Republic of Kenya

Ministry of Health

Strategy for Community Health 2014-2019

Transforming health:
Accelerating the attainment of health goals

Community
Health Services
"Afya Yetu, Jukumu Letu"

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Foreword

Kenya's second National Health Sector Strategic Plan (NHSSP II: 2005-2010) defined a new approach to the way the sector would deliver health care services to Kenyans, using the Kenya Essential Package for Health (KEPH) and community involvement approaches. To operationalize community involvement in the community health strategy, the document, "Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services," was developed in 2006.

This strategy document has now been revised to the current strategy: "Strategy for community health." The revisions are the result of thorough consultations and feedback from stakeholders in the sector who gained useful experience in the implementation of the previous strategy. The document has been developed in line with the new Constitution of Kenya 2010, Kenya Vision 2030, Kenya Health Policy Framework 2014-2030, National Health Strategic and Investment Plan 2014-2018, and other health policy guidelines. Like the previous one, this strategy envisages building the capacity of households to not only demand services from all providers, but also to know and progressively realize their rights to equitable, good quality health care as provided for in the constitution. The strategy introduces an innovative, developmental approach, where the determinants of health are addressed through people's participation at the community level, for health system issues as well as for a broader range of health actions in various sectors. The strategy has four key objectives:

1. Strengthen the delivery of integrated, comprehensive, and quality community health services for all population cohorts.
2. Strengthen community structures and systems for effective implementation of community health actions and services at all levels.
3. Strengthen data demand and information use at all levels.
4. Strengthen mechanisms for resource mobilization and management for sustainable implementation of community health services.

Implementing community health services is a top priority of the Ministry of Health and its partners in the sector. I am fully confident that the implementation of this strategy will help us provide equitable access to health services, and move us closer to our goal of achieving universal access and reversing downward trends in health outcome indicators.

I am aware that we will have to collectively, as stakeholders, face many technical, managerial, and other challenges and resolve them along the way. During the implementation process, we will learn many lessons, and these will enrich this strategy further. I call on County governments, their communities, and all implementing partners to exert their maximum effort to transform the aspirations of this strategy into a reality. It is incumbent on all of us to raise awareness and ensure that the objectives of this CHS are understood and fully owned by the various stakeholders and implementing partners. I also call on our development partners to prioritize this strategy in their support to the health sector.

Dr. Khadijah Kasschoon
Principal Secretary – Ministry of Health

Acknowledgement

The second edition of the Community Health Strategy, "Strategy for Community Health 2014-2019, Transforming health: Accelerating the attainment of health goals," has been developed through the collaborative efforts of many individuals and organizations. The Ministry of Health would like to acknowledge all those who were involved in its development. In particular we are greatly indebted to all the county governments for their valuable contribution to the content of this document. The document would not have been complete without the inputs from the county health officers, the community health extension workers and the community health volunteers. We also wish to acknowledge the contribution of all the community members who gave valuable inputs during the situation analysis. The development of this document was financed by USAID Kenya through the FANIKISHA Institutional Strengthening Project, the Health NGO Network (HENNET), KANCO, WOFAK, NEPHAK, Omega Foundation, and I Choose Life Africa. Technical support was offered by different organizations which included; FANIKISHA, UNICEF, JICA, MSH, World Vision, Pathfinder, AMPATH International, Save the Children UK, Christian AID, Population Council, Capacity Kenya, AMREF, MEASURE, AFYA INFO, GLUK, PSI Kenya, LVCT Health, FHI 360, WHO among others. We are very grateful to all officers from the Ministry of Health involved in this process, among them representatives from the Division of Family Health, the Division of Environmental Health, and the Division of Disease Control.

We are particularly indebted to the technical working group and task force group that took the lead in the development of this strategy. The task force members included representatives from FANIKISHA, UNICEF, Pathfinder International, World Vision, Population Council, Capacity Kenya, JICA CHS, and Ministry of Health officers from the Community Health Services Unit. We appreciate the support offered by the Goodwill Ambassador for Community Health Services, Professor Miriam Were, and the inputs of the consultant guiding the review process.

It is my sincere hope that the implementation of this strategy will be useful in improving and promoting the health of the people of Kenya.

Dr. Nicholas Muraguri
Director of Medical Services
Ministry of Health

Glossary

Accreditation:	A form of qualification or individual registration awarded by a professional or regulatory organization that confirms an individual is fit to practice.
Advocacy:	A combination of individual and social actions designed to gain political commitment, policy support, social acceptance, and systems support for a particular activity.
Burden of disease:	A measurement of the gap between a population's current health and the optimal state where people attain full life expectancy without suffering major ill-health.
Collaboration:	A recognized relationship among different sectors or groups, which has been formed to take action on a matter in a way that is more effective or sustainable than might be achieved by one sector or group acting alone.
Community:	A specific group of people, usually living in a defined geographical area, who share common values, norms, culture and customs, and are arranged in a social structure according to relationships which the community has collectively developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values, rituals, and norms which have been developed by the community in the past and may be modified in the future.
Community development:	Refers to the process through which a given group of people collectively identify and address health and other issues, using both internal and external resources. Usually, community development involves use of participatory approaches and methodologies.
Community Health Volunteer (CHV):	Female and/or male individuals chosen by the community and trained to address health issues of individuals and communities in their respective localities, working in close relationship with health facilities. A CHV acts as a catalyst and a change agent to enable people to take control and responsibility of their own health achievement efforts.
Health:	Usually defined as a state of complete physical, spiritual, mental, and social well-being and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end. In this sense, health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities (Adapted from the Ottawa Charter for Health Promotion).

Health development:	The process of continuous, progressive improvement of the health status of individuals and groups in a population.
Health promotion:	The process of enabling people to increase control over the determinants of health and thereby improve their health. The goal of health promotion practice is to provide and maintain conditions that make it possible for people to make healthy choices and facilitate environmental conditions that support healthy behaviors. Health promotion represents a comprehensive social and political process, which embraces actions directed at strengthening the skills and capabilities of individuals, and actions directed towards changing social, environmental, and economic conditions so as to alleviate their impact on public and individual health.
Health behavior:	Any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting, or maintaining health, whether or not such behavior is objectively effective towards that end.
Integration:	Refers to combining health care services and components of health care services that are currently delivered and/or managed separately, for the purpose of optimizing the use of scarce resources, maximizing coverage of services, and improving health outcomes.
Primary health care:	Essential health care based on practical, scientifically sound, and socially acceptable methods and technologies made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.
Social determinants of health:	The conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities, which are the unfair and avoidable differences in health status seen within and between countries.
Stakeholders:	Individuals or groups with an interest or stake in an outcome, project, program, or organization.
Strategy:	A high-level plan that aims to achieve one or more goals within the context of given constraints and limited resources. Strategies often include a framework of how and when the strategy will be implemented.

Acronyms

CHCs	Community Health Committees
CHEWs	Community Health Extension Workers
CHIS	Community Health Information System
CHS	Community Health Strategy
CHU	Community Health Unit
CHV	Community Health Volunteer
CIDP	Community Integrated Development Plan
CSOs	Civil Society Organizations
CUs	Community Units
DHIS	District Health Information System
DQA	Data Quality Assurance
FBOs	Faith Based Organizations
HFA	Health for All
HiAP	Health in All Policies
HIS	Health Information System
HRH	Human Resource for Health
HSSF	Health Services Sector Fund
IGAs	Income-generating Activities
KEPH	Kenya Essential Package for Health
M&E	Monitoring and Evaluation
MCHUL	Master Community Health Unit Listing
MDGs	Millennium Development Goals
MOH	Ministry of Health
NHSSP	National Health Sector Strategic Plan
OR	Operation Research
PHC	Primary Health Care
SQA	Standards Quality Assurance
SWOT	Strengths, Weaknesses, Opportunities, Challenges and Threats
TBD	To Be Decided
WHO	World Health Organization

Summary

Kenya Vision 2030 emphasizes preventive health care and health promotion to improve health care and reduce the burden of illness in the community. In 2006, the Ministry of Health developed and adopted the community health strategy as a core component of the Kenya Essential Package for Health (KEPH) as applied in the National Sector Strategic Plan 2005-2010. The overall goal of the community strategy is to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, and child and maternal deaths, as well as improve education performance across all stages of life.

Since the implementation of the strategy, there have been observable changes in health indicators where the community health strategy has been rolled out, as evidenced by the "Evaluation Report of the Community Health Strategy Implementation in Kenya – 2010." However, a situation analysis conducted in 2013 to inform the review of the 2006 strategy revealed a number of weaknesses, including weak coordination mechanisms between community health committees (CHCs) and health facility committees, lack of a mechanism for motivating and retaining community health volunteers, lack of clear monitoring and evaluation mechanisms, and lack of community financing mechanisms, among others. The analysis recommended a number of measures to strengthen community health services, among them the development of this strategy.

This strategy is guided by the new Kenya Constitution 2010, the Kenya Vision 2030, the Kenya Health Policy Framework, and the National Health Sector Strategic and Investment Plan. This strategy provides a strategic approach for the provision of community health services for the period 2014-2018. It contains the vision, mission, purpose, strategic objectives, strategies, and monitoring mechanisms. It cuts across the six pillars of the health system, and is envisioned to be actualized through the various implementation guidelines as proposed in the document. The strategy addresses the gaps identified in the situation analysis with a focus on consolidating and expanding existing structures, mechanisms, and actions. The strategic objectives of the strategy are:

1. Strengthen the delivery of integrated, comprehensive, and quality community health services for all population cohorts.
2. Strengthen community structures and systems for effective implementation of community health actions and services at all levels.
3. Strengthen data demand and information use at all levels.
4. Strengthen mechanisms for resource mobilization and management for sustainable implementation of community health services.

The implementation of the strategy will be guided by the following principles:

1. Health as a basic human right
2. Technical and cultural appropriateness
3. Participatory approach
4. Inter-sectoral, multidisciplinary, and inter-institutional collaboration
5. Use of innovation and appropriate technology
6. Due consideration for gender, equity, and the dignity of human life

Introduction

A large proportion of Kenyans bear one of the highest preventable burdens of ill health in the world. The community health approach is an effective means for improving health and contributing to general socioeconomic development. The determinants of health are best addressed through integrated responses and achieved through people's active participation, especially at the community level. Facilitating people's participation is a key element of community health strategy (CHS) implementation in Kenya.

Implementing community health services is a top priority of the Ministry of Health and its partners in in the sector. This is well articulated in the Ministry of Health Joint Program of Work and Funding, 2006/2007-2009/2010, Ministry of Public Health and Sanitation (MOPHs) Strategic Plan 2008-2010, the second National Health Sector Strategic Plan, NHSSP II: 2005-2010, the National Health Strategic and Investment Plan 2013-2017, and the Health Policy Framework 2014-2030.

The Kenya Essential Package for Health (KEPH) introduced in the NHSSP II: 2005-2010 described six life cycle cohorts and six service delivery levels. One of its key innovations was the recognition and introduction of level one service, which aimed at empowering Kenyan households and communities to take charge of improving their own primary health care. Currently, the main national policy documents intended to direct these efforts are the Kenya Constitution 2010, Kenya Vision 2030, Kenya Health Bill, Kenya Health Policy Framework, and the Kenya Health Sector Strategic and Investment Plans. Additionally, the various programmatic agendas have an impact on implementing program activities on the ground.

Background

The Primary Health Care (PHC) strategy was adopted globally as a means for ensuring health for all (HFA) by the year 2000. PHC emphasizes the role of community participation in health development.[1]

The Declaration on the Millennium Development Goals (MDGs) and the WHO Report on Macroeconomics and Health point to the intricate and close linkage between general socioeconomic development and health.[2]

The WHO Report on the Social Determinants of Health (2006) highlights social justice (among other things) as a factor in health and other development.

A number of declarations and resolutions of WHO AFRO and the African Union call upon Member states to create enabling environments for community health development, undertake health system-wide actions, and improve financing of community health programs, among other recommendations. These declarations have led to increased commitment to community health and have raised attention to health in all policies (HiAP).[3]

Considering these developments, and recognizing the important role of community health interventions, Kenya has incrementally endeavored to expand the coverage of community health programmes. The first national strategy for community health (2006) had as its overall goal the enhancement of community access to health care in order to improve productivity, and thus reduce poverty, hunger, and child and maternal deaths, as well as to improve education performance across all stages of life. The main focus of the strategy was to improve and consolidate delivery, access to, and demand for Level One services. The next section describes developments in community health within the context of the first strategy.

Regional Community Health Policy Orientations

In traditional Africa, health and illness were viewed holistically. Community members worked collaboratively to prevent disease, manage illness, and promote behaviors believed to safeguard well-being, and promote social and spiritual harmony.[4]

In 2006, a declaration on community health by regional actors at the International Conference on Community Health in the African region outlined the actions required of member states to ensure universal access to health care and a healthier future for the African people. It called upon member states to, in brief:

- Create enabling environments for community health development;
- Undertake concrete actions within the context of health systems; and
- Improve financing of community health programs.

This declaration was intended as a top-level guide for the development of community health in the region. A number of countries, including Liberia, Madagascar, and South Africa have taken these up and consequently

1 International Conference on Primary Health Care, Alma Ata Declaration ,USSR, September 1978
2 http://www.un.org/millenniumgoals/bkgd.shtml
3 The world health report 2000:Health Systems :improving performance
4 WHO Regional Office for Africa, 2008 Report on the Review of Primary Health Care in the African Region

developed their own policy documents to guide the delivery of community health services in their domestic environments . Kenya has also embarked on an ambitious process to realize the recommendations of this declaration and those of domestic policy documents, as evidenced by the development of the 2006 CHS strategy.

Within the East African region, the First Regular Sectoral Council of Ministers of Health (5-8 August 2005) and the 10th Full Council of Ministers (EAC/CM10/Decision 34) on 8-9 August 2005 approved the establishment of the Regional East African Community Health (REACH) Policy Initiative within the EAC Secretariat. This initiative was to be the mechanism used to broker linkages between policy makers, health researchers, and other vital research users in a bid to foster the creation of evidence-based policy.

Kenyan context

Kenya is a signatory to the international declarations: the Alma Ata declaration of 1978, the Bamako Initiative of 1988, and the Millennium Development Goals of the year 2000. To achieve these commitments, the country has been implementing several health sector plans and strategies. The KDHS of 2003-2004 and 2008-2009 showed slow progress towards achieving these commitments.

Kenya's second National Health Sector Strategic Plan (NHSSP II: 2005-2010) defined a new approach to the way the sector would deliver health care services to Kenyans, shifting the emphasis from burden of disease to the promotion of individual and community health. It did this by introducing the KEPH, which focuses on the health needs of individuals through the six stages of human life, and emphasized strong community involvement in health care. One of the key innovations of the KEPH is the recognition and introduction of Level One service, which aimed at empowering Kenyan households and communities to take charge of improving their own health. The Ministry of Health adopted the community health strategy to actively engage communities in managing their own health. The strategy aimed at improving health indicators by implementing critical interventions at the community level. The overall goal of the community strategy is to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, and child and maternal deaths, as well as to improve education performance across all stages of the life cycle.

Situational Analysis

Epidemiology context

Kenya continues to face a number of public health problems, especially relating to maternal health and child mortality, communicable diseases, and, increasingly, non-communicable diseases such as diabetes, cancer, hypertension, heart diseases, and chronic respiratory illnesses. Mortality rates have decreased over the years, especially compared to before the introduction of the strategy when maternal mortality was 488/100,000 deliveries, infant mortality was 77/1000 live births, and under-five mortality was 74/1,000 births (KDHS 2008). A great proportion of these deaths occur as a result of predictable and preventable causes. There is a double tragedy in Kenya since incidences of both communicable and non-communicable diseases are high.

Non-communicable conditions are increasing, mainly because of changing lifestyles, lack of awareness, and inadequate health services and facilities. Many complications go undetected and untreated, resulting in premature morbidity and mortality. Non-communicable conditions currently represent 50-70% of all hospital admissions, and up to half of all in-patient mortality. Due to increasing programming by government and partners, especially at community level, modest gains have been made in disease prevention, and general improvements in health have been recorded. The disease burden of communicable diseases has decreased as a result of creating awareness of high-impact interventions. For example, HIV and AIDS control has resulted in reductions in incidence, prevalence, and mortality. TB control efforts have resulted in improvement in key indicators such as case notification, case detection, and treatment success.

The determinants responsible for major public health problems are known, and most are modifiable. These include, on the negative side, inadequate allocation of national budget to health, poverty, marginalization, stigma and discrimination; inadequate knowledge and skills to enable effective participation in health action; and policy, legislative, and fiscal environments that do not fully support health. On the positive side, there have been improvements in educational and income standards and protective family environments, increased access to health services, and more civil society support to facilitate health improvements. Community health action addresses both positive and negative determinants of health.

Policy Context

This section highlights the major global and national policy orientations and provisions that guide the planning and implementation of community health programmes in the country.

The World Health Organization (WHO) views health not merely as the absence of disease, but as a positive concept that emphasizes the harnessing of social, personal, and physical resources for the improvement of health-enhancing conditions and wellbeing. It is for this reason that community health programmes increasingly address social, behavioral, and policy elements in addition to provision of curative services. The WHO Report on Macroeconomics and health inextricably links economic development and health. The WHO Commission Report on the Social Determinants of Health[5] demonstrates that the high burden of illness responsible for appalling

5 CSDH(2008).Closing the gap in a generation: health equity through action on the social determinants of health. Geneva, World Health Organization.

premature loss of life arises in large part because of the conditions in which people are born, grow, live, work, and age.

Primary health care (PHC) provides the broad policy basis for community health. PHC is founded on the concept that health is a fundamental human right and that the attainment of the highest possible level of health is an important social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. PHC constitutes the backbone of community health of the poor. Experience now shows that MDG achievement requires countries to engage in partnerships to facilitate implementation and support active community participation in programmes aimed at achievement of MDG targets.

Kenya's Vision 2030 clusters health within the social pillar. This clustering emphasizes the need to tackle broad, underlying determinants of health such as food security, most of which lie outside the health sector. Vision 2030 recommends the devolution of funds and management of health care to communities in counties. Revitalization of community health centers is a government of Kenya priority aimed at promoting preventive health care (as opposed to curative intervention) and healthy lifestyles. Two chapters of Kenya's new Constitution – the bill of rights and the devolved government – indicate the responsibilities of the state in the allocation of and accountability for health resources; the rights of individuals to the highest attainable standards of health, life, freedom from hunger; and the rights of special groups. The new Kenya Health Policy 2012 addresses several issues relevant to community health. The policy delineates the various stakeholder roles in health. Most importantly, the policy stipulates the community level as an official (first) tier of the health system. The Kenya Health Sector Strategic and Investment Plan (KHSSP) 2013-2017 provides the Health Sector's Medium Strategic Term focus. Priority interventions of this Strategy are aligned to the six policy objectives listed in the KHSSP. Kenya's health promotion strategy has components directly relevant to community health. The strategy calls for implementation of comprehensive, participatory interventions to ensure maximum impact and sustainability. The strategy identifies five areas of action (build healthy public policy, creating supporting environment, enhancing community empowerment, develop personal skills and reorient health services)[6] for any community health intervention.

Political Context

Since devolution, Kenya has allocated more resources and responsibilities for delivery of health care to the counties, thereby empowering Kenyan households and social groups to take charge in improving their own health.

There is a limited health work force at the community level, although the community strategy received a major boost when the economic stimulus program employed 2,100 community health extension workers (CHEWs) on contract, and the current government has prioritized the preventive strategy which envisages working with community health workers.

Legal and Institutional Context

The Kenya Constitution 2010 demands the highest attainable standard of health for every citizen. To fulfil the constitutional requirement, the country developed Vision 2030. In order to achieve the aspirations of this vision, especially the social pillar, good health is important. The community health strategy is one of the approaches the government has adopted in its quest to achieve Vision 2030. The importance of community health services (CHS) has since been restated in the Kenya Health Policy Framework 2013-2030, as well as in the Kenya Health Strategic and Investment Plan 2014-2018.

6. MOH 2013, National health promotion strategy (2013-2018); reorienting health

Social, Economic, and Cultural Context

The country has diverse socio-economic features as well as cultural contexts. The current poverty level is 45% (MTP II)[7]. Marginalized and nomadic populations have poor access to health services, and limited budgets from the treasury support the community health strategy. Government health investment as per the WHO recommended 5km radius reach of health facility in Kenya is at 48 % (MTP II). Social reciprocity and strong social community structures networks have supported uptake of health services. However, there are cultural barriers that hinder uptake of health services.

Technological Context

There is wide coverage of mobile phone ownership in Kenya: approximately 93% of Kenyan households own mobile phones (WHO 2011)[8]. However, the proportion of the population that has access to this technology varies from community to community, depending on socioeconomic conditions. The Ministry of Health has an eHealth strategy aimed at facilitating delivery of health services in the country. Various platforms are used for reporting health indicators and health care service delivery in the communities and health facilities. The use of mHealth and eHealth technology is increasing. The implementation of mHealth and eHealth is, however, siloed and at micro levels, and most of the platforms are managed independently by diverse development partners who are supporting community health volunteers (CHVs) with smart phones for relaying data. It is important that community health services and facilities stay up to date with the current widely used technologies.

7GOK 2013,2nd MTP(2013-2017);transforming Kenya: pathway to devolution social economic development equity and national unity.
8. WHO 2011, m-Health- new horizons for health through mobile technologies; Global observatory for ehealth series-volume 3

SWOT analysis by theme according to the 2006 Community strategy document

The SWOT focuses on the community strategy document, and analyses each of the seven building blocks in the Kenyan health care model:

1. Leadership and governance

There is a well-defined structure of linkages between the community and facilities, with the Community Health Committee (CHC) as the governing structure at the community level. These committees have played a key role in increasing awareness of health rights, raising social accountability, and growing advocacy efforts. The CHC roles and structures are also clearly defined. However, coordination mechanisms and the linkages between CHC and Health Facility Management Committees (HFMC) are weak. Irregular stakeholder forums coupled with lack of guidelines for CHC members on their tenure, poorly oriented staff, absence of remuneration for work done, poor feedback and information flow and use, the split of the Health Ministry into two parts in 2008 (now reintegrated), CHCs' demands for stipends, and frequent transfers and/or removal of focal persons and CHEWs greatly affects leadership and governance at the community level. The existence of the CHS focal persons at county and sub-county levels, the approved scheme of service, county health stakeholder forums for advocacy and sensitization, and the recognition of the CHCs present opportunities for strengthening community leadership and governance.

2. Health Workforce

The well-defined roles of the CHVs and CHEWs, and their spirit of volunteerism and social reciprocity, form a strong base for community health services. However, the high dropout and turnover rates of CHVs and lack of clear training guidelines and job descriptions at the managerial level have weakened service delivery. In addition, the community strategy, 2006 assumed a uniform structure for the whole country that has not worked well due to the diversity of populations. Lack of a uniform human resource model gave room for diverse number of CHEWs in community units. The approved scheme of service for CHEWs is an opportunity for those interested in delivering community health services, but the heavy workload could be a threat. A human resource model for community health personnel comprising of 5 employed CHEWS per community health unit was recommended.

3. Service Delivery Systems

The 2006-10 community health strategy defined service delivery by age specific cohorts, and since its launch, there has been improved uptake of these services. The community entry process is also well defined. However, there are no stipulated working hours for CHVs, and the process of assigning households to CHVs uniformly has greatly affected their output. Other factors affecting service delivery include; unclear terms of service, poor linkage mechanisms, weak engagement of communities, and poor understanding of dialogue days. The major

opportunities for the new strategy include: devolved system that engenders local planning and decision making, the scheme of service for CHEWs, and the dialogue philosophy.

4. Information System

The existence and linking of the Community Health Information System to the District Health Information system, and the revision of tools, are important steps toward ensuring that this information is used for decision making. However, the information system faces a number of challenges which include: lack of a clear M&E plan, inadequate reporting tools, limited knowledge of the indicators among the users, and erratic reporting, among others. The newly hosted Community Health Services website and the Master Community Unit Listing, the acceptance of eHealth by the ministry, operations research for evidence, and the on-going review of the strategy and the many guidelines in the process of development will further address the weaknesses of the information system. Currently there is low demand and use of the Community Health Information System, which threatens further development of the system.

5. Commodities and Supplies

Some Community Health Volunteers have bags and kits for service delivery, but these are only in selected partner-supported community health units. Even where available, lack of guidelines on managing the kits is a challenge. In addition, the cost of the kit and poor forecasting are major challenges in its consistent use. In some instances there is revision of the kit content and its alignment to what is available at the link health facility, and with the responsibility of kit mobilization integrated in the health facility supplies.

6. Community Health Financing

This is one of the weakest areas of the 2006 community health strategy, as there are no provisions for sustainable mechanisms and incentives in place. The revised strategy will therefore focus on the use of the popular Income-generating Activities (IGAs), as well as provide for sustainable funding mechanisms and incentives. The other opportunities that exist are the use of the devolved governments' resources, the National Hospital Insurance Fund (NHIF), and the exploration of domestic financing for specific health interventions. The main challenge is the irregularity, inconsistency, and inadequacy of remuneration which has stifled CHVs motivation.

7. Health Infrastructure

Few areas have been supplied with means of transportation, such as motorcycles and bicycles. However, current guidelines do not address the provision and management of motorcycles and bicycles. There are also no designated meeting places for the community health workforce. Guidelines for transport and community resource centres would improve the situation.

Justification for the Review

The first edition of the Community Health Strategy, "Taking KEPH to the Community: A Strategy for Delivery of Level One Services", was launched in 2006. The strategy was based on the National Health Policy Framework 1994 and the second National Strategic Plan 2005-2010, which has since been revised in line with the new Constitution of Kenya 2010.

The new Kenya Health Policy 2012-2030 provides direction to ensure significant reduction in the overall ill health in Kenya in line with the country's Vision 2030 and the Constitution of Kenya 2010. This is a sector-wide commitment under government stewardship to ensure the country attains the highest possible standards of health in a manner responsive to needs of the population. As a result of these policy changes, the implementation strategies, including the community health strategy, needed to be revised. In addition, the implementation experience of the first community strategy calls for innovative approaches where the determinants of health are addressed through people's participation. This revised strategy introduces an innovative, developmental approach, in which the determinants of health are addressed through people's participation at community level in both health systems issues as well as in a broader range of health actions in various sectors. It envisages building the capacity of households not only to demand services from health providers, but also to know and progressively realize their rights to equitable, good quality health care. The strategy is designed to be comprehensive, balanced, and coherent, and focuses on the two key obligations of health: contribution to economic development as envisioned in Vision 2030, and the realization of fundamental human rights, including the right to health, as enshrined in the Constitution of Kenya 2010 and other key policy documents, Constitution of Kenya 2010

The constitution provides an overarching conducive legal framework for ensuring more comprehensive and people-driven health services, and ensuring that a rights-based approach to health is adopted and applied in the country. Two critical chapters define the ways of addressing health issues and have direct implications on the health sector focus, priorities, and functioning: The Bill of Rights, and the Devolved Government.

Main constitutional articles that have implications on health

ARTICLE	CONTENT
20	20a) Responsibility of State to show resources are not available 20b) In allocating resources State will give priority to ensuring widest possible enjoyment of the right
43	(1) Every person has the right— (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; (b) to accessible to reasonable standards of sanitation; (c) to be free from hunger and have adequate food of acceptable quality; (d) to clean and safe water in adequate quantities; (2) A person shall not be denied emergency medical treatment
26	Right to life: ▪ Life begins at conception ▪ No person deprived of life intentionally ▪ Abortion is not permitted unless for emergency treatment by trained professional
32	Freedom of conscience, religion, belief, and opinion

ARTICLE	CONTENT
53-57	Rights of special groups: ▪ Children have right to basic nutrition and health care ▪ People with disability have right to reasonable access to health facilities, access to materials and devises ▪ Youth have right to relevant education and protection to harmful cultural practices and exploitation ▪ Minority and marginalized groups have right to reasonable health services
174	Objectives of devolution vs fourth schedule on roles; **National:** Health policy; National referral facilities; Capacity building and technical assistance to counties **County health services:** County health facilities and pharmacies; Ambulance services; Promotion of primary health care; Licensing and control selling of food in public places; Veterinary services; Cemeteries, funeral parlors and crematorium; Refusal removal, refuse dumps and solid waste **Staffing of county governments:** Within frame work of uniform norms and standards prescribed by Act of Parliament establish and abolish offices, appointment, confirmation and disciplining staff except for teachers
176	County Governments will decentralize its functions and its provision of services to the extent that it is efficient and practicable
183	Functions of County Executive Committees
235	Transfer of functions and powers between levels of Government

Kenya Vision 2030

The Government of Kenya developed Vision 2030 as a long-term development plan for the country. The aim of the Kenya Vision 2030 is to create "a globally competitive and prosperous country with a high quality of life by 2030" through transforming the country from a third world country into an industrialized, middle income country.

Kenya Vision 2030 recognizes the revitalization of community health centers, referred to as Community Health Units, through the implementation of a community health strategy. The strategy is a flagship project for the Kenya Vision 2030 aimed at promoting preventive health interventions as opposed to curative care. Increased attention will be given to improving the nation's health infrastructure, particularly in rural and severely deprived areas and communities. This approach will achieve major gains through the involvement of local communities in the management of health services.

The vision recognizes the role of the private sector in improving the delivery of health care in partnership with the public sector. The overall goal is a paradigm shift that will bring fundamental changes to the way health services are delivered in Kenya.

Kenya Health Policy Framework (2014-2030)

The health sector has the Kenya Health Policy framework (KHPF) to guide attainment of long-term health goals sought by the country, outlined in the Vision 2030 and the 2010 constitution.

The policy framework has, as an overarching goal, **"attaining the highest possible health standards in a manner responsive to the population needs".** The policy aims to achieve this goal through supporting provision of *equitable, affordable, and quality health and related services at the highest attainable standards to all Kenyans.*

The **target** of the policy is to attain distribution of health at a level commensurate with that of a middle income country. It focuses on attaining two critical obligations of the health sector: a rights-based approach, and ensuring health sector contribution to the country's development.

The Kenya Health Policy recognizes the need to facilitate provision of health promotion and targeted disease prevention /curative services through community based initiatives as defined in the 2006 Community Health Strategy. The aim of the community health strategy is to empower communities to actively participate in health related issues and interventions. The community will be able to decide, implement, and monitor interventions initiated in their communities. The community strategy will build demand for services through improving

community awareness and health seeking behaviors of households. Some of the key services that the community health strategy will facilitate include: facilitate individuals, households, and communities to embrace appropriate healthy behaviors; provide agreed upon health services; recognize signs and symptoms of conditions requiring referral; and facilitate community diagnosis, management, and referrals.

Kenya Health Sector Strategic & Investment Plan (2013-2018)

The Health Sector in Kenya is designed to respond to expectations of the state (through the Constitution), the Government (through the Vision 2030), and the international community (through international obligations). This strategic plan provides the Health Sector Medium Term focus, objectives, and priorities to enable it move towards attainment of the Kenya Health Policy Directions. It guides both County and National Governments on the operational priorities they need to focus on in health. The sector strategic plan focuses on five life cycle cohorts and four tiers of service delivery under KEPH. Community (tier one), is the foundation of the health care service delivery system for demand creation, health promotion, diseases prevention, and referrals.

Strategy for Community Health Service

Preamble

The Constitution of the World Health Organization (WHO) states that "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition."8 The right to health is not only about access to health services; it is also about access to the underlying determinants of health, such as safe drinking water, adequate sanitation, and housing. The right to health also contains freedoms, entitlements, and responsibilities. The community health approach is an effective means for bringing about improvement in health as well as for addressing the underlying determinants that contribute to a heavy burden of disease, and thus contribute to health and socioeconomic development. This strategy provides a strategic approach for the provision of community health services for the period 2014-2018. It contains the vision, mission, purpose, strategic objectives, strategies, and monitoring mechanisms. It cuts across the seven building blocks of the Kenyan health model and is envisioned to be realized through the various implementation guidelines as proposed in the document.

Vision, Mission, goal and guiding principles

Vision

Healthy people living healthy and good quality lives in robust and vibrant communities that make up a healthy and vibrant nation.

Mission

The community health approach will become the modality for social transformation for development by establishing equitable, effective, and efficient community health services all over Kenya.

Overall Goal

The goal of the strategy is to improve people's health and wellbeing through comprehensive, participatory community programmes that effectively address the determinants of health.

Purpose

The purpose of the strategy is to put in place a framework for the development and implementation of comprehensive community health services for Kenya. The framework is built through consolidation of existing structures, mechanisms, and tools, as well as the introduction of new ones as needed.

Guiding Principles

The implementation of the strategy shall be guided by the following principles:

a. Health is a basic human right

b. Technical and cultural appropriateness

c. Participatory approaches

d. Inter-sectoral, multidisciplinary, and inter-institutional collaboration

e. Use of innovation and appropriate technology

f. Due consideration for gender, equity, and the dignity of human life

Strategic objectives

1. Strengthen the delivery of integrated, comprehensive, and quality community health services for all cohorts
2. Strengthen community structures and systems for effective implementation of community health actions and services at all levels
3. Strengthen data demand and information use at all levels
4. Strengthen mechanisms for resource mobilization and management for sustainable implementation of community health services

Key Interventions with Expected Results and Action Areas per Strategic Objective

Strategic Objective 1:

Strengthen the delivery of integrated, comprehensive, and high quality community health services for all cohorts

Expected Result 1: Integrated and comprehensive community health service implementation

Reviewed community health service package

Indicator – Finalized harmonized community health service package

Operationalized CHS package

Indicator – Operational guidelines developed

Indicator – Number of counties disseminated to with community health service package

CHS personnel conversant with the reviewed service package

Indicator – Proportion of community health personnel oriented on updated community health service package

Indicator – Number of community health units (CHUs) implementing updated community health service package

Expected Result 2: Standardized Implementation of CHS

CHS standards developed

Indicator – Tier one standards in place

Tier one standards disseminated to counties

Indicator – Number of tier one standards dissemination meetings

Institutionalized community health component in pre service health related courses

Indicator – Number of training curricula with community health component incorporated

Expected Result 3: Increased CHU coverage in underserved population

Indicator – New CHU established in underserved population

Nonfunctional CHU operationalized

Indicator – Proportion of functional CHU

Expected Result 4: Increased utilization of health services especially among the vulnerable populations

Households aware of available CHS

Indicator – Proportion of households aware of CH services

Increased utilization of health services

Indicator – % increase in health services utilization

Strengthened referral systems at the community level

Indicator – Number of referrals from the community to higher levels of care

Strategic Objective 2:

Strengthen community structures and systems for effective implementation of community health actions and services at all levels

Expected Result 1: Strengthened governance and leadership for community health actions at all level

Community Health Policy developed

Indicator – Community health policy document

CHS Policy disseminated

Indicator – Number of counties where CHS policy has been disseminated.

CHU functionality assessment tool customized

Indicator – Customized CHU functionality assessment tool

CHU functionality assessment conducted

Indicator – Number of CHU assessed

Quarterly meetings between tier one and other levels held

Indicator – Proportion of CHUs holding meetings between tier and other levels of care

Quarterly stakeholder's fora held

Indicator – Proportion of CHUs holding quarterly stakeholders forums

Quarterly dialogue days held

Indicator – Proportion of CHUs holding quarterly dialogue meetings

Monthly community action days held

Indicator – Proportion of CHUs holding monthly action days

Expected Result 2: Increased human resource for health for tier 1

A human resource model for community health workforce adopted and institutionalized

Indicator – proportion of counties implementing the HRH community personnel model

Increased health workforce for Tier 1 of the health system

Indicator – Number of tier one workforce recruited and deployed.

Indicator - Proportion of community units with the recommended number of community health personnel (5 CHEWS)

Expected result 3: Enhance human resource capacity for development and implementation of community health at all levels

Competency based Training and Accreditation tools for community health personnel developed and operationalized

Indicator – Proportion of counties using approved curricular and accreditation tools

A competency based CH training facilitator's guide developed and used to facilitate trainings

Indicator – Proportion of institutions using the facilitator guide

Adoption of motivation guideline for tier one workforce by counties

Indicator – proportion of counties using the motivation guideline

Expected Result Area 4: Strengthen institutional capacity for implementation of community health services at all levels

Policy briefs developed and disseminated

Indicator – Number of policy briefs developed

Indicator – Number counties disseminated with policy briefs

Capacity of CHS workforce strengthened

Indicator- Training needs assessments

Indicator- Number of CHS workforce trained / retrained

Expected Result Area 5: Empower communities to ensure improved capacity to take charge of their own health

Stakeholder's forums held

Indicator – Proportion of sub-counties holding stakeholders forum

Households trained on livelihood improvement

Indicator – % of household being trained on livelihood improvement

Community champions for positive behavior in place

Indicator – Proportion of CHU with community champions

CHVs using job aid

Indicator – CHV job aid in place

Indicator – Proportion of CHVs using the CHV job aid

Strategic Objective 3:

To strengthen data demand and information use at all levels

Result Area 1: Strengthened Community Health Information Management System

CHS dashboard developed and routinely updated

Indicator – Updated CHS Dashboard

MCHUL fully operationalized and utilized to inform strategic programming decisions at national, county and CHU levels

Indicator – Updated MCHUL

Orientations/Trainings of CHEWs, Sub-County and County CHS Focal persons on MCHUL, DHIS2, revised CHIS tools conducted

Indicator – Number of orientations / trainings conducted

Indicator – Proportion of CHEWs, sub-county and county focal persons trained

Zero stock out of CHIS tools

Indicator – Proportion of community health units reporting zero stock outs of CHIS tools

Adoption of mhealth in routine reporting

Indicator – Proportion of sub county reporting through the mHealth application

Result Area 2: Strengthened performance monitoring of community health program

Civil Society Organization (CSO) data interoperable with routine Community Health Information System

Indicator – Interoperable system in place

HRH data base for Tier1 Developed and linked to the MOH HRH database

Indicator – Availability of tier 1 HRH database

Revised standardized Community Health Information Data Capture and Reporting Tools (MOH: 100, 513, 514, 515, 516,), serialized and disseminated to all counties

Indicator – Number of data tools dissemination meetings held

CHU Functionality matrix/score card harmonized

Indicator – A harmonized matrix in place

DQA, Data Quality Checks and Data Quality Improvement Plans Institutionalized

Indicator – Number of routine data quality audits/checks

Routine CHU Data Quality Audits conducted and action plans developed to inform activity programming

Indicator – Proportion of CHU data quality audits with action plans developed

Quarterly CHS-ICC held

Indicator – Number of ICC meetings

Quarterly AWPs review meetings held

Indicator – Number of AWP review meetings

Routine support supervision conducted to improve quality of service provision

Indicator – Number of sub counties conducting supportive supervision

Harmonized quarterly and annual reporting of CHS services

Indicator – Harmonized CHS reporting tool

Indicator – Proportion of counties reporting through the standardized tool

Result Area 3: Mechanisms for Knowledge Management in Place

CHS knowledge management framework and portal developed and utilized

Indicator – Knowledge management framework and portal

A Community of Practice (CoP) for the CHS developed and operationalized

Indicator – A functional community of practice

CHS workforce capacity in research and implementation strengthened

Indicator – Number of CHS workforce trained in research

Technical documentation of CHS conducted and knowledge products shared with the global community

Indicator – Number of CHS knowledge products developed

Cost-benefit analysis, cost-utility, and cost-effectiveness of CHS evaluative researches conducted

Indicator – A research agenda

Indicator – Number of evaluative research conducted

Research on performance-based Incentives/funding conducted

Indicator – Number of performance based incentives researches

Data-based evaluations/ evaluative studies conducted

Indicators – Community Health Services (CHS) Policy briefs developed

Indicator – Number of policy briefs

Community Health Services (CHS) annual newsletter produced

Indicator – Annual newsletter

M&E PLAN finalized and aligned to the CHS Strategy

Indicator – M&E plan

CHS research institutionalized

Indicator – OR unit in CHS

Indicator – Research agenda

Strategic Objective 4:

Strengthen mechanisms for resource mobilization and management for sustainable implementation of community health services

Expected Result 1: Strengthen Advocacy and Lobbying

Advocacy training for national and county teams conducted

Indicators – Proportion of counties with trained health teams on advocacy

Indicator – Number of national CHU personnel trained on advocacy

Mass media campaigns executed

Indicator – Number of mass media campaigns

Advocacy packs disseminated

Indicator – proportion of counties reached with dissemination meetings

Branded campaigns supported through social media

Indicator – Number of branded campaigns

Advocacy forums for local media at national and county level held

Indicator – Number of media advocacy forums

Resource mobilization strategy developed and utilized

Indicator – Resource mobilization strategy

Expected Result 2: Strengthened Partnerships and Collaboration (institutional linkages) for increased resource mobilization

Partners' participation scale up of Community Health Services increased

Indicator – Number of partners participating in CHS

Expected Result 3: Health Financing for CHS strengthened

Increased establishment of CHUs

Indicator – Proportion of new CHUs established

Strengthened Public-Private Partnerships

Indicator – Number of private partners participating in CHS activities

Tier-1 itemized in the HSSF budget allocation and disbursements

Indicator – Budget allocation for tier 1 in the health sector service fund (HSSF)budget

Increased NHIF coverage at tier 1

Indicator – Number of households covered under NHIF

Strengthened entrepreneurial/ livelihoods activities at community health unit level

Indicator – proportion of Community Health units with active Income generating activities (IGAs)

Implementation Framework

Implementation Context

The community health arena is more complex than ever before. There are more stakeholders, most of whom interact with – but are not from – the health sector. Communities are more diverse and are assertive regarding their rights to health to a degree previously unimaginable. All of these developments, together with a new constitution and devolved governance, call for innovative ways of organizing implementation of interventions so that they can yield maximum benefits to communities. The national and county governments will coordinate inputs from all players and stakeholders in implementation of the Community Health Strategy.

In the devolved system of governance, county governments have primary responsibility for implementing community health programs. County governments shall therefore undertake the following:

- Convene and host working groups
- Adopt/adapt the revised CHS implementation package
- Conduct participatory monitoring and evaluation
- Manage and share knowledge

The national government shall have the following specific responsibilities:

- Carry out analyses and determine the technical resource requirements and structures required for development and implementation of CHS
- Organize training/orientation for Counties
- Provide technical support for County Teams for CHS
- Guide and support program monitoring and operations research relating to CHS
- Facilitate synthesis of results and sharing of lessons learned in successful implementation of CHS in counties

Coordination of Interventions

The implementation of the community health strategy (CHS) will utilize the Ministry of health management structure which will guide the mechanisms for collaboration, coordination, and partnerships. The national Community health unit shall provide the necessary guidance and protocols for CHS implementation while the County governments shall provide coordination of the strategy activities within the county through designated county community health coordinators. will be re-aligned to the devolved governance system.

Partner/Stakeholder roles and responsibilities

1. **National and County Government**
    - Develop policies and guidelines for community health services
    - Allocate resources for community health and coordinate resource mobilization, allocation, and management from partners/players

- Disseminate policies, principles, and guidelines for community health services
- Provide leadership for the mobilization, generation, and allocation of resources for community health services
- Enhance the capacity of stakeholders for community health implementation
- Create/strengthen linkages with public and private sectors involved in community health programs
- Advocate for the support of community health programs
- Coordinate all stakeholders and players
- Monitor and evaluate community health services
- Create an enabling environment for community health development
- Establish and maintain relevant management structures
- Facilitate prevention and resolution of disputes among stakeholders
- Pioneer technology and innovation in community health services
- Facilitate appropriate community health knowledge management

2. Community health committees (CHC)

- Understand and own the strategy
- Actively contribute to the implementation of the strategy
- Evaluate the strategy implementation and provide feedback to stakeholders at the community level, including the link health facilities
- Implement relevant aspects of the strategy, e.g., provide the work force
- Provide social accountability to community members by attending dialogue days and sharing community issues and participating in action days
- Participate in annual work plan development at community level
- Participate in health data collection and utilization
- Advocate to the county leadership for various community health needs
- Generate information towards the future review process

3. Development/Implementing Partners

- Model implementation and share experiences
- Provide technical support in developing policies strategies and guidelines
- Mobilize resources, e.g., financial support, equipment, and supplies
- Support implementation of CHS work plan
- Support monitoring and evaluation of CHS activities
- Promote innovation in CHS
- Undertake human resource support-engagement, capacity building and motivation
- Support coordination of CHS through participation in relevant interagency coordination committees (ICCs) and stakeholders forums
- Advocate with government at all levels for community health
- Conduct research to inform policy

- Promote equity in the implementation of CHS
- Support documentation of best practices in the implementation of CHS

4. Private Sector

- Contribute financial resources
- Facilitate community infrastructure repair and establishment
- Engage in health promotion activities
  - service provision – medical camps
  - promotion through campaigns
  - humanitarian responses
- Support capacity building
- Provide advocacy and communication support.
- Target the community health services through corporate social responsibility
- Conduct social mobilization activities
- Improve livelihood through employment to the community
- Develop products that promote health
- Conduct health education through advertisement

5. Academic and research institutions

- Provide trainings for community health professionals
- Provide continuous education for community health professionals
- Undertake operational and other research on community health
- Publish research results and experiences on community health and disseminate

6. Civil society organizations

- Advocate for community health strategy implementation
- Initiating public accountability and transparency in resource allocation and utilization
- Represent public interest in policy development
- Mobilize and build consensus and enhance public support for CHS
- Promoting Equity in provision of health services

Implementation Plan and Budget

Strategic Objective 1: Strengthen the delivery of integrated, comprehensive and quality community health services for all cohorts

Specific objective 1.1: To establish an integrated and comprehensive community health service package

Expected Outcome: Integrated and comprehensive community health service implementation

AWP: Activity Ref:	Indicator Ref:	OUTPUT	Source (Ministry/Other)	ACTIVITY	TARGET	Responsible Party	YEAR					Budget (Kshs)
							1	2	3	4	5	
		1.1.1: Reviewed community health service package		1.1.1.1 Review and update existing community health service package with emphasis on high impact interventions.	13 High impact interventions	Directorate of planning		x	x			10m
		1.1.2: Operationalized CHS package		1.1:2.1 Develop operational guidelines for implementation of the updated community health package		Directorate of planning		x	x			5m
				1.1.2.2 Disseminate community health service package and guidelines to counties	47 counties/ implementing partners	CHU			x	x		6m
				1.1.2.3 Implement the reviewed community health service package	47 counties/ implementing partners	CHU		x	x	x		TBD
		1.1.3: CHS personnel conversant with the reviewed service package		1.1.3.1 Re-orient community health personnel on the updated community health service package	47 counties	CHU		x	x	x	x	11m
				1.1.3.2 Quality Assurance on roll out of the community health service package	47 counties	CHU		x	x	x	x	25m

Specific objective 1.2: To establish norms and standards for community health services

Expected Outcome: Standardized implementation of CHS

		1.2.1 CHS standards developed		1.2.1.1 Develop CHS standards		CHU/Div. SQA	x					2m
		1.2.2: CHS standards disseminated to counties		1.2.2.1 Disseminate CHS standards to 47 counties		CHU/Div. SQA		x				6m
		1.2.3: Institutionalized community health component in pre service health related courses		1.2.3.1 Advocate for inclusion of community health component in pre- service training curricula for all health related courses	50% of accredited institutions	Training institutions		x	x			TBD
Specific objective 1.3: To increase access to community health services especially among the vulnerable populations **Expected Outcome.** Increased coverage of CHUs in underserved populations **Expected Outcome:** Increased utilization of health services especially among the venerable populations												
		1.3.1: Increased CHU coverage in underserved population		1.3.1.1 Establish new CHUs targeting underserved regions	1500 CHUs	Counties and partners	x	x	x	x	x	450m
		1.3.2: Nonfunctional CHUs operationalized		1.3.2.1 Conduct basic training and refresher training for CHEWs and CHVs in providing community health services including special groups	4461 CHEWs and 80% of CHVs	Counties and partners	x	x	x	x	x	TBD
				1.3.2.2 Ensure continuous supply of community health services kit	A kit for 80% of CUs	Counties and partners	x	x	x	x	x	TBD
				1.3.2.3 Provide transport facilities for community-level workforce	Motorbikes for 80% of CHEWs, bicycles for 80% of CVHs	Counties and partners	x	x	x	x	x	179m
				1.3.2.4: Conduct joint meetings between CU and link facility e.g. conduct dialogue and action days	71, 376 dialogues	Counties and partners	x	x	x	x	x	714m
		1.4.1: Household aware of available community health services		1.4.1.1: Raise awareness about available community health services	80% households in established CUs	Counties and partners	x	x	x	x	x	TBD
		1.4.2: Increased utilization of health services		1.4.2.1.Mobilize the community to demand CHS services	80% households in established CUs	National Counties and partners	x	x	x	x	x	TBD
		1.4.3 Strengthened and functional referral systems at the community level		1.4.3.1: Sensitize link facility health workers on existence and functionality of community referral system	80% of link facility staff	Counties and partners	x	x	x	x	x	TBD

Strategic Objective 2: Strengthen community structures and systems for effective implementation of community health actions and services at all levels

Specific Objective 2.1: Strengthened governance and leadership for community health actions at all level

Expected Outcome: National Community Health Policy operationalized and institutionalized
Expected Outcome: CHS governance and leadership structures strengthened at all levels
Expected Outcome: Increased demand for Health services
Expected Outcome: Increased accountability for health services

AWP: Activity Ref:	Indicator Ref:	OUTPUT	Source (Ministry/ Other)	ACTIVITY	TARGET	Responsible Party	YEAR					Budget (Kshs)
							1	2	3	4	5	
		2.1.1 Community health policy developed		2.1.1.1 Develop a framework for community health policy	Policy framework	National MOH UNICEF	x	x				13 m
				2.1.1.2 Develop a CHS policy document	Policy framework	National MOH UNICEF	x	x				
		2.1.2 CHS policy disseminated CHU functionality assessment tool customized CHU functionality assessment conducted		2.1.2.1 Disseminate the CHS policy document	47 counties	National Counties and Partners		x	x			10m
				2.1.2.2 Adapt existing CHU functionality assessment tool and operationalize		National Counties and Partners		x				1.2m
		2.1.3 Meetings and dialogues between tier 1&2 stakeholders held		2.1.3.1Hold quarterly meeting between tier one and other levels		Counties and Partners	x	x	x	x	x	TBD
				2.1.3.2 Conduct quarterly stakeholder forums	4 national, 188 county	Counties and Partners	x	x	x	x	x	TBD

Specific Objective 2.2: Strengthen community structures and systems for effective implementation of community health actions and services at all levels

Expected Outcome: Strengthened HRH Capacity at tier 1
Expected Outcome: Motivated tier 1 health workforce

AWP: Activity Ref:	Indicator Ref:	OUTPUT	Source (Ministry/ Other)	ACTIVITY	TARGET	Responsible Party	YEAR					Budget (Kshs)
							1	2	3	4	5	
		2.2.1.Increased health workforce for Tier 1 of the health system		2.2.1.1 Lobby County Governments to recruit and retain adequate health workforce for Tier-1 as per the HRH model	47 Counties	MoH	x	x	x	x	x	5m
		2.2.2 Increased capacity of tier 1 health workforce		2.2.2.1 Develop and operationalize competency-based curricular and accreditation tools for community health personnel		MoH	x	x				6m
				2.2.2.2 Develop a CHEW training manual		MoH	x	x				0.5m
		2.2.3 Motivated tier 1 health workforce		2.2.3.1 Develop guidelines for motivation and retention of Community health volunteers		National and counties	x	x	x			2m
				2.2.3.2 Print and disseminate guidelines for motivation and retention of CHVs		National and counties	x	x	x	x	x	1.5m

Specific Objective 2.3: Strengthen community structures and systems for effective implementation of community health actions and services at all levels

Expected Outcome: CHS implementation structures and systems streamlined
Expected Outcome: Empowered health workforce at all levels of Community Health Service
Expected Outcome: Enhanced Collaboration among stakeholders and players
Expected Outcome: Strengthened Coordination structures and engagement procedures for community health programming

AWP: Activity Ref:	Indicator Ref:	OUTPUT	Source (Ministry/ Other)	ACTIVITY	TARGET	Responsible Party	YEAR					Budget (Kshs)
							1	2	3	4	5	
		2.3.1 Capacity of CHS workforce strengthened		2.3.1.1 Conduct training needs assessment	47 county focal persons	National	x	x	x	x	x	0.6m
				2.3.2.2 Provide technical support to CHS workforce at the county level		National and counties	x	x	x	x	x	47m

Specific Objective 2.4: Strengthen community structures and systems for effective implementation of community health actions and services at all levels

Expected Outcome: Enhanced Community participation in recognizing and rewarding community workforce
Expected Outcome: Improved livelihoods of households members
Expected Outcome: Improved social and health behaviour change

AWP: Activity Ref:	Indicator Ref:	OUTPUT	Source (Ministry/ Other)	ACTIVITY	TARGET	Responsible Party	YEAR					Budget (Kshs)
							1	2	3	4	5	
		2.4.1 Communities participate in decision making		2.4.1.1 Advocate for community involvement in stakeholders forums	188 stakeholder forums	Counties partners	x	x	x	x	x	TBD
				2.4.1.2 Advocate for social audits to be conducted	80% of all counties	Counties partners	x	x	x	x	x	TBD
				2.4.1.3 Advocate for the use of a generic template for community work planning and reporting.	80% of all counties	Counties partners	x	x	x	x	x	TBD
		2.4.2 CHVs using job aid		2.4.2.1 Develop community health volunteers job aid		National		x	x	x	x	6m
				2.4.2.2 Disseminate community health volunteers job aid	80% of focal persons and directors	National		x	x	x	x	3m
				2.4.2.3 Print job aids for CHVs	500 copies per county	County		x	x	x	x	12m
				2.4.2.4 Train CHVs on use of job aid	80% of the CHVs trained			x	x	x	x	15m

Strategic Objective 3: To Strengthen data demand and information use at all levels.

Specific Objective 3.1 Strengthened Community Health Information management system

Expected outcome: Improved systems for quality data capture and reporting at all levels
Expected outcome: Collection, analysis and dissemination of key health statistics (both national and sub/national)
Expected outcome: Institutionalized quality audit of Community data

AWP: Activity Ref:	Indicator Ref:	OUTPUT	Source (Ministry/ Other)	ACTIVITY	TARGET	Responsible Party	YEAR					Budget (Kshs)
							1	2	3	4	5	
		3.1.1 CHS dashboard developed and routinely updated		3.1.1.1 Develop a dashboard in DHIS2	47 counties	National/ County		x	x	x	x	Nil
		3.1.2 MCHUL fully operationalized and utilized to inform strategic programming decisions at both national, sub-national and CHU levels		3.1.2.1 Routinely update the MCHUL system		National/ County	x					Nil
		3.1.3 Orientation of CHEWs, Sub county and county CHs focal persons on MCHUL, DHIS2, the revised CHIS tools conducted		3.1.3.1 Facilitate orientation of CHEWs, Sub county and county CHs focal persons on MCHUL, DHIS2, the revised CHIS tools	32 counties	County	x	x				9.6m
		3.1.4 Zero stock out of CHIS tools		3.1.4.1 Provide CHIS to all established CHUs to ensure zero stock of CHIS tools	47 counties	County		x	x	x	x	TBD
		3.1.5 Adoption of mHealth in routine reporting		3.1.5.1 Adopt mobile application for reporting Introduce mHealth in routine reporting		National		x	x	x	x	TBD

Specific objective 3.2: To strengthen performance monitoring of community health program

Expected Outcome: Enhanced results based management of CHS
Expected Outcome: Evidence based decision making

AWP: Activity Ref:	Indicator Ref:	OUTPUT	Source (Ministry/ Other)	ACTIVITY	TARGET	Responsible Party	YEAR					Budget (Kshs)
							1	2	3	4	5	
		3.2.1 Civil society organizations (CSOs) data inter operable with routine community health information system		3.2.1.1 Adopt an interoperability model		National County	x	x	x	x		2m
		3.2.2 HRH data base for tier one developed and linked to the MOH HRH data base		3.2.2.1 Develop tier one human resources data base and link it to the MOH HRH database		National County		x				1.5m
				3.2.2.2 Regularly update the data base		National		x				Nil
		3.2.3 Routine DQA, data quality checks and data quality improvement plans institutionalized		3.2.3.1. Conduct routine CHU Data Quality Audits		National	x	x	x	x	x	5.5m
				3.2.3.2. Develop action plans to inform activity programming		National and county	x	x	x	x	x	0.5m
		3.2.4.Quarterly AWPs review meetings held		3.2.4.1. Convene AWP review meetings	Quarterly	National/ County	x	x	x	x	x	5m
		3.2.5 Routine support supervision conducted to improve quality of service provision		3.2.5.1. Operationalize utilization of the newly-developed support supervision tools	47 counties	County		x	x	x	x	TBD
				3.2.5.2 Conduct routine supportive supervision	47 counties	County	x	x	x	x	x	TBD
		3.2.6 Harmonized quarterly and annual reporting of the CHS services		3.2.6.1 Harmonize program progress reporting using standardized reporting templates at both national and sub-national levels	Monthly and quarterly	National/ County	x	x	x	x	x	0.5m

Specific objective 3.3: To develop mechanisms for knowledge management in place

Expected Outcome: Improved learning and knowledge management based decision making
Expected Outcome: Strengthened evidence base for CH services

AWP: Activity Ref:	Indicator Ref:	OUTPUT	Source (Ministry/ Other)	ACTIVITY	TARGET	Responsible Party	YEAR					Budget (Kshs)
							1	2	3	4	5	
		3.3.1 CHS knowledge management framework and portal developed and utilized		3.3.1.1. Develop a knowledge management framework for the CHS		National		x				1.5m
		3.3.2 A Community of Practice (CoP) for the CHS developed and operationalized		3.3.2.1. Develop a community of practice (CoP) and a Data Use Net for the Community Health Service		National		x				TBD
		3.3.3 CHS workforce capacity in research and implementation strengthened		3.3.3.1 Train CHS workforce in operational research	National and 47 counties	National and county		x	x	x	x	TBD
		3.3.4 Technical documentation of CHS conducted and knowledge products shared with the global community		3.3.4.1. Conduct technical documentation of the CHS (policy brief, program briefs, program updates, technical briefs, technical updates, human interest stories, case studies, success and lessons learned, and best/emerging best practices)		National		x	x	x	x	6m
		3.3.5. Cost benefit analysis, cost utility, cost effectiveness of CHS evaluative researches conducted		3.3.5.1. Conduct operational research on benefit analysis, cost utility, cost effectiveness		National			x	x		TBD

		3.3.6 Research on performance based incentives/funding conducted		3.3.6.1Conduct performance-based incentive research		National		x	x	x		TBD
		3.3.7. Data based evaluation/evaluative studies conducted		3.3.7.1 Conduct evaluations	Annual evaluations	National / County		x	x	x	x	TBD
		3.3.8. Community health service annual newsletter produced		3.3.8.1 Produce CHS annual newsletter	Annual newsletter	National		x	x	x	x	4m
		3.3.9. M&E plan finalized and aligned to the CHS strategy		3.3..9.1 Develop the M&E plan		National		x				6m
		3.3.10. CH research institutionalized		3.3.10.1 Strengthen CHS implementation/health systems research capacity through technical and partnership with research institutions		National		x				TBD

Strategic Objective 4: Strengthen mechanisms for resource mobilization and management for sustainable implementation of community health services

Specific Objective 4.1: Strengthen advocacy and lobbying

Expected Outcome: Strengthened Capacity for expanding resource base for community health interventions
Expected Outcome: Increased Resource envelope for CHS both at the national and County levels
Expected Outcome: Evidence based advocacy kit developed and utilized to guide advocacy efforts

AWP: Activity Ref:	Indicator Ref:	OUTPUT	Source (Ministry/ Other)	ACTIVITY	TARGET	Responsible Party	YEAR					Budget (Kshs)
							1	2	3	4	5	
		4.1.1. Advocacy meetings for national and county teams conducted		4.1.1.1 Conduct advocacy meetings for both national and county teams	47 counties	National and counties	x	x	x	x	x	10m
		4.1.2.Public awareness campaigns executed		4.1.2.1.Develop and execute branded mass media campaign through multiple channels at national and county level to create awareness on the CHS approaches		National and counties	x	x	x	x	x	TBD
				4.1.2.2.Develop and disseminate advocacy packs with different materials targeted to the national, county and community leaders with information on CHS approach		National and counties	x	x	x	x	x	TBD
				4.1.2.3. Support branded campaigns with direct communications through social media (Facebook, twitter), emails, e-shorts, PDF of print adverts.		National and counties	x	x	x	x	x	TBD
				4.1.2.4. Conduct advocacy workshop for local media at National and County level to keep CHS approach issues on the spotlight.	48 media workshops	National and counties	x	x	x	x	x	TBD

Specific Objective 4.2: Strengthen mechanisms for resource mobilization and management for sustainable implementation of community health services

Expected Outcome: Strengthened partnerships and collaboration for increased resource mobilization
Expected Outcome: Increased resources envelope to support CHS implementation at county levels
Expected Outcome: Health financing for CHS strengthened
Expected Outcome: Increased functionality and sustainability of Community Health units
Expected Outcome: Increased resource allocation for community based health financing
Expected Outcome: Improved household livelihoods

AWP: Activity Ref:	Indicator Ref:	OUTPUT	Source (Ministry/ Other)	ACTIVITY	TARGET	Responsible Party	YEAR					Budget (Kshs)
							1	2	3	4	5	
		4.2.1 Increased partners participation in community health scale up		4.2.1.1 Strengthen ICC at national and county level to drive the agenda for repositioning CHS	Quarterly	National and counties	x	x	x	x	x	10m
				4.2.1.2 Map the key stakeholders in community health services		National and counties	x					Nil
				4.2.1.3 Develop a guideline for stakeholder engagement and networking		National and counties		x				0.5m
		4.2.2 CHUs financing mechanisms increased		4.2.2.1 Support CHUs through health financing mechanism	80% of CHUs	County	x	x	x	x	x	TBD
		4.2.3 CHC Gazetted		4.2.3.1 Advocate for a legal framework for gazzettement of Community Health Committees (CHCs)		County	x	x	x	x	x	TBD
				4.2.3.2. Advocate for adoption of community units as spending units	47 counties	County	x	x	x	x	x	TBD
		4.2.4 Tier-1 itemized in the HSSF budget allocation and disbursements		4.2.4.1 Lobby for full roll-out of component 2 of the HSSF which has an allocation for CHS		Natiional and county	x	x	x	x	x	TBD
		4.2.5 Universal health coverage through NHIF at tier 1		4.2.5.1 Advocate for NHIF support to Tier 1		Natiional and county	x	x	x	x	x	Nil
		4.2.6 strengthened entrepreneurial/ livelihoods activities at household level		4.2.6.1 Initiate/strengthen entrepreneurial/ livelihoods support mechanisms at the community level		County	x	x	x	x	x	TBD

Annex

List of Drafters

1	Dr. Patrick Amoth	MOH
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7	Ruth Ngechu	MOH
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15	Kenneth Ogendo	MOH
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17	Daniel Kavoo	MOH
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19	Benjamin Murkomen	MOH
20	Mr. John Mugenyo	Nyeri County
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30	Dr. Linet Aluoch	Capacity Kenya
31	Janet Shibonje	World Vision
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34	Caren Tarus	AMPATH
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37	Salmon Owii	JICA
38	Tom Ngaragari	PSI/Kenya
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40	Joel Milambo	Siaya County
41	Carol Ndegwa	Embu County
42	Rael Kiilu	Nairobi County
43	Francis Odhiambo	Kakamega County
44	Daniel Mwangi	Nakuru County
45	Cathrine Munyoki	Kilifi County
46	Anne Antitu	Kajiado County
47	Margaret Kabue	KANCO
48	Awino Nyamollo	Omega Foundation
49	Florence Anam	NEPHAK
50	Ann Karau	I choose Life
51	Damaris Oyando	WOFAK
52	Jane Otai	JHPIEGO
53	Joshua Malwanga	PS Kenya
54	Lilian Nderitu	MEASURE Evaluation
55	Siyat Gure	Garissa County
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60	Dr Margret Njenga	World Vision
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