NAKURU COUNTY COMMUNITY HEALTH SERVICES STRATEGY

2023 -2028

REPUBLIC OF KENYA

NAKURU COUNTY

A COUNTY OF DIVERSITY AND UNLIMITED OPORTUNITIES

A healthy population living high-quality lives within productive and vibrant communities in Nakuru County

The Nakuru County Community Health Services Strategy (2023 – 2028)

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LIST OF ABBREVIATIONS

CBOs	Community Based Organizations
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
CHP	Community Health Promoter
ICCM	Integrated Community Case Management
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. The health services at this level are basic curative, preventive, and promotive.
Community health unit (CHU):	This is a health service delivery structure within a defined geographic area covering 5,000 people. Each unit is assigned one community health assistant/officer and ten Community health promoters.
Community health promoters (CHPs)	A community member selected to serve in a community health unit.
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 responsible for 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 sound 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, appropriate incentives, and 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:	Means that all individuals and communities receive the health services they need 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, 2021).

FOREWORD

The Astana Global Conference on Primary Health Care was premised on the Alma-Ata Declaration of 1978, which committed to attaining universal health coverage and sustainable development goals. The Africa Health Strategy (2016-2030) aligns with that and seeks to ensure “a high standard of living, quality of life and well-being for all citizens.” The strategy is part of the African Union Agenda, which aims to achieve universal health coverage by fulfilling existing global and continental commitments from member countries such as Kenya.

The Kenya 2010 Constitution provides the overarching legal instrument guiding health in the country. Article 43 (1) (a) entitles every person to the highest attainable health standards, including the right to health care services and reproductive health care. Article 43 (2) states that a person shall not be denied emergency medical treatment, while article 53(1) (c) provides for the rights of every child to access basic nutrition, shelter, and health care.

The Kenya Primary Health Care Strategic Framework (2020–2024) recognizes the role of the community as key to the attainment of population health and places community health units as the first level of healthcare delivery in Kenya. The framework envisions the transformation of service delivery teams by linking all CHUs to primary health facilities while introducing multidisciplinary teams comprising of CHPs. The CHPs carry out person-centred functions that address social determinants of health and promote health care access, patient engagement, and outcomes.

The Nakuru county community health program was incepted in 2006 when the National government trained the first batch of thirty CHEWs. By then, community health units and the relevant workforce were non-existent. In 2008, a pilot program in which 50 CHWs (currently referred to as CHPs) underwent training in Nakuru West with GAVI support, with one unit set up. The program has continued to experience exponential growth, to the current 362 CHUs, with 3620 CHPs.

The Nakuru County Community Health Services Strategy (2023 – 2028) aims to build a responsive and sustainable community health system to provide primary health care at level-1 towards attaining universal health coverage through robust community and primary health care services.

Jacqueline Osoro,
County Executive Committee Member - Health Services

PREFACE

Given community health programs’ impact on achieving the Millennium development goals (UN, 2000) in many countries, more emphasis has been made on encouraging countries worldwide to strengthen the community health program to achieve the Sustainable Development Goals (SDGs) (WHO, 2018). Community Health Workers have emerged as a significant cadre in low- and middle-income countries, especially in Africa, South America, and Asia. They have demonstrated effectiveness in delivering various preventive, promotive, and curative services related to reproductive, maternal, newborn, and child health; infectious diseases; non-communicable diseases; and neglected tropical diseases.

The strategy acknowledges the crucial role of community health services in attaining universal health coverage for the population of Nakuru county. The strategic plan aims to empower individuals, households, and communities to achieve the highest possible health standard. Specifically, the strategy focuses on strengthening community health services across all health domains.

The strategy focuses on six health systems building blocks as recommended by the World Health Organization: leadership and governance, health financing, human resources for health, service delivery, supplies, and community health information systems. Through a consultative process with key stakeholders, the proposed interventions under each of the pillars have been delineated to guide the implementation of community health services.
This strategy comes at an opportune time as we seek to achieve universal health coverage as a county. We believe that with the implementation of the strategy, we will be taking steps in the right strategic direction.

Dr. John Murima,
Chief officer, Medical Services

Alice Abuki
Chief Officer, Public Health

ACKNOWLEDGEMENT

The county Department of Health Services is grateful for the immense contribution of all the organizations and individuals in developing the Nakuru Community Health Services Strategy. The strategy now calls for the concerted efforts of the county leadership, healthcare workers, partners, and stakeholders to adopt it and commit to its successful implementation.

We acknowledge the leadership and support of Jacqueline Osoro, County Executive Committee Member Health Services, Dr. John Murima, County Chief Officer, Medical services and Alice Abuki, Chief Officer, Public Health. We also appreciate the contribution and support of Elizabeth Kiptoo, Director Public Health, Dr. Daniel Wainaina, Director Medical Services, and Dr. Joy Mugambi, Director Administration and Planning.

The compilation of the Strategy document was made possible by the efforts of the indefatigable Writing Team, jointly coordinated by Rita Ochola (County CHS Focal Person) and Lucy Muriithi (Health Financing Technical Advisor). Other members of the Team were Kizito Mukhwana (USAID Tujenge Jamii), Hillary Omala (Carolina for Kibera – Africa), Luke Kiptoon (County HRIO), George Gachomba (County Public Health Officer), and Wendy Tirop (County Nursing Officer). The Writing Team also received technical review support from Dennis Munguti (Health Financing Manager, with overall guidance and support from Dr. Angela Gichaga (CEO, FAH).

We also acknowledge the support of the County Health Management Team and the Sub-County Health Management Teams who have walked with us throughout this journey. Your contributions are highly appreciated.

Elizabeth Kiptoo
Director, Public Health

Dr. Daniel Wainaina
Director Medical Services

Dr. Joy Mugambi,
Director, Administration and Planning

EXECUTIVE SUMMARY

Community health is the first level of service delivery within the six-leveled health system. According to the Kenya Community Health Strategy (2021-2025), community health services are provided within a community health unit (CHU) by a community health workforce composed of Community Health Committees (CHCs), Community Health Assistants (CHAs), and Community health promoters (CHPs). The services offered at level-1 (community) are majorly preventive and promotive with little or no basic curative services.

Since 2006, Nakuru county has invested in the community health program, significantly impacting Nakuru's health systems, employment, and quality of life. However, a recent situational analysis conducted by the Nakuru county department of health with support from the Financing Alliance for Health highlighted gaps in implementing the community health services that need to be addressed to tap the program's full potential. The program is experiencing challenges ranging from inadequate financing, uncoordinated field supervision of CHPs, inadequate training for the workforce, and missed or delayed opportunities for the provision of essential services due to insufficient CHPs capacity.

The Nakuru county department of health services has identified and prioritized key strategic directions and objectives to guide the County Community Health Strategy 2023- 2028 implementation through an active stakeholder engagement and a situational analysis. The strategy details interventions under each of the six strategic directions that are based on the World Health Organization's health systems building blocks:

Strategic Directions & Objectives	Key Interventions
Strategic Direction 1: Strengthen management and coordination of community health governance structures at all levels	
Strategic objective 1.1: Strengthen community health services oversight through policies and guidelines	**1.1.1.** Disseminate national community health policy, strategy, and guidelines to the county and sub-county health management teams **1.1.2.** Disseminate the county 2020 CHS Act to the community health management teams and workforce **1.1.3.** Disseminate the county community health strategy to the community health management and workforce **1.1.4.** Strengthen political goodwill for implementing the CHS Act and strategy by building advocacy efforts through the county assembly health committee **1.1.5.** Operationalize the CHS act through the implementation of the CHS strategy
Strategic objective 1.2: Strengthen the functionality of the community health units	**1.2.1.** Map new CHUs for the sub-counties currently with suboptimal coverage of CHUs **1.2.2.** Recruit CHC members for the new CHUs and ensure registration in the Kenya Master Health Facility List **1.2.3.** Train CHC members using the national training curriculum and regularly conduct refresher training and capacity-building sessions **1.2.4.** Conduct quarterly CHC functionality review meetings in the CHUs **1.2.5.** Conduct quarterly CHC supportive supervision visits by the CHMT SCHMTs **1.2.6.** Develop a monitoring and evaluation framework to assess the CHC's functionality and hold quarterly performance evaluation meetings
Strategic objective 1.3: Strengthen the participation and engagement of CHCs with the community	**1.3.1.** Facilitate quarterly dialogue days and monthly action days within the CHUs **1.3.2.** Strengthen support supervision and reporting mechanisms of the dialogue and action days **1.3.3.** Capacity-build CHC members on public participation sessions facilitation and involvement **1.3.4.** Train CHC members on social accountability using the national community scorecard guidelines **1.3.5.** Conduct community scorecard meetings

Strategic Objective 1.4: Strengthen community health stakeholder and partnerships coordination	1.4.1. Establish a county community health technical working group 1.4.2. Establish a CH partnerships coordination committee to enhance partner alignment and engagement
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.** Recruit and deploy CHPs in all the CHUs following the national policy selection criteria **2.1.2.** Replace inactive and attrition CHPs quartely during community public barazas **2.1.3.** Develop a community health workforce registry, which will be updated annually **2.1.4.** Conduct phased recruitment of CHAs over the next five years to meet the staffing gap needs
Strategic objective 2.2: Strengthen the capacity of the community health workforce to improve service delivery	**2.2.1.** Conduct initial and refresher training on CH Basic and Technical modules for existing and newly recruited community health workforce **2.2.2.** Build capacity of CH workforce on emerging diseases and population needs and pandemic response
Strategic objective 2.3: Strengthen the community health workforce performance and supervision management	**2.3.1.** Capacitate SCHMTs, CHAs, and CHEWs on supportive supervision and mentorship **2.3.2.** Sensitize and disseminate supervision toolkits to the SCHMTs, CHAs, and CHEWs **2.3.3.** Conduct quarterly supportive supervision visits to the CHAs/CHEWs by the SCHMTs **2.3.4.** Conduct annual CHU functionality assessments and review results during the quarterly supportive supervision visits
Strategic objective 2.4: Ensure a standardized framework for financial and non-financial remuneration for CHPs	**2.4.1.** Develop a performance-based framework for CHPs remuneration **2.4.2.** Develop a framework for providing non-financial incentives to CHPs, such as NHIF enrolment and annual recognition awards **2.4.3.** Ensure timely remuneration of CHPs with a minimum stipend of KES 2,000 monthly **2.4.4.** Conduct CHV certification exercise and develop a recognition mechanism **2.4.5.** Facilitate the involvement of CHPs in other health-related international and national events **2.4.6.** Regularly facilitate cross-sharing exchange programs and learning visits for the CHPs
Strategic Direction 3: Increase sustainable funding and innovative financing solutions for community health	
Strategic objective 3.1: Develop policies and guidelines on financing community health	**3.1.1.** Develop an investment case and advocacy toolkit for the CHS strategy to aid in resource mobilization efforts for CHS **3.1.2.** Institutionalize a CH partnerships coordination committee **3.1.3.** Deepen the engagement and participation of community health representatives in PFM/MTEF oversight committees to ensure appropriate allocations for CH at the county level **3.1.4.** Generate evidence and impact of CHS activities through publications **3.1.5.** Build the capacity of the County and Sub County level MoH staff on advocacy and resource mobilization for community health
Strategic objective 3.2: Explore and scale up innovative financing and co-financing mechanisms	**3.2.1.** Build and maintain strategic public-private partnerships for CH financing **3.2.2.** Establish viable Income Generating Activities within the CHUs

Strategic Direction 4: Strengthen the delivery of integrated, comprehensive, and high-quality community health services	
Strategic objective 4.1: Increase community health services coverage, demand, and utilization	**4.1.1.** Review the existing CH service package to include missing essential services and expand the scope of the current essential services package **4.1.2.** Sensitize communities on CHS and the role of CHPs through outreaches, community dialogues days, monthly action days, and routine household visits **4.1.3.** Employ multi-sectoral approaches to dealing with barriers to accessing health care services, for example, utilizing chiefs and community gatekeepers to access hard-to-reach, resistant and rebellious groups
Strategic objective 4.2: Strengthen referral and linkages between the community and health facilities	**4.2.1.** Provision of adequate and updated referral reporting tools **4.2.2.** Build capacity of community health workforce and primary health care workers on the referral pathways and facility linkages **4.2.3.** Strengthen existing and innovative referral mechanisms from the community to the primary health care facilities and back to the community **4.2.4.** Build the capacity of the community health workforce to understand the linkages, coordination, service provision, and monitoring of primary care networks
Strategic Direction 5: Improve the availability and utilization of quality data for community health	
Strategic objective 5.1: Develop and implement a harmonized digital community health information system	**5.1.1.** Digitize and harmonize health data reporting tools into the eCHIS platform **5.1.2.** Capacitate the community health workforce on the eCHIS based on the national training manual **5.1.3.** Equip CHPs and CHAs with smartphones for data collection **5.1.4.** Align digital platforms to the MoH SOPs
Strategic objective 5.2: Enhance the capacity of the community health workforce to collect and report quality data effectively	**5.2.1.** Orientate the community health workforce on data collection, analysis, and reporting **5.2.2.** Conduct quarterly integrated report review meetings **5.2.3.** Set reporting targets for the community health units aligned to the County planning documents
Strategic objective 5.3: Enhance data collection, review, and reporting	**5.3.1.** Provide CHPs and CHA with monthly airtime allowance to facilitate data collection and transmission **5.3.2.** Conduct data quality audits using the national guidelines
Strategic Direction 6: Ensure the availability and rational distribution of safe and high-quality commodities and supplies	
Strategic objective 6.1: Ensure commodity security, quality, and safety of community health supplies	**6.1.1.** Establish a digital community health equipment and commodity inventory **6.1.2.** Conduct a baseline survey to assess the health needs in the communities **6.1.3.** Adopt and disseminate guidelines for forecasting and quantification of community health commodities **6.1.4.** Capacitate community health workforce on commodity management and forecasting **6.1.5.** Purchase and distribute CHV kits, medicines, and supplies

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BACKGROUND & INTRODUCTION

EXECUTIVE SUMMARY

1.1 County Overview

Nakuru County is one of the 47 Counties, and Nakuru city is the newest city in the Republic of Kenya, following its upgrade in 2022. The county lies within the Great Rift Valley and borders eight other counties: Kericho and Bomet to the West, Baringo and Laikipia to the North, Nyandarua to the East, Narok to the South-West, and Kajiado and Kiambu to the South. The county covers an area of approximately 7,498.8 Km², with a population density of 288/km2, and is located between Longitude 35.41º East or 35º 24' 36" East and 36.6º East or 36 º36' 0" East and Latitude 0.23º North or 0º 13' 48" North and 1.16º South or 1º 9`36" South. The county's key economic activities include agriculture, financial services, and tourism.

Figure 1: Map showing Nakuru's geographical position and political boundaries

1.2 Administrative and Political Units

The county, headquartered in Nakuru City, is divided into eleven administrative sub-counties: Naivasha, Nakuru Town West, Nakuru Town East, Kuresoi South, Kuresoi North, Molo, Rongai, Subukia, Njoro, Gilgil, and Bahati (Nakuru North) and further into 55 wards. Naivasha is the most populous sub-county, followed by Njoro. The least populated sub-county is Subukia.

1.3 Socio-economic Status

People living in the county primarily practice mixed farming as the main economic activity. The county also boasts a good road network that shapes transport infrastructure with some originating from the early colonial era, e.g., rail network and roads. The Trans-Africa Highway (Northern Corridor) traverses the county with positive and negative effects. The positive impact is the ease of transport to and from all corners of the country. The road infrastructure has made Nakuru city one of the fastest-growing cities in Africa. Some notable negative effects include high mortality from motor vehicle accidents, given the high traffic density. The Nakuru highway is one of the country's major contributors to road traffic accidents. It is also a conduit to communicable diseases since Nakuru is a major transit city.

1.4 Population and Demographic Trends

The county's estimated population from the 2019 census was 2,162,202, out of which 1,077,272 were males and 1,084,835 females, with an annual growth rate of 3.05 percent[1]. The total number of households was 828,707, with 24.3% of the population living below the poverty line. The distribution of the population by sub-counties is shown in Table 1.

Table 1: Nakuru county population disaggregated by sub counties

Sub county	Male	Female	Total	Households	Area (KM²)	Density
Gilgil	92,955	92,247	185,209	49,405	1,075	172
Kuresoi North	87,472	87,599	175,074	40,168	618	283
Kuresoi South	78,204	77,117	155,324	34,543	591	263
Molo	78,129	78,598	156,732	41,439	483	324
Naivasha	179,222	176,132	355,383	111,493	1,958	181
Nakuru East	92,956	100,960	193,926	60,066	231	840
Nakuru North (Bahati)	106,155	111,880	218,050	61,582	387	563
Nakuru West	101,797	96,854	198,661	64,429	72	2,764
Njoro	118,361	120,408	238,773	61,156	699	341
Rongai	99,976	99,922	199,906	52,248	988	202
Subukia	42,045	43,118	85,164	21,708	402	212
County Total	**1,077,272**	**1,084,835**	**2,162,202**	**598,237**	**7,505**	**288**

Source: KNBS, 2019

[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

1.5 Epidemiological Profile

Nakuru county has a young population where 0–14-year-olds constitute 38% (937,268) of the population. The economically active population aged 25 to 59 comprises 35% (870,142) of the total population. As shown in Table 2, females form the largest component of the population (50.1%). Women of childbearing age constitute 26.3% of the county population, while children under five constitute 12.6%.

Table 2: County-level population segment estimates

	Description	Population Segment Estimates	County Projected 2022 Population
1	Population total		2,486,121
2	Population Female	50.1%	1,245,547
3	Population Male	49.9%	1,240,574
5	Population under 1 year	2.9%	72,098
6	Population under 5 years	12.6%	313,251
7	Population under 15 years	37.7%	937,268
8	Population 15-24 years	20.7%	514,627
9	Women of childbearing age (15–49yrs)	26.3%	653,850
10	Population 25-59 years	35%	870,142
11	Population over 60 years	3.5%	87,014

Source: NHSSIP 2018-2022

1.6 Key Health Indicators

The county has made significant progress on key health indicators, some of which performed better than the national average[2], as shown in Table 3.

Table 3: Nakuru county performance of key health indicators

Indicator	Nakuru county (%)	National average (%)
Stunted Children(Under five)	19	18
Wasted children (Under five)	3	5
Underweight (Under five)	9.2	10
Immunization Coverage	91.5	80
Maternal Mortality Rate	375/100,000 Live births	362/100,000 live births
Deliveries by skilled Health workers	93	89
Modern contraceptive prevalent rate	66	62.5
HIV prevalence rate	4.1	4.8

Source: KDHS, 2022

[2] Kenya National Bureau of Statistics, Ministry of Health /Kenya, National AIDS Control Council / Kenya, Kenya Medical Research Institute, National Council for Population and Development / Kenya, and ICF. 2017. 2014 Kenya Demographic and Health Survey: Ministry of Health Kenya.

1.7 Disease Burden

The county department of health data shows that upper respiratory tract infections remained the highest cause of morbidity in 2021, followed by other lower respiratory tract infections among the over five years population, as shown in Table 4:

Table 4: Top ten most common health conditions

Under five years		Over five years	
Condition/Issue (in order of priority relevance to the County) (quantitative or qualitative rating)	**Occurrence (quantitative or qualitative rating)**	**Condition/Issue (in order of priority relevance to the County) (quantitative or qualitative rating)**	**Occurrence (quantitative or qualitative rating)**
Upper Respiratory Tract Infections	179,834	**Upper Respiratory Tract Infections**	352,604
Diseases of the skin	42,514	**Diseases of the skin**	124,494
Diarrhoea	27,052	**Other Lower Respiratory tract infections**	112,020
Lower Respiratory Tract Infections	15,588	**Urinary Tract Infections**	92,346
Tonsillitis	15,066	**Pneumonia**	69,900
Intestinal worms	13,828	**Diarrhoea**	67,074
Pneumonia	12,956	**Ear Infections/ Conditions**	46,454
Eye Infections	11,770	**HIV/AIDS(Above 1 year)**	42,250
COVID 19	101	**COVID 19**	5,776
HIV/AIDS(Below 1 Year)	21	**Tuberculosis**	2,996

Source: Nakuru County AWP, 2022/23

With the majority of the leading causes of death being from preventable conditions, it points to the pivotal role a resilient community health system will play in averting the same.

1.8 Health Sector Financing

Nakuru county had the highest government expenditure on health as a proportion of overall government expenditure in FY 2016/17 (54.2%), with an absorption rate of 89.07% over the same period. The high allocation is commendable, but there is fiscal space for more allocations and absorption. More efforts are required towards increasing the proportion of funding that goes to preventive and promotive health services, reducing the fiscal burden requirements for outpatient and inpatient curative healthcare services.

Currently, the bulk of the financing of health care services in the county comes from the county government (68.7% in 2020/21). Development partners' support for FY2020/21 stood at 1.2% of the overall health sector kitty.

County Health Financing Sources, FY 2020/21

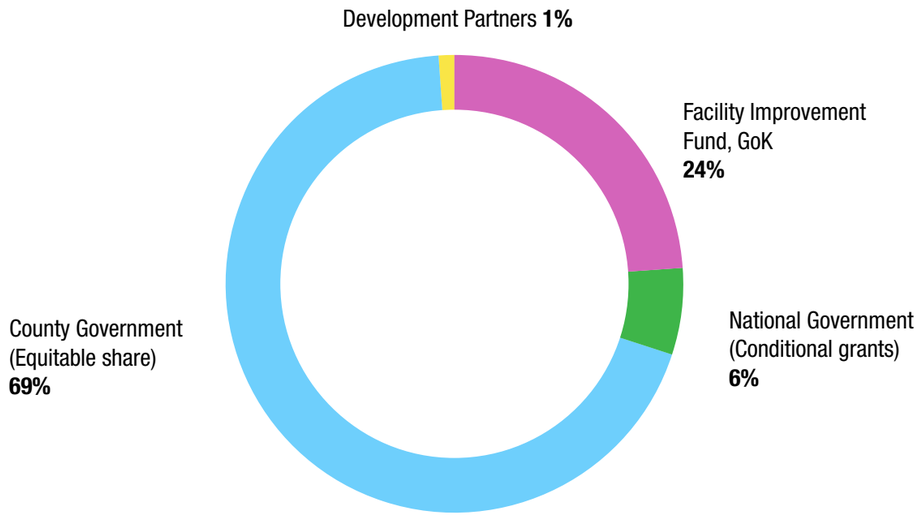


Figure 2: County health financing disaggregated by sources

1.9 Community Health Legal frameworks and Policy Landscape

The development of the Nakuru county Community Health Strategy (2023-2028) is underpinned by global, regional, and national policies and strategic frameworks, especially primary healthcare and universal health coverage goals, as depicted in Figure 3:

Global policy contexts:

– Astana Declaration 2018
– WHO Policy Guidelines on Community Health 2018

Regional regulations and policy:

– Africa Health Strategy 2016-2030
– Agenda 2036: The Africa We Want

County policies contexts:

–County Health Act 2017
–County Integrated Development Plan 2018-2022
– Nakuru County Health Services 2022 Act

National Community health legislation:

– Kenya Constitution 2010
– Kenya Vision 2030
– Kenya Community Health Policy 2020 - 2030
– Kenya Community Health Strategy 2020-2025
– Kenya Primary Health Care Strategic Framework 2019-2024
– Kenya Universal Health Coverage Policy 2020 - 2030

Figure 3: Summary illustration of community health policies and legal frameworks

1.9.1 Global Policy Context

1.9.1.1 Declaration of Astana, 2018[3]

The growing global health momentum increasingly supports 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 primary healthcare systems. 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.

1.9.1.2 WHO Guidelines on Health Policy and System Support to Optimize CHW Programmes, 2018[4]

The World Health Organization Policy Guidelines for Community Health Workers (CHWs) provides 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 universal health coverage. It contains pragmatic recommendations on selection, training, and certification; management and supervision; and integration into primary healthcare systems.

1.9.2 Regional Policy Context

1.9.2.1 The Africa Health Strategy, 2016-2030[5]

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. The strategy entails strengthening community health and information systems and decentralizing service delivery with a focus 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 key step towards achieving sustainable development goals.

1.9.3 Kenya Legal & Policy Context

1.9.3.1 The Constitution of Kenya, 2010[6]

The 2010 Constitution provides the overarching legal instrument guiding health in Kenya. As an integral part, Article 43 (1) (a) entitles every person the right to the highest attainable standards of health, including the right to health care services and 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 rights of every child to access basic nutrition, shelter, and health care. Under Article 56 (e), the state is mandated to 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.

1.9.3.2 Kenya Vision 2030[7]

Kenya Vision 2030 is a developmental blueprint that covers all sectors, including health. One of the goals under the health objectives is to revitalize community health centres to promote preventive health care instead of curative and promote a healthy individual lifestyle. The development blueprint shows that community health is a key contributor to Kenya's development agenda.

[3] Global Conference on Primary Health Care (2018), Declaration on primary health care. Astana
[4] WHO guidelines on health policy and system support to optimize community health worker programmes. Geneva, 2018
[5] African Union (2016). Africa Health Strategy 2016 – 2030. Addis Ababa.
[6] Laws of Kenya (2013). The Constitution of Kenya, 2010. Chief Registrar of the Judiciary. Nairobi
[7] Government of Kenya (2008). Kenya Vision 2030: A Global Competitive and Prosperous Kenya. National Economic and Social Council, Nairobi.

1.9.3.3 Kenya Primary Health Care Strategic Framework, 2019 - 2024[8]

The Kenya Primary Health Care Strategic Framework 2019–2024 outlines the implementation pathway and management of primary health services in the country. The framework recognizes the role of community health services as key to attaining a healthy population and acknowledges that community health units are the first level of healthcare delivery in Kenya. 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 composed of CHPs focused on promotive and preventive health services.

1.9.3.4 Kenya Community Health Policy, 2020 - 2030[9]

The Kenya Community Health Policy 2020–2030 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 Nakuru community health strategy will be anchored on this document to streamline the implementation of community health services in the county.

1.9.3.5 Kenya Community Health Strategy, 2020 - 2025[10]

The third edition of the Kenya Community Health Strategy 2020–2025 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.

1.9.4 County Level Legal and Policy Context

1.9.4.1 Nakuru County Integrated Development Plan, 2018-2022[11]

The county development plan aimed at building upon the community health achievements of the previously lapsed 2013-2017 development plan. The plan enabled the establishment of 139 CHUs, which led to increased community health coverage for households. The plan also recognized the role of CHPs in eliminating infectious diseases, halting and reversing the rising burden of non-communicable diseases, and minimizing the exposure of households to health risk factors.

1.9.4.2 Nakuru County Community Health Services Act, 2022[12]

The Nakuru County Community Health Services Act (2022) offers clear guidelines on the duties and responsibilities of each community health stakeholder, including the county leadership and the Community health promoters. It also offers guidelines on Community health promoters' remuneration, the scope of their services, recruitment criteria, rights, and each community health Unit's structural and administrative duties. The Act is a significant milestone in the county's institutionalization of community health services.

[8] Government of Kenya (2020). Kenya Primary Health Care Strategic Framework2019–2024. Ministry of Health, Nairobi.
[9] Government of Kenya (2021). Kenya Community Health Policy 2020 – 2030. Ministry of Health, Nairobi.
[10] Government of Kenya (2021). Kenya Community Health Strategy 2020 – 2025. Ministry of Health, Nairobi
[11] Nakuru County integrated Development Plan 2018-2022
[12] Nakuru County Community Health services Act, 2022

1.10 Rationale for the Development of the Nakuru Community Health Services Strategy

The delivery of community health services in Nakuru county has been hampered by budgetary allocations that do not match the growing population's health needs, sub-optimal community referral services, and the lack of a guiding strategy for community health. The challenges are there despite global evidence that investing in community health effectively fast tracks the progress to key health indicators, especially regarding child and maternal health, infectious disease prevention, water and sanitation issues, and non-communicable diseases.

In Kenya, previous studies have linked community health services to an increase in the women attending at least four ANC visits (39% to 62%), an increase in skilled birth attendants deliveries (31% to 57%), increased testing for HIV during pregnancy (73% to 90%), increase in exclusive breastfeeding (20% to 52%) and an increase in women receiving intermittent preventive treatment for malaria (23% to 57%).

With the country's devolved healthcare service delivery structures, the counties retain the crucial role in putting in place measures to ensure that community health systems are responsive and can contribute to hastening progress towards the various county, national, regional, and global health goals.

The Nakuru Community Health Services Strategy (2023 – 2028) aims to build a responsive and sustainable community health system to provide primary health care at the community level and attain universal health coverage through robust community and primary health care services.

1.11 Community Health Services in Nakuru County

1.11.1 Evolution of the County Community Health Services Program in Nakuru

The county community health program dates to 2006 when the first batch of 30 CHEWs were trained. By then, there was no community health unit and no CHWs. In 2008, a pilot of 50 CHWs (now referred to as CHPs) were trained in Nakuru West location with GAVI support, and one community health unit was formed. The program has continued to experience exponential growth, to the current 362 units, with 3620 CHPs. However, there has been a 12% attrition rate, leaving 44 units and 440 CHPs inactive. Figure 4 illustrates the evolution of the community health services in the county:

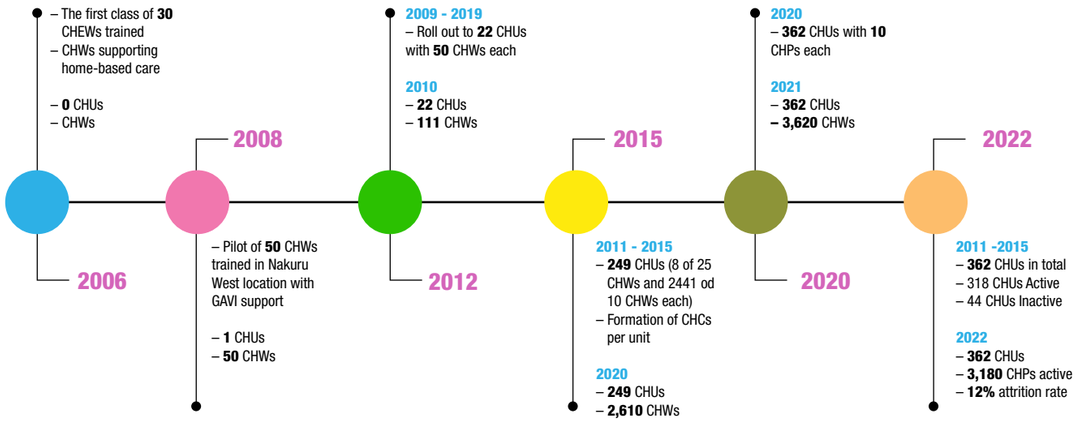


Figure 4: Illustration of the evolution of the Nakuru Community Health Program

1.11.2 Distribution of Community health Units in the County

The County currently is functioning with 362 CHU. Out of these, 44 CHUs are inactive, leaving 306 CHUs serving the whole population. To meet the demand of the growing population, the County is in the process of establishing more CHUs within the sub-counties. Table 5 shows the distribution of the CHUs as well as the gaps existing in the sub-counties.

Table 5: Distribution of community health units disaggregated by sub-counties

Sub-county	Established CHUs	Required CHUs	CHUs to be Activated	CHU Coverage (%)	CHU Gap
Gilgil	35	37	31	94.6	2
Kuresoi north	32	35	24	91.4	3
Kuresoi south	34	32	26	106.3	-2
Molo	32	32	28	100.0	0
Nakuru north	32	44	25	72.7	12
Nakuru east	35	38	27	92.1	3
Nakuru west	40	40	39	100.0	0
Naivasha	38	70	39	54.3	32
Njoro	48	48	37	100.0	0
Rongai	34	40	27	85.0	6
Subukia	29	32	27	90.6	3
Total	**389**	**448**	**330**	**86.8**	**59**

Source: Nakuru CDoH, 2022

Although sub-counties such as Kuresoi South, Nakuru West, and Subukia show 100% coverage, they do not align with the national recommended CHV to person ratio for the region, which is 1:200. With the development of the community health services strategy, the county plans to ensure that the coverage is aligned to the national strategy recommendations.

02

SITUATIONAL ANALYSIS

NAKURU COUNTY COMMUNITY HEALTH SERVICES SITUATIONAL ANALYSIS

2.1 Situational Analysis Overview

The County Department of Health Services conducted a situational analysis of the community health program to pave the way for the strategy development process. The situational analysis employed a mix of methodologies including; a desk review to establish the program's status guided by the six WHO building blocks for health systems, focused group discussions with CHPs, and a two-day community health stakeholder's inception workshop to share the findings of the situational analysis and propose possible interventions to the identified problems.

Using the WHO's health system building blocks, this section details the community health programme's status and challenges.

2.2 Community Health Leadership & Governance

The Kenya Community Health Strategy 2020 - 2025 places the CHCs as the drivers in the leadership and governance component of community health units (CHU). A CHU comprises of a population of 5000 - 10,000 persons living within the same geographical areas and sharing similar economic activities, facilities and challenges. Strong leadership through the CHCs contributes to great success for the CHU and the achievement of the CHS goal. However, in Nakuru, the CHUs face some challenges including:

i. **Non- Functional CHCs -** The role of CHCs has long been overlooked and often left out during CHS activities. Only 20% of the CHCs are actively involved in the CHS activities. In return, this has caused demoralisation of the CHC members rendering them inactive in their CHUs.
ii. **Inadequate training -** For optimal performance, the recommendation is that all the CHCs undergo training on advocacy and resource mobilization, communication and networking, and conflict resolution. Additionally, the CHCs must meet quarterly to review the CHU's progress and plan. However, due to limited resources, only 175 CHC members have been trained, but they still don't hold their quarterly meetings, resulting in inefficiencies.
iii. **Inadequate CHS Structures, policies and guidelines -** The county has for the longest time been operating without the required strategic plan and CHS policy to guide the implementation of CHS activities. As a result, many CHS activities have been development partners-led instead of community health driven. Additionally, the county lacks a CHS technical working group to steer CHS resources and activities within the county. The lack of coordination has led to duplication of activities within the same areas leaving other regions abandoned.
iv. **Sub-optimal Functionality of CHUs -** Currently, 20% of the CHUs in Nakuru County are nonfunctional, with other CHUs having more households than the recommended distribution, hindering optimal functionality. Due to the growing population over the years, the county requires 80 more functional CHUs to ensure adequate coverage

To assess the functionality of the CHUs, the MOH-Community Health Unit Functionality Tool was employed[13]. The tool computes percentage scores and categorizes the total score as (<49%) non-functional, (50%-79%) Semi-functional, and (>80%) Functional. The CHUs were assessed to be semi-functional with a score of 58%, as demonstrated in Table 6.

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

Table 6: Nakuru county community health units functionality status

Indicator	Recommendations by County and national policies and strategies	Score (0 or 1)	Comments
Existence of trained community health committees that meet at least quarterly	175 CHCs trained; however, they do not meet regularly on quarterly	0	Due to inadequate resources, other CHCs are not trained and do not meet regularly.
Trained Community health promoters and Community Health Assistants that meet prescribed guidelines	The CHPs, CHEWs, and CHAs meet monthly as required	1	The meetings happen at the link facility level. All 362 CHUs have link facilities.
	3258 CHPs trained on the basic modules	0	1110 CHPs have been trained on basic modules and technical modules
	CHAs not trained on the basic and technical modules	0	CHAs are yet to be trained on basic and technical modules.
Coordination by county community health leadership	There are clear coordination mechanisms at the county leadership level	1	
Supportive supervision for all community health personnel done at least quarterly	The sub-county health management team ensures support supervision is done	1	County-level CHMT supervision has not been done due to inadequate resources
All Community health promoters and Community Health Assistants have reporting and referral tools	Some trained community health promoters and CHA/CHEWS have tools	0	The county is in the process of purchasing more tools
	a) MOH 513	0	
	b) MOH 514	0	
	c) MOH 100	0	
	All trained CHAS have MOH 515	1	
	All CHU should have MOH 516	0	
All Community health promoters make household visits as per their targets and at least to each household once per quarter	The CHPs have achieved at least 80 percent of their household targets in the last year.	1	
Availability and use of a mechanism for feedback local tracking and dialogue	There exists no clearly outlined mechanism of feedback	0	CHPs and CHCs to provide feedback and track down all agreed indicators
Presence of functional health information system structure per prescribed guidelines	CHU uses the DHIS2 to report on key indicators such as 4 ANC visits	1	
Availability of community health supplies and commodities as defined by prescribed guideline	30 CHUs which are ICCM trained have access to commodities	0	The County has not purchased kits for the CHPs. This limits the number of services that they can offer.
Community Health Units registered in Master Community Health Unit List (MCHUL) and linked to a health facility	3060 Community health promoters meet every month to submit monthly reports	1	The meetings occur at the link facility level at the beginning of every month
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 dialogue days conducted regularly	1	Quartley dialogue days conducted regularly with or without resources
	Monthly data review meetings health monthly	1	Monthly data review meetings are held at the link facilities
	1836 CHUs registered as CBO, Self Help Groups, and SACCOs, evidenced by a certificate	1	
Total score/ Percentage score		**10/17 58%**	

Additionally, a functionality assessment was conducted on each of the active 318 CHUs, and the results were as follows: 49 CHUs were functional, 184 CHUs were semi-functional, and 73 CHUs were non-functional. There is a need for more support and involvement of CHCs, given that only 20% of CHCs are currently active.

2.3 Community Health Workforce

The community health workforce in a CHU comprises seven CHC members, a community health assistant, and ten CHPs. Nakuru county has 3180 actively engaged CHPs covering 87.8% of the CHU. The community health program is headed by a Community Health Strategy Coordinator and 11 Sub County Community Health Strategy Coordinators. The following are the challenges for each cadre:

2.3.1 Community Health Assistants

i. Inadequate numbers of CHAs and huge workloads

Currently, the county has 28 CHAs covering the 362 CHUs. Although the CHAs get help from the CHEWs, the numbers are still not adequate at 203. The CHEWs are nurses or public health officers with competing priorities hence limited time for CHS activities. This has led to huge workloads for the few CHAs causing inefficiencies in the delivery of services. The national recommendations require one CHA to be in charge of the ten CHPs in one CHU. However, due to the shortage, the current CHAs have to cover more than 10 CHUs.

ii. Inadequate training

To offer the required supportive supervision, the CHAs/CHEWs require training in CHS modules and supportive supervision. However, most are trained as nurses and public health officers with little or no training on supportive supervision, hindering optimal service delivery. Additionally, all the 28 CHAs are yet to be trained on the basic and technical modules.

2.3.2 Community health promoters

i. Inadequate numbers of CHAs and huge workloads

With the growing County population, there is a need to establish more functional CHUs and deploy more CHPs. Currently, the county has 3620 CHPs, of which 440 (13%) are inactive. The attrition of CHPs is also a challenge the county faces besides the need to increase the number of CHPs to 4,310 for adequate county coverage. The distribution of the CHPs in the sub-counties is as shown in the Table 7 below:

Table 7: County distribution of the CHPs

Sub-County	Deployed CHPs	Current active CHPs	Required CHPs	Inactive CHPs	Gap of the required CHPs
Gilgil	320	290	370	30	50
Kuresoi North	290	280	350	10	60
Kuresoi South	320	240	320	80	0
Molo	270	270	320	0	50
Nakuru North	270	270	440	0	170
Nakuru East	340	250	380	90	40
Nakuru West	390	240	390	150	0
Naivasha	350	350	700	0	350
Njoro	460	360	480	100	20
Rongai	340	240	400	100	60
Subukia	270	270	270	0	0
County Total	**3620**	**3180**	**4310**	**440**	**800**

Source: Nakuru CDoH, 2022

ii. Huge CHV workload
Some CHUs comprise of more than the recommended population of 5,000 persons leading to huge workloads for the CHPs. This has yielded from the county's delays in creating more CHUs to cater to the growing population.

iii. Sub-optimal supportive supervision
The CHPs do not receive the required supportive supervision from the CHAs and CHEWs regularly. The lack of supervision has resulted in the CHPs not receiving the expected on-the-job training and guidance to improve their efficiency.

iv. Low motivation
All the challenges mentioned have resulted to low motivation due to inadequate remuneration and other non-financial incentives. Low motivation then leads to decreased productivity and poor performance.

2.4. Community Health Financing

The Nakuru County has made significant progress in allocating substantial funding toward the health sector over the years. For financial planning, the Department of Health utilized a program-based budgeting approach, which yielded an 89% absorption rate in the 2019/2020 financial year budget. Although CHV stipends are allocated in the annual budgets, the monthly runumeration is not processed timely and consistently. Further, with the rising living costs, the CHPs have requested an increase of the monthly stipend amount of KES 2,000. Other challenges identified include:

i. Inadequate policies and guidelines - to guide and ring-fence the financing for community health. Currently, the county lacks a CHS operational plan and a CHS resource mobilization strategy to guide the planning and implementation of CHS activities.

ii. Lack of a community health partnership and coordination committee - The county lacks a partnership coordination committee for harmonizing community health partners to harness maximum benefit for community health, create coordination between the partners and reduce duplication of CHS activities within the county.

iii. Inadequate financing to support community health program activities - The most significant percentage of the health budget currently goes to curative services leaving little for community health and other preventive and promotive programs. Additionally, funding from development partners for community health remained very limited at 1.2% in 2021, hindering the optimal implementation of CHS activities.

iv. Inadequate sustainability mechanism - To enhance the sustainability and growth of the program, each CHU ought to run a community-based organization with income-generating activities. Due to insufficient support and training on entrepreneurship, there are only five registered CBOs, one Sacco, and 312 selfhelp groups within the CHUs.

2.5 Community Health Services Delivery

The community health services package is aligned to the national stipulated community health services package. These services include preventive, promotive, management of minor ailments and referral of complicated cases to health facilities. However, due to various challenges, the community health workforce cannot deliver these services as expected. These challenges include:

i. Inaccessibility of some areas in the county - Due to the regions' vastness, the CHPs are forced to cover huge distances to reach the households resulting in fatigue and high transport costs, which are not catered for by the County. This hinders service delivery to some regions as the CHPs cannot afford the cost of transportation. Additionally, due to high poverty levels and stigma resulting from diseases such as HIV and TB, some households are very hostile, hindering accessibility of the CHPs and service delivery.

ii. Inadequate training - To efficiently deliver the service package, all the CHPs require training on basic and technical modules. Currently, only 33% of the CHV have been trained on the Technical modules leaving a gap of 67%. On the basic modules, all the CHPs require refresher training. The initial basic module training was done in 2015 and 2018 for the new CHPs. However, with emerging diseases, such as covid-19, they need to upgrade their skills to keep them up to date. In some instances, the CHPs encounter new challenges at the household level beyond their knowledge leading to a loss of trust by the community members.

iii. Inadequate branding of the CHPs - The CHPs lack uniforms and badges for ease of identification within the community leading to hostility and hindering service delivery.

iv. Inadequate supply of the CHV kits - The CHPs require a comprehensive kit for optimal service delivery. Currently, the CHPs do not have complete kits, limiting the number of services they can offer in the community. Additionally, they experience an irregular supply of essential commodities such as dewormers, oral rehydration salts and zinc tablets, leading to delayed treatment within the community.

v. Inadequate job aids to guide the CHPs – The job aids offer guidance and standard operating procedures for service delivery. All the CHPs require these job aids, which unfortunately are not available.

vi. Underutilization of community health services - The county lacks a communication and demand generation strategy to increase CHS's awareness and demand in the communities.

vii. Sub-optimal referral and linkage system - The CHPs act as the linkage between the community and the health facilities. Efficiency in the referral system requires feedback from the facilities and the community, which does not often occur. The CHPs also require an adequate supply of referral booklets for the optimal referral. However, only 59% of the CHPs have referral booklets hindering effective referral.

2.6 Community Health Information Systems

The county recognizes the role of information systems in the performance measurement and evaluation of health service delivery. However, the use of information technology for community health service delivery and data management continues to be limited. Digital systems used for community health services are siloed at micro levels and independently managed by implementing partners. The situational analysis revealed 28 different digital interventions for community health, indicating an appetite for digital solutions; however, digitization efforts are uncoordinated.

Accurate and timely data is the basis for proper planning and decision-making. The CHPs use the MOH 100, 513, 514, 515, and 516 tools for reporting. From the situational analysis, 87% of CHUs were actively reporting. As required, the health facilities in charges were actively involved in the monthly data review meetings, and CHS data was uploaded and available on the DHIS2 system, which is commendable. However, to ensure that the CHS program operates optimally, the following challenges need to be addressed:

i. Inadequate reporting rates - 13% of the CHUs are not reporting due to their inactivity, while 87% are yet to achieve regular 100% reporting rates. This hinders the achievement of comprehensive data for communities in the county. Additionally, the quality of the CHS data is sub-optimal for decision-making.

ii. Inadequate supply of reporting tools with regular stock-outs.

iii. Lack of training and tools for eCHIS - The CHPs are yet to be trained on eCHIS and equipped with the required smartphones for reporting

2.7 Community Health Supply Chain Management

Community health commodities and supplies are enabling factors for community health service delivery. The situational analysis identifies the following issues:

i. Inadequate Chalkboards within the CHUs - Only 47% of the CHUs have frequently updated chalkboards.

ii. Inadequate motorbikes enhance supportive supervision for the CHAs - There are only 55 motorbikes available versus the required 362 units, impairing effective supportive supervision activities.

iii. Inadequate bicycles for the CHPs to enhance their movements within the communities. Currently, only 12% of the CHUs have bicycles.

iv. Lack of a digital inventory management system to track commodities and supplies.

v. Inadequate training on community health commodity management for all the CHPs and CHAs.

03

NAKURU COUNTY COMMUNITY HEALTH STRATEGY

NAKURU COUNTY COMMUNITY HEALTH STRATEGY

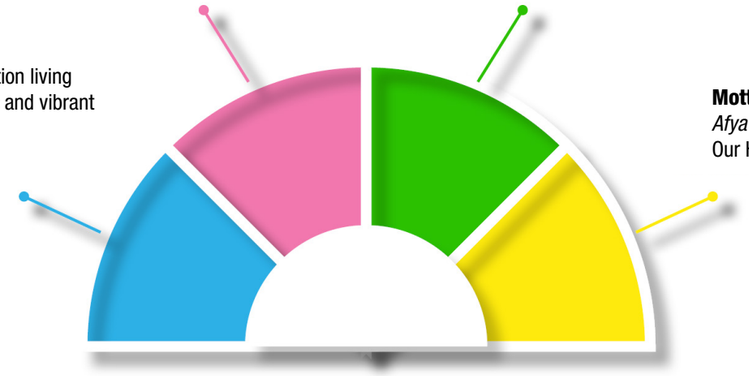
This chapter provides details on the community health services strategic directions and interventions over the next five years. The Nakuru County Community Health Strategy is anchored on the county department of health vision, mission, goal statements, and the overarching national health sector policies and strategies.

3.1 Vision, Mission, and Goal Statements

Mission
To employ the primary health care approach to empower people to live healthy lives through transformative, responsive and sustainable community health services.

Goal
To improve service delivery to communities through integrated, participatory, and sustainable community health services towards attaining universal health coverage.

Vision
A healthy population living within productive and vibrant communities.



Motto
Afya Yetu, Jukumu Letu
Our Health, Our Responsibility.

3.2 Community Health Services Guiding Principles

The county community health services guiding principles are aligned to the national community health program principles of:

- Health is a fundamental 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 (PHC) as a driver of Universal Health Coverage
- Attainment of the highest standards of Health in alignment with the Kenya Constitution
- Increased community ownership, participation, and social accountability
- Enhanced use of innovation and appropriate technology

3.3 Community Health Strategic Directions and Objectives

The implementation of the Nakuru Community Health Services Strategy (2023-2028) will be guided by the strategic directions discussed below. The strategic directions were proposed through an active stakeholder engagement and a situational analysis. The strategic directions and objectives are anchored in the national community health policy and strategy documents. The key strategic directions are:

Strategic direction 1: Strengthen management and coordination of community health governance structures at all levels
Strategic direction 2: Build a motivated, skilled, equitably distributed community health workforce
Strategic direction 3: Increase sustainable funding and innovative financing solutions for community health
Strategic direction 4: Strengthen the delivery of integrated, comprehensive, and high-quality community health services
Strategic direction 5: Improve the availability and utilization of quality data for community health
Strategic direction 6: Ensure the availability and rational distribution of safe and high-quality commodities and supplies

The strategic directions are discussed in detail below:

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

A functional community health system requires strong leadership, institutional support, and coordination mechanisms to provide oversight and guidance in implementing community health services. Effective governance structures enhance accountability, coordination, strategic resource alignment, and policy adherence.

Strategic Objective 1.1: Strengthen community health services oversight through policies and guidelines

Key Interventions:
1.1.1 Disseminate national community health policy, strategy, and guidelines to the county and sub-county health management teams
1.1.2. Disseminate the county community health services Act (2022) to the community health management teams and workforce
1.1.3. Disseminate the county community health strategy to the community health management teams and workforce
1.1.4. Strengthen political goodwill for the implementation of the CHS Act and Strategy by building advocacy efforts through the county assembly health committee
1.1.5. Operationalize the CHS Act through the implementation of the CHS strategy

Strategic Objective 1.2: Strengthen the functionality of the community health units

Key Interventions:
1.2.1 Establish as per the community health policy and strategy new CHUs for the sub-counties currently with suboptimal coverage of CHUs
1.2.2. Recruit CHC members for the new CHUs and ensure registration in the master community health units list
1.2.3. Train CHC members using the national training curriculum and conduct refresher training and capacity-building sessions
1.2.4. Support quarterly CHC functionality review meetings in the CHUs
1.2.5. Conduct quarterly CHC supportive supervision visits by the CHMT/SCHMTs
1.2.6. Develop a monitoring and evaluation framework to assess the CHC's functionality and hold quarterly performance evaluation meetings

Strategic Objective 1.3: Strengthen the participation and engagement of CHCs within the community

Key Interventions:
1.3.1 Facilitate quarterly dialogue days and monthly action days within the CHUs
1.3.2. Strengthen support supervision and reporting mechanisms of the dialogue and action days
1.3.3. Capacity-build CHC members on public participation sessions' facilitation and involvement
1.3.4. Train the CHC members on social accountability using the national community scorecard guidelines[14]
1.3.5. Conduct community scorecard meetings

[14] Ministry of Health, Division of Community Health Services, Republic of Kenya (2021). *Kenya Community Scorecard Guidelines for Social Accountability in Primary Health Care. Nairobi, Kenya.*

Strategic Objective 1.4: Strengthen community health stakeholder and partnerships coordination

Key Interventions:

1.4.1. Establish a county community health technical working group
- 1.4.1.1. Define the TWG terms of reference, including the scope, roles, and responsibilities
- 1.4.1.2. Appoint eligible TWG members based on the terms of reference
- 1.4.1.3. Hold quarterly TWG meetings

1.4.2. Establish a CH partnerships coordination committee to enhance partner alignment and engagement
- 1.4.2.1. Define the partnerships coordinating committee's terms of reference
- 1.4.2.2. Hold the partnerships coordinating committee meetings quarterly

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

The following strategic interventions intend to build a motivated workforce and ensure the recruitment and deployment of the required workforce to enhance the implementation of CHS activities.

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

Key interventions

2.1.1. Recruit and deploy CHPs in all the CHUs following the national policy selection criteria
2.1.2. Replace inactive and attrition CHPs annually during community public barazas
2.1.3. Develop a CHV and CHC members digital registry, updated annually with details such as identification number, name, age, contact information, and CHU details
2.1.4. Conduct phased recruitment of CHAs over the next five years to meet the staffing gap needs

Strategic Objective 2.2: Strengthen the capacity of the community health workforce to improve service delivery

Key interventions

2.2.1. Conduct initial and refresher training on CHS basic and technical modules for existing and newly recruited community health workforce following the national guidelines and curriculums
2.2.2. Build capacity of CHS workforce on emerging and re-emerging diseases and population needs, and pandemic response

Strategic Objective 2.3: Strengthen the community health workforce performance and supervision management

Key interventions

2.3.1. Capacity build the SCHMTs, CHEWs, and CHAs on supportive supervision and mentorship
2.3.2. Sensitize and disseminate supervision toolkits to the SCHMTs, and CHEWs
2.3.3. Conduct quarterly supportive supervision visits to the CHAs and CHEWs by the SCHMTs
2.3.4. Conduct annual CHU functionality assessments and review results during the quarterly supportive supervision visits

Strategic Objective 2.4: Ensure a standardized framework for financial and non-financial remuneration for CHPs

Key interventions

2.4.1. Develop a performance-based framework for CHPs remuneration
2.4.2. Develop a framework for the providing of non-financial incentives to CHPs, such as NHIF enrolment and annual recognition awards
2.4.3. Ensure timely remuneration of CHPs with a minimum stipend of KES 2,000 monthly
2.4.4. Conduct CHV certification exercise and develop a recognition mechanism
2.4.5. Facilitate the involvement of CHPs in other health-related international and national events
2.4.5. Regularly facilitate cross-sharing exchange programs and learning visits for the CHPs

Strategic Direction 3: Increase sustainable funding and innovative financing solutions for community health

Limited financing for community health was highlighted as a major impediment to the county's optimal and successful implementation of community health services. The strategy will implement the following interventions to address the funding gaps and increase sustainable financing options:

Strategic Objective 3.1: Develop policies and guidelines on financing community health

Key interventions

3.1.1. Develop an investment case and advocacy toolkit for the CHS strategy to aid in resource mobilization efforts for CHS
3.1.2. Institutionalize a CHS partnerships coordination committee
3.1.3. Deepen the engagement and participation of community health representatives in PFM/MTEF oversight committees to ensure appropriate allocations for CHS at the county level
3.1.4. Generate evidence and impact of CHS activities through publications
3.1.5. Build the capacity of the County and Sub-County level DOH staff on advocacy and resource mobilization for community health

Strategic Objective 3.2: Explore and scale up innovative financing and co-financing mechanisms

Key interventions

3.2.1. Build and maintain strategic public-private partnerships for CH financing
- 3.2.1.1. Conduct annual CH partnership forums to enhance stakeholder alignment and engagement
- 3.2.1.2. Map and engage existing and potential CH partners to foster strategic partnerships
- 3.2.1.3. Sensitize CH stakeholders on the strategy implementation plan and annual work plans to ensure alignment and avoid duplication of CH activities by the different stakeholders
- 3.2.1.4. Develop targeted approaches to private, corporate, and philanthropy institutions for seeking their contributions in cash and in-kind and their active participation in CHS implementation

3.2.2. Establish viable Income Generating Activities within the CHUs
- 3.2.2.1. Capacitate CHC members and CHPs on income generation and entrepreneurship to equip them with skills to manage the IGAs
- 3.2.2.2. Build collaborative partnerships with CH stakeholders to provide and support seed grants and capital for the IGAs
- 3.2.2.3. Facilitate the registration of CHUs as community-based organizations (CBOs) through the Department of Gender and Social Services

Strategic Direction 4: Strengthen the delivery of integrated, comprehensive, and high-quality community health services

According to the Kenya Essential Package for Health (KEPH), community health services should provide comprehensive promotive, preventive, and basic essential curative health services in line with the Kenya Quality Model for Health (KQMH for level 1). Community health services access, availability, and coverage are critical success drivers to achieving this goal. Below are interventions to address gaps in access to quality community health services in line with the county community health services essential package.

Strategic Objective 4.1: Increase community health services coverage, demand, and utilization

Key interventions
4.1.1 Review the existing CH service package to include missing essential services and expand the scope of the current essential services package
4.1.2. Sensitize communities on CHS and the role of CHPs through outreaches, community dialogues days, monthly action days, and routine household visits
4.1.3. Employ multi-sectoral approaches to dealing with barriers to accessing health care services, for example, utilizing chiefs and community gatekeepers to access hard-to-reach, resistant and rebellious groups

Strategic Objective 4.2: Strengthen referral and linkages between the community and health facilities

Key interventions
4.2.1. Provision of adequate and updated referral reporting tools
4.2.2.Build capacity of community health workforce and primary health care workers on the referral pathways and facility linkages
4.2.3.Strengthen existing and other innovative referral mechanisms from the community to the primary health care facilities and back to the community
4.2.4.Build the capacity of the community health workforce to understand the linkages, coordination, service provision, and monitoring of Primary Care Networks (PCNs)

Strategic Direction 5: Improve the availability and utilization of quality data for community health

The strategy recognizes the role of information systems in the performance measurement and evaluation of health service delivery. However, the use of information technology for community health service delivery and data management continues to be limited. Digital systems used for community health services are siloed at micro levels and independently managed by implementing partners. The situational analysis revealed 28 different digital interventions for community health, indicating an appetite for digital solutions; however, digitization efforts are uncoordinated. The interventions below are geared at closing the identified gaps in this strategic direction.

Strategic Objective 5.1: Develop and implement a harmonized digital community health information system

Key interventions
5.1.1 Digitize and harmonize health data reporting tools into the eCHIS platform
5.1.2. Capacitate the community health workforce on the eCHIS based on the national training manual
5.1.3. Equip CHPs and CHAs with smartphones for data collection
5.1.4. Align digital platforms to the MoH SOPs

Strategic Objective 5.2: Enhance the capacity of the community health workforce to collect and report quality data effectively

Key interventions
5.2.1. Orientate the community health workforce on data collection, analysis, and reporting
5.2.2. Conduct quarterly integrated report review meetings
5.2.3. Set reporting targets for the community health units aligned to the County planning documents

Strategic Objective 5.3: Enhance data collection, review, and reporting

Key interventions
5.3.1 Provide CHPs and CHAs with a monthly airtime allowance to facilitate data collection and transmission
5.3.2 Conduct data quality audits using the national guidelines

Strategic Direction 6: Ensure the availability and rational distribution of safe and high-quality commodities and supplies

The Kenya Community Health Policy 2020-2030 provides guidelines on the requisite commodities, supplies, and tools to help the community health workforce execute their duties effectively while being accountable for the appropriate use of the commodities and supplies issued. The situational analysis gaps in supplies and commodities ranged from financial limitations, operational and planning issues, availability, and access which impede service delivery. The interventions below seek to address these challenges and improve access, availability of supplies, and commodities.

Strategic Objective 6.1: Ensure commodity security, quality, and safety of community health supplies

Key interventions
6.1.1 Establish a digital community health equipment and commodity inventory
6.1.2. Conduct a baseline survey to assess the health needs in the communities
6.1.3. Adopt and disseminate guidelines for forecasting and quantification of community health commodities
6.1.4. Capacitate community health workforce on commodity management and forecasting
6.1.5. Purchase and distribute CHV kit, medicines, and supplies

04

IMPLEMENTATION FRAMEWORK

IMPLEMENTATION FRAMEWORK

4.1 Implementation Overview

This section outlines the community health strategic directions, objectives, and key interventions to ensure implementation over their respective periods. The implementation framework will be guided by the interconnected nature of government departments' mandates, such as local government, education, water, agriculture, environment, youth and gender, and non-government entities. The multiple entities involved in community health-related activities also work with communities and public and private institutions to attain outlined health and development goals.

4.2 Strategic Approach

A combination of rights-based, multi-sectoral, public-private partnerships, socially inclusive, consultative, and participatory approaches will be adopted to implement the Nakuru County Community Health Strategy. The implementation framework will leverage the existing public participation 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.

4.3 Strategy Implementation Matrix

Table 7 outlines a detailed summary of the community health strategic directions, objectives, expected outcomes and outputs, key interventions and activities, and the implementation timelines over the five-year strategy period.

Strategic Objectives	Expected Outputs	Expected Outcomes	Interventions	Activities	Implementation Matrix				
Strategic Direction 1: Strengthen management and coordination of community health governance structures at all levels					22/23	23/24	24/25	25/26	26/27
Strategic Objective 1.1: Strengthen community health services oversight through policies and guidelines	Comprehensive understanding of community health policies and guidelines	Disseminated community health policies and guidelines	1.1.1. Disseminate national community health policy, strategy, and guidelines to the county and sub-county health management teams	1.1.1.1. Disseminate documents to county and sub-county health management teams	X				
			1.1.2. Disseminate the county 2020 CHS Act to the community health management teams and workforce	1.1.2.1. Disseminate document to county and sub-county teams	X				
			1.1.3. Disseminate the county community health strategy to the community health management and workforce	1.1.3.1. Disseminate CHS strategy during launch event	X				
			1.1.4. Strengthen political goodwill for implementing the CHS Act and strategy by building advocacy efforts through the county assembly health committee	1.1.4.1. Hold biannual advocacy meetings with the county assembly health committee	X	X	X	X	X
			1.1.5. Operationalize the CHS ACT through the implementation of the CHS strategy	1.1.5.1. Hold regulation meetings for the CHS ACT	X	X	X	X	X

Strategic Objective 1.2: Strengthen the functionality of the community health units	Functional Community health Units	Functional community health committee	1.2.1. Establish new CHUs for the sub-counties currently with suboptimal coverage of CHUs	1.2.1.1. Conduct CHU mapping exercise for new CHUs	X				
				1.2.1.2. Conduct community sensitization on the new CHUs	X				
			1.2.2. Recruit CHC members for the new CHUs and ensure registration in the master community health units list	1.2.2.1.Hold public barazas in the new CHUs	X				
			1.2.3. Train CHC members using the national training curriculum and regularly conduct refresher training and capacity-building sessions	1.2.3.1. Initial Training of new CHC members using national CHC curriculum	X				
			1.2.4. Conduct quarterly CHC functionality review meetings in the CHUs		X		X	X	X
			1.2.5. Conduct quarterly CHC supportive supervision visits by the CHMT/SCHMTs		X	X	X	X	X
		Defied monitoring and evaluation framework	1.2.6. Develop a monitoring and evaluation framework to assess the CHC's functionality and hold quarterly performance evaluation meetings	1.2.6.1.Hold quarterly CHC performance evaluation meetings	X	X	X	X	X

Strategic Objective 1.3: Strengthen the participation and engagement of CHCs with the community		Fully trained community health committee members	1.3.1. Facilitate quarterly dialogue days and monthly action days within the CHUs	1.3.1.1. Hold quarterly dialogue days in the CHUs	X	X	X	X	X
				1.3.1.2. Hold monthly action days in the CHUs	X	X	X	X	X
			1.3.2.Strengthen support supervision and reporting mechanisms of the dialogue and action days	1.3.2.1. Ensure SCHMT supportive supervision and reporting mechanisms during dialogue and action days	X	X	X	X	X
			1.3.3. Capacity-build CHC members on public participation sessions facilitation and involvement	1.3.3.1. CHC capacity building on dialogue days facilitation and involvement	X	X	X	X	X
			1.3.4. Train CHC members on social accountability using the national community scorecard guidelines	1.3.4.1. Initial SCHMT training on community scorecard using national curriculum	X				
				1.3.4.2 Initial CHCs training on community scorecard using national curriculum	X				
			1.3.5. Conduct community scorecard meetings	1.3.5.1. Conduct community scorecard meetings at the community level	X	X	X	X	X
				1.3.5.2. Conduct community scorecard meetings at the facility level	X	X	X	X	X
				1.3.5.3. Conduct community scorecard interface meeting	X	X	X	X	X
				1.3.5.4. Conduct quarterly scorecard review meetings	X	X	X	X	X

Strategic Objective 1.4: Strengthen community health stakeholder and partnerships coordination	Improved donor coordination and resource distribu	A functional technical working group	1.4.1. Establish a county community health technical working group	1.4.1.1. Define the TWG terms of reference, including the scope, roles, and responsibilities	X				
				1.4.1.2. Appoint eligible TWG members based on the terms of reference	X				
				1.4.1.3. Hold quarterly TWG meetings	X	X	X	X	X
		A functional partnership coordination committee	1.4.2. Establish a CH partnerships coordination committee to enhance partner alignment and engagement	1.4.2.1. Define the partnerships coordinating committee's terms of reference	X				
				1.4.2.2. Hold the partnerships coordinating committee meetings quarterly	X	X	X	X	X
Strategic Objective 2.1: Ensure optimal community health workforce recruitment and deployment	Adequate and well distributed community health workforce	Adequate and well distributed community health workforce	2.1.1. Recruit and deploy CHPs in all the CHUs following the national policy selection criteria	2.1.1.1. Hold public barazas in all CHUs annually	X	X	X	X	X
			2.1.2. Replace inactive and attrition CHPs annually during community public barazas	2.1.2.1. Replace attrition CHPs during public barazas	X	X	X	X	X
			2.1.3. Develop a community health workforce registry, which will be updated annually with details such as identification number, name, age, contact information, and CHU details	2.1.3.1. Develop digital community health workforce registry	X				
			2.1.4. Conduct phased recruitment of CHAs over the next five years to meet the staffing gap needs	2.1.4.1. Conduct induction to newly recruited CHAs		X	X	X	X

Strategic Objective 2.2: Strengthen the capacity of the community health workforce to improve service delivery	Well trained community health workforce	Phased out basic and technical modules training	2.2.1. Conduct initial and refresher training on CH Basic and Technical modules for existing and newly recruited community health workforce following the national guidelines and curriculums	2.2.1.2. Conduct an initial basic module training for all CHPs	X				
				2.2.1.3. Conduct an annual phased training on technical modules for all CHPs over the next five years		X	X	X	
				2.2.1.4. Conduct regular refresher training for the CH workforce in basic and technical modules			X		X
			2.2.2. Build capacity of CH workforce on emerging diseases and population needs, and pandemic response	2.2.2.1. Conduct CHV initial training on community event-based surveillance		X			
				2.2.2.2. Conduct CHA initial training on community event-based surveillance		X			
				2.2.2.3. Hold quarterly community event-based surveillance meetings		X	X	X	X
Strategic Objective 2.3: Strengthen the community health workforce performance and supervision management	Structured and targeted supportive supervision	Number of SCHMTs, CHAs and CHEWs trained on supportive supervision Number of quarterly supportive supervision meeting held	2.3.1. Capacitate SCHMTs, CHAs, and CHEWs on supportive supervision and mentorship	2.3.1.1. Capacitate SCHMTs, CHAs, and CHEWs on supportive supervision and mentorship	X				
			2.3.2. Sensitize and disseminate supervision toolkits to the SCHMTs, CHAs, and CHEWs	2.3.2.1. Disseminate supervision toolkits	X	X	X	X	X
			2.3.3. Conduct quarterly supportive supervision visits to the CHAs/CHEWs by the SCHMTs	2.3.3.1. Conduct quarterly supportive supervision visits in the CHUs	X	X	X	X	X
			2.3.4. Conduct annual CHU functionality assessments and review results during the quarterly supportive supervision visits	2.3.4.1. Conduct annual CHU functionality assessments	X	X	X	X	X

Strategic Objective 2.4: Ensure a standardized framework for financial and non-financial remuneration for CHPs	Well remunerated and motivated community health workforce	A comprehensive performance based framework	2.4.1. Develop a performance-based framework for CHPs remuneration		X				
			2.4.2. Develop a framework for providing non-financial incentives to CHPs, such as NHIF enrolment and annual recognition awards		X				
			2.4.3. Ensure timely remuneration of CHPs with a minimum stipend of KES 2,000 monthly		X	X	X	X	X
			2.4.4. Conduct CHV certification exercise and develop a recognition mechanism		X				
			2.4.5. Facilitate the involvement of CHPs in other health-related international and national events		X	X	X	X	X
			2.4.6. Regularly facilitate cross-sharing exchange programs and learning visits for the CHPs		X	X	X	X	X

Strategic Objective 3.1: Develop policies and guidelines on financing community health	Structured community health advocacy tools for resource mobilization	A County community health investment case	3.1.1. Develop an investment case and advocacy toolkit for the CHS strategy to aid in resource mobilization efforts for CHS		X	X			
			3.1.2. Institutionalize a CH partnerships coordination committee			X			
			3.1.3. Deepen the engagement and participation of community health representatives in PFM/ MTEF oversight committees to ensure appropriate allocations for CH at the county level			X	X	X	X
			3.1.4. Generate evidence and impact of CHS activities through publications		X	X	X	X	X
			3.1.5. Build the capacity of the County and Sub County level MoH staff on advocacy and resource mobilization for community health			X	X		

Strategic Objective 3.2: Explore and scale up innovative financing and co-financing mechanisms			3.2.1. Build and maintain strategic public-private partnerships for CH financing	3.2.1.1. Conduct annual CH partnership forums to enhance stakeholder alignment and engagement		X	X	X	X
	Increased and sustainable community health financing	Strong strategic public-private partnership for CH financing		3.2.1.2. Map and engage existing and potential CH partners to foster strategic partnerships		X			
				3.2.1.3. Sensitize CH stakeholders on the strategy implementation plan and annual work plans to ensure alignment and avoid duplication of CH activities by the different stakeholders		X	X	X	X
				3.2.1.4 Develop targeted approaches to private, corporate, and philanthropy institutions for seeking their contributions in cash and in-kind and their active participation in CHS implementation		X			
		Sustainable IGAs in all the CHUs	3.2.2 Establish viable Income Generating Activities within the CHUs	3.2.2.1 Capacitate CHC members and CHPs on income generation and entrepreneurship to equip them with skills to manage the IGAs		X			
						X			
				3.2.2.2 Build collaborative partnerships with CH stakeholders to provide and support seed grants and capital for the IGAs		X	X	X	X
				3.2.2.3 Facilitate the registration of CHUs as community-based organizations (CBOs) through the Department of Gender and Social Services		X	X	X	X

Strategic Objective 4.1: Increase community health services coverage, demand and utilization	Increased demand and utilization of CH services within the county	A comprehensive CHS package for the County	4.1.1 Review the existing CH service package to include missing essential services and expand the scope of the current essential services package		X	X	X	X	X
			4.1.2 Sensitize communities on CHS and the role of CHPs through outreaches, community dialogues days, monthly action days, and routine household visits		X	X	X	X	X
			4.1.3 Employ multi-sectoral approaches to dealing with barriers to accessing health care services, for example, utilizing chiefs and community gatekeepers to access hard-to-reach, resistant and rebellious groups		X	X	X	X	X

Strategic Objective 4.2: Strengthen referral and linkages between the community and health facilities	Effective and well defined CH referral system owned at the CHU and the facility level	Number of MOH 100 referrals filed at the facility level and the CHU level	4.2.1. Provision of adequate and updated referral reporting tools	4.2.1.1 Provision of reporting tools	X	X			
			4.2.2. Build capacity of community health workforce and primary health care workers on the referral pathways and facility linkages	4.2.2.1 Sensitize SCHMTs on referral pathways, and facility linkages		X			
				4.2.2.2 Sensitize CHAs, CHEWs, and Facility in-charges on referral pathways and facility linkages		X			
			4.2.3. Strengthen existing and other innovative referral mechanisms from the community to the primary health care facilities and back to the community			X			
			4.2.4. Build capacity of the community health workforce to understand the linkages, coordination, service provision and monitoring of primary care networks (PCNs)			X			

Strategic Objective 5.1: Develop and implement a harmonized digital community health information system	Availability of quality and timely CH data for decision making	Well trained and equipped CHPs on eCHIS	5.1.1 Digitize and harmonize health data reporting tools into the eCHIS platform		X	X			
			5.1.2 Capacitate the community health workforce on the eCHIS based on the national training manual	5.1.2.1 Conduct initial eCHIS training for SCHMTs to be ToTs in a phased approach	X	X	X		
				5.1.2.2 Conduct initial eCHIS training to CHAs and CHEWs in a phased approach	X	X	X		
			5.1.3 Equip CHPs and CHAs with smartphones for data collection	5.1.3.1 Purchase Smartphones for CHPs in a phased approach	X	X	X		
				5.1.3.2 Purchase Smartphones for CHAs in a phased approach	X	X	X		
			5.1.4 Align digital platforms to the MoH SOPs		X	X			
Strategic Objective 5.2: Enhance the capacity of the community health workforce to effectively collect and report quality data		Quarterly data review meetings conducted	5.2.1. Orientate the community health workforce on data collection, analysis, and reporting		X	X	X		
			5.2.2. Conduct quarterly integrated report review meetings		X	X	X	X	X
			5.2.3. Set reporting targets for the community health units aligned to the County planning documents		X	X	X	X	X
Strategic Objective 5.3: Enhance data collection, review, and reporting			5.3.1 Provide CHPs and CHA with monthly airtime allowance to facilitate data collection and transmission	5.3.1.1 Provide monthly airtime allowance to CHPs	X	X	X	X	X
				5.3.1.2 Provide monthly airtime allowance to CHAs	X	X	X	X	X
			5.3.2 Conduct data quality audits using the national guidelines		X	X	X	X	X

Strategic Objective 6.1: Ensure commodity security, quality, and safety of community health supplies	Improved service delivery at the Community level	Number of Community health workforce trained on commodity management. Number of CHPs kits purchased and distributed.	6.1.1. Establish a digital community health equipment and commodity inventory		X	X	X	X	X
			6.1.2. Conduct a baseline survey to assess the health needs in the communities		X				
			6.1.3. Adopt and disseminate guidelines for forecasting and quantification of community health commodities			X			
			6.1.4. Capacitate community health workforce on commodity management and forecasting			X			
			6.1.5. Purchase and distribute CHV kits, medicines, and supplies	6.1.5.1 Procurement and distribution of kits for all the CHPs	X	X	X	X	X
				6.1.5.2 Provide drugs and other medical consumables to CHPs	X	X	X	X	X

05

MONITORING & EVALUATION PLAN

MONITORING AND EVALUATION PLAN

5.1 Monitoring and Evaluation Framework

The overall purpose of the monitoring and evaluation framework is to improve the accountability of the community health strategy through strengthening the capacity for information generation, validation, analysis, dissemination, and utilization of the information. Over the five-year strategy implementation period, monitoring and evaluation will be conducted as follows:

i. **Monitoring:** Performance monitoring meetings will be held quarterly to review the progress of implementation against targets in the annual work plans. The department will conduct semi-annual stakeholder performance monitoring and review meetings at the county and sub-county levels to review performance against targets, address any constraints in implementation, and re-focus activities if needed.

ii. **Evaluation:** The CHMT and SCHMTs will conduct a mid-term evaluation (Year 3 of strategy implementation) and an end-term evaluation in the final year, 2026/27.

This monitoring and evaluation framework is based on the six WHO building blocks. It shows 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).

Table 8: Strategy implementation monitoring and evaluation indicators

Input indicators	Output indicators	Outcome indicators	Impact indicators
Strategic Direction 1: Strengthen leadership and governance for community health services			
Community health technical working group terms of reference	Number of community health TWG meetings	Improved coordination of community health activities	• Reduction in maternal, infant, and under-five mortality rates • Reduction in childhood illnesses • Reduction in TB defaulter rates • Reduction in TB prevalence rates • Reduction in HIV prevalence rates
TWG progress report to track community health implementation plan	Number of quarterly progress reports produced Number of annual progress reports produced	Functional community health strategy TWG	
Functional community health oversight committee *(scope, composition, meetings, reports, performance of the indicators)*	Number of community health oversight committees established at the CHU level	Existence of community health oversight committees at the CHU level	
	Number of oversight committee meetings held	Evidence of oversight committee meetings	
Availability of community health services Act	A community health services act	Community health services Act which guides community health services implementation	
Availability of partnership engagement framework	Number of partnership engagement frameworks developed	Change in the way community health partners are coordinated to increase resources for community health	
Bi-annual community health stakeholder forums	Number of community health stakeholder forums held	Coordinated community health stakeholders	
Strategic Direction 2: Mobilize innovative and sustainable financing for community health services			
Community health expenditure as a % of the total County health expenditure	% of budget allocation to community health	% of community health expenditure over total County health expenditure	
Domestic community health expenditure as % of the total community health expenditure	% of budget allocation from domestic funding	% domestic community health expenditure over total community health expenditure	
CHUs financially sustainable	Number of CHUs registered as CBOs and SACCOs	Number of CBOs and SACCOs accessing funding through different financial institutions	
CHUs innovative financing mechanisms	Number of CHUs with evidence of established viable IGA activities such as CHUSLA	Number of CHUs generating incomes from the IGA activities	
Strategic Direction 3: Build a highly motivated, skilled, and equitably distributed community health workforce			
Community health volunteer distribution and coverage per 5,000 population	Number of Community health promoters distributed per 5,000 population	% distribution of Community health promoters	
A financial and non-financial incentive package	Evidence of a financial incentive package for CHPs	Number of Community health promoters on performance-based contracts	
Capacity-building CHPs provided with mobile phones, bicycles, motorcycles, and kits	Number of CHPs supplied with mobile phones, bicycles and motorcycles, and kit	% increase in the number of households visited	
	Number of CHPs fully trained on basic and technical modules	% of CHPs trained and demonstrated increased knowledge in community health services basic and technical modules knowledge	
Performance improvement guidelines and tools	Availability of CHV job descriptions	% of CHPs oriented and provided with job descriptions	
	Number of community health feedback meetings held		
	Number of integrated support supervision visits held at the CHU level	Number of CHUs receiving integrated community health services support supervision at all levels	
Strategic Direction 4: Improve community health data reporting systems			
Availability of community health reporting tools	Evidence of availability of community health reporting tools	% improvement on community health data reporting	
Accuracy and completeness of community health reporting in DHIS2	Number (%) of CHUs reporting in DHIS2	DHI2 regularly updated with community health information	
	Number of integrated community health data quality reviews and check meetings held	Community health information used for decision, planning, and policy level	

Strategic Direction 5: Increase access, coverage, and utilization of community health services		
Functional CHUs	Number of CHUs established and functional	The proportion of functional community health units
	Number of dialogue days held	Community better understand their health situation and make informed decisions for further action
	Number of monthly action days held	Community responsible for timely action on identified health problems
	Number of CHUs with a nominated community health champion	Community health champions actively engaged in healthy
Community health service referral system	Number of community health workforce trained on the community health referral system	The proportion of link facilities with functional referral systems
	Number of health facilities with a community health linkage desk with a full-time CHW	The proportion of facilities with a community focal person to receive CHV referrals
Strategic Direction 6: Ensure efficient and sustainable commodities and supplies		
Availability of community health essential medicines, commodities, and supplies	Adequacy of essential medicines, commodities, and supplies	Percentage of community health workforce reporting stock-outs
		The average time taken to replenish stock out

5.2 Performance framework

Table 9: Strategy implementation performance indicators

Indicators	Baseline 21/22		Target					Sources of data
	Year	Value	22/23	23/24	24/25	25/26	26/27	
Strategic Direction 1: Strengthen leadership and governance for community health services								
Number of Community Health TWG meetings held	2022	0	4	4	4	4	4	Meeting minutes, participants list, technical report
% of community health oversight committees established at CHU level	2022	0	25	45	65	75	100	Meeting minutes, participants list
Community Health Services Act	2022	0	1	1	1	1	1	Gazette Notice
Number of Community Health stakeholder forums held	2022	1	2	2	2	2	2	Meeting minutes, participants list, technical report
Strategic Direction 2: Mobilize innovative and sustainable financing for community health services								
% of community health expenditure over total County health expenditure								Annual Work plans, County CIDP
% domestic community health expenditure over total community health expenditure								Annual Work plans, County CIDP
% of CHUs registered as CBOs and SACCOs (per ward)	2022	0	15	100	100	100	100	Health department reports
% of CHUs with evidence of established viable IGA activities	2022	0	15	100	100	100	100	Health department reports
Strategic Direction 3: Build a highly motivated, skilled, and equitably distributed community health workforce								
% of certified Community health promoters	2022	0	25	50	100	100	100	HR records
% of community health workers fully trained on basic modules	2022	100	100	100	100	100	100	Health department reports
% of community health workers fully trained on technical modules	2022	49	75	85	95	100	100	
(%) of Community health promoters on performance-based remuneration	2022	0%	50	100	100	100	100	HR records
% increase in the number of households visited	2022	43	80	90	100	100	100	DHIS2
(%) of CHUs receiving integrated community health services support supervision	2022	30	50	75	95	100	100	Health department support supervision reports
Strategic Direction 4: Improve community health data reporting systems								
Number (%) of CHUs reporting in DHIS2	2022	90	100	100	100	100	100	DHIS2 reports
Number of integrated community health data quality checks and review meetings held per CHU	2022	12	12	12	12	12	12	Meeting minutes, participants list
Strategic Direction 5: Increase access, coverage, and utilization of community health services								
Proportion of community health units that are functional	2022	15%	30%	50%	75%	100%	100%	Health department reports
Proportion of CHEWs preparing and submitting quarterly implementation reports	2022	0%	25%	50%	100%	100%	100%	
Number of dialogue days held per CHU	2022	4	4	4	4	4	4	Meeting minutes, participants list
Number of monthly action days held per CHU	2022	12	12	12	12	12	12	Meeting minutes, participants list
% of facilities with a facility CHEW/CHA to receive CHV referrals	2022	0	50	100	100	100	100	Health department reports
% of CHPs issued with minimum proposed CH commodities and supplies	2022	10	20	30	50	75	100	

06

COSTED IMPLEMENTATION PLAN

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 levels of the health system.

6.2 Components of the programme included in the costing

The costing analysis is based on an ideal-case scenario aligned with the County Department of Health Services recommendations of the number of community health workforce to be deployed for the implementation period of the strategy.

The components included in the costing analysis were as follows:

- **Baseline year:** 2022
- **CHPs:** Scaling up CHPs from 3,620 to 5,020 for a coverage of 1 CHV per 25 households while factoring in annual attrition
- **Supervisors:** Deployment of 502 CHAs and 175 CHEWs supervising an average of 10 CHPs in 502 CHUs and fully paid by the county government
- **Management staff:** County Community Health Focal Persons (1) and Sub County Community Health Focal Persons (11)
- **Supervision:** Support supervision, monthly data review meetings, and quarterly dialogue days
- **Training:** Basic and technical modules initial and refresher training for all existing and new CHPs 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 CHPs, CHAs, and CHEWs equipment, including reporting tools (Appendix 2)
- **Capital costs:** Smartphones and Establishment of new CHUs
- **Supplies and commodities:** Medicines and consumables

6.3 Costing Assumptions

Key assumptions include:

- Costs are allocated assuming price stability, governance based on devolved units, and political and policy goodwill to implement the strategy.
- Inflation factored in based on the inflation rate in the baseline year (2022)
- Costs relating to supervision (CHAs and CHEWs) and management (Community health focal persons) salaries and benefits are not included, as expenditures for these would still have been incurred regardless of the existence of this strategy
- As a cost-saving measure, some activities are merged with other similar activities

6.4 Costed Implementation Plan by Strategic Directions

The total implementation cost of the program over the five years is KES 2,424,095,819, with a resource need of KES 544,861,294 in the first year, KES 459,213,552 in the second year, KES 505,803,177 in the third-year, KES 459,133,743 in the fourth-year, and KES 455,084,053 in the fifth-year (Table 11).

Table 11: Summary of costs disaggregated by strategic directions

Strategic Directions Description	Estimated Annual activity costs					Total SD Costs
	2022/23	2023/24	2024/25	2025/26	2026/27	
Strategic Direction 1: Strengthen management and coordination of community health governance structures at all levels	178,121,280	163,014,147	172,631,916	182,826,751	193,633,276	890,227,369
Strategic Direction 2: Build a motivated, skilled, equitably distributed community health workforce	197,159,400	197,250,928	223,001,404	192,724,428	173,287,394	983,423,553
Strategic Direction 3: Increase sustainable funding and innovative financing solutions for community health	-	3,744,000	-	-	-	3,744,000
Strategic Direction 4: Strengthen the delivery of integrated, comprehensive, and high-quality community health services	21,976,556	13,860,205	-	-	-	35,836,761
Strategic Direction 5: Improve the availability and utilization of quality data for community health	21,534,591	30,452,011	31,460,554	30,870,000	30,870,000	145,187,155
Strategic Direction 6: Ensure the availability and rational distribution of safe, high-quality commodities and supplies.	126,069,467	50,892,261	78,709,303	52,712,565	57,293,383	365,676,980
Total Annual Costs	**544,861,294**	**459,213,552**	**505,803,177**	**459,133,743**	**455,084,053**	**2,424,095,819**

The activity inputs considered in the various strategic directions include start-up, training, and community-level service delivery costs, support supervision, and management costs. Reimbursements of monthly stipends to CHPs were the highest cost driver by KES 602 million over the five years of implementation, followed by supervision visits, meetings, and CHUs activities. Since the community health program is not new, the start-up costs were relatively low at KES 40.1 million (2% of the total costs).

Table 12 summarizes the strategy's costs disaggregated by inputs.

Summary of Costs by Inputs	Estimated Annual Input Costs					Total Input Costs
	2022/23	2023/24	2024/25	2025/26	2026/27	
CHPs Stipend	120,480,000	120,480,000	120,480,000	120,480,000	120,480,000	**602,400,000**
CHV Equipment	132,636,800	61,753,955	89,374,793	44,616,946	47,293,962	**375,676,457**
CHPs Training	62,286,000	58,240,000	83,048,000	51,772,000	31,276,000	**286,622,000**
Medicines and supplies	4,384,667	5,542,867	6,723,344	8,095,619	9,999,421	**34,745,917**
CHAs/CHEWs Equipment	272,000	404,496	428,766	-	-	**1,105,262**
CHAs/CHEWs Training	4,522,500	9,220,500	4,424,500	2,823,000	2,823,000	**23,813,500**
Supervision Visits and Meetings	161,907,580	171,622,035	181,919,357	192,834,518	204,404,589	**912,688,079**
Management Training	1,174,900	1,610,000	816,000	-	-	**3,600,900**
Management Meetings	2,718,000	2,718,000	2,718,000	2,718,000	2,718,000	**13,590,000**
Other Recurrent Costs	381,600	404,496	428,766	454,492	481,761	**2,151,115**
Start-up Costs	22,705,200	3,977,544	4,216,197	4,469,168	4,737,319	**40,105,428**
Capital Costs	31,392,047	23,239,660	11,225,455	30,870,000	30,870,000	**127,597,161**
Total Annual Costs	**544,861,294**	**459,213,552**	**505,803,177**	**459,133,743**	**455,084,053**	**2,424,095,819**

APPENDICES

Appendix 1: Strategy development process

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

Activity	Participants	Objectives	Approach
Situational Assessment December 2021 - January 2022	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 2022 – 2025	Interviews, desk reviews, meetings with the CDoH
Community Health Stakeholders Forum February 15th-16th 2022	~ 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	The two-day workshop incorporated various approaches to facilitate learning and engagement, such as PowerPoint presentations, breakout sessions for problem-solving, plenary discussions, and a 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 March-June 2022	~ 7 participants from the TWG	• Writing of the strategy/policy • Ensure alignment of the strategy to the County Community Health Policy and Strategy	Monthly meetings of the TWG to develop the thematic areas
Strategy validation meeting July 2022	~ Participants from the CDoH, TWG, and partners	• Review and approval of the final version of the strategy	A one-day workshop where the draft strategy document was reviewed under the leadership of the CDoH and necessary iterations to the document made to result in a final version of the strategy

Appendix 2: CHPs basic kit items

Kit Item	Description
Equipment	• Weighing scale • Lab glucometer strips • Bag pack bag • Glucometer • CHV name tag • Flashlight torch • Colour-coded salter scale (for children) • First aid box (spirit, disposable gloves, cotton wool, strapping, crepe bandage • BP machine • Jacket with logo (with reflectors) • Digital thermometer • Timer • MUAC tape • Waist circumference 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 • Medical dispensing envelopes
Technology	• Digital mobile phone

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