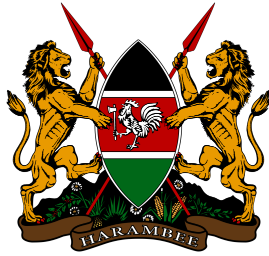

REPUBLIC OF KENYA

GOVERNMENT OF THARAKA NITHI COUNTY

Tharaka Nithi Community Health Strategy 2021 - 2025

To accelerate the attainment of universal health care through improvement of community and primary health care services

Tharaka Nithi County Department of Health ©2021

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Tharaka Nithi County Community Health Strategy 2021–2025
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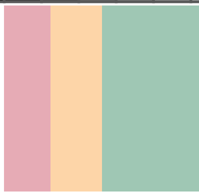
LIST OF ABBREVIATIONS

CBS	Community Based Surveillance
CHA	Community Health Assistant
CHC	Community Health Committees
CHV	Community Health Volunteer
CHU	Community Health Unit
CH	Community Health
CHW	Community Health Worker
C-GGHE	County Government General Health Expenditure
CIDP	County Integrated Development Plan
DHIS2	District Health Information System
eCHIS	Electronic Community Health Information System
FY	Financial Year
KES	Kenya Shillings
KHSSP	Kenya Health Sector Strategic and Investment Plan
NCD	Non-Communicable Diseases
NHIF	National Health Insurance Fund
MOH	Ministry of Health
TNCCHS	Tharaka Nithi County Community Health Strategy
URTI	Upper Respiratory Tract Infection
UHC	Universal Health Coverage
WHO	World Health Organization

DEFINITION OF TERMS

Community Health:	This is the first level of Kenya health system structure. Health services at this level are basic curative, preventive and promotive.
Community Health Unit:	Is a health service delivery structure within a defined geographic area covering a population of 5,000 people. Each unit is assigned one Community Health Assistant/ Officer and 10 Community Health Volunteers.
Community Health Volunteer (CHV):	Is a member of the community selected to serve in a community health unit. A CHV is well known to his/her community and is selected to the role of CHV by his/her community members.
Community Health Assistant / Officer:	Is a formal employee of the County Government forming the link between the community and the link health facility.
Community Health Committee:	Refers to a committee that is charged with the governance and oversight of a community health unit.
Functionality of Community Health Unit:	Refers to the extent to which a community health unit attains the eleven criteria as outlined in the Kenya Community Health Policy (2020 – 2030).
Health Systems:	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 have to function together to be effective.
Health Systems Building Blocks:	The World Health Organization recommends supporting and strengthening a health system based 6 building blocks. When you strengthen a health system, you improve the six-health system building blocks and manage their interactions in ways that achieve more equitable and sustained improvements across health services and health outcomes.
Service Delivery:	Good service delivery comprises quality, access, safety and coverage.
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.
Medical Products:	Procurement and supply programs need to ensure equitable access, assured quality and cost-effective use.
Health Financing:	A good health financing system raises adequate funds for health, protects people from financial catastrophe, allocates resources, and purchases good and services in ways that improve quality, equity, and efficiency.
Leadership and Governance:	Effective leadership and governance ensures the existence of strategic policy frameworks, effective oversight and coalition building, provision of 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 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).
Universal Health Coverage:	Universal Health Coverage: UHC 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, April 2021).



Foreword

Universal Health Coverage is an essential part of the sustainable development goals with one of its vital aspects being the services offered at the community level by the Community Health Volunteers. Kenya is a signatory to the 2030 United Nations Sustainable Development Goals, hence the keen focus by Tharaka Nithi County on their attainment. In 2006, Kenya adopted a community-based strategy which defined a new approach for health care services delivery to Kenyans. This helped accentuate the focus on promoting health at the individual and community levels for better health outcomes. Community health is one of the flagship projects in Kenya's Vision 2030 and is recognized as the first level of health care in the Kenya Health Act, 2017.

The Astana Declaration (2018) highlights the importance of community health services in advancing UHC. It involves services that are rendered at the individual, household or community level to persons living in the same neighbourhoods. Such services are offered by Community Health Volunteers who are members of the community. This approach has been identified as one of the strategies to address the growing shortage of health workers globally, and to reach the marginalized communities with the essential health services.

The County Government of Tharaka Nithi has prioritised the provision of equitable, affordable, and quality health and related services at the highest attainable standards to all its residents in line with the Big Four Agenda.

In efforts to improve the health of our citizens and achieve UHC, the county has embraced community health. Currently, the county is served by 1,265 Community Health Volunteers equitably distributed within the six sub-counties. Community health services offered are mainly promotive and preventive services. Anchored on the third edition of the Kenya Community Health Strategy (2020–2025), the county has developed its community health strategy that is contextualized to its community health needs.

The development of this strategy has been a consultative process involving all the key stakeholders in community health and is aimed at providing a framework for all the implementation of community health services in a standardized manner. We look forward to greater cooperation and participation from the same stakeholders and more in the implementation of this strategy.

Dr. Gichuyia Nthuraku M'riara
County Executive Committee Member,
Health Services and Sanitation

Preface

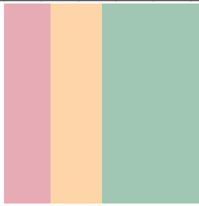
Countries around the world are looking to reduce the cost of health care services and increase access to basic health services. Community health is a driver to achieving both goals. Many of our citizens suffer from preventable diseases and due to socioeconomic challenges, they have limited access to health care services. Community Health Volunteers bridge this gap by delivering health care services at the household level hence reducing the barriers to accessing health care. These efforts are backed by our Governor's manifesto to improve the access to quality and affordable health services in the county.

In efforts to achieve this goal, the county has partnered with the Financing Alliance for Health to develop its first-ever Community Health Strategy (2021–2025). The strategy aims at providing guidelines for the implementation of community health services in Tharaka Nithi County. The development process of the strategy involved a thorough consultative process with all the relevant stakeholders to ensure that all the community health needs are considered.

The strategy focuses on these 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 highly consultative process with key stakeholders, the various strategies and key interventions under each of these pillars have been delineated to guide the implementation of community health services that are accessible to our people, of high quality and integrated into the Primary Health Care system in the county.

This strategy comes at a very crucial time where we are seeking to achieve Universal Health Coverage as a county, and I believe with the implementation of the strategy we will be taking steps in the right direction.

Madam Evelyne Kaari
Chief Officer,
Public Health and Sanitation



Acknowledgement

The Tharaka Nithi County Department of Health takes this opportunity to thank everyone who took part in the development of the Tharaka Nithi County Community Health Strategy (2021–2025). The community health strategy would not have been realized without your undying efforts.

We appreciate our able County Health Management Team under the leadership of Dr. Gichuyia Nthuraku. We recognize the great contribution of the ever-responsive health departments including the public health department, records, procurement, pharmacy, finance, and the nursing departments, who have always provided data and information whenever required. Community health services are cross-cutting, and we extend our sincere gratitude to our colleagues in these ministries: social services, education, water and sanitation and administration we highly appreciate your immense contribution to this document.

We sincerely acknowledge the technical and financial support from Financing Alliance for Health under the leadership of Dr. Angela Gichaga and Nelly Wakaba. Special thanks to Lucy Muriithi and Dennis Munguti who are embedded with us at the county, and the writing team comprising of Mr. Nicholas Thiora, Dennis Mbae, Johnney Muriithi, Kennedy Kimanthi, Kelvin Miriti, Lucy Muriithi and Dennis Munguti led by Mr. Samuel Mugendi. Your efforts cannot go unrecognized.

We also thank other partners including the Village Hope Core, Kenya Red Cross Society, Fred Hollows Foundation, Plan International Kenya, CARITAS Meru among others, for enriching the document through participation in the multi-stakeholders fora.

Mr. John Mbogo
County Director of Health and Sanitation Services

Executive Summary

Community health is the first level of service delivery within the six-tiered health system. According to the Kenya Community Health Strategy (2020–2025), community health services are provided within a community health unit (CHU) by a community health workforce composed of Community Health Committees (CHC), Community Health Assistant (CHA) or Community Health Officer (CHO), and Community Health Volunteers (CHVs). The services offered at level 1 (community) are majorly preventive and promotive with little or no basic curative services.

The community health program in Tharaka Nithi County was initiated in 2007 and has evolved over time, resulting in significant health impact at the last mile that has seen Tharaka Nithi blazing the trail in health service delivery in the country. However, the program is faced with a myriad of challenges. Based on an in-depth situational analysis conducted at the beginning of the year 2021, some of the key challenges included: inadequate training of Community Health Volunteers hindering optimal service delivery, a limited-service package limiting the number of services that the CHVs can offer in the community and the limited partnership coordination leading to duplication of programs in the county by different partners and inequality in coverage leaving some regions in the county disenfranchised. Further, the Community Health Units are semi-functional (scored 58%) and hence the need for key interventions to reach functionality (>80%).

As an important step towards addressing these challenges, the Tharaka Nithi County Community Health Strategy, 2021–2025, was developed through a multi-stakeholder and multi-sectoral participatory process led by the County Department of Health and in collaboration with development partners. This strategy is aligned and hinged on the recommendations from the Kenya Community Health strategy 2020–2025, the Kenya Community Health Policy, 2020-2030 and other guiding policies and frameworks at the global and regional level.

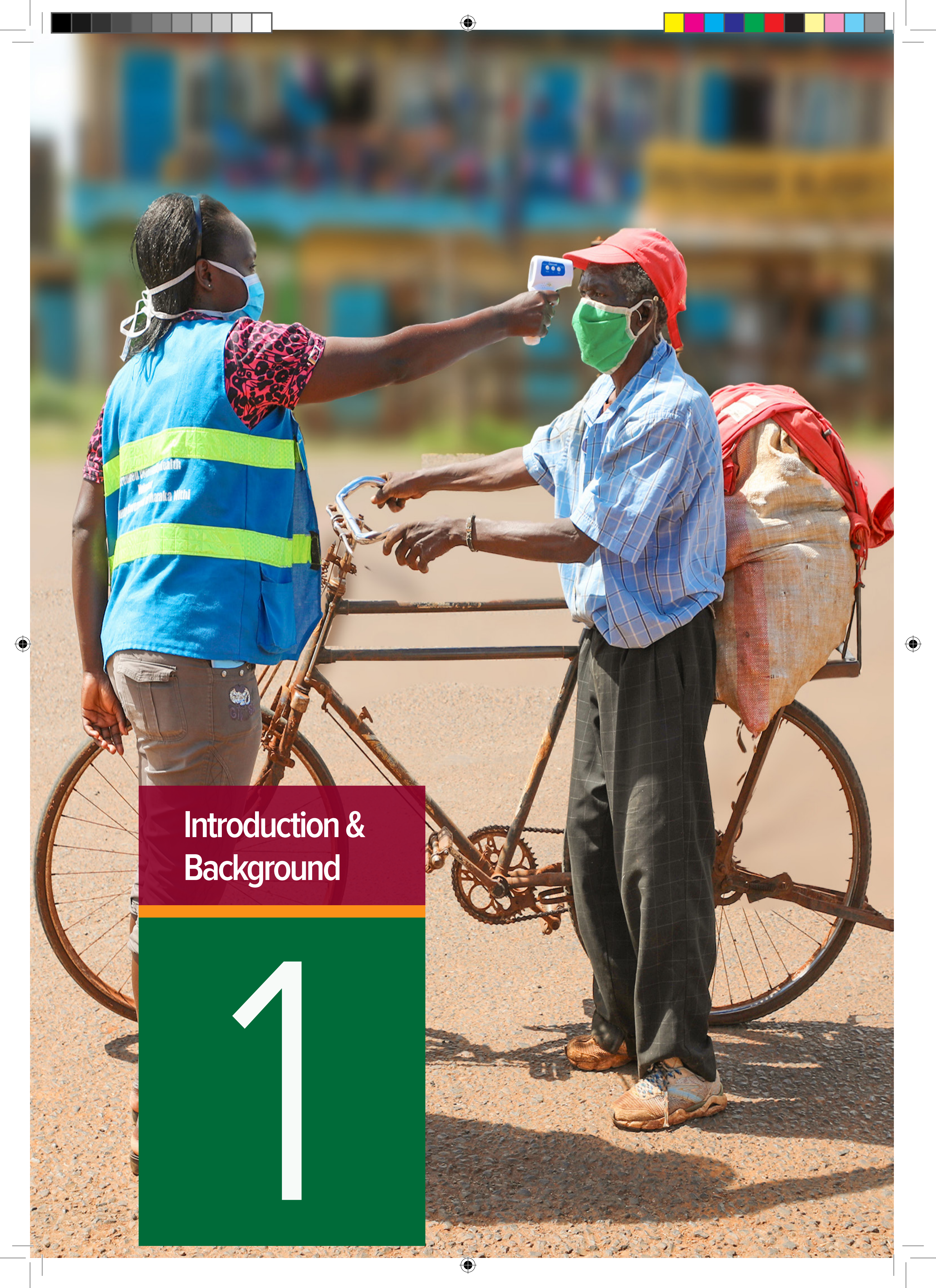
To comprehensively address these challenges, this strategy details out key interventions under each of the six strategic directions that are based on the World Health Organization health systems building blocks:

Strategic objective	Key Interventions
Strategic Direction 1: Strengthening leadership and governance for community health services	
1.1: Establish functional community health committees	1.1.2 Train the CHCs using the national manuals for CHCs
1.2 Strengthen the participation and engagement of CHCs with the community	1.2.1 Provide CHC members with identification badges
	1.2.2 Support CHCs to hold quarterly meetings
1.3 Strengthen performance monitoring mechanism for community health governance structures	1.3.1 Develop and operationalize an M&E structure for CHC performance
1.4 Strengthen and develop advocacy mechanisms for the prioritization and implementation of community health services	1.4.1 Establish advocacy forums for CHCs for partnerships, awareness creation and resource mobilization for community health services
Strategic Direction 2: Mobilize innovative and sustainable financing for community health	
2.1 Increase stakeholders' participation and coordination in the county community health financing plans and mission to reduce the funding gap	2.1.1 Establish a community health financing stakeholder coordination mechanism
	2.1.2 Develop a community health partnership framework to enhance partner alignment and engagement
2.2 Explore and scale up innovative financing and co-financing mechanisms	2.2.1 Support the establishment of viable income-generating activities within the CHUs

Strategic Direction 3: Build a motivated, skilled, and equitably distributed community health workforce	
3.1 Ensure optimal recruitment and deployment of community health workforce	3.1.1 Conduct a CHV mapping exercise
	3.1.2 Activate the pending 265 CHVs by training them on the basic modules and deploying them to the CHUs according to need
	3.1.3 Update all CHVs and CHC registers annually
	3.1.4 Replace inactive CHVs and CHCs and those that have left services on an annual basis
3.2 Ensure adequate training for both the new and the existing CHVs	3.2.1 Conduct annual training for both the new CHVs and refresher training for the old ones.
	3.2.2 Train the CHVs on technical modules to equip them with the knowledge to carry out their work
	3.2.3 Train CHAs and CHEWs to be trainer of trainers on both Basic and Technical modules
3.3 Strengthen the capacity of the community health supervisors on mentorship and supervision	3.3.1 Map out the distribution of CHEWs and CHAs to ensure total coverage of the whole county
	3.3.2 Facilitate mobility of CHAs by providing motorbikes
	3.3.3 Facilitate CHMT/SCHMT to conduct supervisory visits to CHVs at respective link facilities
3.4 Provide a harmonized and standardized framework for financial and nonfinancial remuneration and incentives for Community Health Volunteers	3.4.1 Design and implement a performance-based reimbursement mechanism for CHVs
	3.4.2 Facilitate the reimbursement of transport expenses to all the CHVs
	3.4.3 Facilitate the reimbursement of monthly stipends to all CHVs
Strategic Direction 4: Strengthen the delivery of integrated, comprehensive and high-quality community health services	
4.1 Increase coverage of community health services to households	4.1.1 Review the existing community health service package to include missing essential services and expand scope on existing essential health services package
	4.1.2 Design programmatic interventions that increase male involvement in RMNCAH services such as escort of wives to health facilities initiate Father2Father support groups, a priority of service for accompanied women
4.2 Increase demand and utilization of community health services	4.2.1 Intensify outreaches and community mobilization on the available services within their communities
	4.2.2 Engage church leaders in creating awareness and promoting community health service
	4.2.3 Involving the chief and community gatekeepers to access the hard-to-reach communities e.g., the Kavonokia people in the Tharaka zone
4.3 Expand community-based surveillance (CBS) to all sub counties in the county	4.3.1 Disseminate community-based surveillance (CBS) guidelines and integrate them into the national disease surveillance system for all the sub-counties
4.4 Reinforce referral and community health linkages at the Hospital level	4.4.1 Strengthen existing and other innovative referral mechanisms from the community to the primary health care facilities and back to the community
	4.4.2 Build capacity of community health workforce on effective linkages and coordination of community health services

Strategic Direction 5: Increase availability, quality, demand, and utilization of data for community health	
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
	5.1.2 Equip all the CHVs with smartphones for data collection
	5.1.3 Conduct training for the community health workforce on digital CHIS
Strategic Direction 6: Ensure availability of commodities and supplies for community health	
6.1 Ensure commodity security, quality, and safety of community health supplies	6.1.1 Procurement and distribution of kits to CHVs
	6.1.2 Train community health workforce on commodity management using the national curriculum
	6.1.3 Provision of medicines and supplies to all CHVs

As the county works towards achieving UHC and contributing towards the Big Four Agenda and the Kenya Vision 2030, this strategy provides the blueprint for the Tharaka Nithi County Government and its partners to guide the implementation of these critical community health services.


Introduction &
Background
1

Introduction and Background

1.1 County Profile

Tharaka-Nithi County is one of the 47 counties in Kenya. It borders the counties of Embu to the South and Southwest, Meru to the North and Northeast and Kitui to the East and Southeast. The county is located in latitude 000 07' and 000 26' South and longitudes 370 19' and 370 46' East and covers a land area of approximately 2,662 km2 (Figure 1). The county, which is headquartered at Kathwana is divided into six administrative sub-counties: Tharaka-North, Tharaka-South, Chuka, Igambang'ombe, Muthambi and Mwimbi (Figure 2).

Figure 1: Map of Kenya.
(Source: Tharaka Nithi county integrated development plan 2018-2022)

Figure 2: Administrative map of Tharaka Nithi County.
(Source: Tharaka Nithi county integrated development plan 2018-2022)

1.2. Population and demographics Trends

In the 2019, the population of Tharaka Nithi County was estimated at 393,177 persons residing in 109,860 households with 51% being female and 49% males. The distribution of the population by sub-counties is shown in Table 1.

Table 1: Tharaka Nithi population disaggregated by sub-county

Sub-county	Male	Female	Intersex	Total
Igambangombe	26,464	26,745	1	53,210
Maara (Mwimbi and Muthambi)	57,689	57,205		114,894
(Chuka)	44,923	46,155	2	91,080
Tharaka North	28,290	30,053	2	58,345
Tharaka South	36,190	39,058	2	75,250
Mount Kenya Forest*	208	190		398
Total population	193,764	199,406	7	393,177
Percent	49%	51%	0%	100%

Not included in the total number of sub-counties. This location is instead a protected area of the county

(Source: Kenya Population and Housing Census 2019 Volume 1)

Table 2: Tharaka Nithi County Demographic profile.

Description	Estimated proportion (%)	Estimated population 2018	Estimated population 2019
Total population		381,775	393,177
Total number of households		107,378	109,595
Children under one year (12 months)	2.68%	102,232	10,537
Children under-five years (0–59 months)	13%	49,631	51,113
Children under 15 years	38%	145,075	149,407
Women of child-bearing age (15–49 years)	25%	95,444	98,294
Total number of adolescents (15–24)	21%	80,173	82,567
Total number of adults (25–49 years)	35%	133,621	137,612
Total number of elderly (60+ years)	8%	30,542	31,454

(Source: Kenya Population and Housing Census 2019 Volume 1)

1.3 Epidemiological profile

1.3.1 Key Health Indicators

Tharaka Nithi County has an average life expectancy at birth of 54 years for male and 57 years for female, with an annual crude death rate of 8 deaths per 1000 persons. The county's maternal mortality rate is almost half the national average (191 vs 342 per 100,000 live births). All child health indicators (neonatal mortality rate, infant mortality rate and under-five mortality rates) in the county are higher than the national average (Figure 3).

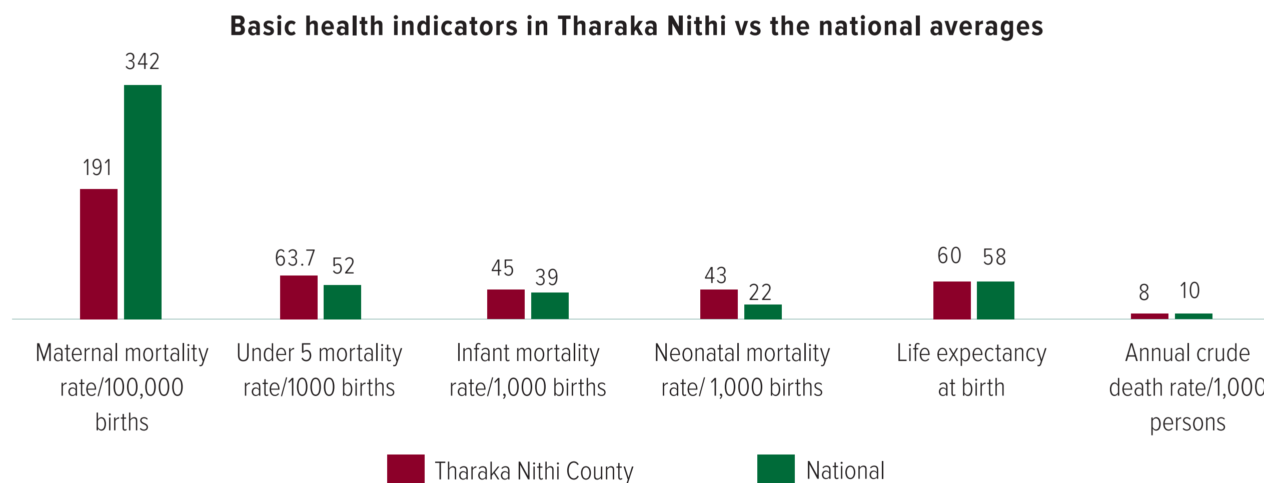


Figure 3: Basic health indicators
(Source: Kenya Demographic Health Survey, 2014)

1.3.2 Disease Burden

The county faces a double burden of communicable and non-communicable diseases. Communicable diseases contribute to the largest disease burden in the county with upper respiratory tract infections, skin diseases and intestinal worms persistently being the leading causes of the county's disease burden. The burden of non-communicable diseases has also recently been on the rise with hypertension and arthritis majorly contributing to the NCDs - associated disease burden. Notably, all the leading causes of morbidity in the county are preventable; highlighting the crucial role of community health in reducing this burden. Figure 4 highlights the top ten causes of disease burden among the over five years population in the county in the last three years.

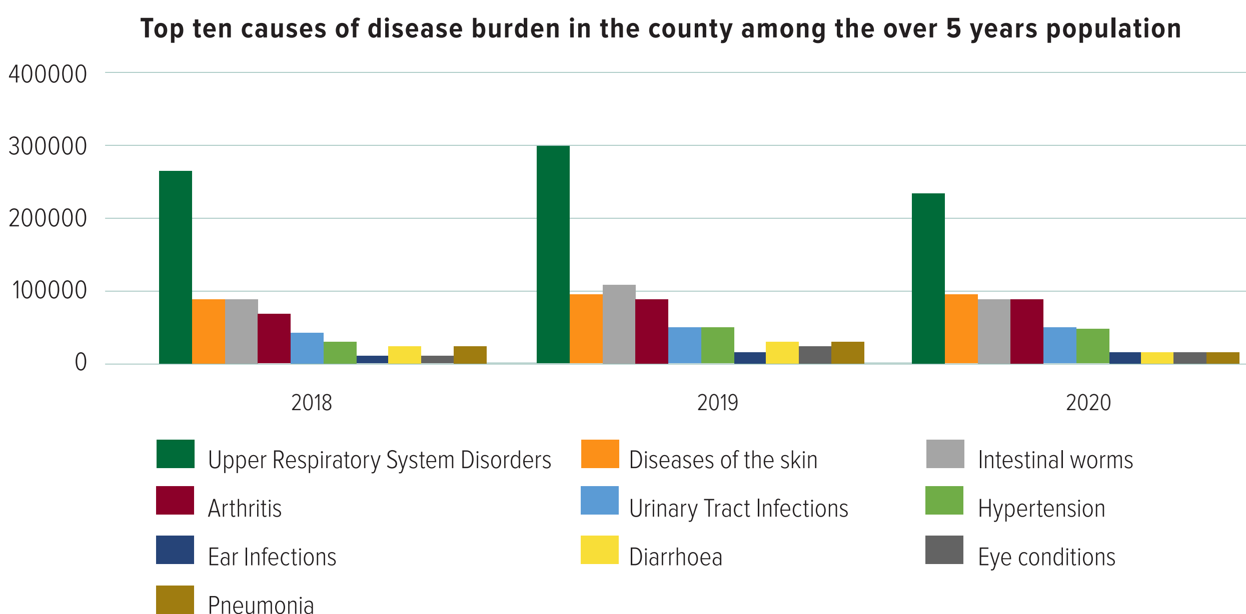


Figure 4: Over 5 years population top ten causes of disease burden
(Source: Annual Work Plans 2018/19,2019/20 & 2020/21)

The leading causes of disease burden among the under five years are diseases of the respiratory system, skin diseases, intestinal worms, other respiratory diseases, pneumonia, and diarrhoea as shown in Figure 5. With a strong community health system and improved preventive, promotive, community awareness and prompt referrals, all these diseases are preventable.

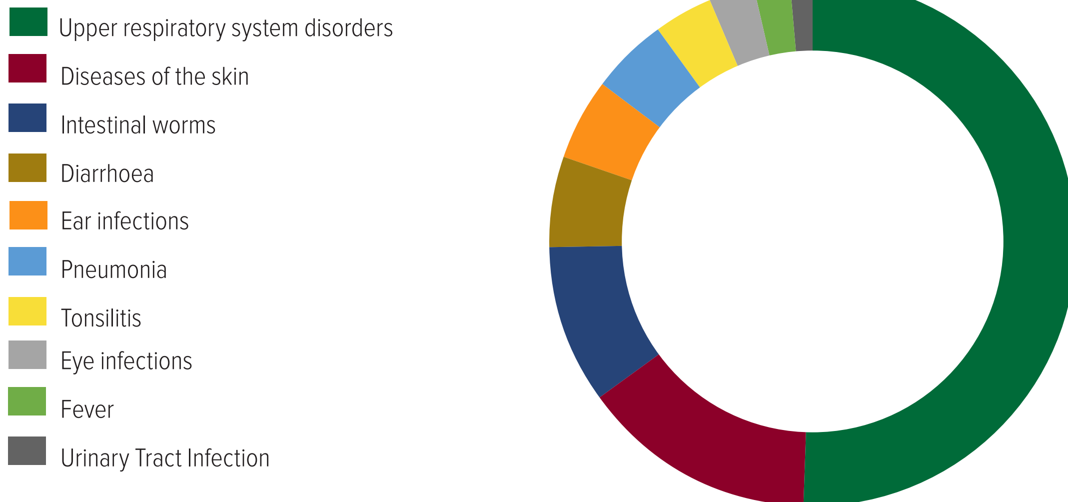


Figure 5: Under 5 years population top ten causes of disease burden
(Source: DHIS2, 2021)

Economic Outlook and Development

Tharaka Nithi County accounted for 0.9% of the national gross domestic product (GDP) in 2017[1]. The agricultural sector—tea and coffee planting, subsistence crop farming, subsistence dairy farming and livestock keeping—contributes about 57% to the gross county product. In 2015/16, the overall poverty rate of the county was 24% with 1.8% of the county's population living in extreme poverty compared to the national rates of 36.1% and 8.6%, respectively[1].

Tharaka Nithi County, through the County Integrated Development Plan, has aligned its development priorities with Kenya's socioeconomic blueprints such as the Vision 2030 and Big Four Agenda and global goals such as the Sustainable Development Goals to progressively improve the living standards of its people. The county aims to achieve an average GDP growth rate of 1% per annum over the next 10 years,[2] and sustain the same till 2030 to generate more resources to reinvigorate the economy and meet its goals and aspirations.

1.4 Legal, Political Context and Policy Landscape

The development of the Tharaka Nithi County Community Health Strategy is underpinned by global, regional, and national policies and strategies. The policy context is summarised in a chronological manner as shown in the diagram below:

Figure 6: Summary of the Community Health Policy Context

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

National Community health legislation:

- Kenyan Constitution 2010
- Kenya Community Health Policy 2020-2030
- Kenya Community Health Strategy 2020/25
- Kenya Primary Health Care Strategic Framework 2019/24
- Kenya's Vision 2030

[1] *Kenya National Bureau of Statistics, 2018*
[2] *The Astana Declaration on Primary Health Care, 2018*

1.4.1. Global Policy Context Supporting the Development of Community Health

There are key policy documents and frameworks globally that provide directions towards the delivery of community health services:

1.4.1.1 Astana Declaration[3]:

The declaration reaffirms the commitments expressed in the ambitious and visionary Declaration of Alma-Ata of 1978 and the 2030 Agenda for Sustainable Development. It highlights the importance of primary health care to achieving just and accessible health care for all. It emphasizes empowering communities to be part of the solution and a part of primary care systems, a key tenet of community health. The operational framework for implementing the foundations of the Astana Declaration focuses heavily on community health workers, their part in primary health care, and connecting them to facility-based teams in an integrated system. Kenya is a signatory to Astana Declaration.

1.4.1.2 WHO Policy Guidelines for Community Health Workers[4]:

These are evidence-based guidelines to identify effective policy options to strengthen community health worker (CHW) programme performance through their proper integration in health systems and communities. Being primarily focused on CHWs, the goal of the guidelines is to assist national governments and international partners to improve the design, implementation, performance, and evaluation of CHW programmes, contributing to the progressive realization of universal health coverage. It contains pragmatic recommendations on selection, training, and certification; management and supervision: and integration into health systems and community engagement.

1.4.2 Regional Regulations and Policies

1.4.2.1 The Africa Health Strategy 2016–2030

The Africa Health Strategy seeks to ensure “a high standard of living, quality of life and well-being for all citizens”. The Africa Health Strategy 2016–2030[6], a part of the African Union agenda, sets as a strategic objective to achieve universal health coverage by fulfilling existing global and continental commitments including the strengthening of health systems and improving social determinants of health in Africa by 2030. One of the strategy’s objectives is improving governance, accountability, and stewardship of the health sector through strengthening community health systems; information systems, decentralizing service delivery with a focus on integrated comprehensive primary health care and efficient use of resources.

1.4.3 Kenya’s National Community Health Legislation

1.4.3.1 The Constitution of Kenya

The Constitution of Kenya (2010)[7] under Article 43 (1) (a) entitles every person the right to the highest attainable standards of health, which includes the right to health care services, including reproductive health care. Further, Article 43 (2) states that a person shall not be denied emergency medical treatment while 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 shall put in place affirmative action programmes designed 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 and to further their development and protect and promote 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.

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

[5] *Africa Union Commission. “Agenda 2063 – The Africa We Want.” (2017).*

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

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

1.4.3.2 Kenya Primary Health Care Strategic Framework 2019–2025

The Kenya Primary Health Care Strategic Framework 2019–2024[8], which is anchored on the Kenyan Constitution, Vision 2030, Kenya Health Policy 2020-2030, and Universal Health Coverage outlines the implementation pathway and management of primary health services in the country. The framework aims to allow greater participation of the communities in the running of health care services, the decisions on their priority health issues, getting involved in the implementation of essential clinical and public health packages.

It gives prominence to community-based primary health care by highlighting the need to maintain the functionality of community health units, support the supervision of CHVs, and scale-up sustainable innovative community health and income-generating activities to compensate the community health workforce.

1.4.3.3 Kenya Community Health Policy 2020–2030 and Kenya Essential Package of Health

The Kenya community health policy 2020–2030[9] seeks to streamline the implementation of community health services by strengthening 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.

1.4.3.4 Kenya Community Health Strategy 2020–2025

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. It provides a framework for all stakeholders to implement community health services in a standardized manner[10] and guide national and county governments, and development and implementing partners in strengthening and scaling up community health services.

1.4.3.5 Kenya Health Sector Strategic Investment Plan 2014–2018 (KHSSP)

The KHSSP[11] identifies the following priorities in community health:

1. Revitalize community health services by guiding counties on how to establish and maintain community health units
2. Revitalize the Community Health Strategy by providing guidelines to the County Department of Health on how to realize its implementation concerning the remuneration of CHVs
3. Support by community health to specific objectives on the non-communicable diseases in the KHSSP including interventions related to violence and injuries

The Kenya Essential Package of Health, which is part of the National Health Sector Strategic Plan II is a comprehensive essential package that defines services and interventions to be delivered at each level.

1.4.3.6 Universal Health Coverage

Kenya has prioritised achieving universal health coverage by 2030[12] through the renewed political prioritisation in the "Big Four Agenda" and increased investment in health.

The community health system in Kenya has benefited from this increased political will to improve healthcare delivery at the community level. The Ministry of Health (MoH), in keeping with global and regional best practices, has prioritized primary healthcare and community health as critical drivers of UHC, as highlighted in the Kenya Primary Healthcare Strategic Framework (2019–2024) and the Kenya Community Health Policy (2020–2030).

[8] *Kenya Primary Health Care Strategic Framework, 2019–2024*

[9] *Kenya Community Health Policy, 2020–2030*

[10] *Kenya community health strategy 2020–2025*

[11] *Kenya health sector strategic investment plan 2014–2018*

[12] *Kenya's vision 2030*

1.4.4 County-level Policies

1.4.4.1 Health Act 2017

The Tharaka Nithi County Health Act of 2017 identifies community health as an essential component of the county health system. The act prescribes the function of the community health services, which includes to:

1. Facilitate individuals, households, and communities to carry out appropriate healthy behaviours
2. Recognize signs and symptoms requiring referral services
3. Provide the agreed-upon health services
4. Facilitate community diagnosis, management, and referral

1.4.4.2 County Integrated Development Plan

Tharaka Nithi county seeks to be "a prosperous, industrialized and cohesive county achieved through the mission whereby the county will enhance sustainable socio-economic growth and optimal utilization of resources." Every five years, the county develops the County Integrated Development Plan (CIDP)[13], which is the principal strategic planning instrument guiding and informing all planning, budgeting, management, and decision-making processes in a county.

The CIDP has linkages with various county pursued development plans and agendas in the global, regional, and local contexts. These include the county 10-year sectoral plan incorporated in the five-year second-generation CIDP and broader plans such as Kenya Vision 2030 five-year Medium Term Plans, SDGs and Africa Agenda 2063. On health, the CIDP is aligned to SDG 3 and seeks to "ensure healthy lives and promote well-being for all at all ages". The county plans to reduce maternal and neonatal mortality, achieve universal health coverage, including financial risk protection and increase access to quality essential healthcare services. It also plans to continue to substantially increase health financing and the recruitment, development, training, and retention of the health workforce including the community health workforce. The CIDP also highlights a need for a strategy to create community health units as part of improving community health services.

1.5 Community Health System in Tharaka Nithi County

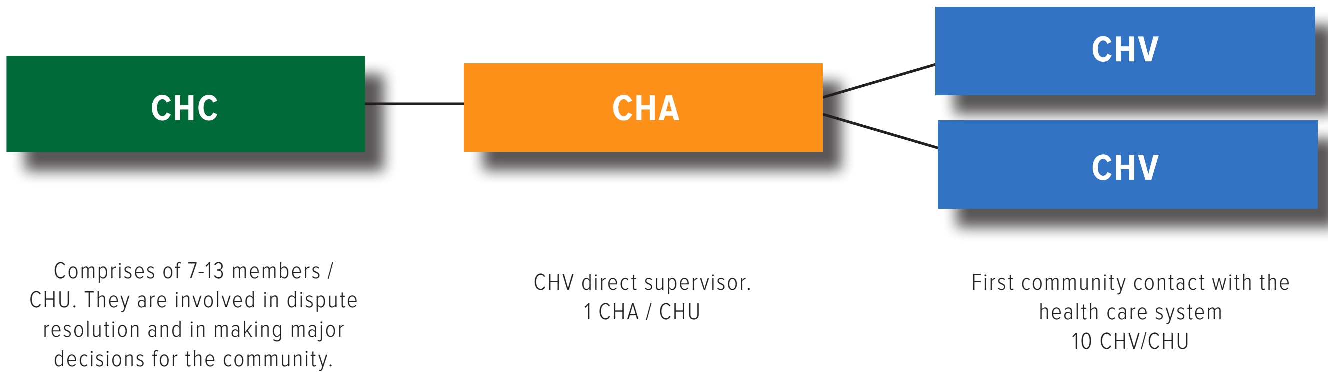
The community health programme in Tharaka Nithi county began in 2007 with six community health units and 300 CHVs. The program has steadily grown over the years through the focused improvements to the program and a strong and dedicated county leadership. In 2020, the county had 100 community health units with 1000 active CHVs offering community health services.

Table 3: County distribution of Community Health Units and Community Health Volunteers

Sub-county	Number of active CHUs	Number of inactive CHUs	Number of active CHVs	Number of inactive CHVs
Mwimbi	20	4	200	40
Muthambi	9	4	90	35
Chuka	19	5	190	50
Igamba Ng'ombe	14	5	140	50
Tharaka South	23	4	230	40
Tharaka North	15	5	150	50
Total	**100**	**27**	**1000**	**265**

[13] *Tharaka Nithi county integrated development plan 2018-2022*

The community health programme is composed of community health units (CHUs) that are governed by a community health committee (CHC) and supervised by a community health assistant (CHA) or a community health extension worker (CHEW) (Figure 7). The CHEWs and CHAs are government officers who are either nurses, public health officers or any other health professionals whose work mainly is to offer technical assistance to CHVs. Besides supervising the CHVs, the CHAs/CHEWs performed other roles in the community and at the link health facility. Each CHU is linked to a health facility to facilitate referrals, feedback, and continuous learning. The CHU are made up of 10 CHVs who are selected by the community members in a public "baraza" as per the set selection criteria. CHVs are distributed based on the population and household coverage with each CHVs serving approximately 100 households or about 500 persons.



Comprises of 7-13 members / CHU. They are involved in dispute resolution and in making major decisions for the community.

CHV direct supervisor.
1 CHA / CHU

First community contact with the health care system
10 CHV/CHU

Figure 7: Tharaka Nithi Community Health System structure

1.6. Health financing for community health

The estimated County Government General Health Expenditure (CGGHE) as a percentage of the total county government expenditure in 2020/2021 was 35.3% (KES 2.41 billion). As shown in Figure 8, the county allocated 8% of the CGGHE to preventive and promotive health services.

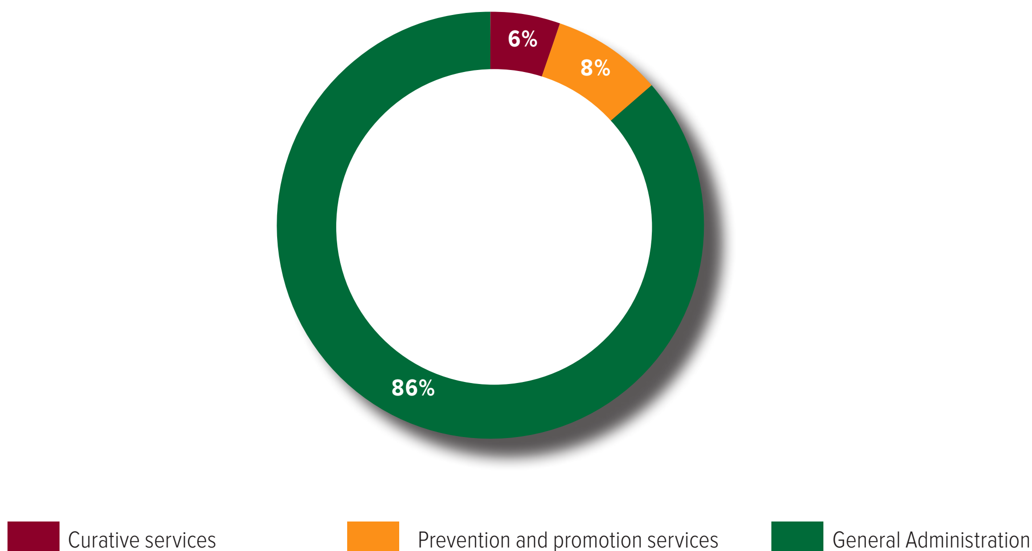


Figure 8: Distribution of County Government General Health Expenditure
(Source: County program-based budget 2020/2021)

[14] *Tharaka Nithi county program-based budget 2020/2021*

Community health services are offered under preventive and promotive services. Between financial year (FY) 2018/19 and FY 2020/21, the budget for preventive and promotive health services declined steadily from 15.4% to 8.4% though the community health budget significantly increased from 3.2% to 33.4% over the same period (Figure 9).

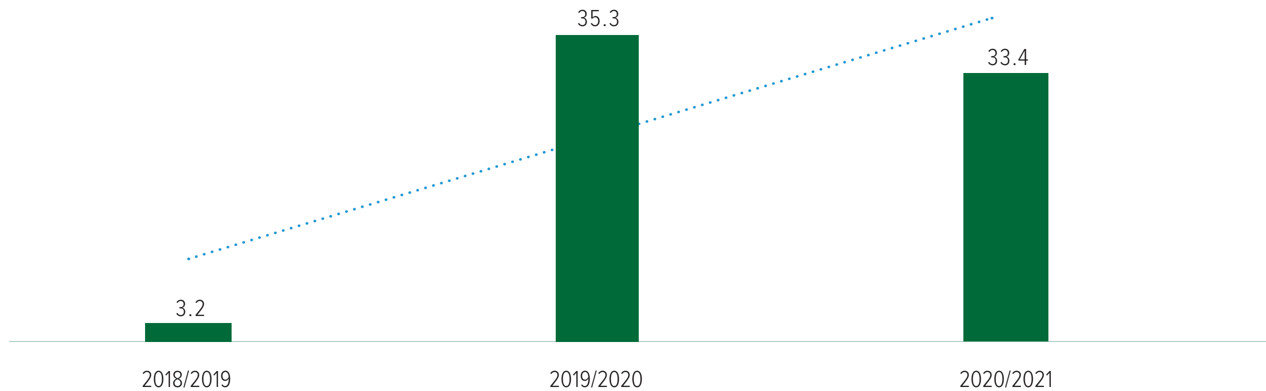


Figure 9: Community health services budget as a percentage of preventive services budget
(Source: Annual work plans 2018/19, 2019/20 and 2020/21)

Additionally, further breakdown of the FY 2020/21 community health budget into spending categories shows that more than half of the budget was spent on CHVs stipends with 31.5% being spent on training and supervision.

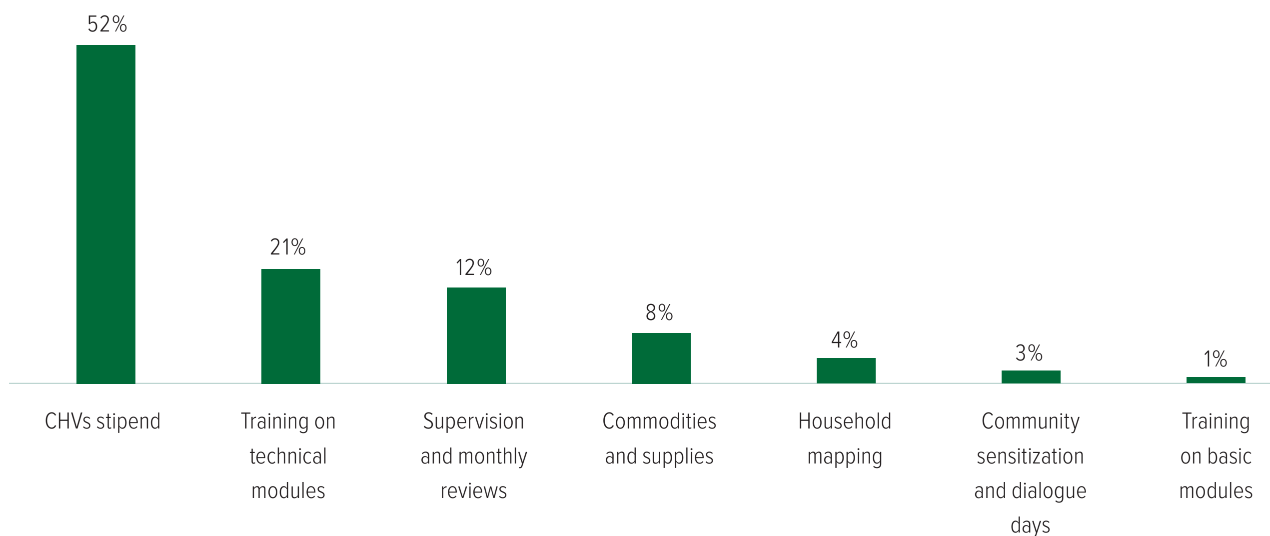


Figure 10: Community Health budget allocations FY 2021/2022
(Source: Annual work plans 2021/2022)

Situational Analysis

2

Tharaka Nithi Community Health Situational Analysis

2.1 Introduction

The situational analysis was performed through a consultative process and in-depth review of literature. A two-day stakeholders' forum was also conducted to deepen the understanding of the county's community health status and propose possible solutions to identified problems based on the WHO health system building blocks about community health. Global cases were also leveraged based on international best practices to demonstrate how other countries are doing and what the county could borrow to improve their CHS. Focused group discussions with the CHVs and CHAs were also conducted to get first-hand perspectives from the CHWs on the ground. Finally, focus group discussions were conducted to delve into specific health systems building blocks and identify possible interventions to the identified challenges.

2.2 Situation Assessment of Community Health

The assessment revealed that the community health program in Tharaka Nithi county has achieved tremendous growth since its inception. Currently, the county has 100 active Community Health Units (CHUs) with 1000 active CHVs and 27 inactive CHUs with 265 inactive CHVs covering more than 90% of the households in the county. Community health service delivery is well integrated with the larger county health care system enhancing provision of seamless health services to the population resulting in the county being ranked among the best nationally. The county health system has also benefitted from the strong and committed county leadership focused on developing primary health care.

Despite the great progress in the Tharaka Nithi community health program, many challenges have persistently hindered the optimal performance of the program including inadequate provision of CHV equipment and supplies and insufficient training. These challenges limit the number and quality of services offered by the CHVs and their overall performance and efficiency as evidenced by the sub-optimal health indicators such as the increasing prevalence of non-communicable diseases, low immunization coverage and low proportion of women attending the recommended four antenatal clinic visits.

The paragraphs below summarize key challenges under each health system building block.

2.2.1 Community Health Leadership and Governance

Strong leadership, institutional support and coordination underpin a well-functioning community health system – and will determine the success of the implementation of the Tharaka Nithi Community Health Strategy. Through consultations, stakeholders highlighted various challenges in this thematic area:

1. **Low motivation and insufficient engagement of the community health committee members in the community health programmes:** The community health committee members often felt excluded during the implementation of community health services. The CHCs members do not benefit from the monthly stipend or participate in all community health activities except the monthly feedback meetings. There is no performance management and adequate reward structure in place to motivate their performance.

2. **Sub-optimal functionality of the community health units.** An assessment of the functionality of the CHUs in Tharaka Nithi County, based on literature review, DHIS2 and interviews with the community health focal person, was performed using the 17 measures of the AIM tool. Percentages were computed based on the total score and classified as non-functional (<49%), semi-functional (50–79%) and functional (>80%). CHUs in Tharaka Nithi County were rated as semi-functional with a score of 58% (Table 4).

Table 4: Tharaka Nithi County Community Health Unit Functionality tool

Indicator	Status in Tharaka Nithi County	Score (0 or 1)	Comments
Existence of trained Community Health Committee (CHC) that meets at least quarterly	All CHC are trained however they do not meet quarterly	0	Due to inadequate resources to support the meetings, the CHCs currently do not the meetings
Trained community health volunteers (CHVs) and community health assistants (CHAs) that meet prescribed guideline	The CHVs, CHEWs and CHAs meet monthly as required	1	The meetings happen at the link facility level. All 100 community health units (CHUs) have link facilities
	All the 1000 CHVs have been trained on the basic modules		All the 1000 CHVs have been trained on basic modules but are yet to be trained on technical modules
	All the 34 CHAs have not been trained on the basic modules		All the CHAs are yet to be trained on technical modules.
Coordination by county community health leadership	It is well done.	1	
Supportive supervision for all community health personnel done at least quarterly	The sub-county health management team ensures that this is done	1	
All CHVs and CHAs have reporting and referral tools	All trained CHVs should have tools		
	MOH 513	1	
	MOH 514	1	
	MOH 100	0	
	All trained CHAS have MOH 515	0	
	All CHU should have MOH 516	0	
All CHVs make household visits as per their targets and at least to each household once per quarter	The CHVs have in the last year achieved at least 80% of their household targets.	1	
Availability and use of a mechanism for feedback local tracking and dialogue	There exists no clearly outlined mechanism of feedback	0	CHVs and CHC to provide feedback and track down all agreed indicators
Presence of functional health information system structure per guideline	Community health uses the DHIS 2 to report on the key indicators such as four antenatal care visits	1	
Availability of community health supplies and commodities as defined by prescribed guideline	All CHVs in a unit should have selected content of CHV kit based on local epidemiology	0	The county has not purchased kits for the CHVs. This limits the number of services offered but plans exist to purchase the kits and train the CHVs on technical modules.

CHUs registered in Master CHU List and linked to a health facility	All CHVs meet every month to submit reports (MoH 514) and minutes filed	1	The meetings occur at the link facility level at the beginning of every month
CHUs conduct meetings at least quarterly for dialogue days and monthly for health action days/ review meetings as well as household registration exercises at least once every six months	Quarterly community dialogue days that are data-informed	1	Occurs in every sub-county quarterly
	Monthly data review meetings	1	Occurs every month at the link facility level
	CHU with sustainable income generating activities (IGAs) and registered as community-based organisation as evidenced by a registration certificate	0	Only 2 CHUs have IGAs
Total Score		**10/17**	
Percentage Score		**58%**	

3. **Conflicting roles between the CHAs and the CHEWs.** Tharaka Nithi county has been working with CHEWs as the direct supervisors to the CHVs until recently when the national government employed CHAs under the universal health coverage program to support the supervision work in community health. The employed CHAs, however, have no adequate community health training, are not sufficient to serve all the CHUs and their roles definitions is not clear.

4. **Insufficient advocacy of community health from the county government.** Currently, there is limited advocacy with the political and administrative structures of the county government for adequate budget allocation and recognition of community health.

2.2.2 Community Health Financing

Inadequate funding has been a major challenge to the achievement of community health goals in the Kenya including in Tharaka Nithi county where the key community health financing issues are:

1. **Inadequate financing for community health.** About 33% of the county's promotive health service budget for FY 2020/21 was allocated to community health, which is very commendable. However, more than half of these budget is spent on CHVs stipends, at a rate of KES 3,000 per month consistently, which is more compared to KES 2000 in some counties and none in most counties. Hence, other critical components such as training, CHV kits and supervision are left with insufficient resources resulting in sub-optimal quality of service delivery.

2. **Limited engagement of key actors (i.e., private sector partners) outside of the county government.** To bridge the financing gap in community health, the county needs to exploit other avenues beyond the domestic funding such as the private sectors who could support community health through their corporate social responsibility.

3. **Inadequate donor coordination** leads to resource skewness in some parts of the county e.g., the Tharaka zone, while others are left without resources and support.

2.2.3 Community Health Workforce

Human resources are the driving force for the healthcare system. Tharaka Nithi community health is currently being served by 1,265 CHVs in 127 community health units and supervised by 35 CHAs and 153 CHEWs. The community health workforce is yet to be fully optimised due to:

1. **Inadequate skills and training for both the CHVs and the CHAs.** The CHVs work without technical training hindering optimal productivity. The CHAs as well lack the required training on community health management and supervision to be able to guide the CHVs.

2. **Inadequate selection criteria for the CHVs.** Provision of community health services is based on volunteerism. Therefore, selection of the desired persons from the community is difficult as there are expected to be acceptable to the community and willing to offer services to the community with little or no compensation. Consequently, most CHVs are above 50 years and efforts to recruit younger CHVs have resulted in remarkably high attrition rates due to relocation in search of jobs, inadequate stipend to motivate them and marriage. Additionally, the undefined qualifications criteria for selecting CHVs pose a challenge during training because of low literacy levels resulting in unprofessionalism, cases of misconduct, lack of decorum and breach of confidentiality.

3. **Inadequate numbers of the community health workforce.** Of the required 127 CHAs and 254 CHEWs, the county has 35 CHAs and 153 CHEWs (Table 6). The shortage of CHAs and CHEWs has limited supportive supervision and on-job training for CHVs. In addition, the county has an inadequate number of CHVs resulting in inefficiencies and lack of community health service coverage in some areas. Besides, the county has a CHVs attrition rate of 6.5% per annum and the replacement takes exceptionally long resulting in increased workload for the remaining staff.

Table 5 highlights the existing gap in the community health workforce based on the current national and county staffing guidelines.

Table 5: Community health workforce staffing gaps

Cadre	CHVs	CHAs	CHEWs
Current number	1,265	35	153
Population	393,177	1,265	1,265
County ratio	1 CHV: 396 persons	1 CHA: 10 CHVs	2 CHEWs/CHU
Required numbers	993	127	254
Gap/surplus	272 surpluses	92 gaps	101
National recommendation	1 CHV: 200 persons	1 CHA/CHU	2 CHEWs/CHU
Required numbers	1965	127	254
Gap	700	92	101

4. **Low motivation of the community health workers.** The county does not have a career progression plan for the CHVs as well as a clear performance reward system to motivate the CHVs. Besides, in cases where incentives such as airtime and allowances are available, they are usually inadequate and random.

2.2.4 Community Health Service Delivery

Community health services—level 1—provides promotive, preventive, and rehabilitative health care services including treatment of minor ailments and referrals. However, the delivery of the community health services is hampered by:

1. **Inadequate training.** For optimal performance, all community health workers require complete and comprehensive training on both the national community health training curriculum basic modules 1–6 and technical modules 7–13. The situational analysis established that:
   - All CHVs have been trained on basic modules but none has been trained on the technical modules, limiting the number of services they can provide. Importantly, the prevalence of non-communicable disease is on the rise in the county necessitating a need to expand the scope of community health services.
   - All the 35 CHAs have not been trained on community health and a majority of them lack the community health qualification hence a need for training to equip them with the requisite knowledge and skills to effectively manage community health services.
   - There are inadequate refresher trainings for CHVs and CHAs to update their knowledge on the essential health service package and equip them with knowledge and skills on new and emerging diseases.
   - Training is still verticalized and fragmented. Both the county and its development partners conduct training, mentorship, and coaching sessions for CHVs and CHAs in uncoordinated manner for a few CHVs or CHUs resulting in varying levels of training among community health workforce.
   - Service delivery is hampered by cultural and religious beliefs in the community especially in the Tharaka zone, which hosts the "Kavonokia" religion that does not believe in medical intervention.
   - Service delivery is delayed in some parts of the county e.g., the Tharaka zone due to its vastness. CHVs in these areas walk long distances to provide services to the households; sometimes incurring significant expenses.
2. **Inadequate service package and CHV kits.** Currently, the community health service package offers reproductive, maternal, new-born, and child health services, immunization, tuberculosis and HIV defaulter tracing, and health education and promotion e.g., on healthy lifestyles and nutrition, hygiene, and sanitation. These services are, however, short of the recommended service package for community health, which also includes services such as:
   - Basis lifesaving skills such as first aid, infant temperature measurement and referral and tetracycline ointment
   - Screening for non-communicable diseases such as diabetes, hypertension, and mental health
   - Linkage of the orphans and vulnerable children and the people living with disabilities to the social department
   - Home-based care for terminally ill patients

   These deficiencies can be attributed to inadequate training on technical modules and inadequate resources to provide a comprehensive CHV kit.
3. **Sub-optimal supportive supervision for the CHVs.** Currently, due to the inadequate number of CHAs, the CHVs offer services in the community without any supervision. The CHEWs also, have many roles at the health facilities hence limited time to supervise the CHVs in the field. Lack of supervision has sometimes resulted in cases of unprofessionalism and misinformation e.g., a CHV was reported to have recommended the use of paraffin to treat food poisoning.
4. **Limited community-based surveillance (CBS).** One of the critical roles of CHVs is CBS especially with an increase in the number of emerging infectious diseases. Currently, only CHVs in two sub-counties have been trained on CBS with the reporting of data being mainly partner-led. There is a great need to ensure CBS in all the sub-counties and better linkages of the data with the county surveillance system for decision making.
5. **Insufficient referral facilities.** The county has over time seen a rise in mental health and drug abuses cases but lacks the required facilities for referral of such cases. Therefore, the CHVs do not know where to refer such patients leaving them to continue suffering in the community.

2.2.5 Community Health Information Systems and Data

Health data is the basis for decision making in the healthcare system. Accurate, timely and reliable data is required for adequate planning. The CHVs have designated reporting tools: MoH 100, 513, 514, 515 and 516 which are used for collecting data monthly. However, the county has difficulties acquiring accurate and reliable data due to:

1. **Inadequate data tools.** The key issues identified include:
    - Stock outs of the MoH 514 resulting in short-term solutions such as photocopying of the tools, which sometimes lead to misreporting because of faint writing and loss or damage to the photocopied tools.
    - Use of single sheets plucked from the bulky reporting tools, which are easily lost or destroyed leading to loss of data.
    - Frequent stock outs of the MoH 100 for referral hinder the optimal performance of the CHVs. Most patients are thus referred to the hospital just by word of mouth with the referral ultimately not being recorded.
    - Compromised quality of data due to limited knowledge on definition of indicator being tracked
2. **Suboptimal adoption of technology for use in data reporting.** Currently, only 250 CHVs out of 1265 CHVs use smartphones for data collection. However, the smartphones are not linked to the District Health Information System and the collected data is only useful to development partners supporting the initiative to equip CHVs with smartphones.

2.2.6 Community Health Supply Chain Management

Community health commodities and supplies are key enabling factors for community health service delivery. However, the county faces the following supply chain management challenges:

1. **Stockouts of drugs and commodities.** The county frequently experiences stock outs of long-lasting family planning methods particularly intrauterine contraceptive devices and implants. Importantly, despite budgeting for CHV kits, insufficient funds are allocated resulting to CHVs lacking kits to facilitate their work.
2. **Training on supply chain management.** The community health workforce has not been trained on community health supply chain and commodities management. The national logistics management information system is also not decentralized and may not meet the community health supply chain needs.

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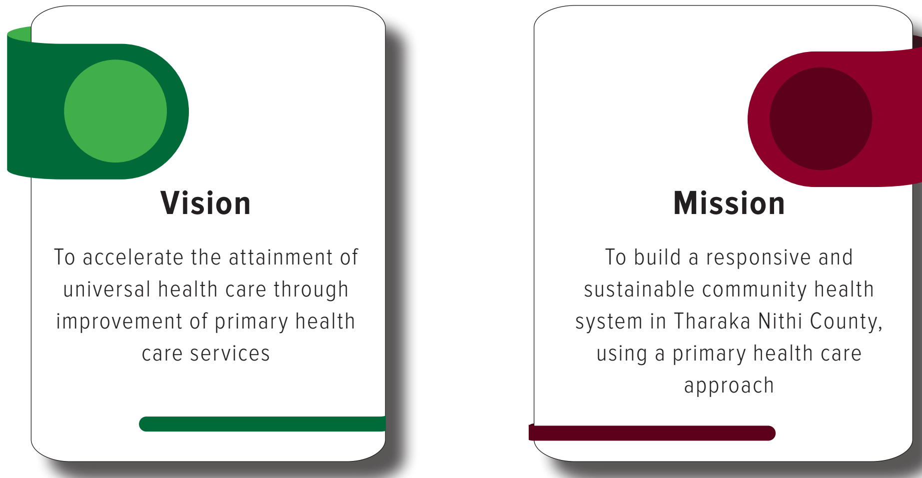
Tharaka Nithi
Community Health
Strategy
3

Tharaka Nithi Community Health Strategy

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

3.1 Vision, Mission and Goals



Goals of the Community Health Programme

The Government of Tharaka Nithi County has taken steps towards institutionalization of the community health program to attain the following goals;

i. Accelerate attainment of universal health coverage.

ii. Strengthen primary health care to reduce the disease burden in the county.

The community health program seeks to meet these four key objectives:

1. Improve access to primary health care services
2. Eliminate communicable diseases through immunization, defaulter tracing, good hygiene practices, and prevention of mother to child transmission
3. Stop and reverse the rise of non-communicable diseases through health education and promoting healthy lifestyles
4. Minimize the exposure to health risk factors through promotion and education on drugs and substance abuse, sexual education, gender-based violence and injuries, among others

3.2 Community Health Strategic Directions and Strategic Objectives

The county identified six strategic directions based on the detailed situational analysis, global lessons learnt and consultative discussions with the key stakeholders to guide the implementation of the community health strategy 2021–2025. The strategic directions include:

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

The chronological flow will be as follows:

Figure 11: The chronological flow of the strategy development

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

Strong leadership, coordination, support, and commitment is the backbone of a well-functioning community health system. This strategic direction focuses on the strengthening of the existing CHCs, to ensure effective management and implementation of community health services.

Strategic Objective 1.1. Strengthen the functionality of the community health units

Key Interventions:

1.1.1. Train the CHCs using the national manuals for CHCs. The CHMT and the SCHMT shall support the CHAs in training the CHC members using the national curriculum on:

- **1.1.1.1.** Applying leadership in the community health context
- **1.1.1.2.** Governance in the context of Community Health Services
- **1.1.1.3.** Role of Committee members in promoting effective communication, advocacy, networking, and social mobilization in Community Unit
- **1.1.1.4.** Personnel management
- **1.1.1.5.** Resource mobilization and financial management
- **1.1.1.6.** Community health information system
- **1.1.1.7.** Monitoring and evaluation

1.1.2. Conduct quarterly CHC functionality review meetings

1.1.3. Conduct quarterly CHC supportive supervision meetings by the SCHMT/CHMT

Strategic Objective 1.2. Strengthen the participation and engagement of CHCs with the community

The CHC members have been feeling left out and neglected. Engaging them more by involving them in most of the community activities and allowing the community to take part in their selection will make them acceptable in the community. Equally, training them on their role to ensure that they understand their duties clearly will equip them for their roles in the community.

Key Interventions:
1.2.1. Brand CHC members
1.2.2. Hold quarterly meetings

Strategic Objective 1.3. Strengthen performance monitoring mechanism for community health governance structures

Key Interventions:
1.3.1. Hold bi-annual review meetings on resource mobilization and utilization by CHCs
1.3.2. Conduct quarterly performance review meetings on the CHCs

Strategic Objective 1.4. Strengthen and develop advocacy mechanisms for the prioritization and implementation of community health services at all levels

Key Interventions:
1.4.1. Adopt and disseminate community health advocacy guidelines from the national government
1.4.2. Adopt and disseminate community health communication strategy from the national government

Strategic Direction 2: Increase sustainable financing for community health

To address the existing funding gaps highlighted in the situation analysis and increase sustainable financing for community health using different financing mechanisms. The community health strategy will focus on the following strategies and interventions:

Strategic Objective 2.1. Improve stakeholders' participation and coordination in the county community health financing plans and mission to reduce the funding gap

Key Interventions:
2.1.1. Institutionalize a partnership coordination committee comprising of senior county health leadership and partners.
2.1.2. Define the partnership coordinating committee's scopes of work
2.1.3. Hold quarterly partnership coordinating committee meeting
2.1.4. Implement a partnership coordination mechanism to ensure that resources are efficiently distributed in the county and avoid duplication of programs in the same region by different donors
2.1.5. Set up collaborative initiative gathering NGOs, private funders, and partners to raise awareness about financing issues and goals on community health, encourage their support and participation

Strategic Objective 2.2. Enhance County government resource mobilization for community health financing.

Key Interventions:
2.2.1. Advocate for counties to allocate and disburse more funds to community health by ensuring that community health activities are adequately outlined and costed in the annual working plans

Strategic Objective 2.3. Explore and scale up innovative financing and co-financing mechanisms. These will help address the CHV stipend and revenue sharing

Key Interventions:
The county proposes two methods to ensure that the CHVs are covered in the NHIF scheme:
2.3.1. Establish viable income-generating activities with the CHUs. The type of IGAs will be determined and agreed on by the CHU members. The income from the IGAs will then be used to pay NHIF premiums for the CHU members

a)Train the CHVs on entrepreneurship to equip them with adequate knowledge to manage the IGAs
b)The county will seek collaborative partnerships with other partners to provide seed grants for the IGAs
The amount and funding will be based on the best performing CHU as a motivation to perform better

2.3.2. Include CHVs in the NHIF cover like any other county worker as a reward for sensitizing and enrolling the community members to enrol in the NHIF program

Strategic Direction 3: Build a motivated, skilled and equitably distributed community health workforce

The delivery of health care services at the community level in Tharaka Nithi is largely dependent on the availability of an efficient, well trained, and motivated community health workforce. With over 90% coverage of CHVs, the following strategic interventions and activities are designed to build, motivate, and equitably distribute a skilled community health workforce.

Strategic Objective 3.1. To ensure optimal recruitment and deployment of community health workforce

Key Interventions:

CHVs:

3.1.1. Conduct household mapping to determine where there are staffing gaps and deploy accordingly based on both population needs as well as geographical needs
3.1.2. Activate the pending 265 CHVs by training them on the basic modules and conducting household mapping to ensure that they are distributed well in the community
3.1.3. Update all CHVs and CHC registers annually with their details such as identity numbers, age, contact phone numbers, their CHUs and the village they serve for easy tracking of the active ones as well as tracking attrition hence facilitating annual replacement of the inactive and those that have left
3.1.4. Replace inactive CHVs and those that have left on an annual basis. This will involve:
  3.1.4.1. Hiring more CHVs

Criteria for hiring:

- Involve the community in identifying the CHV based on their reputation in the community. They must be very respectable, accepted in the community and permanent residents of the community for which they are hired
- They should be able to read and write both English and Swahili
- They should be at least 18 years and above. There shall be no upper age limit since it is based on volunteerism
- They should be able to speak the local language fluently

Strategic Objective 3.2. Clearly outline the county's community health workforce requirements

Table 6 below shows a breakdown of the community health staffing needs in the county.

Table 6: Community health staffing needs

Cadre	CHVs	CHAs	CHEWs
Current number	1265	35	153
Population	393177	1265	1265
County ratio	1 CHV: 396 persons	1 CHA: 10 CHVs	2CHEWs/CHU
Required Numbers	993	127	254
Gap/surplus	272 surpluses	92 gap	101 gap
National recommendation	1 CHV: 200 persons	1 CHA/CHU	2 CHEW/CHU
Required numbers	1965	127	254
Gap	700	92	101

3.2.3 CHEWs

The county shall continue working with the available 153 CHEWs to supervise community health work. Each CHU requires two CHEWs comprising of a nurse and a public health officer. The CHEWs will work with the CHA since they are a more permanent cadre under the county government. Additionally, they perform multiple duties making it very cost-effective for the county.

For the additional 27 CHUs, the county will require 54 more CHEWs to ensure that they are well covered and that the existing ones are not overstretched.

Key interventions on CHAs and CHEWs
In the short to medium term:

1. The county shall allow the CHEWs and the CHAs to work together for easy transition and on the job training of the CHAs by the CHEWs
2. Train existing CHAs on community health matters to ensure that they are well conversant with their work

In the short term to long term:

1. The county shall hire the CHAs so they continue working in the county after their three years national contract. Currently, the CHAs have been hired and deployed by the national government under the universal health care program for three years. At the end of the national government contract, the county will consider the hiring of the CHAs into their payroll to retain them and hire more to fill any gaps
2. However, as the county is transitioning the role of the CHEWs will still be retained as they are a more affordable cadre and do not increase the county wage bill

Recruitment CHAs will be done based on the following selection criteria:

a. The CHA must have the relevant health background for ease of training and good performance
b. They must have undergone training of two years from Kenya Medical Training Centre (KMTC) or any other recognized institution
c. The current CHAs who have not undergone training will be required to pursue the recommended course at the KMTC at their costs to ease the transition into the county public service

Strategic Objective 3.3. Ensure adequate training for both the new and the old CHVs

Key Interventions:
3.3.1. Conduct annual training for both the new CHVs and refresher training for the existing ones. The training will be done annually, since within a year an adequate number of new CHVs will have been hired to warrant training
3.3.2. Training the CHVs on both basic and technical modules to equip them with knowledge to carry out their work. The current 1000 CHVs have been trained on the basic modules but lack training on technical modules. The inactive 265 CHVs will require both basic and technical modules

Strategic Objective 3.4. Strengthen the capacity of the community health supervisors on mentorship and supervision

Key Interventions
3.4.1. Map out the distribution of CHEWs and CHAs to ensure total coverage of the whole county
3.4.2. Increase mobility of CHAs by providing motorbikes and allowances

Strategic Objective 3.5. Provide a harmonized and standardized framework for financial and nonfinancial remuneration and incentives for Community Health Volunteers.

Key Interventions:
3.5.1. Develop a performance-based reimbursement mechanism for CHVs to motivate them and improve their performance
3.5.2. Advocate for the passing of the county health bill which clearly outlines the remuneration guideline for Community health
3.5.3. Develop a framework for the provision of non-financial incentives for CHVs

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). To achieve this goal, community health services access, availability and coverage are critical success drivers. Below are interventions to address gaps in access to quality community health services in line with the community health services essential package.

Strategic Objective 4.1. Increase coverage of community health services

Key Interventions:
4.1.1. Review the existing community health service package to include missing essential services and expand scope on existing essential health services package e.g. (non-communicable diseases e.g., hypertension and diabetes, mental health, gender-based violence, drug, and substance abuse)
4.1.2. Train the CHVs on the expanded service package such as testing for blood sugars and hypertension
4.1.3. Design programmatic interventions that increase male involvement in RMNCAH services such as escort of wives to health facilities, initiate Father2Father support groups, a priority of service for accompanied women

Strategic Objective 4.2. Increase demand and utilization of community health services

Key Interventions:
4.2.1. Increase outreaches and community mobilization on the available services within their communities
4.2.2. Sensitize the community on the role of CHVs in the community for acceptability and ease in the delivery of services
4.2.3. Employ a multisector approach to deal with barriers to accessing health care services
- **4.2.3.1.** Engage church leaders in creating awareness and promoting community health service
- **4.2.3.2.** Involving the chief and community gatekeepers to access the hard-to-reach communities e.g., the Kavonokia people in the Tharaka zone

Strategic Objective 4.3: Expand community-based surveillance to all sub counties in the county

Key Interventions:
4.3.1. Develop and disseminate community-based surveillance (CBS) guidelines and integrate them into the national disease surveillance system for all the sub-counties
4.3.2. Build capacity of the community health workforce to implement CBS through training on CBS. The county can leverage on the current partner offering the training to ensure that all the sub counties are covered

Strategic Objective 4.4: Reinforce referral and community health linkages at the Hospital level

Key interventions:
4.4.1. Strengthen and institutionalize referral follow up of patients from the facility to the community
4.4.2. Strengthen existing and other innovative referral mechanisms from the community to the primary health care facilities and back to the community
4.4.3. Build capacity of community health workforce on effective linkages and coordination of community health services
4.4.4. Strengthen reporting and documentation for community health referrals

Strategic direction 5: Increase availability, quality, demand, and utilization of data for community health

Decisions are based on data. Therefore, to ensure adequate, correct, and timely data is collected and transmitted improve the quality of data and ensure that it is adequate, and available for use whenever needed.

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
5.1.2. Equip all the CHVs with smartphones for data collection. Currently, only 200 CHVs have smartphones hence 1065 CHVs require a mobile phone for harmonized data collection and reporting
5.1.3. Train the CHV on eCHIS using the national training manual
5.1.4. Ensure continuous sensitization on health data reporting: strengthen data reviews meetings on a monthly and quarterly basis

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

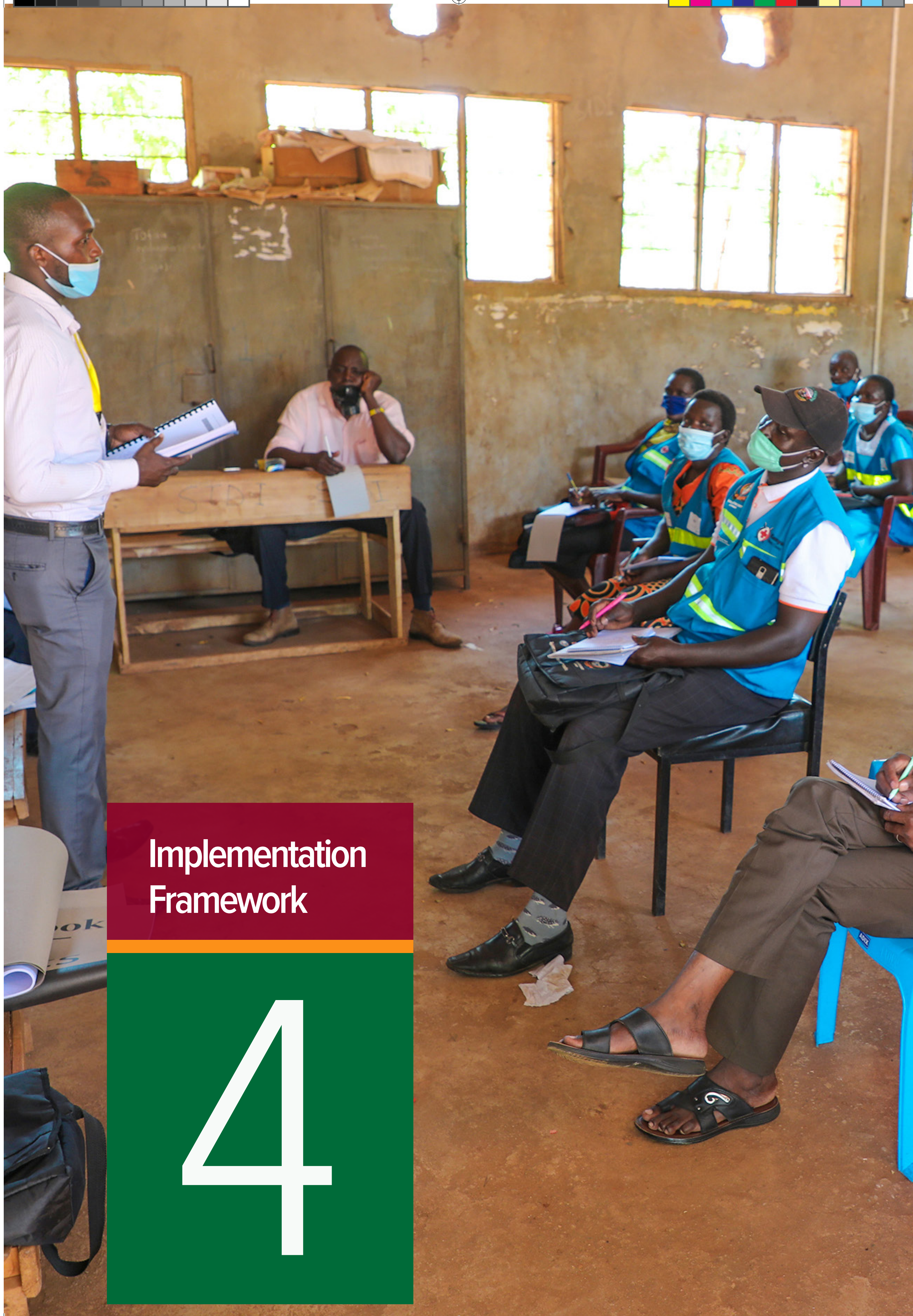
Key Interventions:
5.2.1. Provide monthly communication allowance to ensure smooth data collection and transmission
5.2.2. Train CHVs on the use of the smartphone for data collection to ensure accuracy and timely reporting of data
5.2.3. Revise and update the data module in the current CHVs training manual to include digital components

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

Currently, community health in the county has limited resources hindering their performance. The CHVs do not have CHV kits, there is frequent stockout of data collection tools, referral forms and inadequate or worn-out uniforms. For optimal performance, each CHV needs to be provided with the required tools through their link facility for accountability.

Key Interventions:
6.1.1. Purchase and distribute CHV kits with the recommended commodities (Appendix 3).
6.1.2. Train community health workforce on commodity management using the national curriculum



Implementation Framework

4

Implementation Framework

4.1 Introduction

Community health is an intersection of interventions in health, water, environment, education, food and agriculture, housing, the justice system, and other related sectors. Tharaka Nithi County has many public and private institutions, civil society organizations including households and communities, community-based, faith-based, and non-governmental organisations, private sector, and development partners among other stakeholders involved in community health services. These stakeholders play an essential role as strategic enablers, implementers, and service providers towards ensuring health for all in the county by 2030. This implementation framework, therefore, aims to:

a. Ensure that mandates, roles and responsibilities among the institutions, stakeholders and sectors are clearly defined
b. Enable all actors to play an effective role in promoting and implementing the community health strategy
c. Foster and maximise strategic partnerships, public participation, stakeholder coordination and accountability
d. Ensure accountability for performance and results by all implementing partners

4.2 Strategic Approach

A combination of approaches including rights based, multi-sectoral, public-private partnership, socially inclusive, consultative, and participatory approaches will be adopted in the implementation of the Tharaka Nithi County Community Health Strategy. The implementation framework proposes a partnership framework and periodic stakeholders' forums, technical working groups meetings and community-based action and dialogue days to engage all the actors—individual citizens, households, communities, private sector enterprises, NGOs, development partners and County Government departments—in a mutual exchange of ideas including complimentary use of expertise and resources with partners. Table 7 below summarizes the strategic directions, objectives, interventions, and implementation timelines.

Table 7: Implementation Matrix

Strategic Objective	Expected Output	Expected Outcome	Key Interventions	Activities	Implementation Matrix				
					21/22	22/23	23/24	24/25	25/26
Strategic Direction 1: Strengthening leadership and governance for community health services									
1.1: Establish functional community health committees			1.1.2 Training of the CHCs using the national manuals for CHCs	Conduct refresher training workshops for all the CHC members			X		
1.2 Strengthen the participation and engagement of CHCs with the community	Easy identification of CHC members in the community	Every CHC member owing an identification badge	1.2.1 Provide CHC members with identification badges	Purchase of identification badges	X				
	CHCs hold quarterly meetings	Quarterly meetings held every year with reports and minutes well documented	1.2.2 Support CHCs to hold quarterly meetings where key issues in the communities are aired out and settled.	Facilitate for 127 CHC quarterly meetings with minutes and reports submitted to the SCHMT	X	X	X	X	X
1.3 Strengthen performance monitoring mechanism for community health governance structures			1.3.1 Develop and operationalize an M&E structure for CHC performance	Development and operationalization of an M&E structure for CHC performance	X	X	X	X	X
1.4 Strengthen and develop advocacy mechanisms for the prioritization and implementation of community health services			1.4.1 Establish advocacy forums for CHCs for partnerships, awareness creation and resource mobilization for community health services	Conduct an initial training to CHAs as trainers of trainers (ToTs) on resource mobilization and advocacy		X			
				Conduct an initial training to CHCs on resource mobilization and advocacy		X			

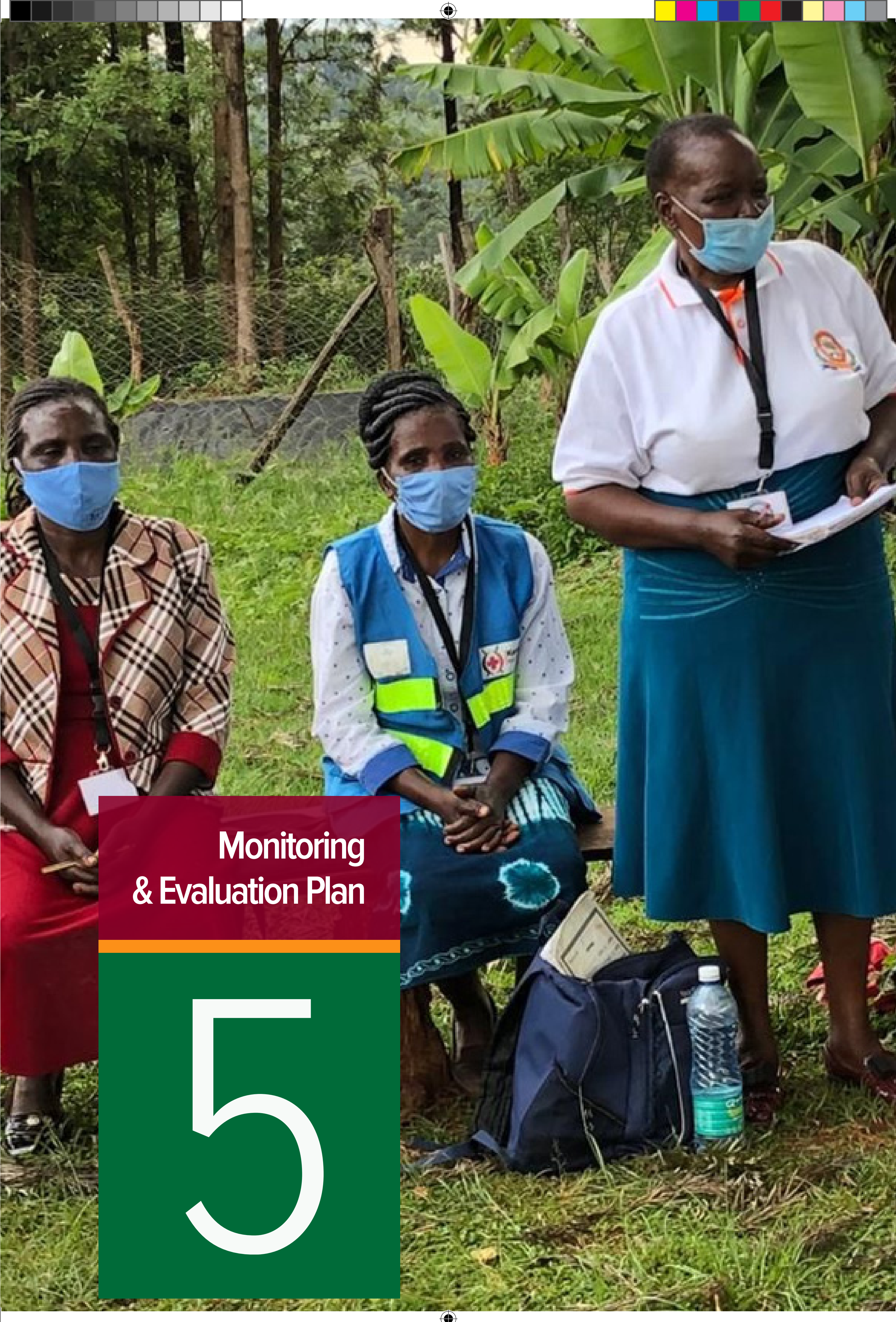
Strategic Direction 2: Increase sustainable financing for community health					21/22	22/23	23/24	24/25	25/26
2.1 Increase stakeholders' participation and coordination in the county community health financing plans and mission to reduce the funding gap	Strengthen partnership and stakeholder coordination mechanisms	Harmonized plans and efficient distribution of interventions by the implementing partners	2.1.1 Develop a stakeholder coordination mechanism in the county community health financing plans in efforts to reduce the funding gap	Hold an initial meeting with the county's NGOs, private sector, and partners to illustrate the importance of community health in the county and the financial gap	X				
	Increased partner resource mobilization and pooling framework	Increased partners and donors supporting community health services	2.1.2 Develop a community health partnership framework to enhance partner alignment and engagement	Hold quarterly meetings with existing donors and stakeholders in the county to discuss the funding gap in community health and financing mechanisms to close the gap	X	X	X	X	X
2.2 Explore and scale up innovative financing and co-financing mechanisms	All CHVs enrolled to NHIF with the benefits from the IGAs being used to pay for premiums	Equip CHVs and CHAs with entrepreneurial skills.	2.2.1 Establish viable income-generating activities in the CHUs.	Conduct an initial training to CHAs/ CHEWs to be ToTs on entrepreneurship and IGAs		X			
				Conduct an initial training to CHVs on Entrepreneurship and IGAs		X			
		127 registered and functional IGAs		Establish viable IGAs for each CHU with the support of the county government and partners		X			
Strategic Direction 3: Build a motivated, skilled, and equitably distributed community health workforce					**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
3.1 Ensure optimal recruitment and deployment of community health workforce	A clear outlined CHV staffing gap in the county based on health needs and population	Mapped CHV need report per sub-county and community health unit	3.1.1 Conduct a CHV mapping	Conduct a comprehensive household mapping	X				
	All the 265 CHVs actively carrying out their duties in the CHUs	Well trained CHVs on the basic modules and deployed in the CHUs accordingly	3.1.2 Activate the pending 265 CHVs by training them on the basic modules and deploying them to the CHUs according to need	Conduct initial basic modules training to all CHVs	X				

	Updated CHV and CHC register with all the members' details	Updated CHV and CHC registers outlining the active and the inactive members as well as those who have left service to aid in recruitment	3.1.3 Update all CHVs and CHC registers annually for easy tracking of the active ones	Carry out annual community health workforce tracking to gather information on attrition and inactive CHVs and CHCs to guide in hiring and updating of the registers	X	X	X	X	X
			3.1.4 Replace inactive CHVs and CHCs and those that have left services on an annual basis	Hold community barazas to recruit more staff	X	X	X	X	X
					X	X	X	X	X
3.2 Ensure adequate training for both the new and the old CHVs	All CHVs trained on basic modules	Annual training on basic modules training conducted	3.2.1 Conduct annual training for both the new CHVs and refresher training for the existing ones. The annual training will be since within a year an adequate number of new CHVs will have been hired to warrant training	Hold an annual workshop at the county level to train the CHVs on basic modules. This will be a refresher for the old ones and an induction for the new ones	X			X	
	All CHVs trained on all technical modules	CHVs are trained on three technical modules each year	3.2.2 Training the CHVs on technical modules to equip them with the knowledge to carry out their work	Carry out phased training of the 12 CHV technical modules. Train on three modules each year	X	X	X		
	CHAs and CHEWs to be ToTs on basic and technical modules	CHAs and CHEWs trained on basic and technical modules	3.2.3 Training CHAs and CHEWs to be ToTs on Both Basic and Technical modules	Conduct training to CHAs and CHEWs to be ToTs on basic modules	X				
					X	X	X		
3.3 Strengthen the capacity of the community health supervisors on mentorship and supervision	Adequate distribution of CHEWs and CHAs	A clearly outlined county coverage by the CHEWs and the CHAs	3.3.1 Map out the distribution of CHEWs and CHAs to ensure total coverage of the whole county	Conduct a CHU mapping to assess the distribution of CHEWs and CHAs	X				
	All the CHAs can move easily to carry out their supervisory work	All CHAs provided with motorbikes	3.3.2 Facilitate mobility of CHAs by providing motorbikes	Purchase of motorbikes for all the 34 CHAs to enhance their mobility	X	X	X	X	X
				Provision of fuel and maintenance to all motorbikes	X	X	X	X	X

	Regular supervisory visits by CHMT/ SCHMT	CHVs supervised by CHMT/SCHMT regularly	3.3.3 Facilitate CHMT/SCHMT to conduct supervisory visits to CHVs at respective link facilities	CHMT/SCHMT conduct quarterly supervisory visits at CHVs link facilities	X	X	X	X	X
3.4 Provide a harmonized and standardized framework for financial and nonfinancial remuneration and incentives for Community Health Volunteers.	A well-structured performance-based reimbursement mechanism for CHVs	Draft performance-based reimbursement mechanism for the CHVs	3.4.1 Design and implement a performance-based reimbursement mechanism for CHVs	Working with the county community health stakeholders to design a community health workforce rewards and recognition mechanism	X				
	Reimbursement of transport expenses and stipends to all CHVs	All CHVs receives monthly stipends and transport allowances	3.4.2 Facilitate the reimbursement of transport expenses to all the CHVs	Provide monthly transport allowance to all CHVs	X	X	X	X	X
			3.4.3 Facilitate the reimbursement of monthly stipends to all CHVs	Provide monthly stipends of KSH. 3,000 to all CHVs	X	X	X	X	X
Strategic Direction 4: Strengthen the delivery of integrated, comprehensive and high-quality community health services					**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
4.1 Increase coverage of community health services to households	A comprehensive essential service package for community health	An updated essential health services package for Tharaka Nithi community health	4.1.1 Review the existing community health service package to include missing essential services and expand scope on existing essential health services package	Update the existing essential community health service package to include all the recommended services according to the national guide	X				
	Increased male involvement in RMNCAH and other services	More interventions that involve the men	4.1.2 Design programmatic interventions that increase male involvement in RMNCAH services such as escort of wives to health facilities initiate Father2Father support groups, a priority of service for accompanied women	Structure more services that involve the men such as priority to accompany women in health facilities	X				
4.2 Increase demand and uptake and utilization of community health services.	Increased access and uptake for community health services	Mobilization, awareness creation and outreach activities	4.2.1 Intensify outreaches and community mobilization on the available services within their communities	Conduct quarterly sensitization outreaches to mobilize the community on CH services available to them	X	X	X	X	X

	Remove all barriers to accessing community health services	Implement innovative demand creation models such as through religious leaders and churches	4.2.2 Engage church leaders in creating awareness and promoting community health service	Hold sensitization sessions in churches to promote community health service	X	X	X	X	X
		More services are accepted in the hard-to-reach communities	4.2.3 Involve the chief and community gatekeepers to access the hard-to-reach communities	Ride-along with chiefs and community gatekeepers when accessing hard-to-reach communities	X	X	X	X	X
				Hold quarterly CHS sensitization meetings in the hard-to-reach communities with the support of the chiefs and the gatekeepers	X	X	X	X	X
4.3 Expand community-based surveillance (CBS) to all sub counties in the county	A comprehensive county community-based surveillance system in place	All Community health workforce trained on CBS	4.3.1 Disseminate community-based surveillance (CBS) guidelines and integrate them into the national disease surveillance system for all the sub-counties	Hold an initial ToTs training on Community-Based Surveillance to all CHAs/CHEWs		X			
				Hold an initial training on Community-based surveillance to all CHVs		X			
				Roll out CBS to all the sub counties and link it to the National surveillance system.		X			
4.4 Reinforce referral and community health linkages at the Hospital level	Functional referral and community health linkage system	Well trained community health workforce on the community health referral system	4.4.1 Strengthen existing and other innovative referral mechanisms from the community to the primary health care facilities and back to the community	Conduct training on the community referral system and tools i.e., MoH 100 to all the CHVs and their supervisors	X				
		A steady supply of referral tools to all the CHVs	4.4.2 Build capacity of community health workforce on effective linkages and coordination of community health services	Provide adequate reporting tool i.e., MoH 100 to all the CHV	X				
		Monthly meetings conducted to review their performance and offer further guidance on the referral system		Conduct monthly reviews of the referral system at the facility level and provide feedback to the CHVs	X	X	X	X	X

Strategic direction 5: Increase availability, quality, demand, and utilization of data for community health					21/22	22/23	23/24	24/25	25/26
5.1 Develop and implement a harmonized digital community health information system	Functional comprehensive electronic community health information system (eCHIS)	All the CH reporting tools linked to the eCHIS	5.1.1 Digitize and harmonize health data reporting tools into the eCHIS	Working with the health records department, link all the community health reporting tools i.e., MoH 513, 514,515 and 516 to the electronic community health information system			X		
				Link the data collection smartphones to the eCHIS			X		
	All the CHVs have smartphone-linked the eCHIS	All the 1265 CHVs provided with smartphones and trained on data collection and reporting	5.1.2 Equip all the CHVs with smartphones for data collection	Purchase 1065 smartphones to ensure that all the 1265 CHVs have smartphones Currently, only 200 have smartphones for data collection			X		
				Provide monthly communication/data allowance to all CHWs	X	X	X	X	X
	All CHWs using eCHIS	All CHWs trained on eCHIS	5.1.3 Conduct training for the community health workforce on digital CHIS	Conduct an initial training for all the CHVs on the effective use of smartphones for data collection			X		
				Conduct an initial ToTs training to all CHAs and CHEWs on eCHIS and smartphone use			X		
Strategic direction 6: Ensure availability of commodities and supplies for community health					**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
6.1 Ensure commodity security, quality, and safety of community health supplies	All CHVs are fully equipped with CHV kits and trained on the use of the commodities	All the 1265 CHVs are equipped with CHV kits	6.1.1 Procurement and distribution of kits to CHVs	Purchase CHV kits for all the 1265 CHVS	X	X	X	X	X
				Purchase kits for all CHAs and CHEWs	X	X			
		Well trained community health workers on community health logistics management	6.1.2 Train community health workforce on commodity management using the national curriculum	Conduct training for all community health workers on community health services logistics management	X				
			6.1.3 Provision of medicines and supplies to all CHVs	An adequate supply of medicines and supplies to CHVs	X	X	X	X	X



Monitoring & Evaluation Plan

5

Monitoring and Evaluation Plan

5.1 Monitoring and implementation framework

The overall purpose of the M&E framework is to improve the accountability of the community health strategy through focusing on strengthening the capacity for information generation, validation, analysis, dissemination, and utilization.[15]

Comprehensive monitoring and evaluation (M&E) framework shall be the basis for:

- Guiding decision on making in the Tharaka Nithi County Community Health Strategy 2021–2025, by characterizing the implications of the progress (or lack of it) being made
- Guiding the implementation of services by providing information on the outputs of the activities being carried out
- Serve as a guide to information dissemination and utilization by the health department amongst its stakeholders and the larger population it serves

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

- **Quarterly performance monitoring:** The quarterly performance review process will be the responsibility of the County Health Management Team. The quarterly monitoring activities will assess achievement against set targets. A 5-page quarterly report will be prepared and shared with the health leadership by the 15th of each month following the end of the quarter/implementation period. During the bi-annual stakeholder forum, the Ccounty Community Health Focal Person shall share the strategy implementation progress with the stakeholders.
- **Mid-term performance review:** A mid-term review of the community health strategy will be conducted at three (3) years (2023/24) following the launch of the strategy document. The review will focus on performance against targets, bottleneck identification, lessons learnt, program refocus if necessary. A 10-page report will be prepared and shared with the health leadership by the 15th of the month following the end of performance review period.
- **Annual performance review:** At the end of each implementation and fiscal year, a performance review will be conducted to assess annual program implementation progress against set targets. This review will help in subsequent annual planning, resource allocation, program activities refocus and provide a reflection of the past implementation year. A 20-page report will be prepared and shared with the health leadership by the 15th of the month following the end of the performance review period.
- **End term/Impact evaluation:** At the end of the five-year implementation period, a detailed evaluation process will be undertaken (2025/26). This exercise will evaluate overall program implementation, achievements, successes, lessons learnt, constraints against set targets. A detailed end of term strategy review report will be prepared and shared with all community health stakeholders. This will also inform strategy review, strategic priorities for subsequent implementation years. A report of not more than 50 pages will be prepared and shared with health leadership within 45 days following the end of the strategy implementation period.

[15] *Kenya primary health care strategic framework 2019-2024*

5.2 Performance framework

Table 8. Indicators compendium

Input indicators	Output indicators	Outcome indicators	Impact indicators[16]
Strategic Direction 1: Strengthening leadership and governance for community health services			
Training of both new and old CHC members	889 CHC members trained using the nation CHC training curriculum	Functional CHUs with strong leadership.	**Maternal, new-born, child, and adolescent health** • % Reduction in maternal mortality rate • % Reduction in neonatal mortality rate • % Reduction in infant mortality rate • % Reduction in under-five mortality rate **TB health** • % Reduction in TB mortality rate **Non-communicable diseases** • % Reduction in mortality rate from NCDs such as diabetes and hypertension
Hold quarterly supportive review meetings	Number of supportive meetings held evidenced by minutes		
Conduct bi-annual resource mobilization and utilization review meetings	Number of resource mobilization and review meetings held evidenced by minutes		
Strategic Direction 2: Mobilize innovative and sustainable financing for community health			
Institutionalize the partnership coordinating committee	A partnership coordinating committee scopes of work developed	Increased community health funding in the county Even distribution of programs to the whole county by partners Number of IGAs established in the CHUs	
	Number of quarterly partnerships coordinating committee meetings held evidenced by minutes		
Training on income-generating activities (IGAs) to all CHVs	Number of CHVs trained on IGAs and seed-funded		
Development of an investment case and advocacy tool kit	Complete investment case and advocacy tool kit		
Strategic Direction 3: Build a motivated, skilled, and equitably distributed community health workforce			
Activation of the 265 new CHVs	Household mapping conducted to distribute the 265 CHVs	Equitable distribution of CHVs Proficient CHVs in their service delivery Highly motivated CH workforce	
CHVs training on technical modules and refresher basic modules training	Number of CHVs trained on both technical and basic modules		
ToTs for CHEWs and CHAs on basic modules and technical modules	Number of CHEWs and CHAs trained on both basic and technical modules		

[17] *WHO 100 core health indicators, 2015*

Strategic Direction 4: Strengthen the delivery of integrated, comprehensive and high-quality community health services			
Expanded community health service package	Updated community health services package	Expanded scope of community health services Increased demand and utilization of community health services 100 % county roll-out of the community-based surveillance system	
Community health services awareness creation outreach activities conducted	Number of community health services awareness creation outreaches conducted		
Training and expansion of community health surveillance system	Number of sub-counties implementing the community-based surveillance system		
Strategic Direction 5: Strategic direction 5: Increase availability, quality, demand, and utilization of data for community health			
Purchase and distribution of reporting tools (MoH 100 & MoH 514)	Adequate reporting tool for all CHVs	Timely and accurate data for decision making Functional ECHIS	
Provide mobile phone to the remaining 1115 CHVs	Number of CHVs with mobile phones		
Training all the CHVs on the key reporting indicators	Number of CHVs trained on key reporting indicators		
Strategic Direction 6: Ensure availability of commodities and supplies for community health			
Purchase and distribution of CHV kits	All CHVs equipped with CHV kits	Efficiency in service delivery and commodity management	
Training on commodity management	Number of CHVs trained on commodity management		

Table 9: Key performance indicators

Key performance indicators	Baseline 2020	Targets					Means of verification
	Year	2021/22	2022/23	2023/24	2024/25	2025/26	
Leadership and governance							
Number of functional community health units	100	127	127	127	127	127	County Community health department/ DHIS
Number of community health committee (CHC) members trained on the CHC curriculum	0	889	889	889	889	889	County community health department
Number of CHC supportive supervision meetings held	0	1	4	4	4	4	
Health financing							
Number of community health volunteers (CHVs) trained on income generating activities (IGAs)	0	0	1265	1265	1265	1265	Signed participants list
Number of active IGAs established, registered, and issued with certificates	0	2	127	127	127	127	County community health department
Number of partnerships coordinating committee meetings held	0	1	4	4	4	4	Documented minutes
% of the community health expenditure over the county total health expenditure							County AWPs
Human resources for community health							
Number of CHVs trained on basic modules	1000	1265	1265	1265	1265	1265	Signed participants lists
Number of CHVs receiving refresher training on basic modules	1000	1265	1265	1265	1265	1265	Signed participants lists
Number of CHVs trained on the technical module							
Water and Sanitation and Hygiene	0	0	1265	1265	1265	1265	Signed participants lists
Nutrition	0	0	1265	1265	1265	1265	Signed participants lists
Integrated community case management	0	0	1265	1265	1265	1265	Signed participants lists
Maternal and new-born health	0	0	1265	1265	1265	1265	Signed participants lists
Family planning	0	0	1265	1265	1265	1265	Signed participants lists
Communicable diseases	0	0	1265	1265	1265	1265	Signed participants lists
Non-communicable diseases	0	0	1265	1265	1265	1265	Signed participants lists
Behaviour change	0	0	1265	1265	1265	1265	Signed participants lists
Care for terminally ill patients	0	0	1265	1265	1265	1265	Signed participants lists

Number of CHVs receiving the monthly stipend	1000	1265	1265	1265	1265	1265	Payment summary lists
Number of CHEWs/CHAs trained to be trainers on basic modules	188	188	188	381	381	381	Signed participants lists
Number of CHEWs/CHAs trained to be trainers on technical modules	188	188	188	381	381	381	Signed participants lists
Service Delivery							
Maternal, newborn and child health							
% increase in the number of women aged 15–49 referred for family planning services	76%	80%	82%	**85%**	**90%**	**95%**	DHIS/AWP
% reduction in the number of home deliveries referred for post-natal care	0.5%	3%	2.5%	**2%**	**1.5%**	**1%**	DHIS/AWP
% increase in the number of children fully immunized	73%	90%	95%	**96%**	**97%**	**100%**	DHIS/AWP
% increase in the number of children dewormed aged 12–59 months	33%	80%	85%	**90%**	**95%**	**100%**	DHIS/AWP
% increase in the number of children aged 6–59 months referred for vitamin A supplementation	5.8%	31%	40%	**47%**	**57%**	**70%**	DHIS/AWP
TB health							
Increase in the number of tuberculosis patients completing treatment	91%	92%	93%	**94%**	**97%**	**98%**	DHIS/AWP
WASH							
% increase in the number of households with handwashing facilities	30%	97%	98%	**99%**	**100%**	**100%**	DHIS/AWP
% increase in the number of households with functional latrines	74%	92.2%	93%	**95%**	**97%**	**98%**	DHIS/AWP
Non-communicable diseases							
Increase in the number of hypertensive cases screened and referred for medication	5304						DHIS
Data and information							
Number of CHVs with digital reporting tools	0	250	**250**	**1000**	**1000**	**1265**	DHIS
Number of CHVs trained on digital community health information system	0	0	**0**	**250**	**1000**	**1265**	Signed participants list
Health commodities							
Number of CHVs with complete kits	0	0	**250**	**250**	**1000**	**1265**	Stock issue/tracking sheets
Number of CHVs trained on commodity management	0	0	**250**	**250**	**1000**	**1265**	Stock issue/tracking sheets

6 Costed Implementation Plan

Costed Implementation Plan

6.1 Costing Methodology and Assumptions

The Community Health Strategy was costed using input-based Activity Costing (ABC) 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, then activities assigned to costs objects based on their use.

The CHPCT was used to model scale-up, coverage and cost of providing community health services over the strategy period. The CHPCT is a spreadsheet-based tool that helps planners and managers to determine the costs and finances of community health services packages. It allowed for 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.

The components of the programme included in the cost analysis were:

- **Baseline year:** 2020
- **CHVs:** Scaling up CHVs from 1,000 to 1,265 for a coverage of 1 CHV per 396 persons while factoring in a 7% attrition rate
- **Supervisors:** 35 Community Health Assistants (CHAs) supervising an average of 10 CHVs in the 127 CHUs and fully paid by the national government. 153 Community Health Extension Workers based in 127 CHU link facilities and fully paid by the County Government
- **Management staff:** Include County Community Health Focal Persons (1) and sub-county Community Health Focal Persons (6)
- **Supervision:** Includes support supervision, monthly data review meetings and quarterly dialogue days
- **Training:** Basic and technical modules initial and refresher training to all existing and new CHVs and CHAs/CHEWs (ToTs). Capacity building training on resource mobilization, entrepreneurship, community-based surveillance, and eCHIS to all CHWs
- **Management training:** Capacity building on resource mobilization and advocacy
- **Equipment:** CHVs kits and CHVs, CHAs and CHEWs equipment including reporting tool (Appendix 3)
- **Capital costs:** Motorbikes and IGAs seed capital
- **Supplies and commodities:** Medicines and consumables (Appendix 3)

6.2 Costing Assumptions

- Costs have been allocated assuming price stability, governance based on devolved units, and political, and policy goodwill to implement the strategy. Inflation was factored in based on the inflation rate in the baseline year (2020).
- The number of CHWs (1265 CHVs, 35 CHAs and 153 CHEWs) is not based on the national policy guidelines recommendations of CHW to population ratio distribution, rather the numbers are based on county resource availability and CHWs recruitment plans.
- Costs relating to supervision (CHAs and CHEWs), and management (Community health focal persons) salaries and benefits have not been included, as expenditures for these would still have been incurred regardless of the existence of this strategy.
- As a cost-saving measure, some activities have been incorporated along with other similar activities.

6.3 Costed Implementation Plan by Strategic Objectives

The total implementation cost of the program over the five years is **KES 751,942,137**, distributed as follows: The first year **KES 169,212,832**, second-year **KES 156,552,501**, third-year **KES 181,158,382**, fourth-year **KES 129,517,356**, and fifth-year **KES 15,501,066** (Table 10).

Table 10: Annual Strategy Costs disaggregated by Proposed Strategic Directions

Strategic Direction	Estimated Annual Costs					
	2021/22	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**Total SD Costs**
Strategic Direction 1: Strengthen management and coordination of community health governance structures	6,352,568	12,194,686	11,648,013	6,072,000	6,072,000	**42,339,267**
Strategic Direction 2: Increase sustainable financing for community health	570,340	13,726,820	260,000	260,000	260,000	**15,077,160**
Strategic Direction 3: Build a motivated, skilled, and equitably distributed community health workforce	121,007,456	92,385,330	94,383,223	95,754,427	80,014,652	**483,545,088**
Strategic Direction 4: Strengthen the delivery of integrated comprehensive and high-quality community health services	4,529,912	6,561,450				**11,091,362**
Strategic Direction 5: Increase availability, quality, demand, and utilization of data for community health	11,100,283	11,677,498	28,857,448	12,923,534	13,595,557	**78,154,320**
Strategic Direction 6: Ensure availability of commodities and supplies for community health services	25,652,273	20,006,716	46,009,698	14,507,395	15,558,857	**121,734,940**
Total Annual Costs	**169,212,832**	**156,552,501**	**181,158,382**	**129,517,356**	**115,501,066**	**751,942,137**

The activity inputs considered include start-up, training, and community-level service delivery costs, as well as support supervision, and management costs at all levels of the health system. Reimbursements of monthly stipends to CHVs was the highest cost driver by KES 227,700,00 over the five years of implementation, followed by equipment for the community health workers. The start-up costs were relatively low at KES 28 billion (3.73% of total costs) since the community health program is not new. Table 11 and Figure 12 below summarises the strategy's costs disaggregated by inputs.

Table 11. Annual strategy costs disaggregated by inputs

Strategy Costs by Input	Estimated Annual Input Costs					
	2021/22	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**Total Input Costs**
CHVs Stipend	45,540,000	45,540,000	45,540,000	45,540,000	45,540,000	227,700,000
CHVs Equipment	24,515,700	14,139,804	56,260,179	12,704,786	13,365,434	120,985,902
Medicines and supplies	1,022,823	1,290,138	1,531,755	1,802,610	2,193,423	7,840,749
CHA/CHEWs Equipment	113,750	4,576,774	1,751,036	-	-	6,441,560
Supervision Visits	4,344,760	4,570,688	4,808,363	5,058,398	5,321,435	24,103,644
CHVs Training	34,509,683	27,457,683	18,935,533	18,009,700	-	98,912,600
CHA/CHEWs Training	4,700,067	5,332,767	2,806,967	-	-	12,839,800
Management Equipment	-	-	65,198	-	-	65,198
Management Meetings	6,332,000	6,332,000	6,332,000	6,332,000	6,332,000	31,660,000
Other Recurrent Costs						
CHWs Communication Allowance	11,100,283	11,677,498	12,284,728	12,923,534	13,595,557	61,581,600
CHVs Transport Allowance	19,163,232	20,159,720	21,208,026	22,310,843	23,471,007	106,312,827
Start-up Costs						
IGAs - Seed Capital	-	7,027,570	-	-	-	7,027,570
Household Mapping	10,054,490			-	-	10,054,490
CHCs Training		5,101,186	5,576,013	-	-	10,677,199
CH Partnership Framework Meetings	310,340	-	-	-	-	310,340
Capital Costs						
Motorbikes	2,695,224	3,346,673	4,058,585	4,835,486	5,682,210	20,618,177
CHWs Reporting Tools	4,529,91	-	-	-	-	4,529,912
CHCs Branding	280,568	-	-		-	280,568
Total Annual Costs	**169,212,832**	**156,552,501**	**181,158,382**	**129,517,356**	**115,501,066**	**751,942,137**

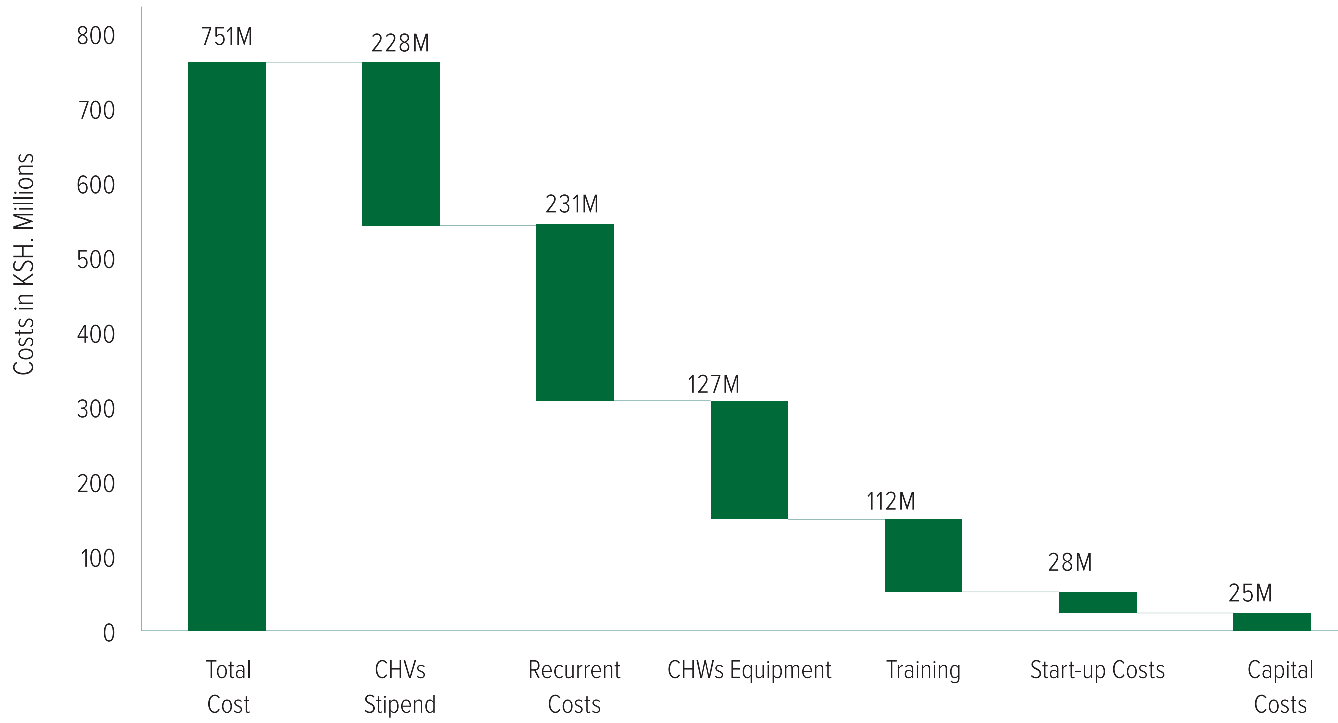


Figure 12. Total strategy costs disaggregated by input categories

Appendices

7

Appendices

Appendix 1: Strategy Development Process

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

Activity	Participants	Objectives	Approach
Situational Assessment January 2021 - February 2021	Participants from the CDoH and partners	• Identify strengths and issues • Synthesize other national, regional and global experiences, and extract lessons for Kenya's community health 2020 - 2025	Interviews, Desk review, meetings with the CDoH
Community Health Stakeholders Forum 25th - 26th February 2021	~47 participants from CDoH, community health partners, and stakeholders	• Establish alignment on community health strategic priorities • Facilitate stakeholder discussions on the development of the community health strategy • Synthesize other national, regional, and global experiences, and extract lessons	Two workshops which incorporated various approaches to facilitate learning and engagement such as PowerPoint presentations, breakout sessions for problem-solving, plenary discussions and gallery walk to review poster presentations. The facilitators for each breakout The session used a facilitator guide which included questions to guide each session
Thematic area writing meetings March - May 2020	~8 participants from the TWG	• Writing of the strategy • Ensure alignment of the strategy to the National Community Health Policy and Strategy.	Bi-weekly meetings of the TWG to develop the thematic areas
Strategy writing review workshop 2nd June 2021	~13 participants from CDoH, TWG and FAH	• Review of the strategy writing progress	One day workshop where the whole document was reviewed and alterations made leading to the final document
Strategy Costing validation workshop 8th September 2021	~37 participants from CDoH, community health partners, and stakeholders	• Update stakeholders on the strategy development progress • Validate the costing results • Define the next steps: strategy finalization and launching • Capacity building on public financial management and budgetary advocacy	One day workshop where the costing approach and methodologies employed were discussed and draft costing results presented for validation
Tharaka Nithi Community Health Strategy finalization workshop 21st October 2021	~13 participants CDoH, TWG, and partners	• Review and approve the final version of the strategy	One day workshop where the entire 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: Community Health Partnership Coordinating Committee

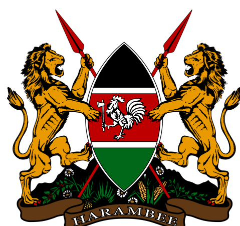
A partnership coordinating committee was developed to strengthen the coordination between partners in the county, and advocacy efforts. The committee members include:

Development Partners	Committee Members
Village Hope Core International	County Community Health Focal Person
Financing Alliance for Health	Chief Officer, Health
Kenya Red Cross Society	Director, Public Health and Sanitation Services
Plan International	Representative – County Health Management Team
Caritas	Representative – Sub-county Health Management Team
	Representative – Sub-county Administration
	County Nursing Officer

Appendix 3: Components of a CHV kit

Components of a comprehensive CHV kit	
Weighing scale	**Drugs and pharmaceuticals**
Backpack	Albendazole 400 mg/ mebendazole 100 mg
Identification badge	Low osmolarity oral rehydration salts 20.5 g/l
Comprehensive first aid box (sprit, disposable gloves, cotton woo, strapping, crepe bandage, povidone, surgical blade, sanitiser, clean string, scissors, and gauze)	Zinc sulphate 20 mg
Blood pressure machine	Male and female condoms
Safety box	Povidone iodine solution
Glucometer and strips	Chlorine/flocculant (coagulant and disinfectant) for turbid water
Colour-coded salter scale for children	Chlorine tablets for clean water
Flashlight torch and umbrella	Dispensing envelops
Biohazard box	
Reflector jacket with a logo	**Other commodities**
Labelled dust coat	Field notebooks and pens
Digital thermometer	Commodity register
Height board	Mobile phone
MUAC tape	Referral forms

GOVERNMENT OF THARAKA NITHI COUNTY



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