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Country Case Study: Kenya

Kenya's community health program was introduced in 2006 and has undergone various evolutions to culminate in an effective and increasingly prominent health program.

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2006:
Global momentum to achieve MDGs led to the development of National Strategy for Community Health in Kenya

2007:
Dispute in the presidential election served as a catalyst for devolution

2010-2012:
Responsibility of health service delivery assigned to the counties while policy, national referral hospitals and capacity building retained with national government. Counties had little clarity on their roles and responsibilities

2014:
Revision of Community Health Strategy (CHS) began

2018:
MTP III (2018-2022) under Kenya Vision 2030 declares CHS as the flagship project and aims to shift CHWs from volunteerism to paid staff

2020:
Development of the Kenya Community Health Strategy and Implementation Plan (2020 - 2024)

2006 — 2007 — 2010 — 2013 — 2014 — 2018 — 2020

2006:
Kenya Vision 2030 launched by President Mwai Kibaki to be implemented through successive five year **Medium Term Plans**

2010:
Kenya moved from being highly centralized to decentralized governance structure that had one national government with 47 counties

2013:
County governments formed and devolution entered a new phase. Health service delivery formally transferred to counties

2014:
Kenya Health Policy framework (2014-2030) called for transformation of health delivery system from being six tiers to a four tier system

The Kenyan health system is organised according to a 4 tier as of 2010. Community Health forms the tier 1 level of care

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Level 1

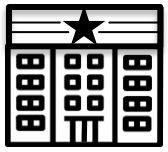
Community Health Services
Comprise community units under Community Health Strategy that provides primary level care to communities

Level 2

Primary Care Services
Comprise all dispensaries (level 2) and health centers (level 3) including those managed by non state actors

Level 3

County Referral Health Services
Comprise primary (level 4) and secondary hospitals (level5) in the county and forms the County Health System



Level 4

National Referral Services
Comprise all tertiary referral hospitals (level 6), National Reference Labs, Govt. owned entities, Research and Training institutions

After Devolution in 2010, counties are responsible to deliver health services and implement health programs

These **services includes**

- Maternal and Child Health
- Prevention and management of communicable diseases
- Prevention and management of non communicable diseases
- Health promotion

Community Health System Review

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Community Health Strategy 2014 - 2019

Strategy Objectives

1. Strengthen the delivery of integrated, comprehensive, and high 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. To strengthen data demand and information use at all levels
4. Strengthen mechanisms for resource mobilization and management for sustainable implementation of community health services

Community Health Stakeholders/Partners

1. National and County Governments
2. Community Health Committee
3. Development/Implementing Partners
4. Private Sector
5. Academic and Research Institutes
6. Civil Society Organizations.

Community Health Structure

One Community Health Unit per 5000 people

10 community health volunteers

5 community health assistants (supervisors)

- Community Health Volunteers (CHVs) are mostly unpaid but under Mid Term Plan III a fixed stipend of 2000 KSH (approx. 20 USD) has been proposed
- Community Health Extension Workers (CHEWs) are recruited and paid by the government. They provide support and supervision to CHWs

Situational Analysis: Community Health Strategy 2014-2019

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What is working well?

- **Devolution** has given County Governments increased ownership and responsibility of health service delivery and an opportunity to prioritize their needs based on the context
- **Robust policy guidelines** under Kenya Vision 2030, Kenya Health Policy Framework (2014-2030) and Kenya Health Sector and Strategic Investment Plan (2013-2018) guides the implementation of CHS by the County Governments
- **Health indicators have improved** especially in terms of maternal and child health since the implementation of the Community Health Strategy (2014 -2019)

What is not working well?

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- Total Health Expenditure remains low at 5.7% of GDP (Abuja Declaration, 2001 pledges at least 15% by all African countries)
- Over reliance of MOH on donors for development budget- > 60% allocation is from donors
- County health budgets continue to remain low
- Some counties face structural and capacity challenges in budget making process
- Some counties invest more in infrastructure of higher level health facilities than investing in CHS

What is not working well?

Program Structure and Prioritization

- Low prioritization by some county governments towards investing in CHS
- Gap in community health workforce to meet the needs of the population
- Dissatisfaction in CHVs due to disincentives like – irregular trainings and supervision, inconsistent remuneration, unclear roles and responsibilities

What is not working well?

Coordination and connection to broader health system

- Many disparate CHV programs across the country with limited or no integration within national health system
- Poor coordination with donors and development partners leading to inefficient utilization of resources and duplication in efforts
- The National Referral System is not standardized compromising the continuity in care from community to higher level
- Lack of evidence underscoring the effectiveness of integrated community health services

Budget allocation to health at a county level: overview of Siaya county

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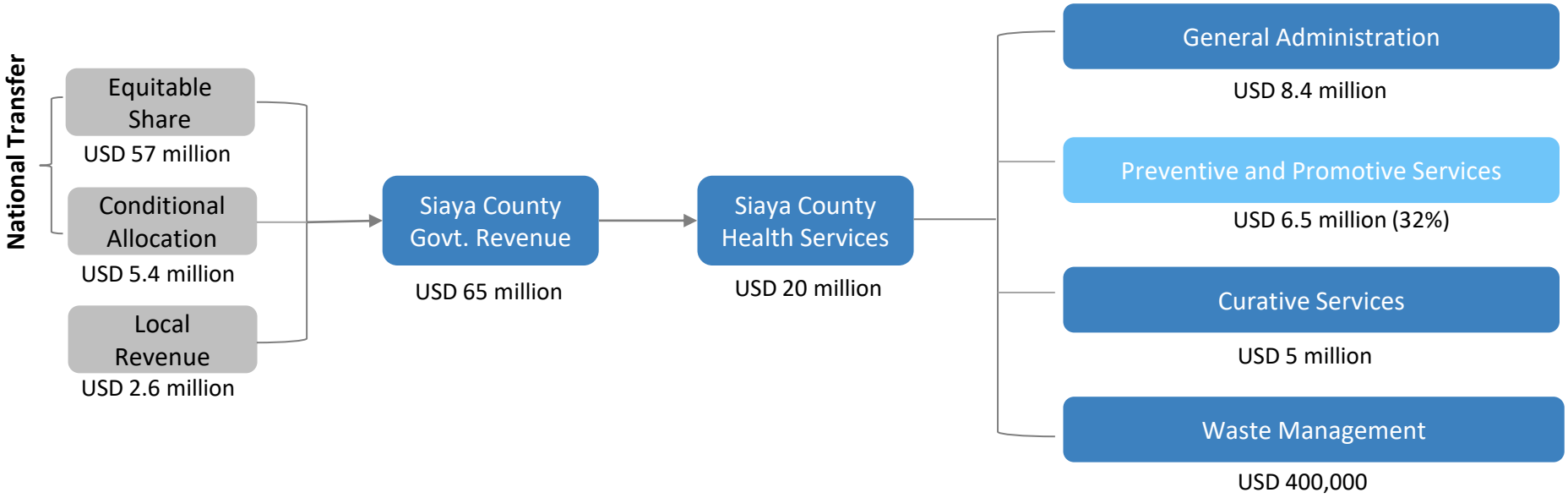
- **Under devolution counties are responsible** for providing primary healthcare services, maintaining dispensaries, health centers and some hospitals
- In addition to transfer from national revenue, **counties are responsible to raise local revenue** from sources like user fees, tax, trade etc.
- In 2016-17, on average the counties allocated **25.2%** of their budget to health **(recommended 30%)**
- Counties that have allocated 30% of their budget to health **are performing better in terms of providing community health services** (example- Elgeyo Markwet, Nakuru, Siaya, Baringo)



Siaya county allocates 32% of its Health Budget to Preventive and Promotive Services, includes CHS

Kenya has multiple independent community health programs with little or no integration with national health system

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	Lwala Community Alliance (LCA)	AMREF Kenya	World Vision International	Millennium Villages Project	Health Right International
Counties Served	North Kamagambo in Migori	Nairobi	35 counties	Kisumu, Siaya (Sauri cluster)	Elgeyo Marakwet
No of CHWs	83	13,586	4725	158	1000
Remuneration	Not salaried but periodically receive monetary incentive	Not salaried but periodically receive monetary incentive	Not salaried but periodically receive monetary incentive	Paid-Salaried	Not salaried but periodically receive non monetary incentive
Categories of Service	MCH, Diarrhea, Family Planning, Immunization, HIV testing	Health promotion, Disease surveillance, Immunization, Sanitation	Child protection and education, Family Planning, Immunization, HIV testing, Sanitation	CCM Malaria, Diarrhea, Family Planning, Immunization, HIV testing, Sanitation	Health Promotion, Family Planning, Immunization, Sanitation
Funding Sources	UNICEF, Child Relief International, Imago Dei, Segal Foundation	UNFPA, USAID, The Global Fund, WHO, other countries	USAID, UNICEF, Global Fund and other international countries	UNICEF, WFP, UNDP, UNFPA	Johnson & Johnson, UN Women, USAID, WHO, Project C.U.R.E, NYU College of Global Public Health
Level of Integration with National Health System	Not integrated	Partially integrated	Partially integrated	Not integrated	Not integrated

1mCHW campaign data exploration tool: http://1millionhealthworkers.org/operations-room-map/
Most of the programs incorporate CHWs recruited under CHS but some NGOs hire independently

Key community health system facilitators

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Key facilitators of a successful and sustainable community health system in Kenya include:

- Mobilizing political will and commitment in a decentralized governance structure
- Feedback loop between county and national government
- Integration of community health into the broader health system
- Mobilizing domestic and innovative financing sources
- Ongoing adaptation and refinement of the community health system
- Fostering coordination with partners for increased harmonization

1) Mobilizing political will and commitment in a decentralized governance structure

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Success factors (in counties doing this well)

Only **9 out of 47 counties** have achieved > 80% target of having one CHU per 5000 population because they:

Allocate greater proportion of their health budget towards CHS and have fixed budget for training, supervision and stipend for CHWs. **Shift from historical budgeting to strategic budgeting**

Organize regular stakeholder meetings and actively participate in county mapping process to determine priority areas and efficient resource allocation

Generate evidence on effectiveness of community health programs to influence other stakeholders

Challenges (in counties that are not doing well)

Less allocation of budget towards Community Health Strategy and more focus towards developing level 2 & 3 health infrastructure

Lack of political influence to engender political will

Poor coordination with development partners

Do not participate in County mapping hence they do not cater to needs of population

Recruitment of CHEWs is a challenge

Opportunities (how they can improve)

Based on expert interviews it is suggested that national govt. should adopt **'Functionality Scorecard'** designed by AMREF to assess Community Health Units on their:

- Management of performance
- Resource allocation
- Decision making

The application of scorecard during pilot phase had led to marked improvement in 16 elements of functionality* in CHUs

Going forward this scorecard can be modified **to capture advanced functionality** of Community Health Units in counties

Appendix slide 29

2) Feedback loop between county and national governments will promote improved dialogue

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Devolution does not automatically translates into increased accountability of county governments if right mechanisms are not in place

CHS was set at the national level, but has not translated into uniform implementation across counties because of gap in knowledge, capacity, and communication. Many counties still struggle with implementing CHS effectively therefore:

- **Establishing feedback loop will improve the dialogue between national and county governments**. Serves as a platform to inform the national level about challenges faced by the local leaders as well as share best practices

- **Capacity development at the county level that focuses on training of county leaders**. At present capacity development is concentrated towards health workforce (CHEWs and CHWs) mostly led by donors. There is a need to strengthen the ability of county leaders to mobilize stakeholders, plan and execute budget and respond promptly to the needs of the public

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3) Integration of community health into the broader health system

In a scenario where multiple fragmented CHW programs exists **recognition of these programs by the MOH** and **incorporation within National Health System** will pave the way for transitioning towards integration

Ideal vs current scenario in Full Integration

Governance

Ideal

Strong leaders at national or local level that drive planning, implementation and coordination.

County governments to have **formal structure for supervision and management** of CHWs.

Provide **technical support** to development partners

Current

Currently Kenya has very fragmented implementation of CHS that varies across the 47 counties

Finance

Ideal

Fixed stipend for CHWs from the county governments.

Increased spending towards community health at county level

Current

In Kenya CHS was based on volunteerism but Mid Term Plan under Kenya Vision 2030 proposes to shift community strategy from voluntarism to paid staff

Service Delivery

Ideal

Standard **guidelines for recruitment & training** of CHWs

CHWs are recognized and accepted by community

Ensuring **availability and accessibility** of supplies and medicines to CHWs

Current

Trainings are irregular and supervision structure is not monitored .
Commodity supplies are mostly funded by donors and sometimes are not available to CHWs

Information System

Ideal

Having **one monitoring framework** that guides collection and transfer of data from community to national level across all CHW programs

Current

Kenya Ministry of Health mandates collection of information at community level. The Information collected by CHW is fed into the District Health Information System by the CHEWs. However, implementation varies widely across counties.

Zulu, J. M., Kinsman, J., Michelo, C., & Hurtig, A. K. (2014). Integrating national community-based health worker programmes into health systems: a systematic review identifying lessons learned from low-and middle-income countries. BMC Public Health, 14(1), 987

4) Mobilizing domestic and innovative financing sources

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Financing to strengthen CHS

- **Nation wide roll out of 'Functionality Scorecard' will drive county governments to increase spending towards Community Health Strategy** in order to improve functionality of the Community Health Units
- **Income Generating Activities (IGAs) –** IGAs empower the CHWs by teaching them skills through which they can seek additional income. These are small scale business managed by a group of people. It can include:
  - Training on organic farming techniques
  - Establishing sewing cooperatives for producing sanitary napkin and uniform at affordable price for community members
  - Training on basic accounting, plumbing, carpentry, brick-laying etc.

  In absence of fixed source of income, county governments should focus on promoting IGAs. **Kenya has started focusing on promoting IGAs but it needs to be adopted across all CHW programs in counties.**

Financing to increase the overall strength of the health system

Government of Kenya abolished user fees for certain groups. For example, expectant mothers can avail primary care facilities free of cost but having other health financing strategy improves access to other health services and strengthens health system

- **National Hospital Insurance Fund:** NHIF covers formal sector workforce in Kenya and offers essential health services free of cost at public and private providers. Recently, NHIF announced working with CHWs in counties to increase enrollment. **Expanding coverage of NHIF will facilitate stronger referrals.**
- **Community Based Health Financing:** Mainly provides coverage to informal sector workforce. **CBHF** funds are used to avail health services at higher level health facilities thus providing the continuum of care across all the levels of the health system. Members of the community play a vital role in mobilizing, pooling, allocating and managing the funds.

5) Ongoing adaptation and refinement of the community health system

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	Original System Design	Changing Implementation or Needs	Adapted System Design
Health Workers and Development	2 CHEWs for 50 CHWs	CHEWs lacked accountability and were seen only as supervisors with minimal community involvement	Revised strategy changed the ratio from 1:25 to 1:2. Better supervision, increased community involvement One CHU for every 5000 people to provide greater accessibility to primary health care
Quality Management	CHS (2006) outlined that a multidisciplinary supervision team will be responsible for performance appraisal	No guidelines on frequency, supervision avenues or how to use data collected	KMQH developed that guides national quality management. Mandates supervision at regular intervals on specific metrics. Supported by various NGOs
Finance	CHWs have irregular source of income	Demotivated CHWs engage in multiple programs to generate income	MTP III (2018-2022) under Kenya Vision 2030 declares CHS as the flagship project and aims to shift CHWs from volunteerism to paid staff Formation of IGAs at Community Health Unit level - additional source of income for CHW and greater community involvement
Information Collection	Multiple data collection source with no formal linkage across programs	Need for readily accessible data for decision making Need to share information with all stakeholders	Establishing Community Health Information System / District Health Information System. All programs whether private, public and NGO have to feed the information on specific indicators

6) Fostering coordination with partners for increased harmonization of CHW programs

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What should Kenya do to increase harmonization of CHW programs?

Although national guidelines suggest adopting **'Three Ones'** to increase mutual accountability, harmonization and alignment in goals between Government and development partners but it is not being implemented.

Kenya should take lessons from **Rwanda** who has successfully adopted 'Three Ones' to bring harmonization across its CHW programs

- One national strategy
- One authority respected by all partners
- One monitoring and accountability framework

EXAMPLE

Kenya AIDS Strategic Framework that guides country's response to HIV/AIDS is aligned with the Three One's principle. However, this needs to be expanded across all CHW programs to facilitate their harmonization

How can community health programs benefit from private sectors and development partners?

Kenya should build strong partnership with development partners, private sector and Faith Based Organizations in order to:

- Strengthen work force and reform incentive mechanism
- Provide technical support and promote innovation in CHS
- Model implementation, generate evidence and share best practices
- Advocacy at all levels for CHS

EXAMPLE

AMREF in collaboration with Global Fund is piloting integrated programs on (HIV+Tb+Malaria) in 3 counties- Homabay, Vihiga and Kwale. At the end of this year, AMREF will generate evidence on effectiveness of integrated community health program, which if proven will help in advocacy.

Also to improve information collection at community level **AMREF has launched m-JALI**, that uses mobile application to record health indicators. This will be integrated in national DHIS.

Community Health Workers and Universal Health Coverage: Framework for Harmonized Support- WHO; Agnes et al. 2016

Key considerations for other countries based on lessons from Kenya

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Lessons from Kenya	Key considerations for other countries
1) Political will	Generating top down political will in a decentralized governance can be challenging. Advocacy for integrated community health program can be driven by generating evidence on improved health outcomes, reduced costs, increased satisfaction of health workers and better social determinants of health that will vouch for benefits of integration and mobilize political buy in
2) Feedback loop between county and national government	Change in governance structure results a shift in responsibility and also demands capability to fulfill it. Taking example of Kenya, where some counties lack direction and focus on implementation of CHS, other governments can avert this situation by creating strong feedback mechanism for improved dialogue between the national and local actors in addition to capacity development at the implementation level
3) Integrating community health into broader health system	Most of the countries have a mix of horizontal and vertical intervention programs run by both government and non government players. Recognition of non governmental CHW programs and integrating them with national health system across all the functions like governance, finance, service delivery, monitoring and evaluation will lead to effective coordination and utilization of resources
4) Mobilizing domestic and innovative financing sources	Governments generally prioritize investment in developing higher level health facilities as it leads to short term tangible outcomes. Building strong community health system will require increasing domestic investment in health and channelizing these investments in strengthening preventive and promotive services. Irregular training, inconsistent remuneration for CHWs and lack of commodity supplies are some of the issues that can be overcome if the government allocates more funds.
5) Ongoing adaptation and refinement	Community health programs should have the flexibility to adapt to the local context and needs of the population. Implementation of these programs should be guided by the change agents that can be in the form of dynamic political situation, changing disease profile of the country or adopting a new technology to be more efficient
6) Fostering partnerships for increased coordination and harmonization of CHW programs	Establishing relationships with private sector and development partners can be meaningful to promote integration of disparate CHW programs with national health system. Additionally, development partners and private sector can support capacity building, drive innovation, generate new source of funds and provide technical support in implementation of community health programs