REPUBLIC OF KENYA

COUNTY GOVERNMENT OF MAKUENI

MAKUENI COUNTY COMMUNITY HEALTH SERVICES STRATEGY

2021 - 2025

Makueni County Community Health Strategy 2021–2025
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MMUNITY HEALTH
VOLUNTEER

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LIST OF ABBREVIATIONS

CBOs	Community-based organisations
CBS	Community-based surveillance
CHA	Community health assistant
CHEW	Community health extension worker
CBHIS	Community-based health information system
CHMT	County health management team
CHS	Community health strategy
CHU	Community health unit
CHV	Community health volunteer
ICCM	Integrated community case management of childhood illnesses
IGAs	Income generating activities
KDHS	Kenya demographic health survey
MOH	Ministry of health
NCD	Non-communicable diseases
WHO	World Health Organization
UHC	Universal health coverage

DEFINITION OF TERMS

Community health (CH):	This is the first level of Kenya's health system structure, health services at this level are basic curative, preventive, and promotive.
Community health unit (CHU):	Health service delivery structure within a defined geographic area covering 5,000 people. Each unit is assigned one Community Health Assistant/Officer and an average of 20 Community Health Volunteers.
Community health volunteer (CHV):	A community member selected to serve in a community health unit. A CHV is well known to his/her community and is selected for the role of CHV by his/her community members.
Community health assistant (CHA):	A formal employee of the County Government forming the link between the community and the link health facility.
Community health committee (CHC):	A committee charged with the governance and oversight of a community health unit.
The functionality of community health unit:	The extent to which a community health unit attains the eleven criteria outlined in the Kenya Community Health Policy (2020–2030).
Health system:	A health system consists of all organizations, people, and actions whose primary intent is to promote, restore or maintain health. Like any other system, it is a set of interconnected parts that must function together to be effective.
Health workforce:	A well-performing workforce consists of human resources management, skills, and policies.
Health Information System:	A well-performing system ensures the production, analysis, dissemination, and use of timely and reliable information.
Health financing:	A good health financing system raises adequate funds for health, protects people from financial catastrophe, allocates resources, and purchases goods and services to improve quality, equity, and efficiency.
Leadership and governance:	Effective leadership and governance ensure the existence of strategic policy frameworks, effective oversight and coalition building, provision of appropriate incentives, attention to system design, and accountability.
Primary health care:	This is essential health care based on practical, scientifically sound, and socially acceptable methods and technology, 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 (Alma Ata, 1978).
Universal Health Coverage:	All individuals and communities have access to quality health care services without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course (WHO, April 2021).

FOREWORD

Article 43 (1) (a) of Kenya's Constitution (2010) provides that every person has the right to the highest attainable standards of health, which includes the right to access health care services. Globally, the community health approach is recognized as an effective way to improve health care delivery and address the heavy burden of diseases.

The community health approach is a crucial pillar for primary health care adopted by countries in 1978 through the Alma Ata declaration in which Kenya is a signatory country. Kenya launched the national Community Health Strategy in 2006. In 2007, the Makueni County government launched its community health program. Over the years, the County has progressively invested in community health services delivery and interventions with support from partners. Given the socio-economic and cultural diversity of the country, Makueni County has approved a County Community Health Policy (2020–2030) to give direction for community health services.

The community strategy has provided an implementation framework that will be instrumental during annual work planning for the implementation period. The strategy emphasizes a more proactive approach to promoting the health of communities and individuals to prevent diseases.

Makueni County has 3477 active community health volunteers, and the strategy seeks to redistribute and deploy them equitably to increase access and coverage. The strategy is also keen on delivering standardized needs-driven community health services.

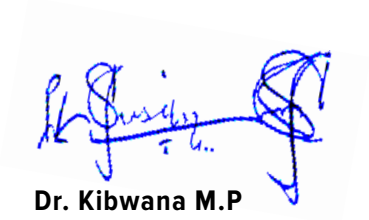
Rosemary Maundu
Ag. Executive Committee Member,
Health Services
Government of Makueni County

PREFACE

The community health approach is based on the concept of primary health care. In Kenya, community health units offer level-1 services. Investing in community health workers is an essential step towards achieving Universal Health Coverage and improving critical health indicators, including containment of health crises, meeting core capacities of international health regulations, elimination of diseases, improving access to health care, saving the lives of mothers and children, and controlling priority diseases such as TB, HIV, and Malaria.

Community health programs are cost-effective while driving specific health outcomes and play a critical role in achieving the global sustainable development goals. Beyond the health returns, investment in community health systems in sub-Saharan Africa can yield an economic return of $10:1. With technical support from the Financing Alliance for Health, the County has be able to determine the actual cost of implementing the community health strategy and develop an investment case to demonstrate the value of investing in primary health care.

With a community health unit serving a population of 5,000 people in each geographical region who share the same socio-economic characteristics, each community health unit is assigned a community health assistant and community health volunteers. This strategy further operationalizes the implementation of the Makueni Community Health Services policy (2020–2030). The distribution of community health volunteers has been a challenge in executing community health interventions. The strategy has highlighted the equitable distribution of CHVs in the six sub-counties while considering other factors besides population density. Hence, the strategy comes at a very crucial time where we are seeking to achieve Universal Health Coverage as a County, and I believe with the implementation of the strategy we will be taking steps in the right direction.



Dr. Kibwana M.P
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ACKNOWLEDGEMENT

The department of health services wishes to thank all those who contributed to the successful completion of this document. We call on all health workers, partners, and stakeholders to adopt and continue supporting this strategy's implementation.

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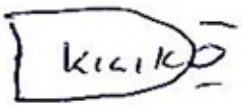

David Kiuluku
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Government of Makueni County

EXECUTIVE SUMMARY

Community health services constitute the first level of care in Kenya. The Makueni community health policy stipulates that community health services are delivered at the community health unit level by community health volunteers, governed by community health committees, and supervised by community health assistants. The policy has comprehensively defined the service package. The services currently offered by CHVs in the County are primarily preventive and promotive. The community health strategy in the County has significantly evolved since 2007. Devolution of health services has revamped community health services by increasing the community health workforce and financing.

The community health service package includes basic, maternal, and new-born health, family planning, water sanitation, hygiene, nutrition, and communicable and non-communicable diseases. Since devolution, the County has significantly improved most of the key indicators and is keen on investing in sustaining the gains and improving on the sub-optimal indicators. Over the years, infectious diseases have posed a significant health burden accounting for approximately 70% of total outpatient cases. The County is further experiencing an epidemiological transition of non-communicable diseases; besides the burden of deaths and disability, NCDs pose a greater social and economic burden to the economy.

Fortunately, infectious and non-communicable diseases are largely preventable. There should be a paradigm shift from focusing on curative services to preventive to cushion the community and the County from the high cost of curative services.

This strategy details key interventions under each of the seven strategic directions based on the World Health Organization's building blocks to address these challenges comprehensively. Within the strategy, the department of health aims to:

1. Strengthen the management and coordination of community health governance structures
2. Build a motivated, skilled, equitably distributed community health workforce
3. Strengthen the delivery of integrated, comprehensive, and high-quality community health services
4. Increase the availability, quality, and utilization of data
5. Ensure the availability and rational distribution of safe and high-quality commodities and supplies
6. Establish a platform for strategic partnership and accountability among stakeholders and sectors at all levels within community health
7. Increase sustainable financing for community health

Strategic objective	Key Interventions
Strategic direction 1: Strengthen the management and coordination of community health governance structures at all levels	
Strategic objective 1.1: Strengthen community health units' governance	**1.1.1** Recruit CHC members for all community health units **1.1.2** Train community health committee members using the revised CHC curriculum **1.1.3** Hold quarterly CHC meetings **1.1.4** Conduct quarterly supportive supervision of the CHCs by SCHMT/CHMT
Strategic objective 1.2: Establish a County community health technical working group	**1.2.1** Define the scope of the County community health TWG **1.2.2** Appoint TWG members **1.2.3** Hold quarterly TWG meetings
Strategic objective 1.3: Strengthen the advocacy mechanisms for the prioritization and implementation of community health services at the community health committee, sub-county, and County level	**1.3.1** Adopt the national government guidelines on community health advocacy and communication strategy **1.3.2** Disseminate the national government guidelines on community health advocacy and communication strategy **1.3.3** Develop a community health advocacy toolkit

Strategic objective 1.4: Increase the effectiveness of performance monitoring for community health governance structures	**1.4.1** Create a monitoring and evaluation framework to evaluate the community health committee's functionality of all existing and new community health units **1.4.2** Hold bi-annual review meetings on resource mobilization and utilization by community health committees. **1.4.3** Conduct quarterly performance review meetings on community health committees
Strategic direction 2: Build a motivated, skilled, equitably distributed community health workforce	
Strategic objective 2.1: Ensure optimal community health workforce recruitment and deployment	**2.1.1** Redistribute CHVs as per the community health policy **2.1.2** Recruit and deploy CHVs at the village level based on prescribed selection criteria in the Makueni Community Health Policy **2.1.3** Replace inactive CHVs at least once per year, identify and address reasons for attrition **2.1.4** Conduct phased recruitment of community health assistants
Strategic objective 2.2: Develop and institutionalize a scheme of service and career progression framework for community health workers	**2.2.1** Develop and implement the service scheme for community health volunteers **2.2.2** Develop a career progression framework for CHVs
Strategic objective 2.3: Increase CHAs and SCHMT mentorship and supervision capacity	**2.3.1** Develop technical assistance plans for individual community health units **2.3.2** Create toolkits for mentorship and supervision of community health services **2.3.3** Sensitize CHAs and SCHMT about community health services mentorship and supervision toolkits **2.3.4** Conduct integrated quarterly supportive supervision visits to community health assistants **2.3.5** Conduct community health volunteers' certification and create a recognition framework **2.3.6** Establish an accreditation system for community health units
Strategic objective 2.4: Standardize the framework for financial and non-financial remuneration for community health volunteers	**2.3.1** Develop a financial and non-financial performance-based remuneration framework for CHVs **2.3.2** Regularly remunerate CHVs with a minimum stipend of KES 2,000 monthly
Strategic direction 3: Strengthen the delivery of integrated, comprehensive, and high-quality community health services	
Strategic objective 3.1: Increase coverage, demand, and utilization of community health services	**3.1.1** Conduct annual household mapping **3.1.2** Intensify household health visits based on community health volunteers' approved movement plan **3.1.3** Intensify community sensitization and mobilization during community and national health events like health outreaches, health talks, dialogue days, and mass immunization campaigns **3.1.4** Develop dialogue centred behaviour change facilitation guidelines for community health volunteers **3.1.5** Mainstream gender in community health services
Strategic objective 3.2: Increase community-owned and led innovations for sustainability for community health services	**3.2.1** Establish intra- and multi-sectoral collaborations with community health units and primary healthcare provides **3.2.2** Implement the Model Household Approach to encourage social behavior change **3.2.3** Train community health volunteers on Participatory Learning and Action Cycle

Strategic objective 3.3: Strengthen referral and linkages between community and health facilities	**3.3.1** Build the capacity of primary health care workers on community health service referral pathways and linkages to health facilities **3.3.2** Strengthen reporting and documentation of community health referrals **3.3.3** Develop innovative referral mechanisms like engaging key influencers **3.3.4** Build the capacity of the community health workforce to understand the linkages, coordination, service provision, and monitoring of primary care networks **3.4.5** Initiate community health volunteers' task-sharing activities at link facilities
Strategic objective 3.4: Strengthen the capacity of the community health workforce for the provision of high-quality community health services	**3.4.1** Train community health assistants as trainers of trainees on community health basic and technical modules **3.4.2** Train community health volunteers on community health basic and technical module **3.4.3** Train community health assistants on social behaviour change and communication strategy **3.4.4** Equip community health workforce with basic community health kit **3.4.5** Conduct refresher training for the community health workforce on community health basic and technical modules and other emerging health issues and needs **3.4.6** Audit the quality of community health services through the community quality improvement teams annually
Strategic direction 4: Increase the availability, quality, and utilization of data	
Strategic objective 4.1: Develop and implement a harmonized digital community health information system	**4.1.1** Digitalize the community health information system **4.1.2** Operationalize the digital community health information system in a phased approach **4.1.3** Build capacity of health workforce on digital community health information **4.1.4** Provide community health workforce with functional smartphones with adequate internet bundles **4.1.5** Procure community health reporting tools in the preparation of phased digitalization
Strategic objective 4.2: Enhance the capacity of the community health workforce to collect, collate and report quality community health data effectively	**4.2.1** Develop a community health data management manual and key performance indicators compendium **4.2.2** Train community health workforce on data collection and quality **4.2.3** Develop community health data quality audit guidelines and tools aligned with the national government **4.2.4** Integrate community health into the other MoH data quality improvement processes
Strategic objective 4.3: Strengthen capacity for community-level research and increase utilization of evidence for decision-making in the community health system	**4.3.1** Conduct a comprehensive mapping of the areas of community health research and learning agendas **4.3.2** Build capacity and mentor the County health management team to conduct community health research and publish results
Strategic objective 4.4: Establish a community-based surveillance system	**4.4.1** Develop and disseminate community-based surveillance guidelines **4.4.2** Sensitize the community health workforce on community-based surveillance guidelines **4.4.2** Build the capacity of the community health workforce to conduct CBS **4.4.3** Form community health committees for maternal and perinatal death surveillance and response
Strategic objective 4.5: Using community health data Institutionalize social accountability in the quality of primary health services.	**4.5.1** Develop a community health scorecard to increase social accountability **4.5.2** Sensitize community health workforce and CHMT and SCHMT on community health scorecards for social accountability. **4.5.3** Implement the community health scorecards in ensuring social accountability

Strategic direction 5: Ensure the availability and rational distribution of safe and high-quality commodities and supplies	
Strategic objective 5.1: Make certain that community health supplies and commodities are secure, of high quality, and safe	**5.1.1** Conduct a review of the community-level commodity management processes **5.1.2** Train community health workforce on forecasting and quantification of community health commodities **5.1.3** Put in place a safety monitoring system for health commodities
Strategic direction 6: Establish a platform for strategic partnership and accountability among stakeholders and sectors at all levels within community health	
Strategic objective 6.1: Strengthen the coordination mechanism for service delivery between national MoH, County governments, and partners	**6.1.1** Create a community health partnership framework to enhance partner alignment and engagement **6.1.2** Carry out mapping exercise for all community health stakeholders, funding flows, and intervention areas **6.1.3** Incorporate a community health agenda into the intergovernmental forum for the health sector **6.1.4** Disseminate the County community health policy and strategy to all stakeholders **6.1.5** Make annual community health reports and periodic newsletters
Strategic direction 7: Increase sustainable financing for community health	
Strategic objective 7.1: Create resource mobilization mechanisms for funding community health	**7.1.1** Create a business case for community health investment **7.1.2** Advocate for increased County budgetary allocation for community health, backed by investment case and advocacy toolkit **7.1.3** Establish a participatory budget and oversight between the link facility and community health units to ensure sustainability considerations are made for services at the community level **7.1.4** Build the capacity of the County, sub-county, community health assistants, and community health committees on resource mobilization for community health **7.1.5** Advocate for and establish community health units-private sector collaboration for long-term community-level services.
Strategic objective 7.2: Strengthen communication and advocacy for community health systems	**7.2.1** Train community health units on income-generating activities and entrepreneurship skills **7.2.2** Register community health units as community-based organizations to access resources **7.3.3** Advocate for inclusion of benefits package for community health in the National Health Insurance Fund scheme **7.3.4** Document challenges and lessons learned from existing income generating activities to inform future income-generating activities **7.3.5** Explore possible income-generating activities and innovations like village savings or cooperatives and loaning associations

COUNTY GOVERNMENT OF MAKUENI

MAKUENI COUNTY COMMUNITY HEALTH SERVICES STRATEGY 2021 – 2025

VISION: A healthy and productive county with high quality of life

MISSION: To build a progressive, responsive, sustainable, and evidence-based health system for accelerated attainment of highest standard of health

REPUBLIC OF KENYA

BACKGROUND

Demographics (2019)[1]
- Total Pop. 987,653
- Male - 49.6% & Female - 50.4%
- Total HHs – 244,669
- Avg. HH size - 4.0

Socio-Economic Status [2,3]
- GCP (2017)* – KES. 100.9 Billion
- GCP per Capita (2017)* – KES. 104,161
- Poverty rate - 34.8%
- Main economic activity- Agriculture

Health Financing Status[3]
- %Health Exp. to Total Govt. Exp. (2020/21) -35.2%
- Total Health budget (2021/22) – KES 3.73 Billion
- Preventive & Promotive HS allocation – KES 283M
- Community Health Allocation – KES 71.7 Million

Community Health Status
- CH program initiated in 2006
- Active CHVs-3,477 /CHUs-241 /CHAs-20
- 235 CHeWs in 235 CHU link facilities
- 1 CHV serves 280 persons/ average 70 households

SITUATION

Strengths
- Strong political will exists
- Community Health Policy exists
- County own Social Health Insurance Program- Makueni Care

Weaknesses
- Inadequate financing for community health
- Inadequate provision of CHV kits & supplies
- Insufficient trainings of CHWs
- Sub-optimal supportive supervision for CHVs
- Lack of CHUs governance structures

Opportunities
- Community health partners
- Integrate eCHIS and harmonize data tools
- Expansion of CHVs service package

Threats
- Change of political leadership
- Retention of CHAs after National government support
- Pandemics

GOAL The strategy aims to accelerate the attainment of UHC and increase primary healthcare service delivery to reduce the disease burden in the county

STRATEGIC DIRECTIONS	STRATEGIC OBJECTIVES	KEY INTERVENTIONS
GOVERNANCE & LEADERSHIP	• Establish CHUs governance structures • Establish a community health technical working group • Strengthen advocacy mechanisms for CH • Develop performance monitoring mechanism for CHCs	• Recruitment & capacity building of CHCs • Support CHCs to hold quarterly meetings with the communities • Develop M&E structure for CHCs performance • Select TWG members and hold quarterly meetings • Establish advocacy forums for CHCs for partnerships, awareness creation and resource mobilization • Adopt national government's community health advocacy and communication strategy guidelines
FINANCING	• Improve CH stakeholders' participation and coordination • Explore & scale up innovative financing and co-financing mechanisms	• Develop a stakeholders coordination mechanism (Government, Private sector, NGOs) • Develop a community health partnership framework • Establish viable income generating activities within the CHUs • Capacity build CHWs on resource mobilization and entrepreneurship • Sustained advocacy for increase domestic resources allocation • Explore innovative financing mechanisms
HUMAN RESOURCE	• Optimal recruitment and deployment of CHWs • Ensure adequate trainings to CHWs • Strengthen capacity of supervisors on mentorship and supervision • Provide framework for financial and non-financial remuneration of CHVs	• Conduct CHVs mapping and household mapping • Train all CHVs on basic and technical modules • Conduct refresher trainings for CHVs • Update CHVs registers annually • Replace inactive CHVs and CHCs annually • Develop technical assistance plans for CHUs • Provide motorbikes to CHAs • Conduct quarterly supervisory visits • Provide a minimum monthly stipend of $20

[1] Kenya Population and Housing Census Report, Kenya National Bureau of Statistics (2019)

[2] Kenya Integrated Household Budget Survey, Kenya National Bureau of Statistics (2015/2016)

*[3] Gross County Product Report, Kenya National Bureau of Statistics (2019), *GCP at current market prices*

[4] Annual Work Plan FY 2021/22, Makueni County Department of Health Services (2021)

STRATEGIC DIRECTIONS	STRATEGIC OBJECTIVES	KEY INTERVENTIONS
SERVICE DELIVERY	• Increase coverage of community health services to households • Increase demand and utilization of community health services • Expand community-based surveillance system • Reinforce referral and linkages systems	• Update the existing essential community health service package • Conduct quarterly sensitization outreaches • Audit CHS service delivery through community quality improvement teams annually • Capacity build CHWs on CBS • Implement the Model Household Approach to encourage social behaviour change • Build capacity of CHWs on referrals and linkages systems
HEALTH INFORMATION	• Develop a digital community health information system • Operationalize the digital CHIS in a phased approach • Build the capacity of the CH workforce to collect and report quality data	• Digitize health data reporting tools • Equip CHVs with smart phones for data collection • Capacity build CHWs on eCHIS and data collection and reporting techniques	• Develop a data management manual and a compendium of key performance indicators • Develop CH scorecards to promote social accountability
DRUGS & SUPPLIES	• Develop a digital community health information system • Operationalize the digital CHIS in a phased approach • Build the capacity of the CH workforce to collect and report quality data	• Procurement and distribution of CHV kits • Capacity build CHVs on commodity management and forecasting	• Provision of medicines and supplies to all CHVs • Establish a commodity safety monitoring system • Review commodity management processes

STRATEGY IMPLEMENTATION COSTS AND RESOURCE NEED

Strategy Costs by Inputs	Estimated Annual Input Costs					
	2021/22	2022/23	2023/24	2024/25	2025/26	Total Input Costs
CHVs stipend	116,568,000	116,568,000	116,568,000	116,568,000	116,568,000	582,840,000
CHVs equipment	131,048,100	43,140,207	124,550,347	41,794,617	43,967,937	384,501,208
CHVs training	4,252,500	54,337,600	59,815,817	45,630,267	45,630,267	209,666,450
Medicines and supplies	1,704,323	2,133,829	2,563,789	3,058,740	3,745,928	13,206,609
CHA/CHEWs equipment	7,296,000	-	-	-	-	7,296,000
CHA/CHEWs training	6,107,350	6,266,133	2,605,983	2,375,383	-	17,354,850
Management training	1,402,789	66,200	-	242,230	-	1,711,219
Supervision visits	7,908,936	8,320,201	8,752,851	9,207,999	9,686,815	43,876,802
Other Recurrent Costs						
CHWs and management meetings	63,277,814	66,537,872	69,967,452	73,575,371	77,370,901	350,729,410
Start-up Costs						
IGAs – Seed capital	11,992,800	-	-	-	-	11,992,800
CHCs training	-	41,733,033	-	-	-	41,733,033
Development of guidelines, frameworks and tools	355,945	1,156,561	445,385	320,345	337,003	2,615,239
Sensitization meetings	3,887,140	260,629	-	-	-	4,147,769
Capital Costs						
CHA motorbikes			12,084,942	3,894,844	4,097,376	20,077,162
CHWs reporting tools	20,121,288					20,121,288
Dissemination of guidelines, frameworks and tools	1,949,093	1,054,579	2,586,911	-	-	5,590,583
Total annual costs	**377,872,078**	**341,574,844**	**399,941,477**	**296,667,796**	**301,404,226**	**1,717,460,422**

Funding Needed:
KES 1.7B
USD 16.1M

Funding Available:
KES 980M
USD 9.2M

Funding Gap:
KES 737M
USD 6.9M

INTRODUCTION & BACKGROUND

01

INTRODUCTION AND BACKGROUND

1.1 County Profile

Makueni County is one of the forty-seven counties in Kenya, situated in the south-eastern part of the country. The County is located between latitude 1°35' and 3°00' in the South and longitude 37°10' and 38°30' to the East. Machakos County borders it to the North, Kitui County to the East, Taita Taveta County to the South, and Kajiado County to the West. The County covers an area of 8,034 km^2, out of which 474.1km^2 is occupied by the Tsavo West National Park and 724.3 km^2 by the Chyullu Game Reserve. Climatic conditions are generally arid and semi-arid, with the distinctive highlands of Kilungu and Mbooni and the rest of the regions being dry lowlands.

The projected population based on the 2019 census is 978,932 (Kaiti 132,936; Kibwezi East 146,305; Kibwezi West 183,639; Kilome 97,242; Makueni 214,484; and Mbooni 204,319), out of which 488,378 are males and 514,601 are females. The County's population composition is also youthful, with 43.8% of the population aged between 0 and 14 years and 5.1% over 65 years.[1] The population density in the County is 125 people per square kilometer. The County has an average household size of 4.0.

1.2 Administrative structure

The County is divided into six sub-counties—Makueni, Mbooni, Kibwezi East, Kibwezi West, Kaiti, and Kilome. The six sub-counties are further subdivided into 30 electoral wards, 60 sub-wards, each, 377 village clusters, which is a grouping of 10–12 villages, and 3643 County villages, which are the lowest administrative structures, comprised of 70–100 households. The total number of households in the County is 244,699.

This devolved governance structure aims to make the delivery of social services easier and closer to people. The County has selected community-owned resource persons to chair the development committees through community participation.

1.3 Socioeconomic status

The poverty level in the County stands at 60.6%, which is higher than the national average of 45.2%, with some wards recording a poverty index of more than 80%. The County is ranked 38 out of the 47 counties in poverty levels.[2] The high rates of poverty, coupled with the youthful population of the County, pose a major socio-economic development challenge. The leading causes of poverty in the County include prolonged drought, underdeveloped infrastructure, overreliance on rain-fed agriculture, limited employment opportunities, weak market systems, inaccessibility to credit facilities, continued environmental degradation, and poor agricultural practices.

1.4 Health status

Makueni County has made commendable progress in improving health indicators since devolution, and this can be attributed to the increased number of health facilities. As a result, improved access to healthcare services, referral networks, staffing, community awareness, an increase in the number of facilities offering comprehensive care, and the rollout of the Makueni Care Universal Health Coverage Programme, among others, have occurred.

[1] *Kenya National Bureau of Statistics. (2019). Kenya Population and Housing Census Results. Kenya National Bureau of Statistics.* https://www.knbs.or.ke/?p=5621

[2] *Kenya National Bureau of Statistics. 2015-2016 Integrated Household Budget Survey (IHBS). Ref. KEN_2015_IHBS_v01_M*

Table 1. Performance of key health indicators

Programmatic area	Indicator	County		National
		2013/14	2017/18	2018
Child health	Child mortality rate	35/1000	32/1000	36/1000
	Neonatal mortality rate	31/1000	29/1000	33/1000
Maternal health	Maternal mortality rate	488/100,000	362/100,000	362/100,000
	Under-five mortality	49/1000	45/1000	47/1000
Public health	Latrine coverage	83%	91%	90%
Nutrition	Stunted children	25.1%	25.1%	26 %
	Wasting in children	2.1%	2.1%	4.5%
	Vitamin A coverage	45%	67%	65%
	Underweight children	10.2%	10.2%	11%

Makueni did better in some of the key indicators compared to the national average in 2018, except for family planning uptake, as shown in Table 1 and Figure 1. The unmet need for family planning in rural areas stands at 20% and 13% in urban areas.[3]

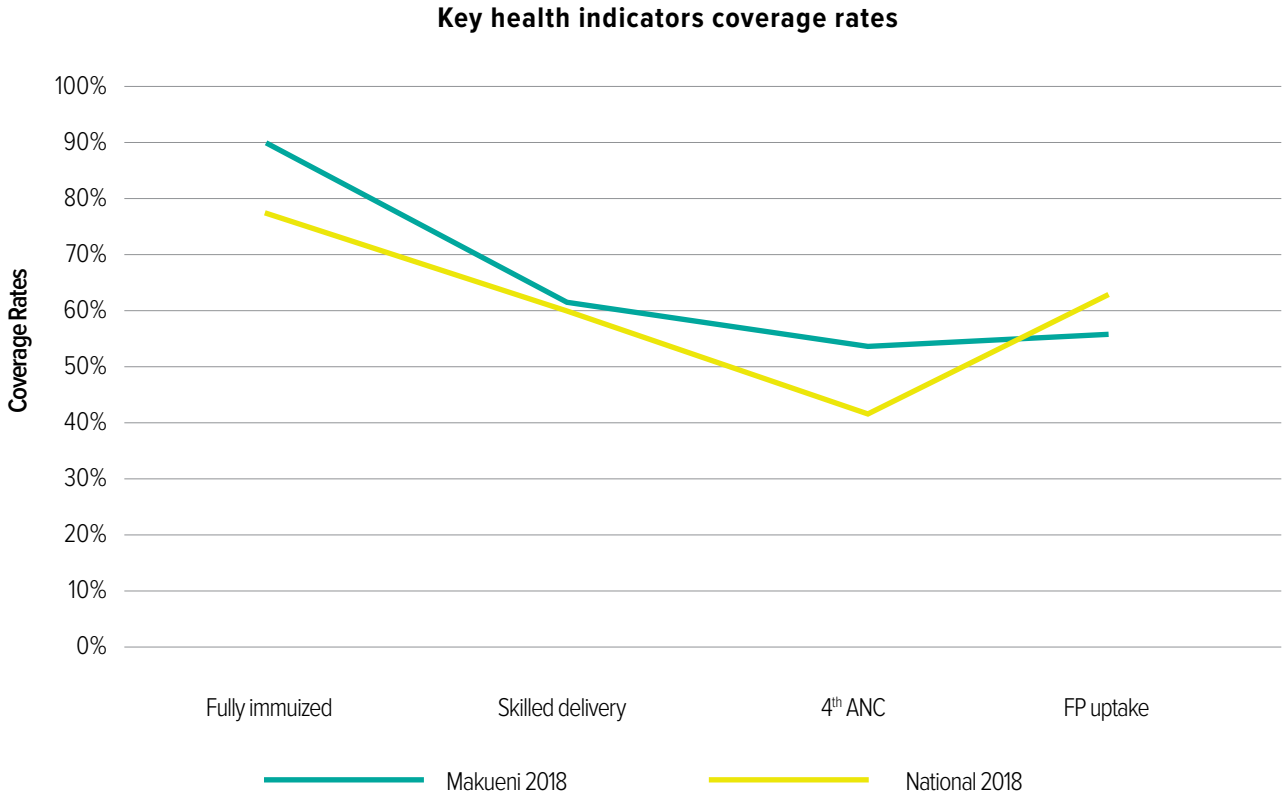


Figure 1: County vs. national key health indicators coverage, 2018
(Source: Kenya Health Information System Report, 2018)

[3] *Kenya National Bureau of Statistics, Ministry of Health/Kenya, National AIDS Control Council/Kenya, Kenya Medical Research Institute, and National Council for Population and Development/Kenya. 2015. Kenya Demographic and Health Survey 2014. Rockville, MD, USA*

Despite these gains, infectious diseases have continued to be a significant health burden over the years in the County, contributing to 70% of all new outpatient cases. Infections of the upper respiratory tract, ear infections, diseases of the skin, urinary tract infections, and other diseases of the respiratory system have remained in the top five conditions.

For HIV and TB, the HIV prevalence among the general population is estimated at 4.2%, slightly lower than the national rate of 4.8%. Tuberculosis also poses a challenge to the department because it has continued to rise over the years. The prevalence was 233 per 100,000 people in 2012 but has increased to 558 per 100,000 in 2017. Figure 2 highlights the prevalence rates of the top five communicable diseases between 2014 and 2019.

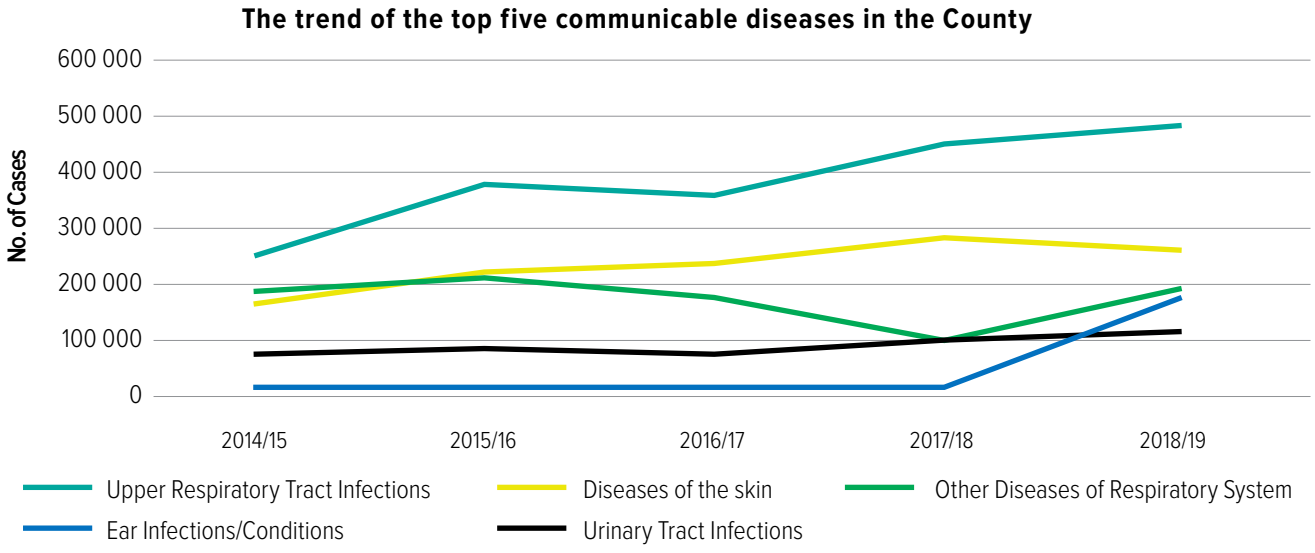


Figure 2: The trend of communicable diseases in the County
(Source: KDHIS, 2018)

Makueni County, like many other counties in Kenya, is experiencing an epidemiological transition. As shown in Figure 3, non-communicable diseases such as hypertension and diabetes show an upward trend. There should be a paradigm shift from focusing on curative to preventive care to cushion the community and County from the high cost of managing the conditions and long-term complications that have taken an economic toll on the affected households.

Community health volunteers play an essential role in preventive and curative interventions by supporting key messaging, referral and linkage, nutrition counselling, and medication adherence.

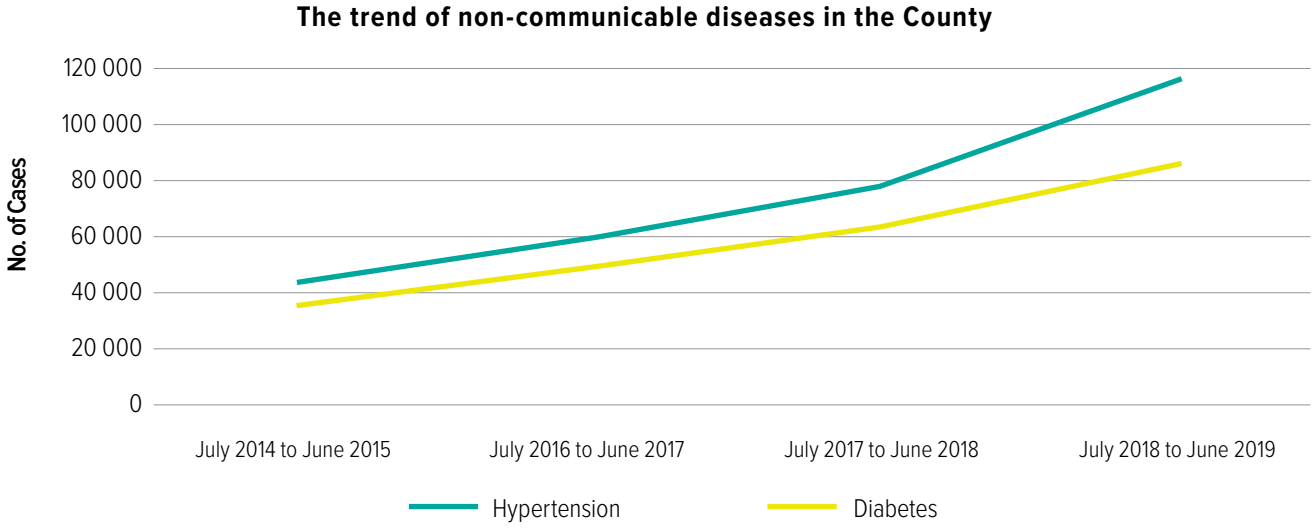


Figure 3. The trend of non-communicable diseases in the County
(Source: KDHIS, 2018)

1.5 Legal framework, political environment, and policy landscape

The development of the Makueni County Community Health Strategy is underpinned by global, regional, and national policies and strategies as outlined below:

1.5.1 Global community health policy environment

A growing global momentum is increasingly supporting the need to strengthen community and primary healthcare systems. The Astana declaration reaffirms the commitments expressed in the ambitious and visionary Alma-Ata Declaration of 1978 and the 2030 Agenda for Sustainable Development.

The Astana Declaration emphasizes empowering communities to be part of the solution and included in primary healthcare systems.[4] The operational framework for implementing the foundations of the Astana Declaration focuses heavily on community health workers, their role in primary healthcare, and connecting them to facility-based teams in an integrated system. Kenya is a signatory to the Astana Declaration.

In 2018, the World Health Organization Policy Guidelines for Community Health Workers (CHWs) provided evidence-based guidelines to assist governments and their partners in improving the design, implementation, performance, and evaluation of CHW programs, contributing to the progressive realization of UHC[5]. It contains pragmatic recommendations on selection, training, certification; management and supervision; and integration into primary healthcare systems.

1.5.2 Africa's Health Strategy 2016–2030

The Africa Health Strategy 2016–2030 establishes a strategic goal of achieving universal health coverage by 2030 by fulfilling existing global and continental commitments to strengthen health systems and improve social determinants of health in Africa.[6] The strategy emphasizes strengthening community health and information systems and decentralizing service delivery, focusing on integrated, comprehensive primary health care and efficient use of resources. In addition, based on the human resources gap in the African region, the African Union recommends prioritization and urgent recruitment, training, and deployment of two million CHWs as a critical step towards the achievement of the Sustainable Development Goals.

1.5.3 Kenya's National Community Health Legislation

1.5.3.1 Constitution of Kenya

The Constitution of Kenya (2010)[7], Article 43 (1) (a) entitles every person the right to the highest attainable standards of health, which includes the right to health care services, including reproductive health care. Further, Article 43 (2) states that a person shall not be denied emergency medical treatment. In contrast, Article 53(1) (c) provides for the right of every child to access basic nutrition, shelter, and health care. Under Article 56 (e), the state shall implement affirmative action programs to ensure that minorities and marginalized groups have reasonable access to water, health services, and infrastructure.

Article 174 recognizes the right of communities to manage their affairs, further their development, and protect and promote the rights of minorities and marginalized communities.

1.5.3.2 Kenya Vision 2030

Kenya Vision 2030 is a developmental blueprint covering all sectors, including health[8]. One of the goals under the health objectives is to revitalize community health to promote preventive health care instead of curative and promote a healthy individual lifestyle. This shows that community health is pivotal to Kenya's development agenda.

1.5.3.3 Kenya's Strategic Framework for Primary Health Care

The Kenya Primary Health Care Strategic Framework 2019–2024[9] outlines the country's implementation pathway and management of primary health services. The framework recognizes the role of community health services as key to attaining improved population health. It acknowledges that community health units are the first level of healthcare delivery in Kenya.

[4] *Global Conference on Primary Health Care (2018), Declaration on primary health care. Astana*

[5] *WHO guideline on health policy and system support to optimize community health worker programmes. WHO, 2018.*

[6] *African Union (2016). Africa Health Strategy 2016–2030. Addis Ababa.*

[7] *Laws of Kenya (2013). The Constitution of Kenya, 2010. Chief Registrar of the Judiciary. Nairobi*

[8] *Government of Kenya (2008). Kenya Vision 2030: A Global Competitive and Prosperous Kenya. National Economic and Social Council, Nairobi.*

[9] *Government of Kenya (2020). Kenya Primary Health Care Strategic Framework2019–2024. Ministry of Health, Nairobi.*

The strategy envisions the transformation of the service delivery team through (a) functionally linking all CHUs to primary health facilities and (b) introducing multi-disciplinary teams comprised of CHVs focused on promotive and preventive health services.

1.5.3.4 Kenya Community Health Policy

The Kenya Community Health Policy 2020–2030[10] seeks to streamline the implementation of community health services by strengthening leadership and coordination structures, ensuring credible human resources for community health, financing, efficient supply of commodities, community-based surveillance, and monitoring, evaluation, and research to provide evidence and strengthen referral mechanisms. The Makueni Community Health Strategy will be anchored on this document to streamline the implementation of community health services in the County.

1.5.3.5 Kenya Community Health Strategy

The third edition of the Kenya Community Health Strategy 2020–2025[11] seeks to build the capacity of individuals and households to know and progressively realize their rights to equitable, quality health care and demand services. The strategy provides a framework for all stakeholders to implement community health services in a standardized system and guides community health stakeholders (national and County governments, development partners, and implementing partners) to strengthen and scale-up community health services.

1.5.4 Policies at the County-level

1.5.4.1 Makueni Community Health Policy

The Makueni County Community Health Policy 2020–2030[12] guides the establishment and implementation of community health structures and service delivery to the households in the County. The policy demonstrates the government's commitment to providing universal health coverage to communities through the delivery of community health services.

1.5.4.2 Makueni County Vision 2025

The Makueni Vision 2025[13] is a development blueprint for the County focusing on socio-economic transformation by 2025. The vision aims to achieve accelerated and inclusive economic growth and development, improve access to quality water and health services, quality education, increase job creation, increase household income, and sustainable food security in the County.

[10] *Government of Kenya (2021). Kenya Community Health Policy 2020 – 2030. Ministry of Health, Nairobi.*

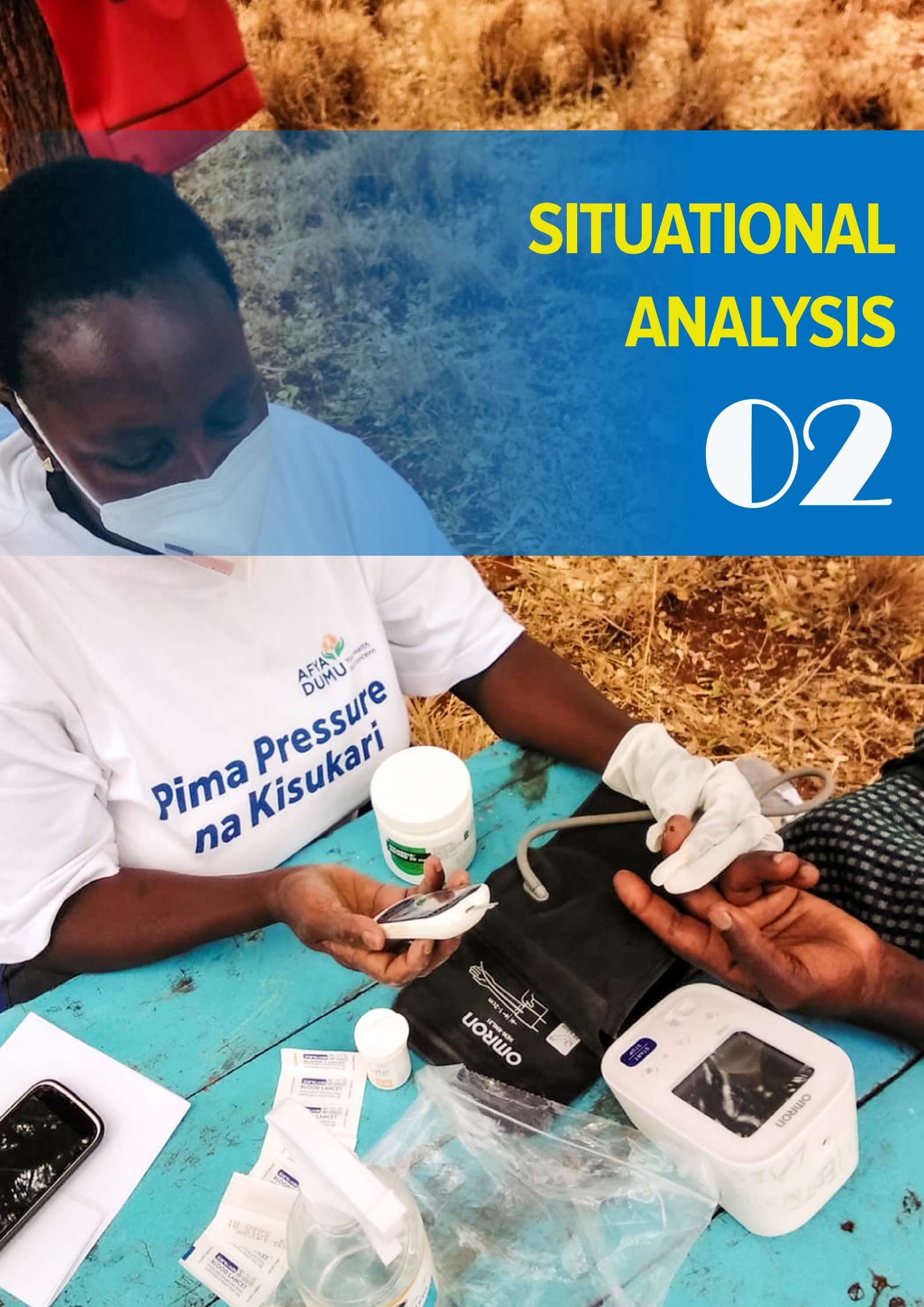
[11] *Government of Kenya (2021). Kenya Community Health Strategy 2020 – 2025. Ministry of Health, Nairobi.*

[12] *Government of Makueni County (2022). Makueni County Community Health Policy 2020 – 2030. Department of Health Services, Makueni.*

[13] *Government of Makueni County (2016). Makueni Vision 2025: Wealth Creation and Socio-Economic Transformation. Makueni.*

SITUATIONAL ANALYSIS

02



SITUATIONAL ANALYSIS OF THE MAKUENI COMMUNITY HEALTH PROGRAM

2.1 Introduction

The County Department of Health Services conducted a situational analysis to understand the community health program and how it fits into the County's primary health care system. A desk review was conducted to establish the program's status guided by the six WHO building blocks for health systems. Focus group discussions were conducted to delve into the specific health system building blocks and identify possible interventions to solve the identified challenges. Using the WHO health system building blocks, this section details the status and key challenges of the community health program.

2.2 Community health situation assessment

2.2.1 Governance and leadership in community health

Community health units (CHUs) serve as the lowest level of care in the Kenyan health structure. They comprise of approximately 1,000 households or 5,000 people who live in the same geographical area and share the same resources or challenges. Each CHU should have 10 members to oversee it.

Strong leadership, institutional support, and coordination underpin a well-functioning community health system and will determine the success of the implementation of community health services. The situational analysis identified the following gaps under leadership and governance:

a) The absence of community health committees (CHCs) within the community health units (CHUs):

The County has 241 CHUs distributed across the six sub-counties. Before devolution, 105 CHCs existed, with the committee members having been trained but only managing to serve for three years before dropping out. This was attributed to poor recognition of the roles of the CHCs, a lack of incentives, their formation being partner-led, and the lack of a sustainability agreement with the County government. Currently, there are community health focal people at both the County and sub-county levels, with defined roles to offer leadership to the CHUs. However, this governance structure is sub-optimal since the CHUs should be led and driven by the community members for purposes of ownership and sustainability.

b) Sub-optimal functionality of the community health units:

The MoH community health unit functionality tool[14] was used to assess the functional status of the CHUs in the County. The tool computes percentage scores and categorizes the total score as non-functional (<49%), semi-functional (50%–79%), and functional (>80%). Overall, the CHUs in the County were assessed to be non-functional with a score of 41%, as outlined in Table 2.

[14] *Government of Kenya (2014). Monitoring and Evaluation Plan for Community Health Services 2014 – 2018. Ministry of Health, Kenya.*

Table 2. Community health units' functionality assessment for Makueni County

Indicator	Recommendations by County and national policies and strategies	Score (0 or 1)	Comments
Existence of a trained Community Health Committee that meets at least quarterly	Community Health Committee members trained (9-13) revised to 10, including co-opted members	0	Community Health Committees do not exist in all CHU
Trained Community Health Volunteers and Community Health Assistants that meet prescribed guideline	Community Health Assistants trained at should be at least 2 per community unit	0	The 20 community health assistants are trained on the basic modules but not on technical modules 241 community health units have active link facility community in-charges who are not trained but support community health volunteers
	Community health volunteers trained on the basic modules	1	232 Community Health Units have all community health volunteers trained on the basic modules, with 9 community units (54 CHVs) all from Mbooni sub-County not trained
Coordination by County community Health Leadership	Community Health Committee have quarterly meeting evidenced by minutes and a clear action plan	0	CHCs do not exist in all CHUs
Supportive supervision for all community Health personnel done at least quarterly	CHU quarterly supportive supervision by SCHMT	0	Integrated facility-level supportive supervision takes place quarterly at the sub-county level. No supervision at CHU and household level
All Community Health Volunteers and Community Health Assistants have reporting and referral tools		CHWs tools include:	
	MOH 513	0	Tools were revised in 2020, the County is yet to procure them, and they are currently photocopying the tools. CHVs are doing verbal referrals due to a lack of MOH 100
	MOH 514	0	
	MOH 100	0	
	All trained CHAS have MOH 515	1	
	All CHU should have MOH 516	1	
All Community Health Volunteers make household visits as per their targets and at least to each household once per quarter	All Community Health Volunteers must report above 80% of the households allocated to them	0	Household visits in Makueni County are below 50% (Oct–March 2021). Mbooni sub-County units are most affected, and it has very scanty data for only 2 months
Availability and use of a mechanism for feedback local tracking and dialogue	Scored under Community dialogue days		No evidence of any feedback mechanism

Presence of functional Health Information system structure following prescribed guideline	All reporting community health units report on 4th ANC 4+ (receiving a stipend of 2000 every month)	0	The data in the DHIS is not reliable since the indicator definition is not understood The County has not yet paid the CHV stipend.
Availability of community health supplies and commodities as defined by prescribed guideline	All community health volunteers in a unit should have selected the content of the CHV kit based on local epidemiology	0	CHUs supported by partners, e.g., Medtronic, have some items in their kits but are not complete as outlined in the strategy
Community Health Units registered in Master Community Health Unit List (MCHUL) and linked to a health facility	All community Health Volunteers meet every month to submit reports (514) and minutes filed	1	167 community health units out of 241 have MCHUL code
Community Health Unit Conduct meetings at least quarterly for dialogue days and monthly for health action days, as well as household registration exercises at least once every six months	Quarterly community dialogue days that are data-informed	1	Oct 2018-September 2019 – Community dialogue days 23% of the expected – Action days 16% – Monthly data review meetings 25% Best year in the County in terms of reporting for the last 5 financial years
	Monthly data-informed action days	1	
CHU with sustainable income-generating activities registered as CBO, IGAs, and SILC evidenced by a certificate		0	Makueni County has 95 out of 241 CHUs provided with motorbikes by the County; however, community health units are not registered as CBOs
Total Score		**7/17**	
Percentage Score		**41%**	

Source: Ministry of Health functionality assessment tool

2.2.2 Community health workforce

The community health workforce in a CHU comprises community health committees, community health assistants, and community health volunteers. A CHA supervises 10 CHVs. The County's community health policy recommends a CHU be formed within a geographical region with a population size of 5,000 people or 1,000 households. There is an average of 20 CHVs per CHU, with each CHV covering 25 households. The following are the challenges for each cadre:

2.2.2.1 Community health assistants

The CHAs play a key role in training, mentoring, and supervising community health volunteers. Only 20 CHAs are deployed across the six sub-counties in 241 CHUs, as shown in Table 3. The inadequate number of CHAs deployed has posed challenges such as:

i. **Heavy workload:** Only 20 CHAs serve the existing 241 CHUs. The County is currently leveraging the nursing staff at Link Facility and Ward Public Health Officers to support community health services. Public health officers and link facility nurses have competing tasks, and prioritizing community health service delivery is challenging.
ii. **Inadequate community health training for CHAs:** on community health management and support supervision.

Table 3. Staffing gaps in the deployment of CHAs

Sub-County	No. of CHAs Deployed	Current no. of CHUs	No. of active CHVs	Gap (CHAs needed according to national guidelines)	Percentage gap
Kaiti	2	34	598	60	97%
Kibwezi East	5	32	445	45	89%
Kibwezi West	1	42	513	51	98%
Kilome	1	28	430	43	98%
Makueni	5	53	618	62	92%
Mbooni	6	52	873	87	93%
Totals	**20**	**241**	**3477**	**348**	**94%**

Source: County Department of Health Services, 2021

2.2.2.2 Community health volunteers

The County department of health services has progressively recruited 4,850 CHVs since 2008. However, as of 2021, 3477 active community health volunteers worked in 241 community health units supporting approximately 244,699 households. With this, some challenges include:

i. **High attrition rate**: A dropout rate of 28%, as highlighted in Table 4, leaves other community health volunteers with a heavy workload and decreased service coverage, which is a threat to service delivery.

Table 4: CHVs attrition rates per sub-counties

Sub-County	CHVs Recruited	CHVs Mapped	No. Dropped	Attrition Rate
Kaiti	630	598	32	5%
Kibwezi East	745	445	300	40%
Kibwezi West	748	513	235	31%
Kilome	586	430	156	27%
Makueni	1020	618	402	39%
Mbooni	1121	873	248	22%
Total	**4850**	**3477**	**1373**	**28%**

ii. **The recruitment criteria of CHVs are based on the link facility's availability**: The selection process of CHVs is currently pegged to the availability of a link facility within the CHU, with CHVs mostly selected from villages that are close to link facilities. Several challenges stem from this approach of attaching units to the availability of link facilities, such as:

- Health facilities serve different population sizes; hence, the CHV to person ratio is not as recommended,
- Some CHUs have all their CHVs selected from the same village. With several villages within the CHUs, this indicates that CHVs travel long distances to other villages that are far from where they reside, thus impeding access, community participation, and ownership,
- Some health facilities are over-represented, and others are under-represented, depending on the catchment population of the respective health facilities,

- There are 106 out of 377 (28%) County clusters that CHVs do not serve, attributed to the lack of a link facility within the CHUs, and
- Some CHVs are allocated households outside their area of residence. The County is one of the vast counties in Kenya, covering 8034 km^2. Due to the vastness of the County and the distribution of its population, the distance to the nearest health facility remains high at 6 km.

iii. Sub-optimal coverage of CHVs in the County villages: Table 5 below shows the distribution of CHVs within the sub-counties, with coverage at 64% in the County villages and 36% unserved by CHVs.

Table 5. Distribution of CHVs in the villages per sub-counties

Sub-County	Public health facilities	No. of wards	No. of CHUs	No. of village clusters	No. of County villages	Villages covered	Villages not covered	% County villages with CHVs	% County villages without CHVs
Kaiti	34	4	34	41	375	233	142	62%	38%
Kibwezi East	26	4	32	51	603	402	201	67%	33%
Kibwezi West	44	6	42	80	696	452	244	65%	35%
Kilome	25	3	28	39	403	283	120	70%	30%
Makueni	62	7	53	94	951	474	477	50%	50%
Mbooni	44	6	52	72	615	419	196	68%	32%
Total	**235**	**30**	**241**	**377**	**3643**	**2263**	**1380**	**64%**	**36%**

Source: County Department of Health Services, 2021

iv. The advanced age of some of the CHVs: The mean age of the CHVs is 46-year-old, with an age range of between 21 and 81 years. 30% of the CHVs are over 50 years of age (Figure 4).

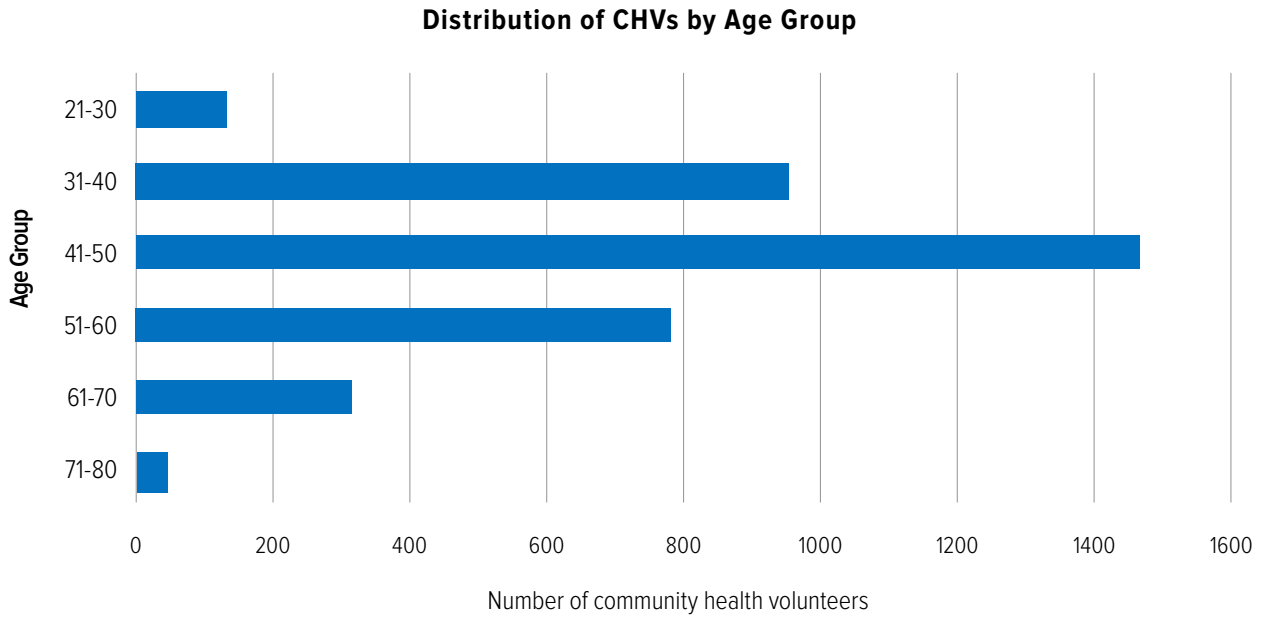


Figure 4. Distribution of CHVs disaggregated by age groups
(Source: County Department of Health Services, 2021

2.2.3 Community Health Services Delivery

The Kenya Community Health Policy stipulates and defines the community health workforce's service packages for provision to households and communities. This package includes a full range of services, including preventive, promotive, rehabilitative, and management of minor injuries and the referral of complicated cases to level-2 health facilities. However, the optimal delivery of community health services is hampered by the following:

a) Inadequate training:

For optimal service delivery, all community health workers require complete and comprehensive training on the national community health curriculum, basic modules 1–6, and technical modules 7–13. The situational analysis established that:

- 98% of the CHVs have been trained on the basic modules, while only 10% have trained on the technical modules *(Table 6)*
- The 20 CHAs who are to offer support supervision to the CHVs do not have the capacity for management and supervision
- Due to financial limitations, the technical modules are trained for a shorter duration. However, the curriculum is not adjusted to suit the shortened training period. Further, given the advanced age, low literacy level, and many topics they must learn at once, the quality of this training remains sub-optimal
- Training is still verticalized and fragmented, with the County and partners selecting a few CHVs from several CHUs for respective training. Consequently, structured refresher training, mentorship, and coaching sessions for both CHVs and CHAs remain a challenge due to this fragmentation, and varying levels of training

Table 6: Distribution of CHVs basic and technical modules training by sub-counties

Sub-County	Basic Module	WASH	Nutrition	ICCM	MNH	FP	HIV & Malaria	NCDs	CBS	TB
Kaiti	558	176	220	4	93	194	8	81	103	91
Kibwezi East	485	0	0	0	0	0	0	0	0	0
Kibwezi West	522	176	240	30	141	151	86	101	77	134
Kilome	385	35	44	7	11	34	28	0	0	0
Makueni	580	75	126	28	58	38	38	38	38	38
Mbooni	894	321	310	145	81	8	50	21	0	0
Total Number	3425	783	940	214	384	426	210	241	218	263
Percentage	98%	22%	27%	6%	11%	12%	6%	7%	6%	7%

Source: County Department of Health Services, 2021

b) Partial service package and lack of CHV kits:

The community health service package currently offers reproductive health, communicable and non-communicable diseases, nutrition, and environmental health services. However, services such as home-based care for the terminally ill, basic curative services, mental health, people living with disabilities, community-based surveillance, and linkage of orphans and other vulnerable groups are not included in the package as recommended by the Kenya Community Health Policy. Additionally, due to the lack of CHV kits, basic curative services that are supposed to be offered by CHVs to improve access to services by clients who reside far away from hospitals remain limited.

c) Other key areas that are affecting service delivery are:

- **Suboptimal household mapping and updating household data annually.** Following the basic module training, CHVs are tasked with household mapping and submitting the data to the CHAs. Subsequently, CHVs, CHCs, CHAs, and sub-county community focal persons reconvene to discuss the data. The mapping activity ought to be done on an annual basis, but only 105 out of 241 CHUs have conducted this activity for 2020.[15]

[14] *Ministry of Health (2021). Kenya Health Information System, Makueni County 2020 Report.*

- **Lack of branding or a form of identification of CHVs.** Lack of branding makes it difficult for the community to identify the CHVs, thus reducing their confidence in the services provided.
- **Limited standard health promotion messaging by CHVs due to lack of job aids.**
- **Suboptimal referral and linkage systems.** CHVs act as the link between the community and health facilities. However, the role of the CHVs is not clearly defined and recognized in the referral and linkage system.
- **Underutilization of CHVs for demand generation for health services.** The County does not have a health demand generation and communication strategy to guide the health workforce in generating demand for health services. CHVs are used mainly during immunization campaigns but not consistently to create sustainable behaviour change.
- **Suboptimal supportive supervision for the CHVs.** Support supervision for CHVs should take place at two levels: quarterly at the CHU level by the CHA and during monthly review meetings by the CHAs, SCHMT, and CHMT to assess progress and identify community needs and CHV training gaps for improvement of community services. However, the current approach to integrated supervision is conducted at the link facility, combining other departments, including the community health focal person, but both the CHAs and CHVs are excluded. The County and sub-counties have different community tools in the integrated checklist, and the outcome of the supervision often does not make it onto the action points for improvement. and the outcome of the supervision often does not make it onto the action points for improvement.

2.2.4 Health information system

Health data is the basis for decision-making in the health care system. Accurate, timely, and reliable data is a prerequisite for proper planning. The CHVs have designated reporting tools: MoH 100, 513, 514, 515, and 516, used for data collection. However, the County has difficulties acquiring accurate and reliable data due to:

- Inadequate reporting rates. For instance, the reporting rate for 2020 was 70 percent
- Lack of a standardized monitoring and evaluation plan for community health
- The reporting tools are inadequate, and they regularly experience stock-outs
- The reporting tools are large and costly to print
- Lack of knowledge among CHVs about the definition of indicators, which jeopardizes the quality of data collected
- Some CHVs are subjected to walking long distances or incurring costs to pay for transport during monthly data review meetings at the link facilities, and this is attributed to the vastness of the County
- Inadequate digitization: Only 13% of CHVs use mobile devices, and digitization efforts are frequently stuck in the pilot phase. For example, only 640 CHVs out of 3,512 were trained through the County's AMREF Mjali platform pilot project

2.2.5 Commodities for community health and the supply chain

Community health commodities and supplies are enabling factors for community health service delivery. The County has good commodity management and rare stock-outs due to reliable and contractual arrangements with suppliers. However, a few challenges exist, such as:

- Community health volunteers are not equipped with kits
- The logistics management information system is not decentralized to incorporate the supply needs of community health

2.2.6 Community Health Financing

The County government has made significant progress in allocating substantial funding to health over the years. However, while the amounts in absolute numbers have increased over the years, a gap in catering for the individual health cost of KES 4000–7000 persists. Further, the growing operational and maintenance costs continue to pose a threat to program implementation as depicted by the overall human resources for health budget, raking more than half of the total budget allocated to health; only 7% goes to prevention and promotive services such as community health; KES 62 million has been earmarked for CHV stipend in 2020/2021. With a monthly stipend rate of KES 2000 per CHV, this covers only 2,583 CHVs (74%) out of 3,477 CHVs. Community health program costs are beyond stipends for CHVs; other critical components such as training, CHV kits, and supervision are left with insufficient resources resulting in sub-optimal quality of service delivery.

MAKUENI COUNTY COMMUNITY HEALTH STRATEGY

03

MAKUENI COUNTY COMMUNITY HEALTH STRATEGY

3.1 Vision, Mission, and Goals

The County Community Health Strategy is anchored on a vision, mission, and goal whose realization is envisaged through various strategic directions and key interventions.

Vision
A healthy and productive County with high quality life

Mission
To build a progressive,responsive and sustainable and evidence based health system for accelerated attainment of highest standard of health

Goal
Acceleration of attainment of Universal Health Coverage

3.2 The guiding principles

- Health is a basic human right.
- Integrated and collaborative service delivery approaches, including partnerships and collaboration with actors in and outside the health system.
- Alignment to primary health care as a driver of Universal Health Coverage
- Attainment of the highest standards of health in alignment with the Kenyan Constitution
- Increased community ownership, participation, and social accountability

3.3 Strategic directions and objectives for community health

The County identified seven strategic directions based on the detailed situational analysis, global lessons learned, and consultative discussion with key stakeholders to guide the 2021–2025 implementation of the community health strategy. The strategic directions include:

Strategic direction 1: Strengthen the management and coordination of community health governance structures at all levels of government and across partners
Strategic direction 2: Build a motivated, skilled, and equitably distributed community health workforce
Strategic direction 3: Strengthen the delivery of integrated, comprehensive, and high-quality community health services
Strategic direction 4: Increase data availability, quality, demand, and utilization
Strategic direction 5: Ensure the availability and rational distribution of safe and high-quality commodities and supplies
Strategic direction 6: Establish a platform for strategic community health partnership and accountability among stakeholders and sectors at all levels
Strategic direction 7: Increase long-term funding for community health

Strategic direction 1: Strengthen the management and coordination of community health governance structures at all levels

A functional community health system needs strong leadership, institutional support, and coordination mechanisms to provide oversight and guidance. This ensures effective management and implementation of community health services.

Strategic objective 1.1: Strengthen community health units' governance structures

Key Interventions:
1.1.1 Recruit CHC members for all community health units
1.1.2 Train CHC members using the revised CHC curriculum
1.1.3 Hold quarterly CHC meetings
1.1.4 Conduct quarterly supportive supervision of the CHCs by SCHMT and CHMT

Strategic objective 1.2: Establish a County community health technical working group

The County community health unit shall work closely with other departments and partners every quarter through the TWG (Table 7). The chair will be the Chief Officer or a representative appointed in writing by the Chief Officer, while the secretary will be the County community strategy focal person.

Key Interventions:
1.2.1 Define the County's community health technical working group scope, roles, and responsibilities
1.2.2 Appoint TWG members
1.2.3 Hold quarterly TWG meetings

Strategic objective 1.3: Strengthen the advocacy mechanisms for the prioritization and implementation of community health services at the community health committee, sub-county, and County level

Key Interventions:
1.3.1 Adopt the national government's community health advocacy and communication strategy guidelines
1.3.2 Disseminate the national government's community health advocacy and communication strategy guidelines
1.3.3 Develop a toolkit for community health advocacy

Strategic objective 1.4: Increase the effectiveness of performance monitoring for community health governance structures

Key Interventions:
1.4.1 Create a monitoring and evaluation framework to evaluate the community health committee's functionality of all existing and newly created community health units
1.4.2 Hold bi-annual review meetings for community health committees on resource mobilization and utilization
1.4.3 Conduct quarterly performance evaluation meetings on community health committees

Strategic direction 2: Build a motivated, skilled, and equitably distributed community health workforce

The delivery of health care services at the community level in Kenya is largely determined by the availability of an efficient, well-trained, and motivated community health workforce. The recruitment, distribution, deployment, and remuneration of the community health workforce will be as per the recommendations of the Makueni CHS policy 2020–2030.

Strategic objective 2.1: Ensure optimal community health workforce recruitment and deployment

Key interventions
2.1.1 Redistribute CHVs as per the County's community health policy
2.1.2 Recruit and deploy CHVs at the village level following the County community health policy's prescribed selection criteria
2.1.3 Replace inactive CHVs at least once per year, and identify and address attrition causes
2.1.4 Recruit community health assistants in phases

Strategic objective 2.2: Increase the mentorship and supervision capacity of CHAs and SCHMT

Key interventions
2.2.1 Develop technical assistance plans for individual community health units
2.2.2 Create toolkits for mentorship and supervision of community health services
2.2.3 Sensitise CHAs and SCHMT about community health services mentorship and supervision toolkits
2.2.4 Conduct integrated quarterly supportive supervision visits to community health assistants
2.2.5 Conduct community health volunteers' certification and create a recognition framework
2.2.6 Establish an accreditation system for community health units

Strategic objective 2.3: Standardise the framework for financial and non-financial remuneration for community health volunteers

Key interventions
2.3.1 Develop a framework for financial and non-financial performance-based remuneration for CHVs
2.3.2 Regularly remunerate CHVs with a minimum stipend of KES 2,000 monthly

Strategic direction 3: Strengthen the delivery of integrated, comprehensive, and high-quality community health services

The CHV distribution in Makueni County is currently based on the existence of a link facility. This strategy will distribute community health volunteers based on population density and other factors defined in the Community Health Policy 2020–2030. The CHUs shall be leveraged to generate the demand for health services required to reverse the increasing trend of some key health indicators. This will be accomplished through community engagement, capacity building, and social behaviour change and communication.

Strategic objective 3.1: Increase community health service coverage, demand, and utilization

Key interventions
3.1.1 Map households within the County annually
3.1.2 Intensify household health visits based on community health volunteers' approved movement plan
3.1.3 Intensify community sensitization and mobilization during community and national health events like health outreaches, health talks, dialogue days, and mass immunization campaigns
3.1.4 Develop a guideline for community health volunteers on how to facilitate behaviour change dialogue
3.1.5 Mainstream gender in community health services

Strategic objective 3.2: Increase community-owned and led innovations for the sustainability of community health services

Key interventions
3.2.1 Establish intra- and multi-sectoral collaboration with community health units and healthcare providers
3.2.2 Implement the Model Household Approach to encourage social behaviour change
3.2.3 Train community health volunteers on the model of Participatory Learning and Action Cycle

Strategic objective 3.3: Strengthen referral and linkages between community and health facilities

Key interventions
3.3.1 Strengthen primary health care workers' knowledge of community health services referral pathways and linkages to health facilities
3.3.2 Strengthen community health referral reporting and documentation
3.3.3 Develop innovative (novel) referral mechanisms such as enlisting key influencers
3.3.4 Build the capacity of the community health workforce to understand the linkages, coordination, service provision, and monitoring of the primary care networks
3.3.5 Initiate community health volunteers' task-sharing activities at link facilities

Strategic objective 3.4: Strengthen the capacity of the community health workforce for the provision of high-quality community health services

Key interventions
3.4.1 Train community health assistants to be trainers of trainees in basic and technical community health modules
3.4.2 Train community health volunteers in basic and technical community health modules
3.4.3 Train community health assistants on communication strategies for social behavioural change
3.4.4 Provide a basic community health kit to the community health workforce (Appendix 2)
3.4.5 Conduct refresher training for the community health workforce in basic and technical community health modules and other emerging health issues and needs
3.4.6 Audit the quality of community health services annually through the Community Quality Improvement Teams

Strategic direction 4: Increase the availability, quality, and utilization of data

The County Community Health Policy emphasizes the need to strengthen the community-based health information system (CBHIS).

Strategic objective 4.1: Develop and implement a harmonized digital community health information system

Key interventions
4.1.1 Digitalize the community health information system as per the roadmap for the digitization of the community-based health information system using a phased approach
4.1.2 Operationalize the digital community health information system in a phased approach
4.1.3 Build the capacity of the community health workforce on the digital community health information system
4.1.4 Provide the community health workforce with functional smartphones with adequate internet bundles

Strategic objective 4.2: Enhance the capacity of the community health workforce to effectively collect, collate, and report quality community health data

Key interventions
4.2.1 Develop a community health data management manual and a compendium of key performance indicators
4.2.2 Train community health workforce on data collection and quality module
4.2.3 Conduct community health data quality audit using guidelines and tools aligned with the national government
4.2.4 Integrate community health into the other data quality improvement processes in the Ministry of Health

Strategic objective 4.3: Strengthen capacity for community-level research and increase utilization of evidence for decision-making in the community health system

Key interventions
4.3.1 Map out areas of community health research and learning agendas in detail
4.3.2 Build the capacity of County and sub-county health management teams to conduct and publish community health research

Strategic objective 4.4: Establish a community-based surveillance system

Key interventions
4.4.1 Develop guidelines for community-based surveillance
4.4.2 Sensitise the community health workforce on the guidelines for community-based surveillance
4.4.3 Build the capacity of the community health workforce to conduct community-based surveillance
4.4.4 Create community committees to monitor and respond to maternal and perinatal deaths

Strategic objective 4.5: Using community health data, institutionalize social accountability in the quality of primary health services

Key interventions
4.5.1 Develop community health scorecards to promote social accountability
4.5.2 Sensitize the community health workforce and County and sub-county health management team on the use and importance of the community health scorecards for social accountability
4.5.3 Implement the community health scorecards to ensure social accountability

Strategic Direction 5: Ensure the availability and rational distribution of safe and high-quality commodities and supplies

For the community health workforce to deliver services efficiently, they require the necessary commodities and supplies, as highlighted in the Kenya Community Health Policy 2020–2030. The proposed solutions to address these challenges and improve the availability of supplies and commodities include:

Strategic Objective 5.1: Make certain that community health supplies and commodities are secure, of high quality, and safe

Key interventions
5.1.1 Review the commodity management processes at the community level to ensure they align to the existing guidelines and procedures
5.1.2 Train community health workforce on forecasting and quantification of community health commodities
5.1.3 Establish a commodity safety monitoring system for community health services

Strategic Direction 6: Establish a platform for strategic collaboration and accountability among all community health stakeholders and sectors

There are multiple partner organizations involved in community health in Kenya at the national and County level that contribute resources to community health and implement diverse activities. These activities include developing policies and tools, providing technical expertise, and training community health workers. The following strategies will be implemented to increase partner and inter-sectoral coordination for community health.

Strategic Objective 6.1: Strengthen the service delivery coordination mechanism between the Ministry of Health, County governments, and partners

Key interventions
6.1.1 Develop a framework for community health partnerships to improve partner alignment and engagement
6.1.2 Map out community health stakeholders, funding streams, and intervention areas
6.1.3 Advocate for a community health agenda in health-related inter-governmental forums
6.1.4 Disseminate the County's community health policy and strategy to all stakeholders
6.1.5 Make annual community health reports and periodic newsletters a regular occurrence

Strategic Direction 7: Increase sustainable financing for community health

The situational analysis highlighted gaps such as inadequate community health financing because of poor linkage between plans and budgets, inadequate resource allocation, irregular funding flows, and poor coordination of funding streams. The strategy will focus on the approaches and interventions described in this section to address this situation and increase sustainable financing.

Strategic Objective 7.1: Develop mechanisms for mobilizing resources to fund community health

Key interventions

7.1.1 Develop an investment case for community health
7.1.2 Use the investment case and advocacy toolkit to advocate for an increase in County budgetary allocation for community health
7.1.3 Establish a participatory budget and oversight between the link facility and the community health units to ensure sustainability considerations are made for the services at the community level
7.1.4 Build the capacity of the County, sub-county, community health assistants, and community health committees on resource mobilization for community health
7.1.5 Establish community health units-private sector collaboration for long-term community-level services

Strategic Objective 7.2: Explore and scale up innovative financing and co-financing mechanisms

Key interventions

7.2.1 Train community health units on income-generating activities and entrepreneurship skills
7.2.2 Register community health units as community-based organizations to access resources
7.2.3 Advocate for the inclusion of a benefits package for community health in the National Health Insurance Fund scheme
7.2.4 Document existing income-generating activities' challenges and lessons learned to inform future income-generating activities
7.2.5 Explore other possible income-generating activities and innovations such as village savings or cooperative and loaning associations

IMPLEMENTATION FRAMEWORK

04

IMPLEMENTATION FRAMEWORK

4.1 Introduction

Since health is not a stand-alone human need, diverse factors contribute directly or indirectly to poor health indicators. Community health service delivery can only function optimally when other line sectors are engaged closely. The strategy outlines the roles and responsibilities of each stakeholder in making community health service delivery more effective and efficient. Community, agriculture, education, gender, culture and social services, County assembly health committee, civil society, faith-based organizations, development partners, and other stakeholders are among the key stakeholders who will help ensure the strategy's success.

4.2 Strategic approach

A combination of approaches, including rights-based, multi-sectoral, public-private partnerships, socially inclusive, consultative, and participatory approaches, will be adopted to implement the Makueni County Community Health Strategy. The implementation framework will leverage on a partnership framework and periodic stakeholders' forums, technical working groups meetings, and community-based action and dialogue days to engage all the actors—individual citizens, households, communities, private sector enterprises, NGOs, development partners, and County government departments—in a mutual exchange of ideas, including the complimentary use of expertise and resources with partners. Table 11 summarizes the strategic directions, objectives, interventions, and implementation timelines.

Table 7: Strategy implementation matrix by strategic directions

Strategic objective	Expected outcome	Expected output	Key intervention	Activity	Implementation matrix				
Strategic Direction 1: Strengthen leadership and governance for community health services					**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
Strategic Objective 1.1: Strengthen community health units' governance structure	Functional community health units	Functional community health committees	1.1.1 Recruit CHC members for all community health units	1.1.1.1 Sensitize communities on recruitment of community health committee members		X			
				1.1.1.2 Recruit community health committee members in a public Barraza		X			
				1.1.1.3 Adopt and disseminate the revised community health committee curriculum		X			
			1.1.2 Train community health committee members using the revised CHC curriculum	1.1.2.1 Train community health committee members		X	X	X	X
			1.1.3 Hold quarterly CHC meetings	1.1.3.1 Conduct quarterly CHC meetings supported by minutes		X	X	X	X
			1.1.4 Conduct quarterly supportive supervision of the CHCs by SCHMT and CHMT	1.1.4.1 Develop a quarterly supervision plan 1.1.4.2 Print quarterly supervision checklist 1.1.4.3 Share supportive supervision findings with CHC, CHAs, and SCHMT for follow up on action points		X	X	X	X
Strategic Objective 1.2: Establish a County community health technical working group (TWG)	More targeted, integrated Community owned service delivery with clear action plans	A County and sub-county community health Technical Working Groups	1.2.1 Define scope, roles, and responsibilities of community Health TWGs	1.2.1.1 Develop Terms of Reference for the TWGs	X				
				1.2.1.2 Identify members of the TWG	X				
			1.2.2 Appoint TWG members	1.2.2.1 Align the community TWG with other technical groups in the County	X				
			1.2.3 Hold quarterly TWG meetings	1.2.3.1 Hold quarterly meetings	X				

Strategic Objective 1.3: Strengthen and develop an advocacy mechanism for prioritization and implementation of community health services	Increased and sustainable funding for community health Standard messaging and defined demand generation platforms in community health		1.3.1 Adopt the national government's community health advocacy and communication strategy guidelines	1.3.1.1 Disseminate community health advocacy guidelines to SCHMT and CHAs	X				
				1.3.1.2 Evaluate the advocacy guideline in the mobilization of resources		X			
			1.3.2 Disseminate national government guidelines on community health advocacy and communication strategy	1.3.2.1 Disseminate communication strategy to CHMT, SCHMT, CHAs, and CHVs	X	X			
			1.3.3 Develop a community health advocacy toolkit	1.3.3.1 Disseminate the community health advocacy toolkits					
Strategic objective 1.4: Increase the effectiveness of performance monitoring for community health governance structures	Functional community health units	Defined monitoring and evaluation framework	1.4.1 Create a monitoring and evaluation framework to evaluate the community health committees' functionality of all existing and newly created community health units	1.4.1.1 CHMT to conduct quarterly supportive supervision to access the functionality of CHC		X	X	X	X
			1.4.2 Hold bi-annual review meetings as resource mobilization and utilization by community health committees	1.4.2.1 Train Community health Committee members on resources mobilization		X			
				1.4.2.2 Sensitize potential funders on the role of CHC in resource mobilization		X	X	X	X
				1.4.2.3 Plan for audit of CHU accounts. Share audit reports with the community and stakeholders for transparency and accountability		X	X	X	X
				1.4.3.1 Develop a community health committee performance review work plan		X			

Strategic Direction 2: Build a motivated, skilled, equitably distributed community health workforce					21/22	22/23	23/24	24/25	25/26
Strategic Objective 2.1: Develop and institutionalize a scheme of service and career progression for community health personnel	Increased retention and motivation of community workforce	Defined scheme of service	2.1.1 Redistribute CHVs as per the Makueni CH policy	2.1.1.1 Develop and maintain a database for community health Volunteers and Community Health Committee members	X	X	X	X	X
				2.1.1.2 Conduct monthly data review meetings at respective link facilities to identify gaps with CHVs	X	X	X	X	X
				2.1.1.3 Distribute CHVs		X			
			2.1.2 Recruit and deploy CHVs at the village level based on prescribed selection criteria in Makueni CH Policy	2.1.2.1 Sensitize community on the selection process		X			
				2.1.2.2 Select and replace the community health volunteers who have left the workforce on an annual basis	X	X	X	X	X
			2.1.3 Replace inactive CHVs at least once per year, and identify and address attrition causes	2.1.3.1 Sensitize community on CHVs replacement		X			
				2.1.3.2 Recruit CHVs as stipulated in the County community health policy		X			
Strategic Objective 2.2: Increase CHAs and SCHMT mentorship and supervision capacity	Structured and targeted supportive supervision	Number of CHAs and SCHMT trained on supervision toolkit	2.2.1 Develop technical assistance plans for respective community health units	2.2.1.1 CHMT and SCHMT to develop phased work plan and cabinet papers to support increased budget allocation	X	X	X	X	X
			2.2.2 Create mentorship and supervision toolkits for community health services	2.2.2.1 Disseminate community health services supervision toolkits		X			
				2.2.2.2 Review community supervision toolkits		X	X	X	X
			2.2.3 Sensitize CHAs and SCHMT on mentorship and supervision toolkits for community health services	2.2.3.1 Identify and prioritize CHAs knowledge gaps, and conduct annual refresher training and quarterly mentorship		X	X	X	X
				2.2.3.2 Review community supervision tool kits		X			
			2.2.4 Conduct quarterly supervisory visits to CHAs	2.2.4.1 Develop a quarterly supportive supervision work plan		X	X	X	X
				2.2.4.2. Conduct supervisory visits and share key action points		X	X	X	X

Strategic Objective 2.3: Standardize the framework for financial and non-financial remuneration for community health volunteers			2.3.1 Develop a financial and non-financial performance-based remuneration framework for CHVs	2.3.1.1 Disseminate performance-based incentives framework for CHVs to SCHMT		X			
			2.3.2 Regularly remunerate with a minimum stipend of 2,000 monthly		X	X	X	X	X
Strategic Direction 3: Strengthen the delivery of integrated, comprehensive, and high-quality community health services					**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
Strategic Objective 3.1: Increase coverage, demand, and community health services	Elaborate distribution of community health volunteers and community health assistants	Number of villages with equitably distributed community health workforce	3.1.1 Conduct annual household mapping	3.1.1.1 Sensitize CHVs and CHAs on the household mapping exercise	X	X	X	X	X
				3.1.1.2 Conduct household mapping highlighting priority households	X	X	X	X	X
				3.1.1.3 Review of household mapping data by the CHVs and CHAs	X	X	X	X	X
	Increased targeted coverage and service delivery to the community Targeted demand generation achieving increased coverage of community services	Number of households visited by CHVs every month Number of demand generation events held	3.1.2 Intensify household health visits based on community health volunteers' approved movement	3.1.2.1 Develop movement plans for CHVs		X	X	X	X
				3.1.2.2 Integrate CHVs plans with CHAs supervisory work plan		X	X	X	X
			3.1.3 Intensify community sensitization and mobilization during community and national health events outreaches, health talks, dialogue days, and mass immunization campaigns	3.1.3.1 Map outreach sites using qualitative and quantitative data		X			
				3.1.3.2 Share outreach sites and schedule		X			
				3.1.3.3 Develop outreach supportive supervision checklist		X			
				3.1.3.4 Conduct biannual outreach supportive supervision			X	X	X
				3.1.3.5 Develop and disseminate demand generation strategy and annual review of the strategy			X	X	X
			3.1.4 Develop dialogue centred behaviour change facilitation guidelines for community health volunteers	3.1.4.1 Conduct quarterly dialogue and monthly action days		X	X	X	X
				3.1.4.2 Develop dialogue facilitation guides for different thematic areas		X	X	X	X

			3.1.5 Mainstream gender in community health services	3.1.5.1 Conduct gender analysis			X		
				3.1.5.2 Orient CHVs and CHAs to offer gender-responsive services		X	X	X	X
				3.1.5.3 Conduct training of CHVs and CHAs on home-based care		X			
				3.1.5.4 Integrate home-based care in supportive household supervision		X			
				3.1.5.5 Create awareness of home-based care to dispel myths associated with a terminal illness		X	X	X	X
Strategic Objective 3.2: Increase community-owned and led innovations for the sustainability of community health services	Functional CHUs that are self-sustainable	Number of functional community health units	3.2.1 Build intra-sectoral and multi-sectoral linkages with community units and health service providers	3.2.1.1 Map community health actors and engage them to understand their role in community health		X			
				3.2.1.2 Share mapped stakeholders engagement framework		X			
			3.2.2 Implement model households' approach to promote sustainable behaviour change	3.2.2.1 Develop a standard guideline for the model household		X			
				3.2.2.2 Train CHAs and CHVs on model household		X	X	X	X
			3.2.3 Train Community Health Volunteers on Participatory Learning and Action Cycle model	3.2.3.1 Develop PLAC training curriculum for different priority thematic areas		X			
						X			
Strategic Objective 3.3: Strengthen community health linkages and referral mechanism	Verifiable and defined referral system that is owned by community and health service providers	Number of MOH 100 referrals filed at the link facilities and community health units	3.3.1 Build capacity of primary health care workers on community health services referral pathways and linkages to health facilities	3.3.1.1 Train CHAs, link facility CHEWs and Community Health Volunteers on referral pathways		X			
				3.3.1.2 Review referral pathways during CHV monthly data review meeting		X			
			3.3.2 Strengthen reporting and documentation for community health referrals	3.3.2.1 Procure referral tools and files		X			
				3.3.2.2 Review referrals done by community Health Volunteers and link facilities for accuracy, completeness, and if action points are executed		X			
				3.3.2.3 Establish Community Health Volunteers desk at the link facilities		X			

			3.3.3 Develop innovative referral mechanisms like engaging key influencers	3.3.3.1 Map out community key influencers		X			
				3.3.3.2 Develop a key influencers' engagement framework		X			
			3.3.4 Build the capacity of the community health workforce to understand the linkages, coordination, service provision, and monitoring of the primary care networks (PCNs)	3.3.4.1 Orient community health workforce on primary care networks		X			
			3.3.5 Initiate community health volunteers' task-sharing activities at link facilities	3.3.5.1 Define roles of the CHVs at the link facilities		X			
Strategic Objective 3.4: Strengthen the capacity of the community health workforce for the provision of high-quality community health services	Targeted trained CHVs equipped with relevant tools of the trade	Number of community health workforce trained	3.4.1 Train community health assistants as trainers of trainees of community health on basic and technical modules	3.4.1.1 Train CHAs on the basic and technical module		X	X	X	X
			3.4.2 Train community health volunteers on community health basic and technical module	3.4.2.1 Train CHVs on the basic and technical module		X	X	X	X
			3.4.3 Train community health assistants on social behaviour change and communication strategy	3.4.3.1 Train CHAs on social behaviour change and communication strategy		X			
			3.4.4 Equip CHVs with a basic community health kit	3.4.4.1 Procure CHVs kit		X			
				3.4.4.2 Orient CHVs on how to utilize the kit during monthly review meetings		X			
			3.4.5 Conduct refresher training for the community health workforce on both community health basic and technical module and other emerging health issues needs	3.4.5.1 Orient Community Health Assistants and link facilities community focal persons on refresher training guidelines		X			
			3.4.5 Community Quality Improvement Teams to audit the quality of community service annually	3.4.5.1 Conduct quarterly quality improvement review meetings at all levels		X			

			3.4.6 Audit the quality of community health services annually through the Community Quality Improvement Teams	3.4.6.1 Conduct annual quality improvement audits		X	X	X	X
Strategic Direction 4: Increase the availability, quality, and utilization of data					**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
Strategic Objective 4.1: Develop and implement a harmonized digital community health information system	Improved indicators due to the implementation of data-driven interventions Quality community data used to make decisions	All community units utilize community data to make decisions. Data quality audits conducted	4.1.1 Digitalize community health Information system	4.1.1.1 Orient community health workforce on community data digitalization roadmap		X			
				4.1.1.2 Migrate community health data and operationalize the digital CHIS in a phased approach		X	X	X	
				4.1.1.3 Build the capacity of the community health workforce in the digitization process		X	X	X	
				4.1.1.4 Conduct training for the community health workforce on the digital CHIS		X	X	X	
				4.1.1.5 Facilitate budget allocation for the purchase of smartphones and provision of monthly data bundles		X	X	X	
				4.1.1.6 Procure community-reporting tools in the preparation of phased digitalization	X	X	X		
			4.1.2 Develop operationalize the digital community health information system in a phased approach	4.1.2.1 Disseminate community health data management manual to community health workforce		X			
			4.1.3 Build the capacity of the community health workforce on digital community health information system	4.1.3.1 Train the community health workforce on the community health data management manual and indicator compendium.		X	X	X	X
			4.1.4 Provide community health workforce with functional smartphones with adequate internet bundles	4.1.4.1 Procure smartphone as provided in the guideline		X			

			4.1.5 Procure community health reporting tools in the preparation of phased digitalization	4.1.5.1 Procure reporting tools and map out areas with poor or no internet coverage		X	X		
Strategic Objective 4.2: Enhance the capacity of the community health workforce to collect, collate and report quality community health data effectively	Quality community data used to make decisions	Data Quality audits conducted	4.2.1 Develop a community health data management manual and key performance indicators compendium	4.2.1.1 Disseminate community health data management manual to community health workforce			X		
			4.2.2 Train the community health workforce on data and quality module	4.2.2.1 Train the community health workforce on the community health data management manual and indicator compendium.			X		
			4.2.3 Conduct community health data quality audits using guidelines and tools aligned with the national government	4.2.3.1 Develop a schedule and conduct quarterly data audits			X		
			4.2.4 Integrate community health into the other ministry of health data quality improvement process	4.2.4.1 Orient staff on the integration of community data to facility data review meetings			X		
Strategic Objective 4.3: Strengthen capacity for community-level research and increase utilization of evidence for decision-making in the community health system	Decisions informed by data	The number of researches conducted targeting the improvement of community indicators.	4.3.1 Conduct a comprehensive mapping of the areas of community health research and learning agendas	4.3.1.1 Engage stakeholders to use data to identify research topics		X	X		
				4.3.1.2 Prioritize research topics			X		
			4.3.2 Build capacity and mentor the CH management team to conduct community health research and publish results	4.3.2.1 Disseminate research results to stakeholders				X	
Strategic objective 4.4: Establish a community-based surveillance system (CBS)	Defined response to health issues and emergencies by community members		4.4.1 Develop community-based surveillance guidelines	4.4.1.1 Disseminate community-based surveillance guidelines			X		
			4.4.2 Sensitize community health workforce on community-based surveillance guidelines.	4.4.2.1 Conduct community health workforce training on CBS		X			
				4.4.2.2 Conduct CBS performance review meetings		X	X	X	X
			4.4.3 Build the capacity of the community workforce to conduct community-based surveillance	4.4.3.1 Engage stakeholders to prioritize CBS rollout	X	X			

			4.4.4 Form community committees for maternal and perinatal death surveillance and response.	4.4.4.1 Train stakeholders on CBS		X	X		
				4.4.4.2 Conduct MPDSR performance review meetings		X	X	X	X
Strategic objective 4.5: Institutionalize social accountability in the quality of primary health services using community health data	Community owned and driven primary healthcare	Social accountability data-driven meetings conducted	4.5.1 Develop community health scorecards to promote social accountability	4.5.1.1 Develop community scorecards		X	X	X	X
			4.5.2 Sensitize community health workforce, County, and sub-county health management team on community health scorecards for social accountability	4.5.2.1 Sensitize community workforce on community scorecards		X	X		
			4.5.3 Implement the use of the community scorecard			X	X		
Strategic Direction 5: Ensure the availability and rational distribution of safe and high-quality commodities and supplies					**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
Strategic Objective 5.1: Make certain that community health supplies and commodities are secure, of high quality, and safe			5.1.1 Conduct a review of the community level commodity management processes for alignment with existing guidelines and procedures	5.1.1.1 Disseminate commodity management guidelines to stakeholders		X	X	X	X
			5.1.2 Train community health workforce on forecasting and quantification of community health commodities.			X	X	X	X
			5.1.3. Put in place a safety monitoring system for community health commodities			X	X	X	X
Strategic Direction 6: Create a platform for strategic partnership and accountability among stakeholders and sectors at all levels within community health					**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
Strategic Objective 6.1: Strengthen the coordination mechanism for service delivery between national MoH, County governments, and partners			6.1.1. Create a framework for community health partnerships to improve partner alignment and engagement	6.1.1.1 Engage stakeholders to use data to identify research topics		X	X	X	X
				6.1.1.2 Prioritize research topics		X			

			6.1.2 Carry out mapping exercise for all community health stakeholders, funding flows, and intervention areas			X			
			6.1.3 Incorporate community health agenda in the health sector inter-governmental forum			X			
			6.1.4 Disseminate the County community health policy and strategy to all stakeholders			X			
			6.1.5 Build partnerships with private sector actors towards addressing the social determinants of health			X			
Strategic Direction 7: Increase sustainable financing for community health					**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
Strategic Objective 7.1: Develop mechanisms for resource mobilization for financing community health	Prioritization of community activities	County community case investment	7.1.1 Create a business case for community health	7.1.1.1 Develop a County community health investment case		X			
				7.1.1.2 Disseminate investment case to stakeholders		X			
				7.1.1.3 Develop an advocacy toolkit for resource mobilization		X			
			7.1.2 Advocate for an increased County budgetary allocation for community health, backed by investment case and advocacy toolkit			X	X	X	X
			7.1.3 Establish participatory budgeting and oversight between the link facility and the CHUs to ensure sustainability considerations are made for services at the community level	7.1.3.1 Conduct a joint meeting between the community Health Committee and link facility committee		X	X	X	X
				7.1.3.2 Conduct performance review meetings for budgets		X	X	X	X
			7.1.4 Build the capacity of the County, sub-county, CHAs, and CHCs on resource mobilization for community health	7.1.4.1 Integrate resource mobilization capacity building in the phased work plan		X			

			7.1.5 Advocate for and establish CHUs-private sector partnerships for long term community-level services	7.1.5.1 Sensitize private sector and faith-based organizations on community health services		X			
				7.1.5.2 Develop a public-private sector engagement framework		X			
Strategic Objective 7.2: Explore and scale up innovative financing and co-financing mechanisms	More sustainable community health	Sustainable community health financing models	7.2.1 Train community health units on income-generating activities and entrepreneurship skills.	7.2.1.1 Develop an IGA viability assessment tool		X			
				7.2.1.2 Engage the ministry of gender and social services to train CHUs on IGAs		X	X	X	X
				7.2.1.3 Develop IGA money distribution criteria since CHVs in CHUs are not equal		X	X	X	X
			7.2.2 Register community health units as community-based organizations to access resources	7.2.2.1 Issue registered community health units with certificates		X	X	X	X
			7.2.3 Advocate for the inclusion of a benefits package for community health in the NHIF	7.2.3.1 CHVs to support creating awareness and referring communities to register with NHIF		X	X	X	X
			7.2.4. Document challenges and lessons learned from existing income-generating activities to inform future income-generating activities			X	X	X	X
			7.2.5 Explore other possible income-generating activities and innovations like village savings or cooperatives and loaning associations	7.2.5.1 Train CHVs on village savings and loaning association model		X	X	X	X

MONITORING AND EVALUATION PLAN

05

MONITORING AND EVALUATION PLAN

5.1 Monitoring and evaluation framework

The overall purpose of the monitoring and evaluation framework is to improve the community health strategy's accountability by strengthening the capacity for information generation, validation, analysis, dissemination, and utilization.

Over the next five years, monitoring and evaluation will be conducted as follows:

- **Monitoring:** Quarterly performance monitoring meetings will be held to review implementation progress against targets in the annual work plans. Semi-annual stakeholder performance monitoring and review meetings at the County and sub-county levels will be conducted to review performance against targets, address any constraints in implementation, and re-focus activities if needed.
- **Evaluation:** A mid-term evaluation led by the CHMT and SCHMT will be conducted in 2022/23, and a final evaluation will be conducted in the last year, 2024/25.

This monitoring and evaluation framework is structured based on the six WHO building blocks. It illustrates how health inputs and processes (e.g., health workforce) are reflected in outputs (e.g., interventions and available services) and consequently reflected in outcomes (e.g., coverage) and impact (morbidity and mortality).[16]

[16] *Monitoring Handbook of the Health System, World Health Organization, 2010. Geneva*

Table 8. Monitoring and evaluation indicators

Input indicators	Output indicators	Outcome indicators	Impact indicators
Leadership and governance			
Functional community Health Committees (Established & Trained)	Number of Community Health Units constituted as stipulated in Makueni Community Health policy 2020-2030	Sustainable community health units with increased funding	%reduction maternal mortality rate % reduction infant and child mortality rates %reduction of teenage pregnancy %reduction in waterborne diseases %reduction in number of long term complications as a result of non-communicable diseases %reduction in number of premature deaths as a result of non-communicable diseases % reduction in number of new patients presenting with non-communicable diseases % reduction in stunting
	Number of Community Health Workforce trained on CHC revised curriculum		
	Number of Community Health Committee members trained		
	Number of functional Community Health Units		
	Number of supportive supervisions conducted by SCHMT/CHMT		
	Number of Community Health Units mobilizing resources and advocating for community contribution towards community health services		
Constituted Community Health Technical Working Group	County and Sub-County Community Health Technical Working Groups constituted	Well-coordinated community health services with timely technical guidance and evaluation results	
	Terms of Reference of Community Technical Working Group developed		
	Number of Technical Working Group meetings held evidenced by minutes		
	Performance measurement based on the M&E framework		
Community health services advocacy and communication guidelines developed	Advocacy guidelines developed for the community, SCHMT and CHMT	Well organized and defined advocacy mechanisms	
	County Community Health Communication strategy developed	Defined and well-coordinated communication	
Monitoring and evaluation framework	Number of evaluation reports developed and disseminated	Timely evaluation, redesigning of community services, and mitigation of risks	

Community health human resource			
Recruitment and deployment of community health workforce	Community health workforce database created and adopted	Increased coverage and improved quality of community health services	
	Number of CHVs trained on both basic and technical module		
	Number of Community Health Volunteers trained to offer gender-responsive services		
	Number of CHUs aligned as stipulated in Makueni community health policy 2020–2030		
	Number of Community Health Volunteers replaced annually		
	Household mapping data is collected and updated annually by all Community Health Volunteers		
	Number of supportive supervision conducted at Community Unit and Household level		
	Number of Community Health Workforce institutionalized certified		
	Number of Community Health Units accredited		
	Number of health workers oriented on referral pathways and Primary Care Networks		
	Number of Health Workers trained on PLAC, and groups formed		
	Number of Health Care Workers trained on MPDSR and active committees constituted		
	Number of MPDSR committees formed and meeting quarterly or within stipulated timing to review deaths		
Scheme of service and career progression of community health personnel	Scheme of service and career progression framework	Motivated staff and increased demand for community services	
Supportive supervision and capacity building	Number of Community supervisors trained on both basic and technical modules		
	Number of supportive supervision conducted		
	Number of Community Health supervisors recruited and deployed		
	Number of community technical assistance plans developed and evaluated by community supervisors		
	Phased integrated work plan disseminated to stakeholders		
	Number of targeted outreaches conducted		
	Number of Community Health Volunteers trained on home-based care		

Community service delivery			
Capacity build community Health Workforce equipped for service delivery	**Maternal new-born child and adolescent health** i. Number of pregnant women referred before or at 13 weeks gestation for ANC (separate adolescents and mature women) ii. Number of immunization defaulters traced and referred for services iii. Number of women referred for SBA iv. Number of diarrhoea and pneumonia cases identified and referred by CHVs		
	Family planning i. Number of Community Health Volunteers trained and providing FP health messages and referring clients for services at link facilities ii. Community Health Volunteers trained and offered FP commodity-based Distribution to the community members iii. Total population reached with FP messages by CHVs		
	WASH i. Number of Villages certified open defecation free with the support of CHVs (Household with latrines and handwashing facilities) ii. Households accessing basic drinking water		
	Geriatric i. Older people ≥60 referred to link facilities for screening and check-ups ii. Number of screening outreaches conducted coordinated by Community Health Volunteers		
	Non-Communicable diseases (hypertension and diabetes) i. The number of people living with non-communicable diseases participating in support groups ii. Number of dialogues targeting vulnerable with NCDs prevention conducted iii. Number of people on home-based care followed up monthly iv. Number of clients adhering to medication, diet, physical activity (controlled diabetes and hypertension)		
	Nutrition i. Number of children under-5 referred for growth monitoring ii. Number of children referred for nutrition review		
	Others i. Number of community dialogue and action days conducted		

Community health financing			
Harmonized and standardized framework for financial and non-financial remuneration of community health volunteers	Number of community health volunteers receiving stipends consistently		
	Existence of a performance-based incentive framework		
	Number of CHVs receiving non-monetary incentives at the recommended time		
Resource mobilization using Community health investment case	Existence of an advocacy tool kit		
Innovative financing mechanisms established	Number of CHUs trained and efficiently running IGA/VSLA		
	Number of CHUs registered for IGAs with certificates and regularly supervised and evaluated		
	Motorbike evaluation report disseminated to stakeholders		
Commodity supplies and management			
Capacity building community health workforce on forecasting and quantification	Number of community health volunteers trained on commodities and supplies management		
	Number of community health volunteers supplied with CHV kits and job aids		
Community health information system			
Training community health workforce on data collection and utilization in decision making	Number of community workforce trained in data collection		
	Number of monthly data review meetings held		
	Number of community data quality audits		
	Number CHUs reporting in DHIS		
	A work plan on community data phased digitalization plan from the financial year 2022/2025		

5.2 Performance framework

Table 9: Key performance indicators target

Key performance indicators	Baseline 2020		Targets			Means of verification
	20/21	21/22	22/23	23/24	24/25	
Leadership and governance						
Number of Community Health Units constituted aligned with Makueni Community Health policy 2020-2030	242	260	278	296	312	Community department & KHIS
Number of Community Health Workforce trained on CHC revised curriculum	0	20	40	50	60	Training signed participant list
Number of Community Health Committee members trained	0	2600	2780	2960	3120	Training signed participant list
Number of functional Community Health Units	0	260	278	296	312	Community department & KHIS
Number of supportive supervisions conducted by SCHMT/CHMT to CHAs	0	4	4	4	4	Support supervision report
Number of CHUs receiving supportive supervision		260	278	296	312	Support supervision report
Number of Community Health Units mobilizing resources and advocating for community contribution towards community health services	0	260	278	296	312	CHC meeting minutes
Number of Technical Working Group meetings held evidenced by minutes	0	1	7	7	7	TWG minutes
Community human resource						
Number of Community Health Volunteers trained on the basic module	3425	639	639	639	663	Signed participant list
Number of Community Health Volunteers receiving refresher training on the basic module	0	3425	4703	5342	6005	Signed participant list
Number of Community Health Volunteers trained on the technical module						
1. Water and sanitation and hygiene	783	855	855	855	855	Signed participant list
2. Nutrition	940	812	812	812	812	Signed participant list
3. Integrated community case management	214	395	395	395	396	Signed participant list
4. Maternal new-born health	384	1406	1405	1405	1405	Signed participant list
5. Family planning	426	1394	1394	1394	1395	Signed participant list
6. Communicable diseases	210	1448	1448	1448	1449	Signed participant list
7. Non-communicable diseases	241	1441	1441	1441	1442	Signed participant list
Number of CHAs /CHEWs trained on the basic and technical module	20	40	50	60	60	Signed participant list
Number of community health Volunteers oriented on gender-responsive services	0	1500	1500	1500	1501	Signed participant list
Number of Community Health Volunteers replaced annually	28%	23%	18%	13%	8%	Community database

Number of Community Health Units performing annual households mapping	0	260	278	296	312	KHIS
Household visits quarterly coverage by Community Health Volunteers	-	80%	85%	90%	100%	KHIS
Number of Community Health Workers trained on PLAC	0	3477	4320	5163	6005	Signed participant list
Number of Community Health Workers trained on model household	0	3477	4320	5163	6005	Signed participant list
Number of Pregnant Women Groups formed by Community Health Volunteers	0	260	278	296	312	Signed participant list
Number of model households formed	0	260	278	296	312	Report
Number of NCD support groups are formed by CHVs	0	260	278	296	312	Signed participant list
Number of Community MPDSR committees trained and constituted	0	26	28	30	30	Minutes
Community service delivery						
Maternal and new-born health						
% of ANC clients visiting for services at or below 13 weeks' gestation	21%	25%	30%	35%	40%	KHIS
Number of immunization defaulters traced by community health volunteers	98%	100%	100%	100%	100%	KHIS
Family planning						
Increasing contraceptive prevalence rate	45%	50%	55%	60%	65%	KHIS
Number of community dialogue days conducted by CHVs targeting the community with family planning information		260	278	296	312	KHIS
WASH						
Latrines coverage	92%	94%	96%	98%	100%	KHIS
% of households with latrines and handwashing facilities		94%	96%	98%	100%	KHIS
Communicable diseases						
Number of suspected TB/HIV cases and defaulters referred by CHVs						KHIS
Number dialogue conducted targeting the community with information on communicable diseases		260	278	296	312	KHIS
Non-communicable diseases						
Number of NCD support groups formed (evaluate if the intervention improves adherence to medication and reduces long term complications)		260	278	296	312	KHIS
Number of people screened for NCDs and referred to link facilities for services						KHIS
Number of community dialogue days conducted by CHVs targeting vulnerable with messages (with executed work plan)		260	278	296	312	KHIS

Nutrition						
Number of children referred for nutrition for growth monitoring	25%	30%	35%	40%	45%	KHIS
Number of children under five on growth monitoring (vitamin A supplementation and deworming)	79%	84%	89%	94%	100%	KHIS
Community health financing						
% of Community Health Volunteers receiving maximum-based incentive	0%	70%	75%	80%	90%	KHIS
Number of Community Units trained on VSLA		43%	80%	85%	90%	Participants list
Number of Community Health Units trained on IGA management and registered and issued certificates		43%	80%	85%	90%	KHIS
% of community health expenditure over total County health expenditure						AWP/CIDP
Commodity supply management						
% Community Health Volunteers with defined service delivery kit	0%	50%	70%	90%	100%	Issue and tracking forms
Community health information system						
Proportion of CHU performing monthly data review meetings	56%	80%	85%	90%	95%	KHIS
Number of Community health Units scoring 80% in annual community DQA	41%	80%	85%	90%	95%	KHIS
Number of CHUs reporting in DHIS	40%	80%	85%	90%	95%	KHIS

COSTED IMPLEMENTATION PLAN

06

COSTED IMPLEMENTATION PLAN

6.1 Costing methodology and assumptions

The Community Health Strategy was costed using an input-based Activity-Based Costing (ABC) approach and the UNICEF/MSH Community Health Planning and Costing Tool (CHPCT). The ABC approach measures the cost and performance of activities, resources, and cost objects. The approach allocates resources to activities, and activities are assigned to cost objects based on their use.

The CHPCT was used to model the scale-up, coverage, and costs of providing community health services over the strategy period. The CHPCT is a spreadsheet-based tool that helps planners and managers determine the costs and finances of community health service packages. The tool allowed for the calculations of the costs and financing elements linked to all aspects of the community health packages, including service delivery, training, supervision, and management costs at all health system levels.

6.1.1 Components of the programme included in the costing

The costing was done for two different scenarios; the first scenario ***(the best-case scenario)*** aligned with the national community health policy recommendations, while the second scenario ***(the ideal case scenario)*** aligned with the CDoH recommendations for CHWs to be deployed for the implementation of the strategy.

The components of ***the best-case scenario (national policy)*** included in the cost analysis were:

- **Baseline year:** 2020
- **CHVs:** Scaling up CHVs from 3,477 to 6,005 for a coverage of 1 CHV per 25 households while factoring in a 28% attrition rate
- **Supervisors:** Deployment of 624 CHAs supervising an average of 10 CHVs in 312 CHUs and fully paid by the County government. 235 CHEWs are based in 235 CHU link facilities and fully paid for by the County government. The rationale behind the deployment of 6,005 CHVs and 624 CHAs is based on the approximation of the distribution of community health volunteers at the cluster level as recommended in the Makueni County Community Health Policy
- **Management staff:** County Community Health Focal Persons (1) and Sub County Community Health Focal Persons (6)
- **Supervision:** Support quarterly supervision, monthly data review meetings, and quarterly dialogue days
- **Training:** Basic and technical modules initial and annual refresher training for all existing and new CHVs and CHAs/CHEWs (ToTs). Capacity building training on resource mobilization, entrepreneurship, community-based surveillance, and eCHIS for all CHWs
- **Management training:** Capacity building on resource mobilization and advocacy
- **Equipment:** CHV kits and CHVs, CHAs, and CHEWs equipment, including reporting tools (Table 10)
- **Capital costs:** Motorbikes and IGAs seed capital
- **Supplies and commodities:** Medicines and consumables

The components of ***the ideal case scenario (CDoH recommendations)*** included in the cost analysis were:

- **Baseline year:** 2020
- **CHVs:** Scaling up CHVs from 3,477 to 4,857 for a coverage of 1 CHV per 50 households while factoring in a 28% attrition rate.
- **Supervisors:** Deployment of 60 CHAs distributed per sub-ward supervising CHVs in 312 CHUs and fully paid by the County government. 235 CHEWs are based in 235 CHU link facilities and fully paid for by the County government. The rationale behind the deployment of only 60 CHAs is that since the County already has 60 established administrative sub-wards, each CHA will be deployed to a sub ward and supervise all CHUs within the sub ward

- **Management staff:** Include County Community Health Focal Persons (1) and Sub-County Community Health Focal Persons (6)
- **Supervision:** Includes support supervision, monthly data review meetings, and quarterly dialogue days
- **Training:** Basic and technical modules initial and annual refresher training for all existing and new CHVs and CHAs/CHEWs (ToTs). Capacity building on resource mobilization, entrepreneurship, community-based surveillance, and eCHIS for all CHWs
- **Management training:** Capacity building on resource mobilization and advocacy
- **Equipment:** CHV kits and CHVs, CHAs, and CHEWs equipment, including reporting tools (Table 10)
- **Capital costs:** Motorbikes and IGAs seed capital
- **Supplies and commodities:** Medicines and consumables

6.1.2 Costing assumptions

- The implementation costs have been allocated assuming price stability, governance based on devolved units, political and policy goodwill
- Inflation was factored in based on the inflation rate in the baseline year (2020)
- Costs relating to supervision (CHAs and CHEWs) and management (Community health focal persons) i.e. salaries and benefits have not been included, as expenditures for these would still have been incurred regardless of the existence of this strategy
- As a cost-saving measure and to ensure more efficiency, some activities have been incorporated along with other similar activities

6.2 Costed implementation plan

6.2.1 Best-case scenario implementation costs (6005 CHVs, 624 CHAs, 235 CHEWs, 312 CHUs, and 235 link facilities)

The total implementation cost for the best-case scenario of the program over the five years is **KES 2,589,513,326,** with a resource need of **KES 550,553,370** in the first year, **KES 522,480,415** in the second year, **KES 592,892,208** in the third-year, **KES 461,713,017** in the fourth-year, and **KES 461,874,315** in the fifth-year (Table 10).

Table 10. Summary of best-case scenario costs disaggregated by strategic directions

Strategic directions description	Annual activity costs					Total SD Costs
	2021/22	2022/23	2023/24	2024/25	2025/26	
Strategic Direction 1: Strengthen leadership and governance for community health services	35,298,590	103,586,074	37,301,555	36,768,344	38,669,087	**251,623,651**
Strategic Direction 2: Build a motivated, skilled, equitably distributed community health workforce	210,713,234	200,695,126	193,184,692	195,248,437	188,042,196	**987,883,685**
Strategic Direction 3: Strengthen the delivery of integrated comprehensive and high-quality community health services	270,245,414	215,477,680	333,402,727	222,755,719	230,994,446	**1,272,875,987**
Strategic Direction 4: Increase the availability, quality, and utilization of data	6,320,626	218,906	26,070,645	213,727	53,859	**32,877,763**
Strategic Direction 5: Ensure the availability and rational distribution of safe and high-quality commodities and supplies	1,704,323	2,133,829	2,563,789	6,357,990	3,745,928	**16,505,859**
Strategic Direction 6: Create a platform for strategic partnership and accountability among stakeholders and sectors at all levels within community health	658,882	268,800	268,800	268,800	268,800	**1,734,082**
Strategic Direction 7: Increase sustainable financing for community health	25,612,300	100,000	100,000	100,000	100,000	**26,012,300**
Total annual costs	**550,553,370**	**522,480,415**	**592,892,208**	**461,713,017**	**461,874,315**	**2,589,513,326**

The activity inputs considered in the various strategic directions include start-up, training, community-level service delivery costs, support supervision, and management costs. Reimbursements of monthly stipends to CHVs were the highest cost driver by KES 720 million over the five years of implementation, followed by equipment for the community health workers. The start-up costs were relatively low at KES 77.29 million (2.98% of total costs) since the community health program is not new.

Table 11 summarizes the strategy's costs disaggregated by inputs.

Table 11. Summary of best-case scenario costs disaggregated inputs

Inputs Description	Estimated Annual Input Costs					Total Input Costs
	2021/22	2022/23	2023/24	2024/25	2025/26	
CHVs stipend	144,120,000	144,120,000	144,120,000	144,120,000	144,120,000	720,600,000
CHVs equipment	159,633,300	53,304,177	153,954,711	51,637,059	54,322,186	472,851,433
CHVs training	7,326,300	74,479,200	85,407,817	64,318,667	64,318,667	295,850,650
Medicines and supplies	1,704,323	2,133,829	2,563,789	3,058,740	3,745,928	13,206,609
CHA/CHEWs equipment	9,608,400	-	-	-	-	9,608,400
CHA/CHEWs training	22,421,550	23,114,600	14,912,850	12,596,850	-	73,045,850
Management training	3,687,102	66,200	-	242,230	-	3,995,532
Supervision visits	53,298,528	56,070,051	58,985,694	62,052,950	65,279,704	295,686,927
Other Recurrent Costs						
CHWs and management meetings	102,698,779	108,008,726	113,594,791	119,471,332	125,653,452	569,427,081
Start-up Costs						
IGAs – Seed capital	11,992,800	-	-	-	-	11,992,800
CHCs training	-	55,901,943	-	-	-	55,901,943
Development of guidelines, frameworks and tools	355,944	1,156,561	445,385	320,345	337,003	2,615,238
Sensitization meetings	6,211,639	572,719	-	-	-	6,784,358
Capital Costs						
CHA motorbikes	-	-	12,084,942	3,894,844	4,097,376	20,077,162
CHWs reporting tools	23,261,298	-		-	-	23,261,298
Dissemination of guidelines, frameworks and tools	4,233,406	3,552,409	6,822,229	-	-	14,608,044
Total annual costs	**550,553,370**	**522,480,415**	**592,892,208**	**461,713,017**	**461,874,315**	**2,589,513,326**

6.2.2 Ideal case scenario implementation costs (4857 CHVs, 60 CHAs, 235 CHEWs, 312 CHUs, and 235 link facilities)

The estimated cost of implementing the ideal case scenario is KES 1.7 billion for five years. Table 16 presents the annual costs for each strategic direction, while Table 12 shows the key cost drivers of the implementation costs.

Table 12. Summary of ideal case scenario disaggregated by strategic directions

Summary of scenario 2 costs disaggregated by strategic directions	Annual activity costs					Total SD Costs
	2021/22	2022/23	2023/24	2024/25	2025/26	
Strategic direction 1: Strengthen leadership and governance for community health services	13,078,456	59,503,391	13,153,102	13,558,013	14,251,819	**113,544,781**
Strategic direction 2: Build a motivated, skilled, equitably distributed community health workforce	137,511,862	129,072,626	123,662,208	123,970,889	123,137,588	**637,355,174**
Strategic direction 3: Strengthen the delivery of integrated comprehensive and high-quality community health services	203,896,527	150,277,292	244,246,651	154,200,577	159,846,233	**912,467,281**
Strategic direction 4: Increase the availability, quality, and utilization of data	3,996,127	218,906	15,946,927	213,726	53,859	**20,429,545**
Strategic direction 5: Ensure the availability and rational distribution of safe and high-quality commodities and supplies	1,704,323	2,133,829	2,563,789	4,355,790	3,745,928	**14,503,659**
Strategic direction 6: Create a platform for strategic partnership and accountability among stakeholders and sectors at all levels within community health	658,882	268,800	268,800	268,800	268,800	**1,734,082**
Strategic direction 7: Increase sustainable financing for community health	17,025,900	100,000	100,000	100,000	100,000	**17,425,900**
Total annual costs	**377,872,078**	**341,574,844**	**399,941,477**	**296,667,796**	**301,404,226**	**1,717,460,422**

Table 13: Summary of Ideal Case Scenario costs disaggregated by inputs

Inputs Description	Estimated Annual Input Costs					Total Input Costs
	2021/22	2022/23	2023/24	2024/25	2025/26	
CHVs stipend	116,568,000	116,568,000	116,568,000	116,568,000	116,568,000	582,840,000
CHVs equipment	131,048,100	43,140,207	124,550,347	41,794,617	43,967,937	384,501,208
CHVs training	4,252,500	54,337,600	59,815,817	45,630,267	45,630,267	209,666,450
Medicines and supplies	1,704,323	2,133,829	2,563,789	3,058,740	3,745,928	13,206,609
CHA/CHEWs equipment	7,296,000					7,296,000
CHA/CHEWs training	6,107,350	6,266,133	2,605,983	2,375,383	-	17,354,850
Management training	1,402,789	66,200	-	242,230	-	1,711,219
Supervision visits	7,908,936	8,320,201	8,752,851	9,207,999	9,686,815	43,876,802
Other Recurrent Costs						
CHWs and management meetings	63,277,814	66,537,872	69,967,452	73,575,371	77,370,901	350,729,410
Start-up Costs						
IGAs – Seed capital	11,992,800	-	-	-	-	11,992,800
CHCs training	-	41,733,033	-	-	-	41,733,033
Development of guidelines, frameworks and tools	355,945	1,156,561	445,385	320,345	337,003	2,615,239
Sensitization meetings	3,887,140	260,629	-	-	-	4,147,769
Capital Costs						
CHA motorbikes			12,084,942	3,894,844	4,097,376	20,077,162
CHWs reporting tools	20,121,288					20,121,288
Dissemination of guidelines, frameworks and tools	1,949,093	1,054,579	2,586,911	-	-	5,590,583
Total annual costs	**377,872,078**	**341,574,844**	**399,941,477**	**296,667,796**	**301,404,226**	**1,717,460,422**

6.2.3 Scenarios costs comparative analysis

This comparative cost analysis of the scenarios aims to provide options that the County government can invest in with a clear understanding of the cost implications and needs. The best-case scenario had the highest cost of implementation at KES 2.59 billion compared to KES 1.72 billion for the ideal case scenario. The substantial cost drivers that resulted in these variances in costs were the different numbers of CHVs and CHAs deployed for each scenario. In the best case scenario, the country would have to employ 624 CHAs who will serve as the supervisors of CHVs and the link between the CHVs and the link facilities. In the ideal scenario on the other hand, the government would have to rely on both CHAs and CHEWs as the supervisors of the CHVs.

Since the community health program in Makueni County is not new, start-up costs for both scenarios were relatively low compared to the recurrent costs. Figure 5 illustrates the cost comparisons by inputs for both scenarios.

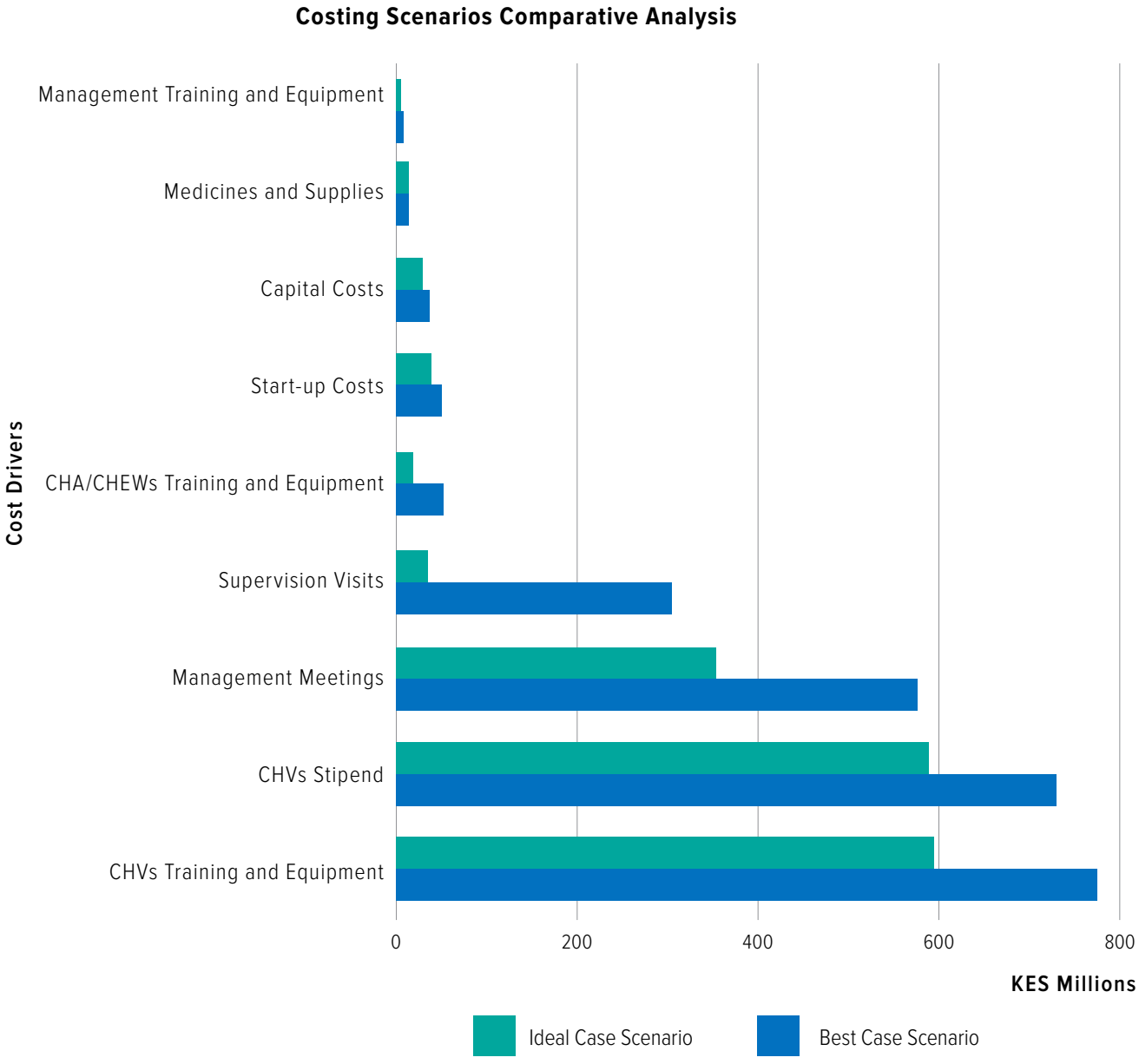


Figure 5. Costing scenarios comparative analysis by inputs

APPENDICES

07

APPENDICES

Appendix 1: Strategy Development Process

The development of the strategy was guided by an extensive consultative, participatory, and evidence-based approach. The document was developed in line with existing policy documents in Kenya, such as the Makueni County Community Health Policy, Primary Healthcare Strategy, Community Health Policy, Kenya Vision 2030, Kenya Health Policy Framework 2014–2030, and other policies. The County community health strategy was developed along with the community health policy. The development process entailed the following key steps:

Activity	Participants	Objectives	Approach
Situational Assessment	Participants from the CDoH and partners	• Identify strengths and issues • Synthesize other national, regional and global experiences, and extract lessons for Kenya's community health 2020 - 2025	Interviews, desk reviews, meetings with the CDoH
Community Health Stakeholders Forum December 17th - 18th 2020	~ participants from CDoH, community health partners, and stakeholders	• Establish alignment on community health strategic priorities • Facilitate stakeholder discussions on the development of the community health strategy • Synthesize other national, regional, and global experiences, and extract lessons	Two-day workshop which incorporated various approaches to facilitate learning and engagement such as PowerPoint presentations, breakout sessions for problem-solving, plenary discussions and gallery walk to review poster presentations. The facilitators for each breakout The session used a facilitator guide which included questions to guide each session
Thematic area writing meetings May-June 2021	~12 participants from the TWG	• Writing of the strategy/policy • Ensure alignment of the strategy to the County Community Health Policy and Strategy	Bi-weekly meetings of the TWG to develop the thematic areas
Strategy writing review meeting June 2021	~70 participants from community health partners and stakeholders	• Presented the policy and strategy of key stakeholders	Present key highlights of the policy/ strategy to partners for input and advocacy for community health financing
Strategy writing review meeting 12th November 2021	~80 participants from community health partners and stakeholders (ward, village administrators)	• Presented the policy and strategy key to the department of devolution	
Policy and strategy presentation to the cabinet 17th December 2021	~15 participants	• Validated CHV distribution of community health workforce • Approved proposed distribution and key interventions	
Policy and strategy presentation to the County assembly health committee 1st to 4th March 2022	~26 participants	• Policy and strategy review by the County assembly • Costing validation	A four-day workshop where the entire policy and key interventions in the strategy document were reviewed under the leadership of the CDoH

Appendix 2: CHVs basic kit items

Kit Item	Description
Equipment	• Weighing scale • Lab glucometer strip • Bag pack bag • Glucometer • CHV name tag • Flashlight torch • Color-coded salter scale (for children) • First aid box (spirit, disposable gloves, cotton wool, strapping, crepe bandage • BP machine • Biohazard box • Biosafety box • Jacket with logo (with reflectors) • Digital thermometer • Timer • MUAC tape
Drugs	• Albendazole 400mg • Paracetamol 500mg • Tetracycline eye ointment • ORS 20.5 mg • Zinc sulphate 20mg • Antibiotics (Amoxicillin 250mg) • Combined Oral Contraceptives • Povidone Iodine • Chlorine /Flocculants (coagulant +disinfectant for turbid water • Chlorine for clear water • Lovibond comparator for measuring chlorine level in the water
Others	• IEC materials • Commodity register • Male condoms • Female condoms • Medical dispensing envelopes
Technology	• Digital mobile phone

Appendix 3. Roles and responsibilities of other County departments and collaborating partners

Line ministry	Relevance and areas of integration
County assembly health committee	• Political buy-in of community activities • Increased budget allocation for community activities • Drafting and reviewing community health bills
Ministry of agriculture	• Leveraging on Community Volunteers working for the ministry of agriculture to improve agri-nutrition • Community health will explore if community health volunteers can learn agri-nutrition skills for income-generating activities for community health units' sustainability
Ministry of education	• Deworming/Vitamin A supplementation • Monitoring immunization, for example, through confirming immunization status for all children before enrolment to playgroup and referring immunization defaulters • Offer comprehensive adolescent sexual health information to delay sexual debut
Ministry of devolution	• Form community health units around devolved governance structures • Social accountability of services offered to the community
Ministry of water	• Constituting water committees • Protecting water sources • Water point rehabilitation • WASH accountability • Water quality assurance • Build capacity of water management committees to maintain springs, shallow wells, and boreholes • Advocate for the link of safe water strategies to other County development strategies • Formulating policies and regulations on water • The Ministry of Health will work closely with the ministry of water to reduce the burden of increasing diarrhoea cases
Ministry of gender and social protection	• Technically assistance in conducting gender analysis to enable the ministry of health to offer gender-responsive services • Integrated awareness of sexual and gender violence and harmful cultural practices • Supporting a platform for health messaging in organized groups • Training health care workers, including CHVs on gender • Clustering and registering Community Health Units as CBOs explore if the government can fund them • Supporting in training CHVs on IGAs • Advocating for equal opportunities for men, women, girls, and boys in terms of accessing health services • Ensuring special interest groups are represented

Ministry of finance and socioeconomic planning	• Capacity building CHVs on how to fundraise • Avail adequate budgetary resources to the department of community health • Undertake community health department audits of sector budgets and expenditures
Individuals and community	• Participating in the CHC selection process guided by criteria stipulated in the Community Health Policy 2020–2030 • Participating in the community health volunteers selection process • Cooperating with community health volunteers during household visits includes honouring referrals and practising desired behaviour advocated by CHVs • Participating in community feedback meetings, for example, community dialogue and action days
Council of elders and traditional groups	• A community council of elders and traditional groups are key influencers in the utilization of health services. The community health department considers them important in achieving sustainable behaviour change. They are key in giving guidance on what is culturally acceptable • They shall be engaged in behaviour change and communication activities
Development partners	• Provide technical and financial resources for community health services • Integrating partners and health department work plan to ensure activities are not duplicated
Health records	• Qualitative and quantitative data to facilitate mapping of outreach sites • Procure register for outreach
Civil society organizations and faith-based organizations	• Supporting sensitizing communities on community health services • Government accountability • Advocating for budgetary allocation and equitable distribution of resources • Sensitize community on community health policy • Support in identifying community health research areas • Participate in TWG
Mass media	• Publicize, inform, and educate the public about community health policy • Disseminating targeted health messages to create awareness • Inform the community of the progress of health indicators • Support in mobilizing for community health activities, e.g., medical camps, outreaches • Support the County health department in increasing social accountability through media – community feedback sessions

Appendix 4. List of Contributors

No	Participant	Designation	Department/Organization
1.	Dr Patrick Kibwana	Chief Officer Health	Makueni Health Services Department
2.	Rael Muthoka	Principal Assistant Secretary	Makueni Health Services Department
3.	Dr Stephen Ndolo Kiio	Director Medical Services	Makueni Health Services Department
4.	Dr James Kanyange	Director Health Products and Commodities	Makueni Health Services Department
5.	David Kiuluku	Director Health Planning	Makueni Health Services Department
6.	Dr Mwaka Mwango	Transforming Health Systems-UHC Project Coordinator	Makueni Health Services Department
7.	Christopher Maitha Muthama	Community Health Services Head	Makueni Health Services Department
8.	Alphonce James Mutinda	County Community Health Services Coordinator	Makueni Health Services Department
9.	Meshack Wambua Matheka	County Community Health Services Advisor	Makueni Health Services Department
10.	Ruth Kaloki	County Nutrition Services Head	Makueni Health Services Department
11.	Bretta Mutisya	County Health Promotion Services Head	Makueni Health Services Department
12.	Stanselous Ndeto	County Clinical Services Head	Makueni Health Services Department
13.	Solomon Mutiso	County Laboratory Services Head	Makueni Health Services Department
14.	Christine Muindi	County Reproductive Health Services Coordinator	Makueni Health Services Department
15.	Denis Matheka Mulwa	County Ambulance Services Coordinator	Makueni Health Services Department
16.	Simon Kavisi	County Health Records Information Officer	Makueni Health Services Department
17.	Antony Mathulu	County Nursing Services head	Makueni Health Services Department
18.	Fredrick Kilonzo	County Nursing Services Deputy Head	Makueni Health Services Department
19.	Judith Makena	County Human Resource For Health Head	Makueni Health Services Department
20.	Margaret Nduku Kieti	Community Health Services coordinator Makueni Sub County	Makueni Health Services Department
21.	Salome Nthambi Peter	Ward Public Health Officer (PHO) ,Wote/ Nziu ward	Makueni Health Services Department
22.	Dr Eunice Ndulu	Counselling Services	Makueni Health Services Department
23.	Joseph Kavoi	PHO, In charge sanitation MCRH	Makueni Health Services Department
24.	Gregory Katiso		Makueni Health Services Department
25.	Susan Mutua	Community Health Volunteer	Makueni Health Services Department
26.	Martin Kioko	Sub-County PHO ,Kibwezi West	Makueni Health Services Department
27.	Justus Muinde	Sub-County PHO ,Makueni	Makueni Health Services Department
28.	Penina Musyoki	MCRH-PHO	Makueni Health Services Department
29.	Charity Mumo		Makueni Health Services Department
30.	George Kitheka		Makueni Health Services Department
31.	Robert Muli		Makueni Health Services Department
32.	Joshua Mutuku	County PHO	Makueni Health Services Department
33.	John Mwaniki	Sub-County PHO ,Kibwezi East	Makueni Health Services Department
34.	Patrick Ndonye	Sub-County PHO ,Mbooni	Makueni Health Services Department
35.	Vincent Maingi	Sub-County PHO ,Kaiti	Makueni Health Services Department

36.	Mercy Kikata	Community Health Services coordinator Kibwezi West Sub County	Makueni Health Services Department
37.	Miriam Wambua	Community Health Services coordinator Kilome Sub County	Makueni Health Services Department
38.	Dr. Makena Gichuru	Sub County MoH, Kilome	Makueni Health Services Department
39.	Dr.Johachim Mulwa	Sub County MoH, Kibwezi West	Makueni Health Services Department
39.	Mary Maiya		Compassion International
40.	Alphonce Kimeu	Community Health Services coordinator, Mbooni Sub County	Makueni Health Services Department
41.	Mirriam Wambua Phillip	Health Promotion Officer	Makueni Health Services Department
42.	Stanlus Matheka		Makueni Planning Department
43.	Abishag Martha		GRM
44.	Mary Muthengi	Technical Officer safe surgery project	JPHIEGO
45.	Anne Nyaga	Monitoring and Evaluation	JPHIEGO
46	Urbanus Musyoki	Senior Operations Associate	Medtronic Labs
47	Dr Angela Nyambura Gichaga	Chief Executive Officer	Financing Alliance for Health
48.	Nelly Wakaba	Country Engagement and Support Director	Financing Alliance for Health
49.	Dennis Munguti	Health Financing Associate	Financing Alliance for Health
50.	Dorothy Wavinya	Technical Advisor	Financing Alliance for Health

COUNTY GOVERNMENT OF MAKUENI

REPUBLIC OF KENYA