MINISTRY OF HEALTH

KENYA
COMMUNITY HEALTH
POLICY

2020 - 2030

**Community
Health Services**
"Afya Yetu, Jukumu Letu"

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FOREWORD

Hon. Mutahi Kagwe, EGH

The Kenya community health policy gives guidance in line with the global commitments, vision 2030, Kenya constitution 2010, and the country's universal health coverage agenda as part of the presidential Big 4 agenda. This policy is designed to be comprehensive and focuses on the two key obligations of health: realization of fundamental human rights including the right to health as enshrined in the constitution of Kenya 2010 and; contribution to economic development as envisioned in Vision 2030. It focuses on ensuring equity, people centeredness and a participatory approach, efficiency, a multisectoral approach, and social accountability in the delivery of healthcare services.

This policy aims to achieve its objectives by streamlining the implementation of community health services by having in place leadership and coordination structures, credible human resources for community health, financing, efficient supply of commodities, community-based surveillance, and monitoring, evaluation and research to provide evidence and strengthening referral mechanisms.

The policy was developed through a consultative process involving all stakeholders including government ministries, departments and agencies; clients, counties, constitutional bodies, development partners (multilateral and bilateral) and implementing partners.

It is my sincere hope that under the devolved system of government, this community health services policy will be a great resource in providing a framework in the implementation and uptake of community health services. With this policy in place, I expect a more robust and well-coordinated community health program in the country.

Cabinet Secretary
Ministry of Health

PREFACE

Dr. Rashid A. Aman BPharm., PhD

Dr. Mercy Mukui Mwangangi

The goal of this policy is to empower individuals, families and communities to attain the highest possible standard of health. Specifically, the policy focuses on strengthening community health service across all the health domains.

The policy will ensure effective leadership and governance in the formation, maintenance, and management of community health structures and participation mechanisms, recruitment and retention of community health human resources for health, including obtaining appropriate numbers and strengthening mechanisms for capacity building and supportive supervision.

Additionally, the policy will ensure provision of high-quality community health services at the household and community level, including referral and follow-up services. It will also support the development and strengthening of community-based health information system (CBHIS) and the monitoring and evaluation of systems to sufficiently inform the implementation of community services at all levels.

Furthermore, the policy will help promote and strengthen supply chain systems for community health that are integrated into the government-led reporting systems and link-facilities including the use of available technology. Besides, it will help provide various mechanisms for mobilising, managing, and appropriately allocating resources for sustainable financing and delivery of community health services at all levels.

Finally, this policy provides a framework for community health services and human resources data, and knowledge management which will inform evidence-driven decision making. It is my hope that all players in community health space in Kenya will embrace and implement this policy.

Chief Administrative Secretary
Ministry of Health

Chief Administrative Secretary
Ministry of Health

ACKNOWLEDGEMENTS

Ms. Susan Mochache, CBS

The community health policy has been developed through a consultative and participatory approach that included many partners and stakeholders involved in community health services. The content development process was rigorous and thorough with a lot of input and feedback for consensus building.

To all those who participated and made contributions towards the development of this policy, we are greatly indebted and thankful to you.

Our gratitude will be incomplete if we do not mention a few of those who participated and steered the process: We are greatly indebted to UNICEF Kenya Country office for both technical and financial support during the process of developing this policy, Council of Governors for making it possible for Governors, County Executive Committee members, County Directors of Health, and County Community Health focal persons to participate in various meetings, and other stakeholders for their great effort and contribution.

Finally, I would like to mention a few individuals who made exceptional contribution to the development of this policy. They include Dr. Salim Hussein, Head Department of Primary Health Care, Dr. Eunice Omesa, Head, Division of Community Health, Mr Daniel Kavoo, Ms Diane Kamar, Mr Francis Ndwiga, Ms Charity Tauta, Mr. John Wanyungu, all of MoH and Ms Rose Njiraini of UNICEF. An additional list of contributors is annexed.

Special thanks and gratitude to the senior management of the Ministry of Health under the leadership of Cabinet Secretary Sicily Kariuki (Mrs) EGH for creating an enabling environment for the implementation of community health services.

Principal Secretary
Ministry of Health

MESSAGE FROM THE DIRECTOR GENERAL

Dr. Patrick Amoth

Community health services program has been implemented in Kenya since 2006. We have had two strategic plans to guide how the program is implemented. The 2006 strategic plan focused on; providing level 1 services for all, building the capacity of the community health extension workers (CHEWs), strengthening health facility–community linkages and strengthening the community to progressively realize their rights for accessible and quality care.

The second strategic plan covered the period 2014 – 2019 and focused on; strengthening the delivery of integrated, comprehensive, and quality community health services for all population cohorts, strengthening community structures and systems for effective implementation of community health actions and services at all levels, strengthening data demand and information use at all levels and strengthening mechanisms for resource mobilization and management for sustainable implementation of community health services.

Throughout this period, the country has not had a policy on community health to guide programming of community health services in the country. This policy is therefore the first of its kind and covers the period 2020 – 2030. With this policy in place, we expect to see better leadership and governance of community health services, more equitable community health workforce, robust community health services delivery in line with the country's universal health coverage agenda and a stronger and responsive community health information system. Additionally, we expect more investment in community health services by both national and county governments, and their partners with sustainable supply of community health commodities.

Ag. Director General
Ministry of Health

ACRONYMS

CBOs	Community Based Organisations
CHA	Community Health Assistant
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CBHIS	Community Based Health Information System
CHMT	County Health Management Team
CHS	Community Health Strategy
CHU	Community Health Unit
CHV	Community Health Volunteer
CPR	Contraceptive Prevalence Rate
CSOs	Civil Society Organisations
HRH	Human Resources for Health
ICC	Inter-agency Coordination Committees
KDHS	Kenya Demographic Health Survey
KEPH	Kenya Essential Package for Health
KHSSP	Kenya Health Sector Strategic and Investment Plan
MOH	Ministry of Heath
MTP	Medium Term Plan
NCD	Non-communicable diseases
PHC	Primary Health Care
SDGs	Sustainable Development Goals
TFR	Total Fertility Rate
WHO	World Health Organisation
UHC	Universal Health Coverage

CHAPTER 1: INTRODUCTION

1.1 Background and Rationale for the Policy

Globally, the community health approach has been recognised as an effective way for making improvements in health care delivery as well as addressing heavy burden of disease and therefore contributing to the health and socioeconomic development [1,2]. The community health approach was a key pillar of the Primary Health Care (PHC) approach adopted by countries in 1978 through the Alma Ata declaration [3]. Kenya developed a PHC approach in 1980, but was focused primarily on healthcare facilities, with little community participation. A 2004 evaluation of the Kenya Health Policy Framework reported an overall decline in health-related indicators, despite increased funding to the health sector. As a consequence, Kenya developed the community health strategy (CHS) in 2006 both as a commitment to global health goals and to support the achievement of the Second National Health Sector Strategic Plan (2005-2010), whose goal was to reverse declining health indicator trends [4]. An assessment of the CHS in 2010 noted that while the strategy had achieved some success in guiding the implementation of community health services, its implementation experienced several challenges that needed to be addressed. The findings of the assessment, together with an overall change in the legal, policy and institutional framework governing the health sector following the promulgation of the Constitution of Kenya in 2010, and a situational analysis done in 2015, highlighted the need for a clear policy direction, informed the MOH decision to develop a community health policy to provide direction for the establishment of quality community health services in Kenya.

1.2 Community Health Approach

The community health approach is based on the Primary Health Care (PHC) concept that focuses on the principles of equity, community participation, intersectoral action and appropriate technology and a decentralised role played by the health system.

Kenya being a signatory member of the UN, is committed to achievement of SDG goal 3 on ensuring good health and well-being for all by the year 2030. SDG target 3.8 spells out the need to achieve Universal Health Coverage that includes financial risk protection, access to quality essential health services, medicines and vaccines for all.

Experience revealed that the achievement of Millennium Development Goals (MDGs) required countries to engage in partnerships to facilitate implementation and support active community participation in programmes aimed at achievement of MDG targets.

In addition to recognition of community health approaches as a means of delivering health for all, Kenya's deteriorating health indicators necessitated the development of a strategy to bring services to the household level and reverse the declining trends in health indicators. This was articulated within the second National Health Sector Strategic

Plan (NHSSP) officially launched in 2005 [4]. The Kenyan Community Health Strategy (CHS) [5] was therefore launched in 2006 as a means to deliver the Kenya Essential Package for Health (KEPH) defined in the Second Strategic Plan. The KEPH introduced six-level cohort levels of health service provision, with level 1 being the Community Unit [6] and level 6 being referral hospitals. It has since then been restructured under the latest Kenya Health Sector Strategic and Investment Plan (KHSSP) in a five-life cycle cohort model to correspond with the devolved four tier health services delivery model.

The 2006 strategy was revised in 2013 to reflect devolution of health services. Under the revised strategy (2014 - 2019), counties are responsible for delivering health services and implementing health programmes including community health.

Kenya is currently implementing Universal Health Coverage in line with sustainable development goal 3 on ensuring good health and well-being for all. Primary health care and community health have been identified as the implementation strategy towards realizing UHC.

A detailed evaluation on Community health services in 2018 showed that there were 6,087 Community Units (CHUs) out of an expected 10,375 CHUs leaving a gap of 4,292 (41%). This means that the current coverage of community health services in Kenya is 59%. Ten counties were documented to be at 90% or above with four counties[1], (Isiolo, Kitui, Nyeri, Tharaka Nithi) being at 100% coverage. Kakamega, Homabay and Siaya counties were documented to be at 99% coverage. Nineteen counties were reported to be at a coverage range of 50% to 89% and eighteen counties were at a coverage below 50%. Lowest coverage was reported in Laikipia, Mombasa, Nandi and Wajir counties all at 17% and Bomet county at 19%.

On community health personnel, it was documented that Kenya has 1,569 community health assistants (CHAs) compared to the expected 10,379 CHAs, leaving a gap of 8,810 (85%). On community health volunteers (CHVs), the country currently has 86,025 out of an expected 103,783 CHVs giving a gap of 17,763 (17%). However, the CHVs documented here were not verified as active or functional.

1.3 Health Indicators

Kenya continues to face numerous public health problems, mainly relating to maternal health and child mortality, communicable diseases, and, increasingly, non-communicable diseases. Health indicators vary considerably across counties and income quintiles. Life expectancy is 59 years for men and 62 for women [7].

Kenya has made significant progress in improving certain indicators, but still lags in other areas. For instance, between the 2003 and 2014 (KDHS), under-five mortality declined from 115 to 52 per 1,000 live births, with the infant mortality rate dropping from 77 to 39 per 1,000 live births [8,9]. The percentage of fully immunized children rose from 57 to 79% over the same period [10].

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1   This information was collected prior to universal health coverage activities towards community health services

On the other hand, much slower progress has been reported across maternal indicators. The maternal mortality ratio, for instance, only reduced from 414 to 362 per 100,000 live births between 2003 and 2014 [11]. The unmet need for family planning is also still relatively high at 17% for married women and 26% for sexually active unmarried women [12]. While significant strides have been made in the fight against HIV and AIDS and malaria, Kenya ranks 13th on the list of 22 high-burden TB countries in the world and has the fifth highest burden in Africa [13].

Overall, infectious diseases remain a major problem. Pneumonia, malaria and diarrheal diseases are the top three leading causes of under-five mortality. Poor sanitation and hygiene, inadequate water supply, environmental factors and malnutrition have contributed to the rise in communicable diseases.

At the household level, improved knowledge and increased access to quality health care services, especially among the marginalised, people living with disability, the vulnerable and high-risk populations could have positive impacts. Improvement in health across the life cycle would release households' resources for investment in other areas, thereby reducing poverty and enhancing the quality of life. Thus, public health, human rights, and poverty alleviation concerns all point to a need to better meet the health needs of the people in Kenya.

1.4   Legal and Policy Context

1.4.1   Constitution of Kenya

The Constitution gives every Kenyan a right to the highest attainable standard of health (including reproductive health), and emphasizes that no person should be denied access to emergency treatment (Article 43) [14]. Articles 53-57 emphasize on human dignity and stipulate attention to the needs and rights of all, with special emphasis on children, persons with disabilities, youth, minorities and marginalized groups, and older members of the society and ensuring that health services are made accessible to all. Article 174 further recognizes the right of communities to manage their own affairs and to further their development and protects & promotes the rights of minorities and marginalized communities. It also provides for the promotion of social and economic development and the provision of proximate easily accessible services in Kenya. Health being a devolved function the role of the National government is articulated in Schedule 4 of the Constitution which includes development of policy and standards, information management, Capacity building and technical assistance to counties.

1.4.2   Kenya Vision 2030

Vision 2030 is Kenya's development blueprint, with the aim of turning the country into a globally competitive and industrialized middle income country by 2030 [15]. The vision identifies economic, social and political pillars to drive the country towards realizing the goal. The first flagship project under Health in Vision 2030 is to "Revitalise Community Health Centres to promote preventive health care (as opposed to curative) and by promoting healthy individual lifestyles". Two approaches identified as key in pushing

the agenda of an efficient and high-quality health care system are (i) devolution of funds and management to the communities and counties, and (ii) shifting the bias of national health from curative to preventive. This implies that Community Health sits at the centre of Vision 2030's priority areas.

1.4.3   Second Medium-Term Plan, 2013 – 2017

The second Medium Term Plan (MTP), 2013 - 2017 (MTP) identified key policy actions, reforms, and programmes that the Government will implement between 2013 and 2017, key Vision 2030 priorities and the constitution. Devolution is a central feature in the plan. MTP emphasized the plan for countrywide scale-up of Community High Impact interventions, including MNCH, strengthening CHA capacity, strengthened linkages to facilities, strengthen community awareness of health rights and accelerating interventions targeting MNCH and sanitation.

A review of the second MTP indicated that there has been good progress in scaling up of community health services during the period 2013 - 2017. Some counties have built that cover the whole population in the county or at least 80%.

The network of National, county and other stakeholders contributes to community health investments.

On treatment, a study conducted in Homabay and Siaya by KEMRI supported by UNICEF and the county governments, showed that with proper support and supervision, CHVs are able to diagnose, manage and treat pneumonia at the community level . This is a significant finding to that implications on the policy direction of the roles and responsibilities of CHVs.

1.4.4   Kenya Health Policy 2014 – 2030

The main aim of the policy is to realize the priorities and flagship projects in Vision 2030, and to move towards making the right to health by all Kenyans a reality [15]. The Policy's primary goal is attainment of Universal Health Coverage and access to essential health services that positively contribute to improved health. The policy identifies six objectives namely, eliminating communicable diseases, halting and reversing the rising burden of communicable diseases and mental disorders, reducing the burden of violence and injuries, providing essential healthcare, minimizing exposure to health risk factors, and strengthening collaboration with other sectors that have an impact on health.

The policy defines the four tiers of the health system as community, primary care, primary referral and tertiary referral services. Tier one, comprises of the community unit, identified as the first level of health services provision. This should focus on creating appropriate demand for services, while primary care and referral services will focus on responding to this demand. In addition, the policy says that the community units should facilitate individuals, households and communities to carry out appropriate healthy behaviours, recognize signs and symptoms of conditions requiring health care and facilitate community diagnosis, management & referral.

1.4.5   Kenya Health Sector Strategic and Investment Plan 2014 – 2018

The Kenya Health Sector Strategic and Investment Plan (KHSSP) 2014 – 2018 forms the guidance for allocation of resources in the Medium-Term Expenditure Framework, and in turn inform annual planning, and performance contracting in health. This KHSSP provides the overall framework for sector guidance in the Medium Term. KHSSP was coined to address priorities identified under its predecessor the National Health Sector Strategic Plan II (NHSSP-2), which included introduced the Kenya Essential Package of Health (KEPH), a comprehensive essential package which defines services and interventions to be delivered at each level and across these five cohorts: (i) Pregnancy and New-born up to 28 days, (ii) Childhood (29 days 59 months), (iii) Children and Youths (5-19 years), (iv) Adulthood (20-59 years) and (v) Elderly (60 years and above).

KHSSP identifies the following priorities in community health:

(i)   Revitalize CHS by guiding counties on how to establish and maintain community health units

(ii)   Revitalize the Community Health Strategy (CHS), providing guidelines to the County Health Departments on how to realize its implementation with regard to the remuneration of CHVs.

(iii) Community health to support specific objectives on the Non-Communicable Diseases (NCD) in the KHSSP; Include interventions related to violence and injuries in the NCDs

These priorities are to be implemented through a Community Health approach.

1.5   Global Health Commitments

During the third Global Human Resource for Health (HRH) forum in Brazil in 2013, Kenya committed to 5 HRH commitments, which included; recruiting 40,000 Community Health Extension Workers (CHAs) by 2017; advocacy to counties to establish community health services by 2017; establishment and operationalization of community health units from 2,511units in June 2012 to 9,294 units by 2017; establish mechanisms for community health insurance as a modality for motivating the community health workers by 2015. In addition, Kenya pledged to the global commitments of achieving universal health coverage and meeting the Sustainable Development Goals (SDGs).

Kenya was a participant to the Astana Declaration on Primary Health Care 2018 in October 2018 where the country strongly affirmed its commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind. Since then the government begun the process of developing the Kenya Primary Healthcare Strategy, 2019 – 2024[2].

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2   Once finalized, amendments to this policy may be made to include any critical sections of the policy necessary

1.6 Guiding Principles

The Community Health Policy will be guided by the following principles, based on provisions of the Constitution, Kenya Health Policy 2014 – 2030, Universal Health Coverage and principles of Primary Health Care:

i.   Human Rights-based approach
ii.   Equity
iii. Community-ownership and social accountability
iv.   National government stewardship and support
v.   Intergovernmental consultation and cooperation
vi.   Effective links between the community link health facilities
vii. Partnerships and collaboration with actors in and outside the health system
viii. Financial protection

1.7 The Policy Development Process

The Kenya Community Health Policy development process has been stewarded by the national government (Community Health and Development Unit) since November 2014. The process, outlined below, was evidence-driven, extensively consultative, and broadly engaging with a wide section of health sector stakeholders such as relevant government ministries, departments, and agencies; county governments; multilateral and bilateral development partners; the civil society and implementing partners. The process involved so far include:

Stage One: Formation of the Taskforce and recruitment of a consultant

A National Taskforce for the Community Health Policy was formed, drawing on membership from the Ministry of Health (MOH) and various partners across the sector, who have been supporting implementation of community health services. The Taskforce brought on board, through a competitive process, a consulting firm, HECTA Consultants, to support the process. The consultant developed an Inception report in January 2015 in preparation for a situational analysis.

Stage Two: Situational analysis of the community health services

The situational analysis was conducted between March and July 2015 and involved two processes – a detailed review of the evidence on community health including key guiding documents, and a field study involving detailed interviews with various stakeholders at the national and county levels. As part of the situational analysis, data was collected from five counties - Nyeri, Homa Bay, Kilifi, Uasin Gishu and Garissa -, with support from the respective county health management teams. The counties, purposively selected to be broadly representative of the 47 counties in terms of demographic and health characteristics, were picked based on various health systems parameters (outlined in detail in the situational analysis report). In addition, interviews were done with national level stakeholders, both at the MOH and among key development partners.

Following the completion of the situational analysis, two stakeholder engagement meetings were held:

a) A national-level stakeholder meeting - to feed back the results and give contributions on what the Draft Community Health Policy should include. The workshop brought together various stakeholders from different departments in the MOH and development partners. The workshop discussed detail the various topics under the Community Health policy. This meeting was held in December 2015.

b) A writers' workshop was held with the policy taskforce and major implementers of community health in Naivasha to drat the actual policy. The draft was developed live with all participants contributing actively to the content of all the sections.

c) A task force and stakeholders' meeting were held, to discuss the details of the draft policy developed following the Naivasha meeting.

d) The draft was then shared with a technical working group (TWG) comprised of the Community Health Strategy goodwill ambassador-Prof. Miriam Were, MOH-DCHS staff and development partners for their input. This second meeting was held on the 17th February 2016

Stage Three: County Engagement

A two-day county engagement stakeholders' meeting was held from the17th-18th March 2016 where the draft policy and the situational analysis report were presented and subjected to in-depth review and subsequent revision by stakeholders. The meeting brought together a cross-section of stakeholders comprising County representatives, development partners involved in Community Health, MOH-DCHS staff and the consultants. All the 47 counties apart from Kajiado and Nandi counties were represented at the meeting. The meeting was highly participatory and engaging with participants working in groups led by County representatives to discuss and provide views on the draft policy. Following this meeting, participants were allowed to send in their comments which were included in the revision of a new draft.

Stage Four: Engagement with Council of Governors

The revised draft was presented to the Council of Governors for their input and discussion with governors and County Executive Cabinet members. The council of governors gave substantial feedback especially in the financing component of the policy. The council then used internal systems to distribute to governors and County Executive Cabinet members for feedback and inputs received were incorporated into a new draft.

Stage Five: Presentation to Cabinet Secretary for approval

The final policy, incorporating all feedback was presented to the Chief Administrative Secretary and Principal Secretary for their endorsement and to the Cabinet Secretary, Health, for approval.

CHAPTER 2: POLICY OBJECTIVES

In this Chapter, the goal of this policy is defined specific objectives outlined, and the various structures needed towards realisation of those objectives elucidated.

2.1 Policy Goal

To empower individuals, families and communities to attain the highest possible standard of health

2.2 Policy Objectives

2.2.1 General Objective

To provide policy guidance for the establishment and implementation of a strong, equitable, holistic and sustainable community health structure.

2.2.2 Specific Policy Objectives

1) **Policy Objective One: Leadership and Governance**

   Secure effective leadership and governance in the formation, maintenance and management of community health structures and participation mechanisms

2) **Policy Objective Two: Community Health Workforce**

   Ensure the recruitment and retention of community health human resources for health, including obtaining appropriate numbers and strengthening mechanisms for capacity building and supportive supervision of community health personnel.

3) **Policy Objective Three: Service Delivery**

   As per the community health strategy, ensure provision of high-quality community health services at the household and community level, including referral and follow-up services.

4) **Policy Objective Four: Community-based Health Information System**

   Support the development and strengthening of Community-based Health Information System (CBHIS) and the monitoring and evaluation of systems to sufficiently inform the implementation of community services at all levels.

5) **Policy Objective Five: Health Products and Technologies**

   Promote and strengthen supply chain systems for community health that are integrated into the government-led reporting systems and link-facilities including the use of available technology.

6) **Policy Objective Six: Financing for Community Health**

   Provide various mechanisms for mobilising, managing, and appropriately allocating resources for sustainable financing and delivery of community health services at all levels.

7) **Policy Objective Seven: Monitoring, Evaluation, Research and community-based surveillance**

   Provide for community health services and human resources data, and knowledge management which will inform evidence-driven decision making.

CHAPTER 3: DETAILED POLICY OBJECTIVES

3.1 Leadership and Governance of Community Health Services

The objective of this section is to secure effective leadership and governance for community health services. This objective also guides the formation, maintenance and governance of various community health structures critical for effective management and governance for an effective community health services platform. Community health services delivery shall be guided by a well-functioning community health governance system described below.

3.1.1 The Community Health Unit (CHU)

Definition of a Community Health Unit

A Community Health Unit (CHU) comprises of households organised in functional villages or sub-locations and formally recognised as the first tier in Kenya's health system. A CHU shall serve a prescribed size of the population and will be supported by a prescribed number of Community Health Volunteers (CHV) and Community Health Assistants (CHA) based on determinants such as population density. The CHU shall be governed by a Community Health Committee (CHC), which shall be linked to a primary health care facility to support the CHU's implementation of its activities.

Formation and setting up of a community Health unit

The formation of the CHU shall follow a structured community entry process which begins with awareness creation, situation analysis, and formation of linkage structures, training teams and establishing the monitoring and evaluation mechanism. The entire process shall be overseen by the CHA representing the county health management team and partners, in collaboration with the county administrative structures. The process shall entail:

1. Creation of awareness among county stakeholders, including the county/sub-county health management teams, health facility managers and local leaders and social mobilization of the community members to attend barazas for the selection of their CHC and CHVs.

2. In a baraza setting, CHCs are selected then trained on their roles and responsibilities using the nationally approved CHC training curriculum.

3. Upon completion of training, CHC members organise a baraza for the selection of CHVs. CHVs are then trained on their roles and responsibilities using the nationally approved CHV training curriculum.

4. Upon completion of classroom training, CHVs then engage in household registration after assignment of the specific areas of the village they will be in charge of. Household registration is done using the nationally approved MOH Household Register MOH 513.

5. Thereafter the CHVs, CHCs, CHAs and sub-county focal persons should reconvene to discuss the data collected and discuss any key issues arising from the household registrations in addition to lessons learnt and best practices.

6. Thereafter the community health unit is provided with a Master Community Health Unit List (MCHUL) code. Establishing an information system allows the community unit to report and share data on regular dialogue and action days, and dissemination its demographic data to other levels of support.

County governments are advised to support efforts aimed at ensuring that all stakeholders understand community health approaches prior to planning and budgeting.

Functionality of a Community Health Unit

Functionality of the CHU should be based on attainment of the following eleven criteria:

1. Existence of trained community health committee (CHC) that meets at least quarterly

2. Trained CHVs and CHAs that meet prescribed guidelines

3. Coordination by county community health leadership

4. Supportive supervision for all community health personnel done at least quarterly

5. All trained CHVs and CHAs have reporting and referral tools

6. All trained CHVs and CHAs make household visits as per their targets and at least to each household, once a quarter.

7. Availability and use of mechanisms for feedback, local tracking and dialogue

8. Presence of functional Health Information System (HIS) structure in accordance with prescribed guidelines

9. Availability of community health supplies and commodities as defined by prescribed guidelines

10. CHU registered in Master Community Health Unit List (MCHUL) and linked to health facility

11. CHU 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

For further guidance on functionality please refer to the MOH functionality/monitoring tool.

3.1.2 Governance of Community Health Services

Community Health Committee (CHC)

The coordination and management of the CHU and its workforce shall be done by a CHC, a group of members selected by the community. The committee shall include:

- A prescribed number of which not more than two thirds shall be from same gender
- Representation from religious and Cultural groups within the context
- Representation from youth and people with disabilities

The members must reside in the community they are selected to serve. They will serve a three-year term that is renewable once, unless agreed by the community. The CHC shall choose its chairperson, and shall have at least one, and at most two CHVs. If a member of the CHC is selected to be a CHV, they cease to be in the CHC unless representing CHVs. The CHA shall be the technical advisor and secretary to the CHC. The treasurer shall be a CHV. The chairperson shall become a co-opted member of the link health facility committee.

The CHC shall be the first organ to be constituted in the establishment of a CHU. The roles and responsibilities of the CHC shall include:

- Provision of leadership and oversight in the implementation of health and other related community services
- Preparation and presentation of the CHU annual work-plans and operational plans to the link facility health committee
- Planning, coordinating and conducting community dialogue and health action days
- Working with the link facility to promote facility accountability to the community
- Holding quarterly consultative meetings with the link facility
- Creating an enabling environment for implementation of community health services
- Resource mobilization for sustainability

Sub-County Health Management Team

The Sub-County Health Management Team coordinates all health matters at the sub-county including Community Health Services. The Team shall provide an enabling environment for operationalization of CHS. Their roles shall include:

- Planning and resource allocation
- Distribution of supplies
- Training
- Support supervision, coaching and mentoring and quality control
- Monitoring & Evaluation

Each county shall designate an officer to be responsible for coordination and management of Community Health Services at the sub-county level.

County Health Management Team

The County Health Management Team (CHMT) coordinates all health matters including Community Health Services. The CHMT shall provide an enabling environment for operationalization of CHS. Their roles shall include:

- Planning
- Procurement
- Resource mobilization and allocation
- Training
- Support supervision, coaching and mentoring and quality control
- Monitoring & Evaluation
- Provide linkage to the executive committee of county government and the National Level
- Manage partnerships
- Interpret and operationalize the Community Health Policy

The County Community Health Officer shall be responsible for coordination and management of Community Health Services at the county level.

National Government

The National government through the ministry of health shall, in consultation with the County governments, do the following to support delivery of community health services:

- Develop community health policies, legislation and guidelines
- Set standards and quality control for Community Health Services
- Resource mobilization for Community Health Services
- Partner coordination and networking
- Support supervision to counties
- Provide technical advice and support
- Conduct implementation esearch to generate evidence for action
- Capacity building to the counties on community health and development
- Advocacy for Community Health Services

3.2 Community Health Workforce

3.2.1 Community Health Assistants / Officers

The Community Health Assistant / Officer (CHA / CHO) is a formal employee of the County Government forming the link between the community and the local health facility. The CHA / CHO is expected to perform the following tasks among others:

a. Household visits for health promotion, disease prevention, treatment of minor ailments and client follow up and referral.

b. Participate in the selection, training and support of Community Health Volunteers (CHVs) and Community Health Committees (CHCs)

c. Be the secretary to the CHC and the Custodian for CHC meeting minutes

d. Support and supervise CHVs in assigned tasks and coach them to ensure achievement of desired outputs and outcomes

e. Training and coaching of CHVs on health service provision at the community level including integrated community case management (iCCM) of common childhood diseases – malaria, diarrhoea, pneumonia and malnutrition

f. Ensure that CHVs have the data collection tools, commodities and supplies (including those for iCCM services)

g. Ensure that CHVs have identity and visibility labels

h. Hold monthly feedback meetings with the CHVs assigned

i. Manage the community-based health information system (CBHIS) and use it to influence continuous improvement in health status in collaboration with health records and information management department

j. Collate information gathered by CHVs to display summaries at strategic sites to provide relevant feedback as well as material for dialogue at household and community levels and maintain records of community health

k. Compile reports from CHVs and submit to the link facility and share with other relevant levels and ensure uploading into DHIS

l. Receive feedback from higher levels and transmit the same to CHCs and CHVs through dialogue and planning that leads to actions to improve identified issues

m. Follow up and monitor actions emerging from dialogue and planning sessions to ensure implementation in collaboration with other sectors

n. Provide support (technical) to CHVs, CHCs and other community actors

o. Monitor the use of simple drugs, commodities and supplies

p. Facilitate and participate in the registration of households

q. Convenor of quarterly community dialogue and mobilizes CHCs to hold meetings.

r. Serve as technical advisor and secretary to the CHC

s. Take Custody of all CHC records

t. Perform other functions as outlined in the Current guidelines/strategy

For appointment as a CHA / CHO, a person should have been trained as set out in the guidelines and/or scheme of service. The CHA / CHO is directly answerable to the link facility in-charge and directly supervised by the sub-county community health coordinator and sub-county MOH. They will also be accountable to the CHCs.

3.2.2   Community Health Volunteers (CHV)

Definition of a community health volunteer

The CHVs should be members of the local communities they are selected to serve in. To qualify as a CHV, individuals shall be required to meet the conditions outlined below:

- Must be a citizen of Kenya
- Must meet the requirements of Chapter Six of the constitution
- Should be above the age of 18 and of sound mind.
- (S)he must be a responsible and respected member of the community
- Is self-supporting and understands that the role of a community health volunteer does not draw a monthly income
- Is willing and ready to provide services to the community without charging
- (S)he must be a resident (including overnight stay) of respective community that is selecting him / her for a continuous period of not less than five years prior to the appointment date
- Is a form four leaver and literate, unless where the situation does not allow
- Is not disqualified for appointment to office by the above criteria or by any law

Selection of a community health volunteer

A community health volunteer will be selected at a community meeting or baraza called by the area leader or the community health committee. Once selected, the community health volunteers will undergo training to prepare them to serve households that would be organized as a community health unit. Each community health unit should meet the minimum number of Workers required to serve a certain size of households/ population, as stipulated in the most Current guidelines/strategy, and subject to contextual factors such as population density and geographical coverage (Urban, Rural, Agrarian & Nomadic).

Training of a community health Volunteers

Training of CHVs is based on a prescribed curriculum with two sections of basic and technical modules.

The first section of training of CHVs is done immediately after selection and the modules are composed of (i) health and development in the community, (ii) community governance and leadership, (iii) communication, advocacy and social mobilization, (iv) best practices for health promotion and disease prevention, (v) basic healthcare and

life saving skills, and (vi) management and use of community health information and community disease surveillance. This first section is completed in 94 hours followed by a one-month field practical. CHVs must complete all basic module before proceeding to the technical modules.

The second section is composed of seven technical modules; (i) integrated community case management, (ii) water, sanitation, and hygiene, (iii) maternal and newborn care, (iv) family planning, (v) HIV, TB and Malaria, (vi) community nutrition, and (vii) non-communicable diseases. The full curriculum is composed of 324 contact hours and 160 hours of practical (app. three months).

Training will be conducted by the community health assistants / officers at the sub-county or link facility level. Training will be done within the locality that the community health volunteers will be serving.

At the completion of the basic training, a community health volunteer shall be provided with a certificate. In addition, at the completion of each technical module will be accompanied by a certificate. At the completion of the basic modules, a volunteer will be provided with a unique identification number to be linked to their community health unit for record keeping purposes. Technical trainings are provided within the year of service of the community health volunteer and are prioritized based on the local needs of the community. Certificates are provided upon completion of each technical module.

Duties of a community health volunteer

The main duties of the CHV will be as follows:

a. Deliver key health messages to households as outlined in the Kenya Essential Package of Health (KEPH)

b. Registration of households at frequencies stipulated in current guidelines

c. Guide community on health improvement and disease prevention

d. Treat common ailments and minor injuries with support and guidance from CHAs including the implementation of Community-based Maternal and New-born Health (cMNH) and Integrated Community Case Management of Common Childhood diseases (iCCM).

e. Diagnose, treat, manage or refer accordingly, common childhood illnesses such as diarrhoea, malaria, malnutrition and pneumonia.

f. With support from the CHA, stock the CHV kit with supplies provided through the respective link facility or other mechanisms outlined in the guidelines/strategy

g. Refer cases to respective link facilities

h. Promote care seeking behaviour and compliance with treatment and advice

i. Visit homes to determine the health situation and initiating dialogue with household members to undertake the necessary action for improvement

j. Recognise danger signs among household members and refer as appropriate

k. Promote appropriate home care for the sick, supported by CHAs and link facilities

l. Participate in community dialogue and action days organized by CHAs/CHCs

m. Participate in monthly feedback meetings as organized by the CHA / CHO
n. Be available to the community to respond to questions and provide advice
o. Motivate members of the community to adopt health promoting practices
p. Organize, mobilize and lead village health activities
q. Maintain household registers and keep records of community health related events.
r. Report to the CHA activities they have been involved in and health problems they have encountered that need to be brought to the attention of higher levels

Remuneration of community health volunteers

Although community health volunteers are recruited to work on voluntary basis, counties shall pay them stipends and compensate them for their time in any other way that would motivate them to continue providing this important health service to their respective communities including support supervision and provision of commodities and supplies. In order to mainstream remuneration of community health volunteer, counties shall legislate community health services through enactment of county community health bills.

3.3 Community Health Service Delivery

3.3.1 Service packages

The core community health service package to be delivered shall consist of the following:

Behaviour Change Communication

All community health activities shall have a component of behaviour change delivered through a behaviour change community strategy which is cognisant of the local context. The strategy should recognise that changing individual and community behaviour is key to the prevention of diseases.

Behaviour change should take place at both individual and societal levels and must be developed alongside the target groups. Being members of the community, community health personnel are credible sources for encouraging positive health behaviour and combating negative Cultural norms that inhibit health promotion.

Behaviour Change Communication can be delivered to the community through various channels such as community dialogues, drama, song and dance, CHU cards and more.

Nurturing Care and Early Childhood Development

Nurturing care is the environment created by caregivers that ensures children's good health and nutrition, protects them from threats, and gives them opportunities of early learning through interactions that are emotionally supportive and responsive. Early childhood development (ECD) refers to the cognitive, physical, language, motor, social and emotional development a child goes through from conception to eight years.

Community health Volunteers and other personnel have a big role to play in ensuring that children in the communities receive nurturing care, get playful opportunities to learn, and are protected from any form of harm. Some specific nurturing care and ECD duties include;

- Community awareness and demand creation on nurturing care including the science of early childhood development, nurturing in-utero, developmental milestones, responsive caregiving, security and safety and opportunities for early learning
- Active case finding and referral for children with delayed milestones and/or disabilities
- Care for children with developmental difficulties and disabilities
- Empowerment of families with children with disabilities and provision of social support by linkage to peer-peer groups
- Information, support and counselling to caregivers about opportunities for early learning, including the use of common household objects and home-made toys
- Promotion of clean environments for children including the elimination of the use of charcoal to improve in-door air quality

Reproductive Health

Community health reproductive services shall be aimed at identifying clients for provision of counselling and timely referral for reproductive health services. In this regard, the CHVs & CHAs shall perform the following roles:

- Counsel for reproductive health – HIV, contraceptives, encourage uptake of screening for cervical and breast cancers
- Identify and register pregnant women through home visits
- Promote early and timely ante-natal (ANC), HIV testing, referrals and follow-ups
- Identify danger signs during pregnancy and signs of early labour, then refer.
- Assist pregnant women & their families to do birth-plans
- Encourage male involvement in pregnancy and accompaniment for delivery
- Promote facility-based deliveries and homecare for the pregnant women
- Conduct ante-natal visits to advise mothers on early initiation & exclusive breastfeeding and refer for post-natal care
- Conduct post-natal (PNC) visits as per the national guidelines and screen for post-partum danger signs
- Counsel mothers to seek family-planning services
- Counsel on maternal nutrition

New-born Care

New-born care aims at ensuring promotion of safe neonatal practices, identifying and dealing with danger signs appropriately, and supporting the mother on infant feeding and nutrition.

- Counsel mothers on personal and new-born hygiene
- Support mothers to initiate and sustain exclusive breastfeeding
- Conduct and demonstrate thermal for a new-born
- Counsel on cord care of the new-born
- Assess, identify and refer new-borns with danger signs
- Refer new-borns for immunization and growth monitoring
- Follow-up visits for referred and small babies
- Counsel on maternal and new-born nutrition
- Encourage responsive and nurturing care for the new-born including play, stimulation and communication

Child Health and Immunization

Aims at ensuring prevention of childhood diseases and improvement of child health

- Encourage responsive and nurturing care for the child including play, stimulation and communication, delayed milestones, child neglect and abuse
- Monitor the growth of children to ensure positive development
- Screen for delayed milestones and disabilities and refer where appropriate
- Raise awareness and counsel on dangers signs of a sick child and when to seek care.
- Diagnose, treat and manage childhood diseases (including diarrhoea, pneumonia, malaria and malnutrition) as per the national guidelines
- Counsel on the immunization schedule and the dangers of not following it strictly
- Mobilize communities during immunization days
- Identify and referral of children for immunization
- Trace and referral of defaulters
- Assist in immunization during immunization campaigns

Nutrition

Nutrition activities include information education and communication (IEC) for good nutrition, screening and follow-up for malnutrition. Roles and responsibilities include:

- Provide IEC on nutrition services available at health facility and community levels
- Screen, identify and make referrals for malnutrition
- Conduct growth monitoring for under fives
- Follow-up and defaulter tracing for clients with malnutrition
- Referrals for micronutrient supplementation
- Promote, protect and support exclusive breastfeeding for the first six months of life and sustained breastfeeding for the first two years and beyond within the community

- Carry out health promotion by providing information education communication about healthy diet for people in all stages of the life cycle, particularly among vulnerable populations
- Promote use of improved home-based recipes and preparation methods for locally available foods, including home fortification
- Liaise and collaborate with other sectors to address food and nutrition security at household level
- Maternal nutrition, screening, advice, referral for further management
- Distribute iron and folic supplements

Environmental Health Services

Environment activities include water, sanitation, hygiene, vector control and hazard detection. Roles and responsibilities of community health personnel here include:
- Carry out health promotion activities on protecting water sources, home water treatment, and safe water storage, hand-washing, proper use of latrines, waste disposal and vector control. This may include demonstration where appropriate.
- Identify water sanitation and hygiene diseases and root causes and to negotiate improved practices and solutions
- Promote community led total sanitation by mobilising the community, linking with environmental health personnel
- Detect early signs of hazard, intervening and/or reporting as appropriate

Home based Care for Terminally ill Residents

Home based care activities include caring for people who suffer from life threatening diseases. This is a hallmark of a humane and caring society. The roles and responsibilities of community health personnel in this area include:
- Generate general responsibility towards the acceptance and continuity of health services for the terminally ill.
- Offer basic counselling support for terminally ill and their families.
- Mobilise local resources for care.
- Motivate of community members, families, caregivers to continue support for terminally ill patients.
- Link terminally ill with families/support groups/institutions for additional support.
- Link and refer terminally ill patients to nutrition and other supportive programmes
- Build a supportive environment and offer information to address and reduce stigma and discrimination at community level.
- Support patients referred from health facility to community for home-based care, including supporting drug adherence.

Basic Curative Services

Basic curative services shall aim at preventing, detecting and providing early treatment for minor illnesses in the community. To facilitate the provision of basic curative, CHVs& CHAs shall:

- Diagnosis and treat – Malaria, Pneumonia, Diarrhoea, Moderate Malnutrition especially in children under five as per nationally issued guidelines
- Screen and refer for Tuberculosis and Severe Malnutrition
- Provide treatment support – HIV, Tuberculosis
- Conduct disease surveillance of emergencies, existing threats and emerging/re-emerging conditions

Communicable Diseases

Communicable diseases (also known as infectious diseases) are illnesses that spread from person to person, or from an animal/insect to a person, through air, blood or other bodily fluid or skin contact. These include HIV and AIDS, tuberculosis, malaria, bacterial and viral diarrhoea, skin conditions among others. They also include global pandemics such as Ebola and Marburg viruses. To help prevent and control the spread of communicable diseases, CHVs/CHAs will be required to:

- Promote health education at household and community level. This includes ensuring households and communities have access to clean safe drinking water and good hygiene practices such as hand-washing among others.
- Strengthen vector and personal protection through promoting initiatives such as insecticide-treated bed-net usage and others
- Promote immunization coverage to minimize communicable diseases
- Early detection of communicable diseases at household/community level

Non-Communicable Diseases

Non-communicable diseases (NCD) are medical conditions that are not infectious or transmissible among people, such as mental health, diabetes, cardiovascular diseases etc. Community health personnel shall assist in identifying, screening and referring of NCDs in the community and promoting healthy lifestyles to reduce related diseases.

Their main roles shall include:

- Discuss and counsel community members on the importance of knowing the risks factors, signs and symptoms of non-communicable diseases.
- Increase awareness on how to prevent non-communicable diseases by: promotion of physical activity, encouraging a healthy diet, maintaining health weight and not using harmful substances such as alcohol, drugs and tobacco.
- Screen for common non-communicable diseases such as hypertension and diabetes, and refer where necessary

- Referral for rehabilitative and counselling services for drug and substance abuse.
- Encourage regular health check-ups for early detection of non-communicable diseases.
- Maintain close contact with members of the community with NCDs to ensure adherence to therapy and treatment protocols.

Mental Health and Gender Based Violence Services

Community Mental health includes peoples' emotional, psychological, and social well-being. It affects how human beings think, feel, and act. It also helps determine how people handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Counties shall ensure community health workforce are enabled to;
- Discuss and counsel community members on the importance of knowing the risks factors, signs and symptoms mental illness
- Increase awareness on how to prevent mental illness and avoid using harmful substances such as alcohol, drugs and tobacco.
- Screen for common disorders and refer appropriately.
- Referral for rehabilitative and counselling services for drug and substance abuse.
- Maintain close contact with members of the community with mental health conditions to ensure adherence to therapy and treatment protocols

Orphans and Other Vulnerable Groups

Community health personnel are key to strengthening the capacity of families to care for Orphans and Vulnerable group, including Children. During home visits, community health personnel can impart knowledge and skills needed to monitor health and care to vulnerable children with particular attention to children and or elderly headed households. They should also ensure that holistic health needs of the elderly, especially on access to health services and psycho-social support are well integrated in the community health package they are offering. Community health personnel shall make efforts to specifically target and identify the needs of the elderly people with both preventive and curative services. Services to orphans and other vulnerable groups and their caregivers shall include:
- Motivation of community members, family support to continue providing support and enhancing social community safety nets
- Link vulnerable children to social and child protection programs
- Refer orphaned and vulnerable children (OVC)s and other vulnerable groups and their caregivers for psychosocial support and other social services including health, nutrition and child protection
- Mentor families on child care and nursing care skills
- Monitor for education outcomes i.e. enrolment, attendance and progressions school attendance

People Living with Disabilities

The Kenya Persons with Disabilities Act, 2003 defines "disability" to mean a physical, sensory, mental or other impairment, including any visual, hearing, learning or physical incapability, which impacts adversely on social, economic or environmental participation. Community units shall play a critical role in supporting the implementation of this Act specially to ensure full participation and awareness of Persons Living with Disabilities (PLWD) in matters of individual and communal health in accordance with the provisions of the constitution, the disability act and this policy. In particular community health personnel shall:

- Advocate for physical access to health services for PLWD.
- Ensure full engagement of PLWD in all community health related activities.
- Advocate or promote special devices that allow PLWD to live a dignified and productive life.
- Support efforts to eliminate stigma and discrimination

Community Based Surveillance

Community Health Volunteers will notify the CHA of any notifiable disease encountered within their areas of work according to the national disease surveillance and response guidelines. They will also:

- Report notifiable diseases by any means including mobile phones
- Report any unusual events within the community for investigation
- Document such cases in relevant community disease surveillance data registers and refer with immediate effect.

3.3.2   Referral Services

The referral system is an interlinked network of service providers and facilities that provide a continuum of care. The network may include both individuals and organizations working to provide care and support to people who are unwell. There are typically four levels to a health referral network: the community, primary, secondary and tertiary levels.

The community level consists of household caregivers, CHVs, CHAs and CHOs, linked to primary health care level. These providers should be trained to recognize illness and gauge its severity in order to provide prompt treatment (if they have the necessary capacity) or refer, when they are unable to treat or need for continuum of care to higher levels or receive facility referral for community care and support.

The Community health personnel shall refer all cases that require procedures outside of their approved scope of work to the nearest link health facility and should have the necessary tools required for referral, receiving feedback from receiving facility staff. It is essential that CHVs refrain from conducting procedures that are beyond their proficiency as outlined by their training and approved scope of work.

3.4 Community Based Health Information System (CHIS)

3.4.1 Definition of a Community Based Health Information System (CHIS)

Community Based Health Information (CHIS) is a system that generates health related information through sources at the community level. It has the potential to be comprehensive as there is the possibility of covering everyone in a community unit under the responsibility of the CHC according to their need for care. Community must be involved in design, implementation, monitoring and evaluation.

3.4.2 Process for setting up a Community Health Information System (CHIS)

A community unit should be registered in the Master Community Health Unit List (MCHUL), and assigned MCHUL number. CHA / CHOs should ensure that the community unit is visible on District Health Information System (DHIS). CHVs and CHAS shall lead in household visitation including data collection and monitoring. CHAs / CHOs should analyse the data, summarise it and forward it for uploading in the DHIS. This is followed by dissemination and use of the data for dialogue and planning through dialogue days leading to community action days to act on the resolutions of the dialogue day, before entering another quarterly monitoring cycle.

3.4.3 Quality of Community Health Data

The system will collect data based on the activities of CHVs, CHAs / CHOs and CHCs as well as general information on community development issues, socio economic, demographic indices of households, community resources, diseases etc. CHVs and CHAs / CHOs are responsible for the quality of data collected. Nationally accredited e-health applications may be deployed in order to ensure quality of community health data collection and reporting.

3.5 Community Health Products and Technologies

Community Health personnel should be provided with the necessary commodities, supplies and tools to carry out their duties through link facilities.

All Community Health personnel will account for usage of supplies and commodities using the appropriate reporting forms and mechanisms.

3.6 Financing for Community Health Services

Community health approach is the foundation of the health system and in the devolved system proper investment for this level is crucial.

- The national governments shall commit adequate financial resources through budgeting processes to meet the objectives of the community health policy.
- The county governments shall adopt programme-based budgeting and commit a prescribed percentage of health budget to meet the objectives of the community health policy.
- Effective implementation of the community health policy will require community participation in the form of resource allocation (human resources, supplies and finances for planned community activities).
- The county and national governments will seek support and mobilise resources from partners interested in supporting community health.
- Civil society organisations (CSOs), community-based organisations (CBOs), faith-based organisations (FBOs) and private sector will be required to support the priorities of the community health by working with the community health units through the existing county health structures.
- The national, county governments and partners shall apply appropriate disbursement mechanisms to ensure efficient flow of finances to support CHUs such as allocations from government for community health services and performance-based financing.
- The national and county governments shall explore various health insurance options to optimise finances available for community health.
- The national and county governments shall work in close partnership with development partners, community-based organizations (CBOs), the National Hospital Insurance Fund and other stakeholders to mobilize funds for community health services and put in place structures for a prudent utilisation of community health resources, including those raised by community members within CHUs.
- The county government shall work with all partners, CBOs and FBOs to ensure a coordinated approach in supporting community health and put in place mechanisms to ensure partners declare their resource envelop and extent of support.

3.7 Monitoring, Evaluation, Research and Community-based Surveillance

3.7.1 Monitoring and Evaluation (M&E)

a) The M&E framework seeks to monitor the process and outcomes of policy implementation in order to report on the progress of the policy implementation process.

b) Implementation of the policy will take place through five-year strategy documents including revision of the current strategy to reflect the policy's needs.

3.7.2   Research

a) Research should be integrated into community health implementation to get evidence to support decision making, planning, implementation, monitoring and evaluation and for policy review.

b) The national and county health leadership shall play an advisory role and will coordinate research implementation. They shall also ensure engagement with community organizations, agencies and diverse population groups to identify research questions critical to the community and to improve methods to reflect community preferences.

c) Community health personnel shall be required to collect quality data while the national level should ensure that community health research priorities are reflected in national surveys.

d) The national and county government shall allocate finances for research and policy review, including but not limited to tapping resources from the national research fund (NRF).

e) Research findings should be disseminated to all concerned stakeholders.

f) All research involving human subjects shall also adhere to national and international research ethical standards and be guided by the Kenya health research priorities guidelines.

CHAPTER 4: PARTNERSHIP AND COORDINATION

Multi-sectoral and inter-governmental coordination, collaboration and team work, shall be encouraged to ensure optimal use of resources for health services to communities. Oversight and coordination is also needed at the National and County levels, as well as structures ensuring smooth coordination with NGO partners and vertical programs having community components.

4.1 Coordination

Community level

At community level, coordination will be done by the CHC with support from the link facility, and SCHMT. Coordination will ensure harmonized programming among partners, and provide a platform for standardized approaches in service delivery and accountability.

Sub-county level

The SCHMT will be responsible for coordination to ensure harmonized programming of the community health work and partners and provide a platform for standardized approaches in service delivery and accountability.

County level

The CHMT will ensure coordination in delivery of services through the community health personnel, including activities of partners at community level. In each CHMT, a focal person will be assigned responsibility for Community Health Services and will ensure coordination within the county and among partners working in that community. This position should have a full-time focus on Community Health Services. The Chair of the CHMT will link the County to the National MOH through the Executive Committee of the county government. The County technical team shall be chaired by county director in charge of health and work in close collaboration and partnership with partners.

National level

At national level, the overall coordination and planning for community health services will be under the leadership of the Head of the Division of Community Health. This will be supported and advised by a technical committee with representation from key implementing partners. The National level will also coordinate efforts with inter-agency coordination committees (ICCs), other arms of government, NGOs and other stakeholders. They will also coordinate efforts with international bodies such as the UN, INGOs and other global actors.

National level will coordinate learning and policy exchanges with other governments and regional intergovernmental bodies for example ECSA, IGAD, and AU. Technical working groups will be formed at MoH level, with participation of partners; chaired by the Head of the Community Health Development Unit or his designees.

4.2 Partnerships

Partnership is a collaborative effort requiring systems and structures that harness and link diverse community resources towards quality improvement of services at level 1. Community partnership is a process of building voluntary strategic alliances among community, government, private, and non-profit making organizations. Alliances and partnership building involves sharing of risks, responsibilities, resources, rewards as well as exchange of information for mutual benefit and to achieve a common community health purpose.

Partnership with communities shall be developed through social mobilization activities carried out to create community interest and motivate and influence community members to take action or to support initiatives that are beneficial for themselves.

Social mobilization will be carried out through village gatherings, village health days, seminars, popular theatre, youth groups, women's groups, and print and electronic media. The CHMT will make sure that community health persons are equipped with knowledge and skills for carrying out their functions in social mobilization and sensitization of the community.

Efforts to build partnership at community level will go into: (i) Identification and recruiting partners to play a role in the implementation of CH services, (ii) Identifying roles and responsibilities for various partners in the implementation of CH services, (iii) Maintaining partnerships and ensuring active partner participation, by engaging them in the planning, implementation, monitoring, evaluation and feedback process. County and National levels will endeavour to build and maintain Public-Private Partnerships in delivery of services.

Figure 1: Kenya Community Health Policy M & E Framework
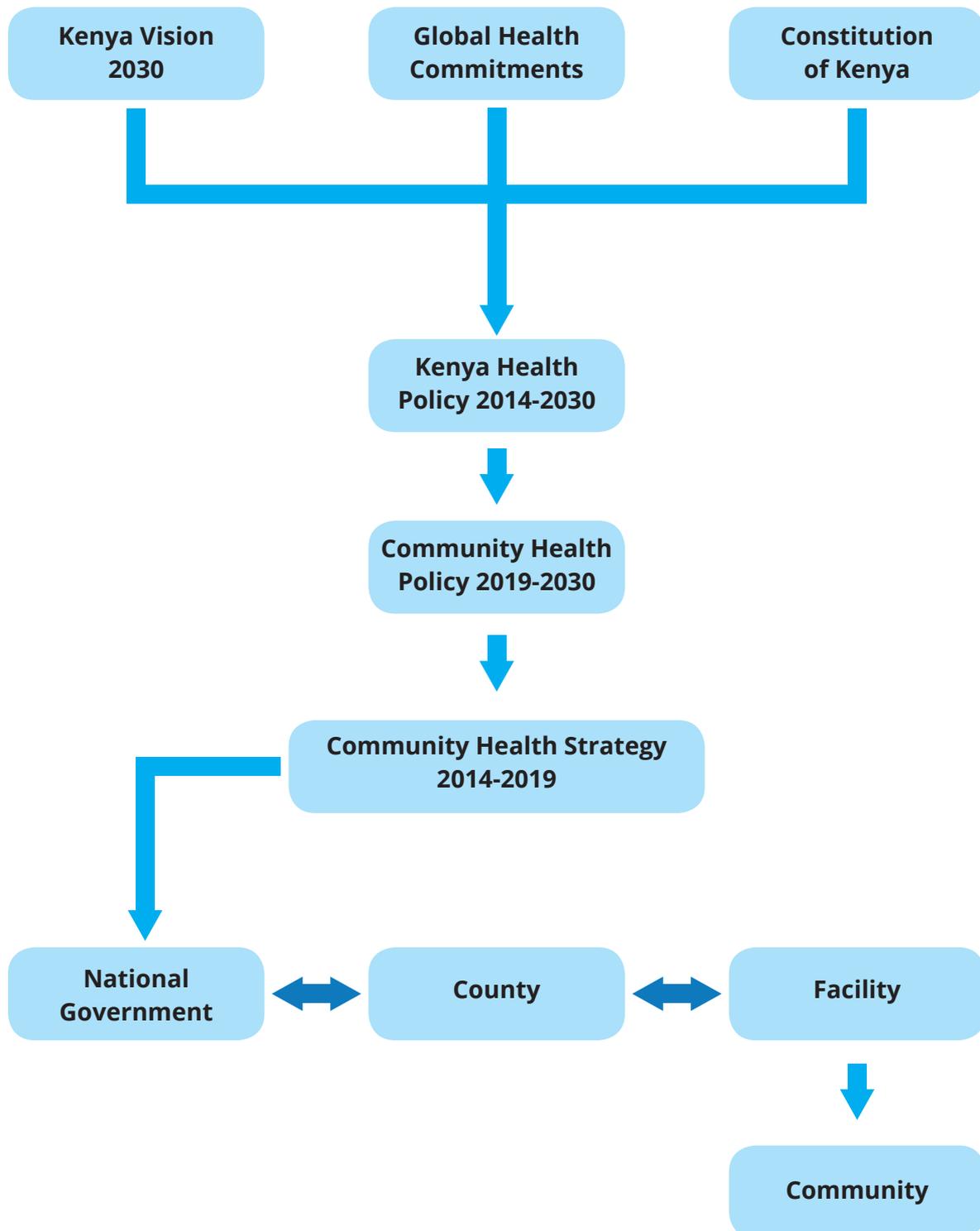
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This policy is intended as a guide for the health sector for the implementation and delivery of community health services in Kenya.