrated into every PCN.

Take-home message: Data only changes outcomes when it reaches the right decision-maker with enough specificity to prompt action.

Endline Findings: Relevance and Coherence

Presenter: Caren Nekesa
Moderator: Dr. Isaac Babu-County Director of Health, Trans Nzoia County

Caren Nekesa presented findings against two of the OECD-DAC evaluation criteria used to assess the project overall relevance and coherence. She grounded both in the project's three phases: inception and county engagement (October–December 2024), institutionalisation and performance review (January–December 2025), and the current transition phase (January–September 2026), focused on handing ownership back to the counties.

Relevance. Interviews with facility in-charges and county leaders found the project was seen as highly relevant precisely because its indicators were not imposed externally; counties' own core teams selected priorities through co-creation, with Hecta facilitating rather than dictating a fixed set. Nekesa argued this was central to the project's traction. The qualitative findings tracked closely with the quantitative results presented earlier in the day: respondents independently named financing, information systems and PCN functionality as the areas of most meaningful improvement, the same domains that showed the largest measured gains.

The more critical findings concerned how the indicators themselves were designed. Facility respondents felt they asked the right broad questions but sometimes missed day-to-day reality; a simple commodity-availability indicator, for instance, does not show whether the stock on hand is actually enough for a facility's workload. Separately, interviews with pregnant clients found some women deliberately bypass their nearest facility for one they trust to better protect their privacy, suggesting availability-based indicators alone miss the experience-of-care factors that drive where people seek treatment.

Coherence. Leadership in both counties reported no meaningful overlap between the project and other partners' work; Trans Nzoia specifically distinguished it from InSupply's narrower supply-chain focus. The more significant coherence finding concerned PCN boundaries. In both counties, these follow administrative sub-county lines rather than geography, so patients are sometimes referred 30–50km to a facility within their administrative PCN while a closer facility outside it goes unused, a real financial burden on patients already in hardship. Respondents recommended counties periodically re-map PCN boundaries against geography rather than administration, regularly rather than as a one-off.

Responding to the presentation, Dr Isaac Babu added that confidentiality and staff friendliness, not just proximity, also shape facility choice, reinforcing the case for indicators that capture patient experience alongside availability, and agreed that administrative-boundary PCN mapping runs counter to the PHC model's goal of access at the nearest facility, calling it something counties "need to honour" going forward.

Take-home message: PCN boundaries need to evolve from being drawn around administration to being drawn around geography so that patients are routed to the nearest facility, not the nearest one within their administrative line.

Plenary: PHC on the Ground — Community Voices

Moderator: Dr Sally Ndung'u
Panellists: Community representatives from Nakuru and Trans Nzoia

This plenary was framed differently, in a deliberate effort to make participants set aside their "scientific hat" and understand why the data matters and to whom. Behind every dashboard metric, the moderator noted, is a family for whom its presence or absence is the difference between a good outcome and a preventable tragedy.

The session was grounded in three personal accounts. Dr Ndung'u opened with her own story as both a mother and a medical professional. A first birth complicated by a race against the system rather than the procedure itself, and the loss of her second child despite mobilising emergency care quickly through her own professional network, and she asked the room whether a household without those connections would have had the same chance. A mother from Nakuru County followed, describing pregnancy, childbirth and ongoing care for a child with special needs requiring occupational therapy, all under severe financial hardship and real barriers to reaching facility-based care, before community members eventually helped connect her and her child to consistent support, by a wide margin the most difficult testimony of the session. A young woman from Trans Nzoia County closed with her experience of teenage pregnancy, the initial rejection it brought from her family, and the role Community Health Promoters (CHPs) played in mediating with her father, connecting her to antenatal care and peer support, and helping her stay in school; she hopes to pursue a degree in the future.

Together, the three accounts made the same point from different angles: the indicators this workshop spends two days reviewing exist, ultimately, for families who lack the advantages. Dr Ndung'u described how sustained, relationship-based community health support is often what closes that gap.

Responding, Hon. Roselyn Mungai reflected that PCNs need to be reoriented beyond disease- and treatment-availability metrics to explicitly account for vulnerability at the family and household levels by asking who, within a community, will never register for SHA or seek care no matter how much outreach is done, and what it would take to reach them. She suggested the true measure of a successful PCN is the extent to which it can "wrap itself around" cases exactly like these. Taken together, the three accounts served as the workshop's counterweight to two days of upward-trending graphs, a deliberate pause to ask what a green, amber or red indicator costs or saves a real family.

Take-home messages: Behind every indicator is a household weighing trust, dignity and survival; sustainability planning must account for the families the data never sees, because PHC-PM's real test isn't availability; it's whether care reaches those least likely to ask for it.

DAY 02

Partner Presentations

Moderator: Harrison Ochieng - HECTA

Presenters:

- AMREF
- AMPATH
- Jacaranda Health
- Deloitte
- HPA CIPS

Day 2 opened with brief updates from five implementing partners active in Nakuru and Trans Nzoia, each reflecting on how their work intersects with the county-led dashboard process.

AMREF Health Africa reflected on its three-year Project Thrive engagement, now ending: NCD and hypertension training, leadership and governance coaching, and mental health integration, now flagged as the leading condition affecting communities generally. AMREF gave one concrete example of dashboard-driven change, which is the attendance data showing outreach sessions skewed heavily female, prompting dedicated men-only sessions to close the gap.

Deloitte described a technical-assistance model working directly through county structures, spanning comprehensive HIV programming across five counties, including an additional women's and children's health arm in Nakuru. Their community social-accountability approach using scorecards shared with facilities, followed by an interface meeting to agree on action points, was highlighted as effective at avoiding finger-pointing. Deloitte also confirmed its role in establishing all 16 of the county's PCNs.

HPA CIPS described a diagnostic-led approach to strengthening county procurement, benchmarking standard operating procedures, resolving longstanding supplier debt with KEMSA, and preparing teams for electronic government procurement. The presenter flagged one gap from a joint quantification exercise with Hecta: community-level CHPs commodities had been excluded from facility-level quantification.

AMPATH focused on reducing perinatal mortality through training, mentorship and equipment support, paired with community-level work supporting CHP performance reviews and joint outreach with chiefs, on the reasoning that facility readiness alone cannot improve outcomes if communities cannot recognise danger signs.

Jacaranda Health traced its work to Kenya's 2018 Confidential Enquiry into Maternal Deaths, which linked a third of maternal and newborn deaths to delays in seeking care. In response, Jacaranda built PROMPTS, a free SMS platform reaching close to 5,000 Nakuru mothers with health information and a two-way question channel, alongside on-site EmOC mentorship that has produced 55 in-facility champions to date.

Harrison Ochieng (Knowledge Management Analyst, Hecta) drew out the common thread: AMREF's own pilot on data-driven decision-making, he noted, mirrors exactly what the county performance management effort is trying to build more broadly. Jacaranda's tracking of maternal and child health indicators feeds directly into the same outcomes the county dashboard monitors. HPA CIPS's procurement work speaks to the same underlying question the engagement keeps returning to: how counties can prioritise better and use existing resources more efficiently. Standing back, he observed that nearly every partner had, in some way, referenced the centrality of county leadership to their own work and read this as a sign that despite different systems and priorities, all were ultimately orientated around the same goal.

Take-home message: The opportunity now is less about adding more partner activity and more about aligning what's already there into "one plan, one project".

Menti Meter Reflections and Recommendations

Discussion, guided by Mentimeter polling, converged on three core lessons:

1. **Core team as a Health Delivery Unit (HDU)**: naming a small, cross-departmental core team to coordinate data collection, review meetings and partner alignment was central to the project's traction and should persist after direct support ends.
2. **Co-creation:** ownership of the indicators, targets and review cadence, not a partner's agenda adopted wholesale, is what sustained engagement.
3. **Embeddedness:** the clearest marker of sustainability was how far dashboard review had been folded into pre-existing governance structures rather than run as a stand-alone project activity.

On commodity availability, a procurement partner representative and a Trans Nzoia pharmacy official discussed the structural limits of demand-driven supply for low-consumption, high-criticality items; facilities need to be resourced to hold buffer stock rather than relying solely on reactive ordering, alongside stronger escalation when national suppliers like KEMSA fail to deliver on time. Participants agreed that resolving supply bottlenecks originating above county level requires leadership to escalate with specific, evidence-based asks, using dashboard data to make the case.

Endline Findings: Impact and Sustainability

Moderator: Dennis Amunga - HECTA
Presenters:
- Dr. Robert Simiyu - PCN coordinator, Trans Nzoia

This session distinguished the project's intended outcomes from a set of unintended but valuable gains identified as the project's funded phase draws to a close.

Key Findings

- The composite performance trajectory (67.3% → 78.6%) reflects sustained, iterative use of data ,not the dashboard's existence alone.
- Both counties used dashboard data for advocacy beyond monitoring. Trans Nzoia used facility-level workload data to advocate successfully for roughly 130 additional health worker positions, alongside the shift to continuous replacement recruitment.
- Nakuru's leadership described an unplanned effect: visibility of facility-level SHA claims and commodity data to finance and pharmacy leadership made resource-allocation decisions across sub-counties easier to explain and defend.
- Both counties shifted internal review from stand-alone project check-ins into their regular county health management structures, cited as the clearest evidence the practice will outlast the project.
- Remaining challenges: reconciling SHA reimbursement owed versus paid; continuing staffing gaps against a recommended minimum ratio; and patients bypassing their nearest facility, which strains catchment-based staffing formulas.

Take-home message: The clearest sign of sustainability is that both counties have already built their own governance habits around the project.

Group Work: What PHC-PM Sustainability Looks Like in the County

Moderator: Benard Bowen - Deputy Director Public Health, Nakuru County

Facilitators posed five guiding questions to both counties: what benefits have been observed; what capacities are needed to sustain them; what activities should be kept; what should be traded off; and what are the key risks. Time pressure meant the session ran as an open, moderated exchange rather than separate breakout groups. Key points from each county are summarised below.

Area	Nakuru County	Trans Nzoia County
Benefits observed	• Individual-level access to previously out-of-reach services • Facility-level capacity built from gaps the data surfaced • CHPs now feel formally integrated into the facility system, with clear roles • A measurable reduction in the facility-level maternal mortality ratio	• Strengthened community services and CHP–facility linkages • Improved facility-level financial management (revenue tracking, claims) • Enhanced community-level supervision • Health budget allocation up from ~26% to 31%
Capacities needed	• Data collection now formally assigned to specific roles (both counties) • Continued monthly support and refresher input still needed to sustain quality • Capacity remains weakest at lower-level facilities and community units • Governance gap: unclear which cadre is responsible for what as level 2 facilities take on new functions	• Data collection now formally assigned to specific roles (both counties) • Continued monthly support and refresher input still needed to sustain quality

Area	Nakuru County	Trans Nzoia County
Activities to keep	• Increase the county's own PHC budget allocation while optimising existing resources • Keep monthly/weekly data review on the standing agenda of county management structures • Keep the dashboard an active decision-making tool, not a static report • Continue EMR use to protect data quality • Formalise cross-county peer-learning visits into both counties' calendars	• Retain performance-management practice across every domain of the project, given demonstrated impact at every level of care • Continued resourcing named as the precondition for keeping this running
Trade-offs	• Discontinue activities that show no demonstrable link to outcomes; keep only what can show measurable impact • Shift from siloed, single-office activities toward joint review meetings involving all relevant departments • Resist "celebrating the vision without sustaining it", treat the practices built (data review, joint planning, cross-county exchange) as the thing worth keeping, not the events around them	
Risks & mitigation	• Regression risk: without sustained review, counties risk reverting to decisions made without evidence, mitigated by formal facility-level reporting commitments and treating every review meeting as a documented "learning space" • Financial risk: dependence on a patchwork of dedicated funding streams (PCN, ambulance, facility improvement funds) with no consolidated contingency plan • Political risk: the upcoming election cycle could unsettle funding commitments and facility management committee support built up over the engagement	

Closing the session, Mike Mulongo built on the open exchange to urge both counties' core teams to carry that same energy into concrete, budgeted action plans, asking directly what it would mean to "embed this in your annual workplans and your budgets." He flagged the need to formalise joint cross-county peer-learning convenings, until now organised informally, into a routine, budgeted activity. He also echoed Dr Robert Simiyu's earlier point: indicators need continued review, not only whether something is available, but whether it meets actual need ,and both counties should work toward measuring distal outcomes, not just activity completion, as the project's direct support winds down.

Closing Remarks

Closing on behalf of the **Gates Foundation,** Yabi Marcos described it as "a rare meeting" to sit through with county leadership engaged for the full two days, evidence of genuine ownership. She highlighted two takeaways: that county teams have taken real ownership of their own decisions from the data and that some of the most valuable results were unintended discoveries counties made about their own systems along the way, achieved in a comparatively short implementation period. She was candid about the limits of the Foundation's future commitments. Gates funding is typically small and catalytic, meant to "unlock the potential of the muscle that's already there", with an expectation that the Foundation steps back once that goal is achieved leaving further scale to larger financing partners such as the World Bank. She acknowledged that such scale partners are currently shrinking, requiring the Foundation's own model to adapt, but reaffirmed Kenya remains a priority country and asked for patience as its strategy continues to evolve.

CECM Health, Nakuru County, Hon. Roselyn Mungai. Closing the workshop, Hon. Mungai thanked both county teams for their consistency of attendance across the full engagement, not only at flagship events but also at routine review meetings, framing that consistency as the foundation of sustainability. Her closing instruction to her own team anchored the session: come to the meeting and bring the data; without it, nothing changes. She named knowledge management candidly as one of the department's biggest unresolved gaps, an area she asked partners to keep helping the county think through.

Closing on behalf of the host county, the **Trans Nzoia CECM for Health,** Hon. Christopher Lorot reflected on the value of co-creation, noting with appreciation that counties, not partners, had chosen the indicators that mattered most to them, and that this ownership would help the work endure. Returning to the theme of inclusion, he challenged participants to keep asking, in every future planning session, "Who is missing at the table?" highlighting community representation specifically as something that should be built in, not treated as an afterthought. He thanked Hecta and the Gates Foundation for the partnership and both counties for openly sharing lessons, reflected on the value of continued cross-county and cross-partner learning, and formally closed the meeting. The closing ceremony ended with a prayer.

Way Forward / Next Steps

1. Institutionalise the PHC dashboard and its review cadence within existing county health management team structures in both counties, rather than as a stand-alone project activity.
2. Strengthen coordination among partners working in the same counties to reduce duplication of dashboards, data requests and review structures.
3. Extend the current focus on input and process indicators (commodity and equipment availability, staffing) to more directly track process and service-delivery outcomes, including skilled birth attendance and adolescent and vulnerable-group access.
4. Continue to prioritise financing and capacity-building at lower-tier facilities and community units, which both counties identified as lagging behind county-level systems.
5. Maintain cross-county peer learning between Nakuru and Trans Nzoia and continue widening participation to include frontline health workers and community representatives in future sessions.

Annexes

1. **Workshop Program**
2. **Presentations**

3. Participants List

1. David Wesaya – County Pharmacist, Ministry of Health, Trans Nzoia County
2. Marvin Mumasi – Monitoring & Evaluation Officer, Trans Nzoia County
3. Liaga Analo John – SCCSFP, Trans Nzoia County
4. Ruth Magak – Public Communications Officer, Nakuru County
5. Grace Wangechi – CHICT, Nakuru County
6. Kizito Mukhwana – Technical Officer – Community, Deloitte Tujenge Jamii
7. Leah Cherop Kiprotich – Community Member, Trans Nzoia County
8. Bismack Wasta – Procurement Expert, CIPS HPA
9. Dr. Simiyu Robert – PCN Coordinator, Trans Nzoia County
10. Bernard Lugah – CMSC, Department of Health, Nakuru County
11. Hilda Ogutu – County Community Health Coordinator, Nakuru County
12. Caroline Vata – County Public Health Officer, Department of Health, Nakuru County
13. Robert Ouko – Regional Program Coordinator, Jacaranda Health
14. Eric Wasilwa – PCN-C, Trans Nzoia County
15. Kevin Awere – CDMS, Nakuru County
16. Zaietuni Akajoroit Mulaa – Primary Healthcare Coordinator, Trans Nzoia County
17. Georges Simiyu – Analyst, Hecta Consulting
18. Benard Bowen – DCHRIO, Nakuru County
19. Christine Barasa – County Health Administrative Officer, Department of Health, Nakuru County
20. Peter Nguhiu – SPM, Hecta Consulting
21. Tatiana Achieng – Data Analyst, Hecta Consulting
22. Sally Wambui – Knowledge Management Specialist, Hecta Consulting
23. Patrick Mwaura – Finance & Administration, Hecta Consulting
24. Beth Armanda Maloba – Rapporteur, Hecta Consulting
25. Nelson Kamanda – Finance & Administration Manager, Hecta Consulting
26. Isaac Babu Kisiang'ani – County Director of Health Services & Sanitation, Trans Nzoia County
27. Dr. Simiyu Judith – County Chief Officer, Trans Nzoia County
28. Nobrah Mutuku – RMNCAH Lead, AMPATH
29. Vyntine Nanjala Mukhwana – QA/QI Coordinator, Trans Nzoia County
30. Wendy Jemeli Tirop – CCNO, Nakuru County
31. Amunga Dennis – Program Associate, Hecta Consulting
32. Joel Mwangale – ICT Officer, Trans Nzoia County
33. Roselyn Mungai – CECM, Nakuru County
34. Rebecca Musyoki – Head – Health Financing, Nairobi
35. Caleb Mike Mulongo – Technical Lead, Hecta Consulting
36. Dr. Alice Gichobi – DCP, Nakuru County
37. Bryson Sifuma – P.O., Nakuru County
38. Matiko Riro – CEO, SGHI
39. Dr. Evelyn Ngugi – SAVANNAH
40. Yabsera (Yabi) Marcos – Senior Program Officer, Gates Foundation
41. Harrison Ochieng – Knowledge Management Analyst, Hecta Consulting
42. Charlene Robi Chacha – Communications, Hecta Consulting
43. Christopher Lorot – CECM, Trans Nzoia County
44. Sarah – HAO, Nakuru County
45. Caren Nekesa – Program Associate, Hecta Consulting

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