Republic of Kenya

Reversing the trends

The Second
NATIONAL HEALTH SECTOR
Strategic Plan of Kenya

Taking the Kenya Essential Package for Health to the COMMUNITY

A Strategy for the Delivery of LEVEL ONE SERVICES

Ministry of Health
June 2006

THIS PUBLICATION is one of a series that the Ministry of Health will produce to support the achievement of the goals of the second National Health Sector Strategic Plan, 2005–2010 (NHSSP II). Aiming to reverse the declining trends in key health sector indicators, NHSSP II has five broad policy objectives. These are:

- Increase equitable access to health services.
- Improve the quality and responsiveness of services in the sector.
- Improve the efficiency and effectiveness of service delivery.
- Enhance the regulatory capacity of MOH.
- Foster partnerships in improving health and delivering services.
- Improve the financing of the health sector.

Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of LEVEL ONE SERVICES

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Email: secretary@hsrsmoh.go.ke
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Abbreviations

AIDS	Acquired immune deficiency syndrome
AMREF	African Medical and Research Foundation
ARI	Acute respiratory tract infection
BCC	Behaviour change communication
BI	Bamako Initiative
CBHC	Community-based health care
CBIS	Community-based information system
CBO	Community-based organization
CBT	Competency-based training
CBWs	Community-based workers
CHEW	Community health extension worker
C-IMCI	Community level integrated management of childhood illnesses
CORAT	Church Organizations Research Advisory Trust
CORP	Community-owned resource person
DC	District Commissioner
DDC	District Development Committee
DHMB	District Health Management Board
DHMT	District Health Management Team
DRC	Democratic Republic of Congo
ECD	Early childhood development
ECN	Enrolled community nurse
EH	Environmental health
KEPI	Kenya Expanded Programme of Immunization
FBIS	Facility-based information system
FHFE	Family health field educator
FP	Family planning
GOK	Government of Kenya
HHs	Households
HC	Health centre
HDC	Health development committee
HE	Health education
HFC	Health facility committee
HIV	Human immunodeficiency virus
HMIS	Health management information system
HSR	Health sector reform
IDCCS	Inter Diocesan Christian Community Services

IEC	Information, education and communication
IMR	Infant mortality rate
ITN	Insecticide treated net
KAP	Knowledge, attitude and practice
KDHS	Kenya Demographic and Health Survey
LDC	Locational development committee
MCH	Mother and child health
MOH	Ministry of Health
NGO	Non-government organization
NHSSP II	Second National Health Sector Strategic Plan, 2005–2010
ORS	Oral rehydration salts/solution
PH	Public health
PHC	Primary health care
PHN	Public health nurse
PHO	Public health officer
PHT	Public health technician
RH	Reproductive health
SDP	Service delivery point
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendant
TICH	Tropical Institute of Community Health and Development
TOT	Training of trainers / Trainer of trainers
VCT	Voluntary counselling and testing
VHC	Village health committee

Foreword

Kenya's second National Health Sector Strategic Plan (NHSSP II – 2005–2010) defined a new approach to the way the sector will deliver health care services to Kenyans – the Kenya Essential Package for Health (KEPH). KEPH introduced six life-cycle cohorts and six service delivery levels. One of the key innovations of KEPH is the recognition and introduction of level 1 services, which are aimed at empowering Kenyan households and communities to take charge of improving their own health.

This document, *Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of LEVEL ONE SERVICES*, intends to make KEPH a reality at level 1 – the community level. The document was developed through wide consultation among stakeholders in the sector to help revitalize community health services in Kenya. The document clearly defines the type of services to be provided at level 1, the type of human resources required to deliver and support this level of care, the minimum commodity kits required, and the management arrangements to be used in implementation.

The strategy sets an ambitious target of reaching 16 million Kenyans (3.2 million households) in the next four years. It envisages building the capacity of households not only to demand services from all providers, but to know and progressively realize their rights to equitable, good quality health care. The strategy introduces innovative approaches for accomplishing these challenging but realizable targets. The approaches include:

- Establishing a level 1 care unit to serve a local population of 5,000 people.
- Instituting a cadre of well trained Community-Owned Resource Persons (CORPs) who will each provide level 1 services to 20 households.
- Supporting every 25 CORPs with a Community Health Extension Worker.
- Ensuring that the recruitment and management of CORPs is carried out by village and facility health committees.

I am fully confident that the implementation of this strategy will help us address the issue of providing equitable access to basic primary health services and by so doing will help to "reverse the trends" in our health indexes in an accelerated manner. However, I am also aware that we will have to collectively, as stakeholders, face many technical, managerial and other challenges and resolve them along the way. During the implementation process, we will learn many lessons from practice and these will enrich this strategy further.

Implementing community health services is the top priority of the Ministry of Health and its partners in the sector. This is articulated well in our Joint Programme of Work and Funding, 2006/07–2009/10.

The opportunity for actualizing the sector stakeholders' main policy agenda – reaching the poor through basic health care – has now presented itself to us in the form of implementing this community strategy. I call on our districts and implementing partners to exert their maximum effort to bring this dream to reality – the dream of having a community health service that is sustainable and responsive to the needs of our many diverse localities. I also call on our development partners to prioritize this service as one of "first call" in supporting the health sector.

Dr. James Nyikal
DIRECTOR OF MEDICAL SERVICES
Ministry of Health

June 2006

1: Introduction and Background

Communities are at the foundation of affordable, equitable and effective health care, and are the core of the Kenya Essential Package for Health (KEPH) proposed in the second National Health Sector Strategic Plan 2005–2010 (NHSSP II). This strategy document sets out the approach to be taken to ensure that Kenyan communities have the capacity and motivation to take up their essential role in health care delivery. The overall goal of the community strategy is to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, and child and maternal deaths, as well as improve education performance across all the stages of the life cycle. This will be accomplished by establishing sustainable community level services aimed at promoting dignified livelihoods throughout the country through the decentralization of services and accountability. Throughout this document, where LEVEL ONE SERVICES appears in all capital letters, it refers to the entire community-based component of the Kenya Essential Package for Health.

1.1 The Context

A large proportion of Kenyans continue to carry one of the highest preventable burdens of ill health in the world. Much of this burden can be lifted and prevented with existing knowledge and resources. Despite having well defined national health policies and a reform agenda whose overriding strategies are focused on improving health care delivery services and systems through efficient and effective health management systems and reform, there has not been a breakthrough in improving the situation of households entrapped in the vicious cycle of poverty and ill health. Poverty compounds powerlessness and increases ill health, as ill-health increases poverty. Both have become progressively worse since the 1990s, with appalling disparity within and between provinces. The situation is further complicated by the emergence of new and resurgence of old communicable diseases. The community systems are faced with the challenge of coping with the growing demand for care, in the face of deepening poverty and dwindling resources.

Poverty compounds powerlessness and increases ill health, as ill-health increases poverty. Both have become progressively worse since the 1990s.

The result has been deteriorating trends in health status throughout the country with unacceptable disparities between and within provinces. In addition, the cost of

health services has escalated well beyond the financing capacity of the Ministry of Health. This is in part the premise for the evidence-based, life-cycle approach to health care introduced in NHSSP II. The approach is critical in order to insure the NHSSP II goals of equity, effectiveness and efficiency.

The worsening indicators include the following:

- Rising infant mortality rate from 64 per 1,000 live births in 1993 to 72 in 1998, 74 in 2000 and 77 in 2003 (KDHS 2003).
- Rising under-five mortality rate from 90.9 per 1,000 live births in 1989 to 115 per 1,000 live births in 2003 (KDHS 2003)
- High maternal mortality rate of 590 per 100,000 in 1998 and 414 in 2002 per 100,000 live births (MOH 2005).

The 2003 Kenya Demographic and Health Survey also revealed that:

- 30.7% of children under five years are stunted.
- Only 2.6% children are still exclusively breastfeeding at six months, while 56.8% are still breastfeeding by the end of 23 months.
- 61.5% of under-fives had child health cards.
- Only 59.2% of children in the second year of life are fully immunized.
- Only 4.3% of under-fives and 4.5% of pregnant mothers sleep under ITNs.
- Only 40.8% of deliveries are assisted by a health professional and only 39.4% occur in health facilities.

Both the health sector reforms (HSRs) and the primary health care (PHC) concept have advocated for better health for Kenyans through people's active initiative and involvement. HSR expanded the community-based health care (CBHC) principles by decentralization to formalize people's power in determining their own health priorities and to link them with the formal health system in order to reflect their decisions and actions in health plans. In addition, people themselves would also participate in resource mobilization, allocation and control. This approach is well articulated in NHSSP II and supported by local government reforms that would ensure the effectiveness of decentralization, as power is shifted to the councils, and governing structures that enhance transparency and accountability.

The overall thrust of the second National Health Sector Strategic Plan (NHSSP II) is to involve the communities in addressing the downward spiral of deteriorating health status.

The community-based approach, as set out in this strategy, *is the mechanism through which households and communities take an active role in health and health-related development issues.* Initiatives outlined in the approach target the major priority health and related problems affecting all cohorts of life at the community and household levels – level 1 of the KEPH-defined service delivery. It is envisioned that the households and communities will be actively and effectively involved and enabled to increase their control over their environment in order to improve their own health status. The intention, therefore, is to build the capacity of communities to assess, analyse, plan, implement and manage health and health related development issues, so as to enable them to contribute effectively to the country's socio-economic development. The second major intended impact of the approach is that the communities will thereby be empowered to demand their rights and seek accountability from the formal system for the efficiency and effectiveness of health and other services.

1.2 Strategic Objectives

The community strategy intends to improve the health status of Kenyan communities through the initiation and implementation of life-cycle focused health actions at level 1 by:

- Providing level 1 services for all cohorts and socioeconomic groups, including the "differently-abled", taking into account their needs and priorities.
- Building the capacity of the community health extension workers (CHEWs) and community-owned resource persons (CORPs) to provide services at level 1.
- Strengthening health facility–community linkages through effective decentralization and partnership for the implementation of LEVEL ONE SERVICES.
- Strengthening the community to progressively realize their rights for accessible and quality care and to seek accountability from facility-based health services.

Turning the competing health care systems into collaborating partners will add value to all and benefit the households more.

1.3 Justification for the Community-Based Approach

Service providers are increasingly aware that households not only take the majority of preventive and promotive health actions, they also provide clinical care of the critically and chronically ill. Studies in Tanzania and Malawi have shown that 70% of child deaths occur at home, without any contact with the health system, caused by preventable or easily curable diseases such as malaria, measles, acute respiratory infections (ARI), pneumonia, diarrhoea and malnutrition.

The culture of dominance among service providers against that of silence among households and communities makes it difficult for the ideas of the communities to be heard. Service providers never really get to know what their clients understand. Thus they often assume that what they have said, advised or given has been accepted and will be done, only to be surprised later that no change has taken place in terms of behaviour or practice and therefore health outcomes. It is to be realized that households have the deepest interest of their own health at heart and they are always trying their best even when what they do appears unreasonable. Yet the providers do not listen enough to hear what the consumers are expressing in their own terms and context, because providers tend to be uprooted from their socio-cultural contexts. This leads to loss of trust as local efforts and initiatives are ignored or displaced by temporary actions that fizzle away.

The providers, like people everywhere, have perspectives and viewpoints on the way things are that under gird their values. They interpret everything they experience through these mental maps. They see the world as they are conditioned to see it. The community people, for their part, also see things through their own legitimate maps, the lenses of their own experiences. People have alternatives in meeting their health needs; they have their own interests that cannot be ignored if we are to do business with them through the community-based Kenya Essential Package for Health (LEVEL ONE SERVICES). Yet traditional approaches to care continue to be ignored at a time when the coverage by the formal facility-based health care system has gradually declined as people's confidence in the formal health sector has eroded. Most service

users turn first to non-formal and traditional sources of care, since they are readily available to the households, and only come to the health facilities as a last resort. These seemingly competing systems of care must be taken into account and strategies to formally strengthen their linkages and synergy have to be thought through in designing LEVEL ONE SERVICES, as part of the sector-wide approach, since they are significantly appreciated by the people regardless of their effectiveness in improving health conditions.

Continued respectful dialoguewith communities will help us to enlarge their choices as we support them in making rational, evidence-based decisions abouttheir health needs.

The people have learnt through experience that they should not rely only on the conventional service providers. There is therefore an overwhelming need to negotiate with people and households as partners in health care, giving them a chance to influence the way care is delivered and thus restore their confidence in the health system. Meeting this need means focusing attention on enhancing the capacity of households to play their role in action for health effectively. Through continued respectful dialogue, we will be able to enlarge their choices as we seek to support them in making rational, evidence-based decisions concerning their health needs across all stages in the human life cycle, and thus reverse the trends in health indicators. Turning the competing systems into collaborating partners will add value to all and benefit the households more.

It is for this reason that the overall thrust of the second National Health Sector Strategic Plan (NHSSP II) is to involve the communities in addressing the downward spiral of deteriorating health status. The goal of reducing health inequities can only be achieved effectively by involving the population in decisions and in the mobilization and allocation of resources, and thereby promoting community ownership and control in the context in which they live their lives. This is a paradigm shift that requires a fundamental change in the way things are governed and managed, as well as in the way services are delivered.

1.4 Learning from Past Experiences in Community-Based Health Care

Currently, Kenya has a large number of well trained public health technicians (PHTs) and enrolled community nurses (ECNs), many of whom are unemployed, who can fulfil the extension role inherent in LEVEL ONE SERVICES. They will do this by linking with households through community-owned resource persons (CORPs). It would not make sense to train another lot of extension workers for LEVEL ONE SERVICES, when these cadres are available if they can be hired. This model of CORPs at sub-locational level being supported by a PHT or ECN was tested by CARE Kenya in Siaya District with excellent results (Olewe, 2003). The main problem, as usual, was lack of sustainability as it was donor dependent. If the scheme could be state supported as provided for in NHSSP II, it would be a sure way of improving the health status of Kenyans.

The effectiveness of community health services and community health workers (CHWs) has been shown in a number of studies and projects. In Democratic Republic of Congo (DRC), CHWs were found to be effective in administering timely and effective treatment of presumptive malaria attacks (Kidane and Murrow, 2000). Since CORPs are also local community members, they are, in principle, always accessible to the villagers. On the other hand, large centrally managed CORP programmes have failed, whilst true community-based ones work well (Friedman et al., 2004).

In Kenya the effectiveness of CORP-based programmes has been demonstrated in districts throughout the country: Kakamega, Busia, Siaya, Bondo, Kisumu, Kisii, Nyeri, Kirinyaga, Meru, Embu, Machakos and Kwale, to cite a few, be it on pilot and small scale. Many lessons can be gleaned from these experiences, as summarized below.

First, it is possible to *build capacity at village level to manage community-based activities* effectively. Communities can be organized into functional units such as villages or sub-locations that are linked to or part of the legal structures of the country, for effective action for health. Health committees and resource persons elected by these structures can be trained for effective actions for health at the village level. These structures work best when linked to administrative structures as well as the health facilities' catchment areas, and when they are in control of tangible decisions, guided by clear guidelines defining their roles. Linkage to other sustainable local structures such as schools, churches and women's groups may be better than introducing a new structure. The communities need facilitation and support from the formal system.

Second, the CORPs as volunteers can provide services at the household level that *include a community-based information system, dialogue based on information, health promotion, disease prevention, simple curative care* using drugs supplied through a revolving fund generated from users, and a referral system established by local health committees. The main problem is that CORPs elected by their own communities, without any guiding criteria, may not be adequately literate to undertake all the tasks assigned. Even though CORPs are nominated by the communities, the criteria for selection can be jointly agreed between the community and the health system. These could include ability to read and write, being a permanent resident of the community, and having demonstrated attitudes valued by the community.

Third, because incentives are lacking, *it is difficult to sustain the morale and motivation of CORPs for long*. They therefore fall prey to agents whose agendas may not be consistent with those of either the community or the Ministry of Health, and who may thus disrupt operations towards set objectives. Incentives tend to be limited to uniforms, protective wear, drug kits, reimbursement of direct costs and periodic rewards for excellent performance. *Whatever the incentives are, they seem to be best if handled by the local committees rather than being paid for centrally*. There are experiences of allowances paid by village governments but not regularly (Tanzania). Elsewhere local government revenue, grain and labour from villagers used to pay CHWs, as well as possibilities for career development to professional health worker, seem to work well (in Sudan, for example, as reported by Erasmas et al., 2003). The majority of the CORPs, however, are dissatisfied with the community compensation system, which leads to demotivation and internal conflict and demands for regular salaries. There is no reason why they should not be paid a stipend based on work actually done. What is important is that the cash should be paid through a local committee to enhance loyalty and accountability to the people served.

Factors that appear to influence the motivation and work behaviour of CORPs include:

- Hopes for a better life through continuous development of life skills and opportunities.
- Personal interests (values, characteristics), giving reason for volunteerism.
- Community factors (acceptance, understanding, involvement).
- Political and policy environment (creation of supportive structures).

- Administrative environment (government regulations, laws, procedures, conditions, support, logistics, supplies available for the work, leading to greater satisfaction).
- The strength of the governing structures linking the community with the health system.
- Training of health workers, supervisors and managers in participatory skills.
- Supportive supervision by a multidisciplinary team of professionals.

Fourth, *community health extension workers (CHEWs) tend to be recruited by the health system and assigned to the local structures*. This seems to work well in Malawi in terms of retention of workers, but has yet to be evaluated in Ethiopia. In both cases the impact on health outcomes has not yet been demonstrated. The approach addresses the problem of attrition that affects the effectiveness of volunteer CORPs However, it may not address the problem of loyalty to the community as was experienced with a similar cadre in Kenya, the family health field educator (FHFE), which was eventually discontinued.

Given an adequate level of transparency in decision making, the community can play a leading role in processes of joint action for health and the management of funds.

Fifth, *effective community health services require well thought out theoretical and practical training modules and programmes*. Most training activities for CORPs take place in the community but with periods of practice at various facilities up to the sub-district level. The initial training covers community organization, community entry and situation analysis, the community information system, community dialogue for behaviour change, and first aid. This is followed by three days a month to cover community-based integrated management of childhood illnesses (C-IMCI), reproductive health (RH), malaria, acute respiratory infections (ARIs), water and sanitation, community nutrition, business management, record keeping, drug management and counselling, agribusiness, poultry keeping, and project implementation, monitoring and evaluation. Some CORPs are trained on recognition (using algorithms), classification and action. They are then supervised and supported by a trainer (a health extension worker) at the sub-locational level, linked to a health facility. CORP training starts with an initial period of two to six weeks, but continues essentially life long, emphasizing problem-based experiential approaches, based on learning needs. The health extension personnel, on the other hand, are trained for periods ranging from one to three years at a training institution.

Sustainability is promoted when community-based activities are built into existing initiatives and based on available resources. Given an adequate level of transparency in decision making, the community can play a leading role in processes of joint action for health and the management of funds. Thus, six, *health actions can be self-sustaining if properly governed by the community, but systems of accountability and transparency must be established and practised*. Ways of enhancing resource generation may include sale of drugs, which can be done at low prices affordable to the community through a social franchise set up to maintain standards. Communities can participate in cost-sharing if they are in control of the money they contribute and can see tangible results. External contributions can be added to their account to cover gaps in costs as well as households that are unable to pay. Communities are thus able to maintain a regular supply of preventive and curative materials, such as medicines and water treatment chemicals. They realize that without adequate accountability, free health services prove to be even more expensive to them than cost-sharing because of informal payments and inefficiency.

Finally, critical to the success of the community approach are *coordinating structures that bring together key players at national and provincial levels to organize and guide the implementation of policy guidelines and key activities*. Such structures are necessary to ensure consistency, the joint assessment of progress and enhanced learning from various sites. Periodic forums for disseminating results and sharing experiences enable sustainability of momentum as well as mutual accountability. In addition, the use of indigenous knowledge is promoted, incorporated and shared for wider consumption. At the local level, village health days once a month are effective in sustaining improvement in health outcomes. Formal cooperation between the Ministry of Health and a non-government organization (NGO) with particular experience in CBHC works well in achieving and sustaining results. A formal contractual agreement enhances efficiency of collaboration, as well as adherence to set standards.

1.5 The Key Role of Households and Communities as Partners in LEVEL ONE SERVICES

Kenya's dismal health status has arisen in part because the formal health care system has exhibited limited effectiveness in changing the behaviour of households, hence the urgency of promoting effective *linkages* with the formal system rather than the *integration* of LEVEL ONE SERVICES into the formal sector. The two systems must become partners in action for health, with due respect for and recognition of the importance of the community/household-based system. The CORPs thus need to be fully part of the community-based system, and partially part of the formal health system, while the CHEWs would be fully part of the formal health system but partially community-based.

Under this system, the households have important responsibilities for addressing health needs at all stages in the life cycle. Among these are:

- ***Health promotion:***
  - Ensuring a healthy diet for people at all stages in life in order to meet nutritional needs.
  - Building healthy social capital to ensure mutual support in meeting daily needs as well as coping with shocks in life.
  - Demanding health and social entitlements as citizens.
  - Monitoring health status to promote early detection of problems for timely action.
  - Taking regular exercise.
  - Ensuring gender equity.
  - Using available services to monitor nutrition, chronic conditions and other causes of disability.

- ***Disease prevention:***
  - Practising good personal hygiene in terms of washing hands, using latrines, etc.
  - Using safe drinking water.
  - Ensuring adequate shelter, and protection against vectors of disease.
  - Preventing accidents and abuse, and taking appropriate action when they occur.

CORP training starts with an initial period of two to six weeks, but continues essentially life long, emphasizing problem based experiential approaches, based on learning needs.

Communities realize that without accountability, free health services prove to be even more expensive to them than cost-sharing because of informal payments and inefficiency.

- Ensuring appropriate sexual behaviour to prevent transmission of sexually transmitted diseases.

- ***Care seeking and compliance with treatment and advice:***
  - Giving sick household members appropriate home care for illness.
  - Taking children as scheduled to complete a full course of immunizations.
  - Recognizing and acting on the need for referral or seeking care outside the home.
  - Following recommendations given by health workers in relation to treatment, follow up and referral.
  - Ensuring that every pregnant woman receives antenatal and maternity care services.

- ***Governance and management of health services:***
  - Attending and taking an active part in meetings to discuss trends in coverage, morbidity, resources and client satisfaction, and giving feedback to the service system either directly or through representation.

- ***Claiming rights:***
  - Knowing what rights communities have in health.
  - Building capacity to claim these rights progressively.
  - Ensuring that health providers in the community are accountable for effective health service delivery and resource use, and above all are functioning in line with the Citizen's Health Charter.

2: Service Provision at Level 1

Before proceeding, some clarification is perhaps in order. According to KEPH, LEVEL ONE SERVICES intend to provide basic community health services (promotive, preventive and simple curative) to Kenyans. One level 1 service "unit" is designed to serve 5,000 people and will work with volunteer CORPs identified by the community and trained and supported by the community health extension worker (CHEW). This strategy paper uses the term "CORP" to include any type of community health workers who are willing to work on voluntary basis. All of them must be taken into consideration and mechanisms of vetting, licensing and control worked out – with their participation – to ensure acceptable standards. Since one of the tasks of the CORP is data gathering it is essential that they be able to read and write. Other characteristics should include permanent residence in the community served and commitment to the service of neighbours as evidenced by their track record. Nominations or volunteers should be vetted by the community at an open meeting before they are recruited by the health team from levels 2 and 3 and the district team.

2.1 Norms and Services at Level 1

The Ministry of Health's newly articulated *Norms and Standards for Health Service Delivery* sets out the specific services that should be offered at different levels as well as the minimum human resources, infrastructure and commodity requirements. Accordingly, the implications of norms and standards for the community services is that:

- One CORP will serve 20 households or 100 people.
- One health extension worker (retrained PHT or any other similar cadre) will supervise and support 25 CORPs.
- One level 1 unit will serve 5,000 people and will require
  - 50 CORPs
  - 2 community health extension workers (CHEWs).

For the CORPs to be effective they need the support of the trained community health extension worker – the CHEW, whose main roles include training and continued support for the CORPs according to the felt needs of the community. The CHEWs are based at a health facility but assigned to work within a specific sub-location to ensure acceptable standards of care at level 1. They provide continuing training to CORPs through demonstration and instruction based on immediate learning needs. They thus

train the CORPs on the job as they provide services at level 1. This is why the CHEWs are referred to in this document as "coaches" of the CORPs. This is the essence of the community system.

The CHEWs will be formal employees of the health system hired and paid through the local Health Facility Management Committee. The CORPs, as volunteer part time workers, may be reimbursed for direct costs incurred in level 1 service provision and provided with protective clothing, bags to carry working materials, and an essential care package supplied and replenished by the CHEW. The CORPs may receive a certificate of recognition after five years of service. Moving away to take up opportunities that may arise should be appreciated, not discouraged and condemned, and the CORP replaced.

On the basis of the lessons learnt from previous experiences in Kenya and elsewhere, the guiding principles in providing LEVEL ONE SERVICES are the following:

- Communities to be organized into functional units of 20 households.
- CORPs to be voluntary, but paid a stipend on the basis of work actually done, and this payment to be made through the local committees to enhance loyalty and accountability.
- CORPs to be nominated by the communities on the basis of predefined criteria.
- CHEWs to be on government payroll and facilitated (e.g., transport).
- Community to play a leading role in joint health actions.
- A strong coordination structure to be established to bring in all actors at all levels.
- Communication to be strengthened through advocacy, social mobilization and interactive dialogue.

2.2 Definition of Services Provided at Level 1

NHSSP II aims to improve the health and well being of all Kenyans, based on a life-cycle approach for ensuring that each age cohort receives health services according to its needs. The plan expects to achieve that goal through selective, highly cost-effective service package interventions for each age cohort that are likely to result in health improvement in the overall population. This strategy takes the NHSSP II objectives to the community level by mobilizing communities towards their active and dynamic involvement in implementing the interventions that contribute to their own health and socio-economic development, to release themselves from the vicious cycle of poverty and ill-health.

The Kenya Essential Package for Health (KEPH) is designed as an integrated collection of cost-effective interventions that address common diseases, injuries and risk factors, including diagnostic and health care services, to satisfy the demand for prevention and treatment of these conditions. Using an evidence-based plan, health committees organize actions for health grounded in their own capacities. The conditions identified and included in their plan are those in which the LEVEL ONE SERVICES can make the most significant contribution to the improvement of the health and well being of Kenyans.

Community level activities focus on effective communication aimed at behaviour change, disease prevention, and access to safe water and basic care. LEVEL ONE SERVICES activities organized by the committees may include:

- ***Disease prevention and control to reduce morbidity, disability and mortality***
  - Communicable disease control: HIV/AIDS, STI, TB, malaria, epidemics

- First aid and emergency preparedness/treatment of injuries/trauma
- IEC for community health promotion and disease prevention

- ***Family health services to expand family planning, maternal, child and youth services***
  - MCH/FP, maternal care/obstetric care, immunization, nutrition, C-IMCI
  - Adolescent reproductive health
  - Non-communicable disease control: Cardiovascular diseases, diabetes, neoplasms, anaemia, nutritional deficiencies, mental health
  - Other common diseases of local priorities within the district, e.g., eye disease, oral health, etc.
  - Community-based day-care centres
  - Community-based referral system, particularly in emergencies
  - Paying for first-contact health services provided by CORPs

- ***Hygiene and environmental sanitation***
  - IEC for water, hygiene, sanitation and school health
  - Excreta/solid waste disposal
  - Water supply and safety, including protection of springs
  - Food hygiene
  - Control of insects and rodents
  - Personal hygiene
  - Healthy home environment: environmental sanitation, development of kitchen gardens
  - Organizing community health days

The Kenya Essential Package for Health defines six life-cycle cohorts:
- Pregnancy and the newborn (first 2 weeks of life)
- Early childhood (2 weeks to 5 years)
- Late childhood (5 to 12 years)
- Adolescence (13-24 years)
- Adult (25-59 years)
- Elderly (over 60 years)

This package has to be incorporated into comprehensive district health plans organized by cohorts to enable districts to properly utilize available scarce resources. Similarly, the filtered health service delivery packages targeted at community level should be incorporated into the community-based health plans. Table 1 summarizes the different services provided to the six life-cycle cohorts.

Table 1: Service activities and requirements at level 1, by cohorts in a population of 5,000

Cohort	Service activities	Minimum kit	Human resource
All cohorts	▪ Sensitize, mobilize and organize community to ensure leadership support and awareness of rights and responsibilities in health ▪ Promote early service seeking behaviour ▪ Promote health awareness through IEC on control and prevention of common diseases, particularly malaria ▪ Promote disease prevention and control through environmental sanitation, safe water supply and good personal hygiene	▪ Preventive materials and supplies (ITNs, water guard) ▪ Health promotion supplies (IEC materials) ▪ Drugs/supplies for treatment of common ailments (anti-malarials, analgesics, first aid supplies) ▪ Referral guidelines	▪ 1 CHEW ▪ 50 CORPs

Continued

Table 1, continued

Cohort	Service activities	Minimum kit	Human resource
	▪ Promote HIV/AIDS control ▪ Provide first aid and treatment of common ailments ▪ Make referrals ▪ Develop and help maintain a community-based information system	▪ Communication and transport support, including bicycles ▪ Stationery and supplies such as forms, household registers, chalkboards	
Pregnancy, delivery and newborn (first 2 weeks of life)	▪ Provide exclusive breast feeding education ▪ Provide IEC on current KAP on safe pregnancy and delivery of a healthy newborn ▪ Advocate for community leadership support for safe pregnancy and delivery of a healthy newborn ▪ Promote safe delivery through pregnancy monitoring, establishment and timely referral ▪ Disseminate key messages to support safe pregnancy and delivery of a healthy newborn ▪ Promote or provide professional supervised home delivery	▪ Safe delivery kit ▪ Antenatal care equipment ▪ IEC with key messages to promote early childhood care ▪ Preventive materials and supplies (ITNs, nutritious foods) ▪ FP pills, condoms	▪ 1 CHEW ▪ 50 CORPS
Early childhood (2 weeks to 5 years)	▪ Promote C-IMCI activities ▪ Conduct de-worming ▪ Mobilize and organize for early childhood development (ECD) ▪ Disseminate key ECD health messages ▪ Support nutrition awareness and support for orphans and vulnerable children (OVC) ▪ Promote food and nutrition security ▪ Monitor growth and development	▪ Expanded programme of immunization (EPI) equipment ▪ Intermittent residual spray equipment ▪ Essential drugs and supplies for common conditions, e.g., anti-malarials, ORS, de-worming tablets ▪ Nutritious food supplements	▪ 1 CHEW ▪ 50 CORPS ▪ Trained caregivers
Late childhood: 5 to 12 years (school-age)	▪ Promote gender responsive school health activities ▪ Equip the children with knowledge and skills to promote a healthy lifestyle including psycho-social development ▪ Train teachers and orient parents in school health services ▪ Promote child-to-child approach to healthy lifestyles	▪ IEC materials with key messages on healthy lifestyles	▪ 1 CHEW ▪ 50 CORPS ▪ Trained teachers ▪ Trained parents
Adolescence and youth 13–24 years	▪ Equip the youth (in and out of school) with knowledge and life skills, and facilitate a supportive environment to enhance adoption of a healthy lifestyle for themselves and the community	▪ Training curriculum for the youth on life skills including psycho-social issues, reproductive health, drug and substance abuse, etc.)	▪ 1 CHEW ▪ 50 CORPS ▪ Trained teachers ▪ Trained parents

Continued

Table 1, continued

Cohort	Service activities	Minimum kit	Human resource
	▪ Initiate comprehensive community-based, youth-friendly centres in collaboration with other arms of government, NGOs, etc. ▪ Raise awareness on disease causation, control and prevention, in particular STI/HIV/AIDS ▪ Provide family life education	▪ Preventive materials such as condoms	
Adults 25-59 years	▪ Conduct C-DOTS activities and defaulter tracing ▪ Raise awareness of non-communicable disease control ▪ Care for chronically ill ▪ Equip adults with knowledge and skills for health and key health messages to promote adoption of a healthy lifestyle and care seeking ▪ Assist with ensuring household food security ▪ Promote participation in actions for health	▪ Health learning materials ▪ Preventive materials (ITNs, condoms) ▪ Drugs and supplies for first aid, treatment of simple common conditions	▪ 1 CHEW ▪ 50 CORPS
Elderly persons (Over 60 years)	▪ Equip elderly persons, the community and health care providers with relevant knowledge about common old age diseases, impairments and disabilities; how to improve quality of life; and sources of care ▪ Advocate for the development of social support systems for the elderly ▪ Develop community home-based care for elderly persons with chronic illnesses	▪ Key health messages and health learning materials ▪ Preventive materials ▪ Drugs and supplies for first aid, treatment of simple common conditions	▪ 1 CHEW ▪ 50 CORPS

2.3 Supportive Supervision

The health system should be able to provide supportive supervision to the LEVEL ONE SERVICES frontline personnel. Multidisciplinary supervisory teams having an appropriate skills mix will ensure that standards of quantity and quality of work are met during service delivery. Multi-sector coordination and collaboration and team work at various levels in creating a supervisory system will be encouraged. Regular performance appraisals based on checklists will be carried out to measure performance, promote good communication and discussions, and determine appropriate rewards to CORPs.

Supervisory teams will be established at national, provincial and district levels. They will be trained in supportive supervision and oriented on tools for peer review and performance. The composition of the teams could be as follows:

- ***National:*** Epidemiology, MCH, administration, finance, environmental health, health promotion, human resource and training.

- ***Provincial:*** Disease prevention and control, public health, MCH, administration and finance, health promotion, and training.
- ***District:*** Public health, public health nursing, environmental health, health education.

During supervisory visits, the team should:

- Discuss with CHEWs and CORPs the aim of supervision and the content and use of checklists
- Discuss with committees and consumers issues for attention.
- Observe performance based on job descriptions; guide, direct and encourage.
- Check recording and data systems.
- Check stocks of supplies, note gaps.
- At end of mission, provide feedback to CORPs (positive and negative findings), and wind up with an agreed plan of action based on displayed community-based information system (CBIS) and facility-based information system (FBIS) data.

The team would then prepare a field report and send it to the location development committee (LDC)/health facility committee (HFC) and the district health management team (DHMT) for follow up and needed action. Such actions may include: in-service training, continuing education, and improvements in the supply of materials provided by the health centre (HC) or District Health Office.

2.4 Communication Strategy at Level 1

Community-based communication is the hub of level 1 health care provision. It facilitates the transfer of knowledge and skills on health matters between individuals and families to make informed choices and decisions for behaviour change. It also creates demand for better health services and builds mutual understanding and trust among key actors within the community. The communications component of this strategy is designed to facilitate behaviour change of individuals at family/household level supported through advocacy and social mobilization. It intends to maximize the use of traditional and multi-media channels as opportunities to effect behaviour change.

District Health Management Teams (DHMTs) and health personnel at levels 2 and 3 have an important role in creating awareness among the community on the importance of LEVEL ONE SERVICES in their respective villages. They should also build the capacity of community leaders and extension workers on IEC techniques for sustaining the process of sensitizing and educating communities on health and health-related problems and related social concerns.

The strategies for effective communication include: advocacy, social mobilization and interactive communication. Each of these categories has its specific purpose but they also overlap.

2.4.1 Advocacy

Advocacy efforts will be intensified, as a means of communication that focuses on policy and decision making processes, to influence support or action on LEVEL ONE SERVICES at village, location, district and national levels. The DHMT will advocate for

support by religious, government and political leaders, other influential people, and NGOs and CBOs for resource mobilization and allocation for LEVEL ONE SERVICES activities at community level. A variety of advocacy channels, including direct contacts, meetings, group discussions and popular theatre, will be used to this end.

This process will involve:

- Promoting political and social commitment, mobilizing resources, and stimulating development of supportive policies.
- Explaining the role of the community and other influential people in the LEVEL ONE SERVICES strategy.
- Informing leaders and other influential individuals about the aims, objectives, strategies and activities of the LEVEL ONE SERVICES strategy.

2.4.2 Social Mobilization

Effective social mobilization activities will be carried out to ensure that community interest is created, and that community members are motivated and influenced to take action or to support initiatives that are beneficial for themselves – taking children for immunization, organizing referral preparedness, etc. Social mobilization will be carried out through village gatherings, village health days, seminars, popular theatre, youth groups, women's groups, and print and electronic media. The DHMT will make sure that CORPs and other extension workers are equipped with knowledge and skills for carrying out their functions in social mobilization and sensitization of the community.

Social mobilization is about sensitizing and motivating social partners to work together in raising awareness and pooling resources, targeting interested organizations, individuals and health related sectors, along with CBOs, NGOs, professional associations and the private sector. Concerted effort will go into:

- Identifying and recruiting partners to play a role in the implementation of LEVEL ONE SERVICES.
- Identifying roles and responsibilities for various partners in the implementation of LEVEL ONE SERVICES.
- Maintaining partnerships and ensuring active partner participation, by engaging them in the planning, implementation, monitoring, evaluation and feedback process.

2.4.3 Interactive/Participatory Communication for LEVEL ONE SERVICES

Interactive communication will be promoted for imparting specific knowledge and skills towards positive change of behaviour and attitudes. Direct interaction involving reflection based on identified limits to the fullness of life will be one mode of operation. This will help to inform and motivate major target groups and bring about desired change in key household practices, targeting caregivers, community leaders and service providers. Activities will include the following:

- Promoting self-directed problem identification.
- Developing relevant cost-effective behaviour change messages.
- Strengthening mutual learning.
- Promoting community initiatives for behaviour change.
- Enhancing household capacity to initiate and maintain household behaviour change.

3: Implementation Framework and Process

Defining the norms and standards and the services to be provided through LEVEL ONE SERVICES is not a sufficient condition for implementing an effective community strategy. The implementation mechanism needs to be elaborated. The mechanism should includes the organizational and coordination structures, entry steps to roll out the strategy, planning and management of operations, and linkages with facility-based health systems. This section highlights these issues.

3.1 Organizational Structures and Coordination Framework

Integrating LEVEL ONE SERVICES into the normal health care system will initially require a concerted effort to oversee its take-off until it becomes a functional component of the health system countrywide. Task forces to oversee the implementation process will be established at national, provincial and district levels. Further, the task forces will be provided with orientation to develop common approaches to the facilitation and management of service provision at level 1. The orientation of the task forces at all levels will be immediately followed by the launch of activities at district and community levels, including community entry and recruitment and training of the CHEWs and CORPs who will be at the frontline of the services.

The programme will be initiated in at least four districts in each province, to be identified on the basis of local interest and likelihood of success. This will form a solid foundation and good experience for scaling up, and it is expected that the programme would then be able to touch all the districts in the country by the end of the second year.

Highlighting the sector-wide approach to the implementation of NHSSP II, and the principles of the health sector reform, an experienced partner will be identified in each province to support the implementation of this initiative. This partner would collaborate with the provincial health team in the processes of mobilization, organization, planning, training, monitoring and evaluation of level 1 activities. The idea is to build on existing experiences and strength, instead of starting from scratch.

The various structures and necessary actions to support the introduction and implementation of LEVEL ONE SERVICES are summarized in Table 2.

Table 2: Levels of action to support level 1 services

Structure	Summary of activities
Household, village, school, congregation	▪ Plan, implement, monitor, evaluate and provide feedback on activities ▪ Mobilize and manage resources ▪ Undertake health promotion, hygiene, lifestyle and care seeking initiatives
Sub-location, parish, dispensary	▪ Provide health status information (systems) ▪ Plan, implement, monitor, evaluate and provide feedback on activities ▪ Mobilize and manage resources ▪ Support, provide and protect water sources at village level ▪ Manage community-based information system ▪ Provide technical support, supportive supervision and coaching ▪ Train CORPs and village leaders on LEVEL ONE SERVICES ▪ Establish and maintain working links, including monitoring) of NGOs and CBOs ▪ Train and conduct social mobilization on rights for health to all communities
Division, health centre	▪ Plan, implement, monitor, evaluate and provide feedback on activities for continuous improvement ▪ Provide training and supportive supervision ▪ Coordinate, collaborate, network, exchange ideas and pool resources
District, diocese, hospital	▪ Carry out comprehensive district planning, implementation, monitoring, evaluation and feedback, budgeting, and supervision ▪ Identify and increase the utilization of existing community organizations and structures and sensitize them on rights for health ▪ Strengthen Health Boards ▪ Build capacity of villages on safe water supply, sanitation facilities ▪ Train extension staff and leaders on LEVEL ONE SERVICES ▪ Facilitate M&E of NGO and CBO activities in the district ▪ Facilitate community capacity for providing technical and material support ▪ Coordinate input of development partners/NGOs/CBOs
Province	▪ Build capacity of districts for implementation of LEVEL ONE SERVICES and assure quality, including rights ▪ Provide technical and material support on planning, implementation, monitoring, evaluation and feedback
National	▪ Formulate and review the LEVEL ONE SERVICES guidelines in relation to national health policy ▪ Build capacity of districts for the assessment, reflection, planning and action process ▪ Ensure multi-sector and donor coordination in health and resource allocation ▪ Ensure that the community-based information system is part of the health management information service (HMIS) ▪ Ensure equity of health services, quality assurance, and technical support

3.2 The Entry Steps

The implementation of this strategy is anticipated to take a structured, step-by-step approach that involves awareness creation, formation of district level working groups and training teams, and establishment of a formal monitoring and evaluation mechanism, all of which precede the actual entry into the community. More details of the planned training are provided in Section 5, but the entry process is expected to involve the following actions:

1. Define a clear implementation guideline: This will include the development of comprehensive message materials, the consolidation of the commodity kit, and the training needs, curriculum and manual for both CORPs and CHEWS.

2. Create awareness among district leaders, including the District Commissioner (DC), the District Development Committee (DDC) and relevant line ministries: The facilitating team should ensure adequate knowledge of the district situation as part of this early step. Among the tools to be used might be an orientation workshop (1–3 days) for the leaders to introduce the LEVEL ONE SERVICES strategy.

3. Form and equip district-level multi-sector working groups and training team: The teams will be trained as trainers for the LEVEL ONE SERVICES strategy. In each district this may involve a ten-day course (to be determined in conjunction with the development of the training manual) in two phases of five days each, in order to launch the programme:

- The first phase will cover the introduction of LEVEL ONE SERVICES concepts, entry process, participatory assessment and household registration, feedback and planning (two days), and service delivery by cohort (two days) reinforced by field practice (one day). The participatory assessment and household registration provide information for planning as well as an evidence base for documenting change in key family practices.
- The second phase would cover competency-based training, to prepare the working groups/teams as trainers. The idea is that the actual LEVEL ONE SERVICES strategy with households should be undertaken by CORPs, who share the same context. Thus the action linked training and implementation are repeated at all the levels in a continuous spiral of action focusing on successful sites. The training can be carried out in a cascade, so that the first phase of training is taken all the way to the village level, and then the second phase, in the same way until each set of actors is fully trained and equipped for their role.

4. Follow up, monitor and evaluate: Once training is completed the CHEWs – as coaches – follow up to monitor activities, provide supportive supervision, assess progress and solve problems. The training with follow up forms the main part of the introduction and establishment of the programme in a district. Scaling up of this intervention is assured through the multi-sector working group, building on existing programmes. This is strengthened by iterative rapid assessment, planning and action reinforced by regular health days.

5. Launch the programme in the communities: Effective community entry will be based on a process of engagement that recognizes the need for the health system to

negotiate its way into the community agendas as an alternative for addressing their livelihood, health and development issues. The steps will involve:

- **Exploration:** This step entails a relatively low-key fact finding mission to enable the service providers coming into the community to gain as much knowledge and understanding of the community's situation as possible. The findings should be written up and shared with the community.
- **Protocol:** This step entails identifying the gatekeepers (formal and informal leaders) in order to enter through them to formalize the process and gain authority to work with the community. The facilitators introduce the LEVEL ONE SERVICES idea to the leaders in order to involve them in the rest of the community process. Together the group clarifies the objectives and identifies the target groups to ensure that they are included. This process should lead to identification of task groups to spearhead detailed assessment and planning.
- **Participatory assessment:** This process starts with discussions with the key individuals at every level and control point down to the household level. This ensures that the introduction of the new idea takes full cognisance of what is going on in the community. The new idea has to be negotiated through the gatekeepers at every level, down to the level of individuals concerned.

The assessment is carried out to determine the current situation and the course of action. The community must be involved in defining the issues to be included in the assessment. The assessment, in turn, should be built into the community-based information system to assist the community to continuously assess and analyse their situation. The process enables the community to see where they are now and where they wish to be. In other words, it allows for the identification of gaps, issues, resources and capacity in order to set objectives for making desired changes.

The assessment task force will define indicators/key questions and identify sources of reliable information, target groups and the most appropriate methods of information gathering for the assessment. These will be used as the basis for developing information gathering tools (checklists, interview guides, etc.). Once the community members and the team agree on methods to be used, the facilitating team, including selected community members, will go through specific training on how to use the tools effectively to ensure standardization and improve the accuracy and validity of findings. The scope of the assessment should include:

- The population
- Community structures and processes of governance and management
- Any existing community information system
- Resource availability, access, management (money, manpower, material)
- Service delivery and the minimum package of care and support
- Communication strategy, networking, collaboration and linkages
- Coping mechanisms, innovations and best practices
- The status of health and well being, based on agreed indicators
- The status of food security and nutrition, based on agreed indicators
- Care seeking behaviour
- The environment (water, sanitation, shelter, soils, vegetation, infrastructure)

The assessment process enables the community to see where they are now and where they wish to be. Information from the assessment, in turn, should be built into the community-based information system to assist the community to continuously assess and analyse their situation.

- Identified issues, concerns, ideas, technologies, best practices, models, tools, techniques and approaches
- Identified dialogue centres and groups (religious institutions, schools, civic leaders, youth groups and other sectors), their roles and responsibilities

Assessment methods may include: transect walks, direct observation, mapping the availability of and access to resources, a seasonal calendar of happenings, activities, diseases, food availability, etc., daily activities by gender, Venn diagrams, key informant interviews of individuals from the community, and focus group discussions.

3.3 Feedback and Participatory Planning of Level 1 Service Activities

Findings of the assessment are to be presented to the rest of the community at a general meeting open to all community members. The community validates the findings and identifies striking themes, expressed with emotion such as anger, frustration, fear or excitement. Such themes are effective in generating energy for community action for health.

The community participants summarize the findings in terms of strengths, opportunities, weaknesses and threats. Strategic action points are based on strengths and opportunities and can be in three categories:

- Actions that can be taken with communities' own resources.
- Actions requiring additional support from local partners.
- Actions requiring external support.

The community participants reflect on the future they want (their vision/dream of the way things ought to be) and agree on the main action points. Identified task forces or interest groups are assigned to prepare plans that are collated and presented to the whole group for consideration and adoption. The process allows for all partners to explore what coping mechanisms are in place and their effectiveness and to add options that are lacking.

Felt needs from different interest groups (e.g., pregnant women, parents of under-fives, parents of school age children, adolescents, adults and the elderly, differently-abled persons) are harmonized into one village plan. These plans are then presented and negotiated at the village meeting, which brings all the plans together into one village plan. After the priorities have been set for the consolidated list, a draft village plan is formulated and monitoring and evaluating indicators identified. The CHEW, CORPs, and local NGOs and CBOs within the village provide technical assistance throughout this process of assessment and planning.

The integrated village plan is submitted to the health facility committee. The draft village plans are then collated and reviewed in relation to resource implications, village capacity and the technical support required for their effective implementation. Finally, the village plans are consolidated into one integrated locational/sub-locational health plan for level 1 activities.

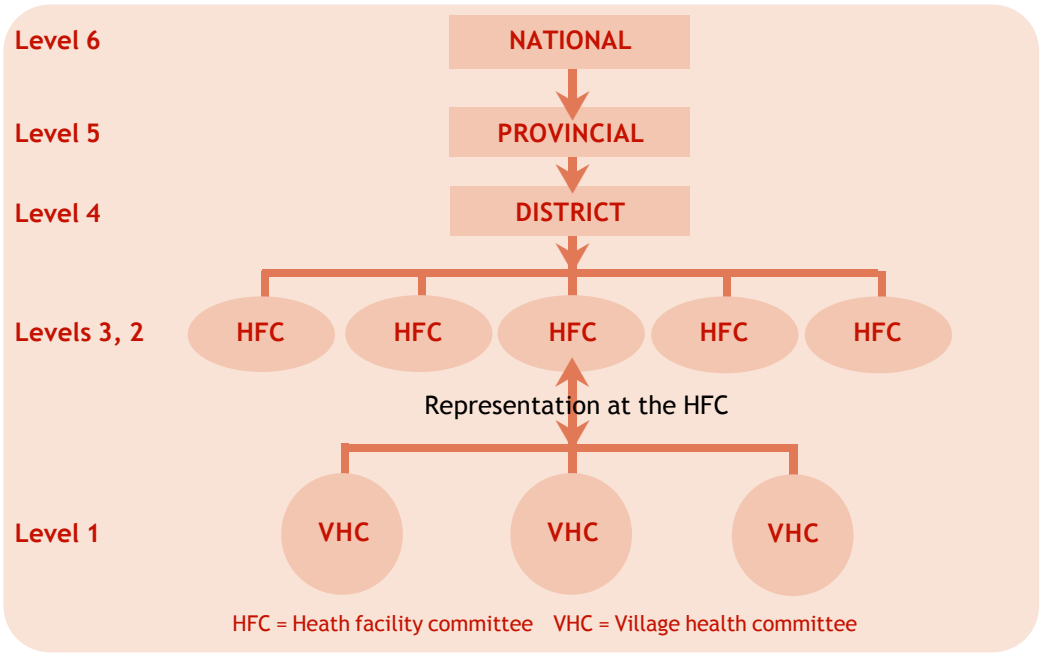
4: Linkage between Community and Health Facility and Sustainability

A clear organizational structure with well defined roles and responsibilities of all actors at all levels is necessary to ensure the success of LEVEL ONE SERVICES. These structures will be built on the existing ones to avoid the creation of unsustainable parallel systems and processes.

4.1 Structures and Their Functions in Supporting Services at Level 1

Figure 1 illustrates the overall health sector structure. At level 1 the governing structures will be based as much as possible on using location, sub-location and village structures, all linked to the local health facilities within them, so that each structure is responsible for a geographically discrete unit based on an administrative division. The implementation of LEVEL ONE SERVICES requires the formation of linkage committees at these levels that would have specific responsibilities based on the respective levels.

Figure 1: Suggested organizational linkages and structures



The intention of the decentralization policy is to enable the community to participate effectively in decision making processes related to matters of health at the community level, as well as at the interface between level 1 and levels 2 and 3. The lower levels of care (levels 2 and 3) are more or less consistent with the administrative and development nodes within the community (although sometimes their catchment population may not correspond to administrative boundaries), and can therefore be robust and sustainable. Health committees at divisional, locational, sub-locational and village levels can be expected to provide citizens with sufficient representation and voice in all issues affecting service provision at level 1. There is thus a need to establish effective linkages between the community and the health system through linking structures. The health facility in-charges (supported by the DHMT), CHEWs, CORPs, village elders, chiefs and other extension workers are the sinews that bind these structures and enable sustained community leadership in addressing health problems.

Decentralization intends to enable the community to participate effectively in decision making processes related to matters of health at the community level.

Health facility management committees, made up of community representatives and the facility in-charges, should meet at least monthly. The committees will review progress from the indicators and baselines generated through the CBIS and FBIS and make decisions for continued actions for health, at facility, community, household, political and administrative levels. The coordinator of CHEWs at the facility level should collate the data obtained from the CHEWs and the health facility in-charge, together with own information, then share the information with the other sectors by displaying it on boards, disseminating summaries and presenting the summaries at stakeholder forums.

4.1.1 District Level

Within the district, the organization and management of the LEVEL ONE SERVICES activities should be integrated into the health sector and local government reform frameworks. The DHMB and DHMT will provide governance and technical support, respectively, to level 1 activities that includes planning, implementation, monitoring and supervision. These structures would take responsibility for:

- Providing technical and administrative support to LEVEL ONE SERVICES delivery at levels 1 to 4 to ensure effectiveness at community level.
- Facilitating recruitment and training of trainers, CHEWs and CORPs.
- Training and preparing coaches and trainers of trainers that are based at the district levels.
- Ensuring that resources reach level one services to implement their village health plans
- Coordinating, monitoring and evaluating the implementation of activities, compiling monitoring data, and producing periodic reports.
- Convening experience sharing forums, preparing and submitting reports to MOH and stakeholders in the district, and organizing evaluation and review meetings.
- Selecting, updating and distributing IEC and health learning materials.
- Facilitating collaboration with stakeholders and securing resources for the programme.
- Organizing and conducting capacity building sessions, including in-service training.

4.1.2 Divisional Level (and Level 3 Health Facility)

If there is no health centre committee, a divisional level subcommittee will be established that will be responsible for health services in the whole division. The subcommittee will also function as the health centre committee where there is a corresponding health centre. The CHEW at this level should provide technical support to level 1, with responsibility for facilitating LEVEL ONE SERVICES activities, reporting to the health centre committee, and providing day-to-day support of CORPs in their service provision. The CHEW would also compile data and reports to the health centre committee for discussion, decision making and action, after which the reports would be submitted to the district. Specifically, the health centre committee, in addition to what is given in the guidelines for facility committees, should:

- Oversee the functioning of the health centre in support of level 1 service provision.
- Oversee the functioning of the different level 1 units to be established under the committee.
- Receive and interpret policy guidelines and follow up their implementation.
- Obtain and distribute standard formats for data collection and reporting.
- Coordinate CBIS and FBIS and divisional experience sharing and dialogue forums.
- Communicate information to the relevant District Offices.
- Strengthen collaboration with divisional level stakeholders.
- Mobilize resources for development of the health facility as well as supporting outreach and referral activities.
- Organize quarterly Divisional LEVEL ONE SERVICES Days.

4.1.3 Locational/Sub-Locational Level (and Level 2 Health Facility)

This is the level of first direct contact with level 1 and will carry out activities relating to LEVEL ONE SERVICES. This level should have a dispensary committee with representation from locational and sub-locational structures as detailed in the decentralization guidelines and would therefore form the main linkage between the health system and the community. The dispensary committee should be linked with and report to the locational/sub-locational development committees on matters of health. The technical resource persons at this level would include the CHEW, trained to train, coach and support CORPs. The committee, in addition to the formal roles assigned to it through the various guidelines, should:

- Plan, implement, monitor, evaluate and provide feedback on LEVEL ONE SERVICES activities.
- Mobilize resources for development of the health facility as well as supporting outreach and referral activities.
- Facilitate regular dialogue between the community and the health service providers based on available information.
- Organize the community for health action.
- Strengthen community involvement in decision making.
- Promote inter-sector collaboration.
- Oversee the processing of CBIS and FBIS, display and discuss the data for action – addressing facility-based and community-based issues causing gaps indicated in the data – by sub-locations to ensure specificity of responsibility.

Community structures work best when linked to administrative structures as well as the health facilities' catchment areas, and when they are in control of tangible decisions, guided by clear guidelines defining their roles.

- Facilitate planning, budgeting, budget controls and accountability, to ensure availability of all the resources needed for LEVEL ONE SERVICES.
- Establish the link between the health system and the community by helping to market the health facility to enhance its credibility based on quality of care and thus promote a culture of good health promotion at the community level.
- Use the services as the place of first choice when in need of care.
- Listen to and address complaints of clients.
- Coordinate the recruitment of CORPs and CHEWs.
- Convene monthly Community Health Days for joint health action.

4.1.4 Village Level (Level 1)

The village health committee will oversee the operations of LEVEL ONE SERVICES in the village and will therefore serve as the link between the village and the household. Through the committee, the Chair will mobilize community resources and undertake social mobilization for implementation, reporting to the Dispensary Committee in matters of LEVEL ONE SERVICES. The CORPs will report to the Chair on their day-to-day activities, with the technical support of the CHEW. The functions of the village structure include:

- Representing the villagers in various health committees at other levels.
- Endorsing the recruitment of the health workers (CHEW and CORPs).
- Planning, implementing, monitoring, evaluating and giving feedback on level 1 service provision, encouraging the implementation of key household practices by all, while voicing any concerns barring them from accessing their rights in matters of health.
- Mobilizing resources for health activities including outreach and referral.
- Facilitating regular dialogue within the community based on the CBIS and FBIS.
- Organizing the community for collective health actions and addressing priority problems.
- Ensuring community involvement in decision making.
- Gathering community-based health information for use at the community level and sharing with the different levels where possible.
- Encouraging and using existing appropriate household-based care.
- Listening to and addressing complaints of clients, for example by reporting to the CORPs or higher level service providers.
- Taking control of development processes, decisions and priorities, and initiating interventions, based on capacity.
- Facilitating provision of specific education on LEVEL ONE SERVICES.
- Making contacts with partners for technical support and resource mobilization while at the same time retaining control over the use of resources.
- Promoting equal opportunities for decision making and control of resources at village level.
- Promoting gender equality and the empowerment of women.

Since health status depends on factors beyond the health sector, coordinated action across sectors at the community level will increase efficiency in improving health outcomes. This includes economic empowerment and transformation, enhancing access to the means of production and marketing, and paying attention to the social determinants of health. The village health committee will work in partnership with different sectors of the community in:

- Planning for departments and sectors to work together with a common vision at community level.
- Lobbying and advocating to gain political support and commitment based on a common stronger voice for change.
- Conducting IEC and training.
- Promoting networking through regular communication and the sharing of information, skills and experience through open forums for dialogue.
- Developing and using common guidelines in working with the community.
- Ensuring the pooling and better use of resources to increase efficiency and effectiveness by reducing duplication of efforts.
- Strengthening the economic capacity of households through professionally managed initiatives to expand options.
- Maintaining joint information systems to enable regular reporting of progress and success and thus enhance commitment.

4.1.5 Household Level

The household consists of individuals associated with and usually headed by the household head. It is the members of households and families who are the primary targets and implementers of level 1 service provision. They are responsible for the day-to-day upkeep of household affairs as well as participating in community-organized health activities. They have contacts with the CORPs and the formal health system where they seek and utilize health services. The household forms the first level of care that is universally available.

Service provision at level 1 is organized in three tiers starting with household-based caregivers, adult members of the household who provide the essential elements of care for health in all dimensions and across life-cycle cohorts These household-based caregivers are normally supported directly by the CORPs.

4.2 LEVEL ONE SERVICES Sustainability

Sustaining LEVEL ONE SERVICES greatly depends on the degree of community ownership, participation and involvement, supported by political will shown in resource allocation for action by the state. Communities will be empowered to manage own resources in addition to external support necessary for facilitation of LEVEL ONE SERVICES activities. The Government through MOH will mobilize additional resources from external partners and allocate resources from the government budget for the sustainability of this initiative.

Any investments made at the community level will focus on enabling the community to be self-reliant, within the limitations of their situation.

4.3 Strengthening Rights to Health Aspects of LEVEL ONE SERVICES

Human rights for health are tools that empower those who are not in a position to assert and defend their claim to equitable, quality health care. It is critical to protect members of the community such as children, women, disabled persons, orphans and others (differently-abled) who may be exposed to jeopardy but are unable to protect their rights. In this way their needs differ from the more advantaged groups in the

community and they should be given due consideration supported by transparent, accessible and effective mechanisms.

The objective of rights for health in the context of LEVEL ONE SERVICES is to enable CORPs, community leaders and communities as a whole to understand and acknowledge their health rights and the reasons some community members are deprived of their rights. Community members should be able to identify and discuss the main challenges and find solutions. Equally important, they should be able to analyse the roles and responsibilities of individuals, family members, the community, the Government, NGOs/ CBOs, religious bodies and the donor/international community in ensuring equitable access to care. They should address power relationships with regard to resource utilization and decision making. Moreover, they should identify mechanisms for voicing, receiving and handling complaints on issues differentially denying the most vulnerable members of the community their right to good health care services.

Districts, locations and village structures including CORPs are responsible for raising and maintaining awareness on rights for health with every member of the community.

It is the responsibility of the districts, locations and village structures including CORPs to raise and maintain awareness on rights for health with every member of the community. This entails ensuring accessibility to KEPH with special attention to marginalized and disadvantaged groups across cohorts. Communities, through participatory processes, should therefore assess their situation, analyse problems and find solutions to address the existing rights-related issues.

5: Recruitment and Training of Service Providers for Level 1 Service Provision

Kenya will need a total of 255,000 CORPs (50 per sub-location for 5,100 sub-locations), to be trained, supervised and supported by 5,100 CHEWs. Achieving a cadre that size and in good time presents an enormous challenge. As indicated earlier, this strategy envisions a cascade approach to the development of an adequate, competent community-based human resource necessary for effective implementation of level 1 of KEPH. The cascade will begin with trainers trained at national level and flow downward all the way to the community.

5.1 Training Trainers of Service Providers at Level 1

Being newly recognized by the health system as a level of care, level 1 requires innovation in the identification and training of appropriate service providers. The training of trainers is intended to result in a core multi-sector team of trainers charged with the responsibility of training CHEWs and CORPs for service provision at level 1.

5.1.1 Selection of Trainers

A multidisciplinary team of trainers of trainers (TOTs) will be constituted at the district level. The team will be made up of four to five people drawn from health and related sectors such as water, education, agriculture and community development who will train divisional level trainers in KEPH principles and services. Similarly at the divisional level, the selection of trainers will be expected to include the relevant sectors where they have extension staff. These divisional trainers will train actual service providers at sub-location levels.

The national level, in collaboration with the provinces, will facilitate capacity development of the district teams of trainers. These teams will, in turn, train the divisional and sub-locational level trainers to train CHEWs and CORPs.

It is estimated that the training duration for the district and divisional TOTs will be two weeks; for the health extension workers it will be four months, starting with an introductory one-month session linked to implementation activities. The actual durations will be determined after the development of the training content and manual. For CORPs, training will begin with four weeks of basic training followed by on-the-job training, essentially life long. The course should be in the community with field and health facility practice elements. Refresher training will be undertaken from time to time, according to need, but at least every quarter.

5.1.2 The Tasks of CHEWs as Trainer-Coaches

The CHEWs, as the trainers and coaches of CORPs, will need to be familiar with all the tasks of the CORPs plus the additional management, supervisory, training and clinical tasks required to support CORPs properly. Their tasks will therefore include:

- Training CORPs using problem-based learning methods in service contexts.
- Implementing NHSSP II and the KEPH at level 1.
- Organizing and facilitating community animation and mobilization.
- Carrying out evidence-based management of service delivery at level 1, grounded in a continuous improvement strategy.
- Supporting CORPs in recognition and classification of health problems and action to resolve them.
- Promoting inter-sector action for health, working with various extension workers.
- Facilitating health promotion through advocacy, social mobilization and interactive communication to improve key household practices for health.
- Functioning as link person between communities and the health system.
- Carrying out immunization, family planning, antenatal care, home delivery, disease surveillance, treatment of common conditions, prevention and control of HIV/AIDS, STI, TB, and promotion of school health.
- Managing resources, and storing and distributing commodities and supplies for CORPs.
- Mobilizing communities and their leaders on LEVEL ONE SERVICES to enable them to take appropriate action.
- Facilitating assessment, planning, implementation, monitoring and evaluation of LEVEL ONE SERVICES.
- Establishing and managing community- and facility-based information systems, to include data collation, storage, analysis, interpretation and utilization, in dialogue for continuous improvement.
- Carrying out baseline survey and analysing data.
- Keeping records of daily activities of services delivered and producing and submitting reports.
- Organizing documentation and filing system.

5.1.3 Training Content

Based on the tasks required of trainer-coachers, the training content will include:

- Concepts in health and development
- Components of NHSSP II, focusing on the KEPH strategy
- Community process
- Community-based education and competency-based training
- Communication strategy, which contains advocacy, social community mobilization and interactive/participatory communication.
- Community- and facility-based information systems, including data collection, storage, analysis, interpretation and utilization in continuous improvement.
- Evidence-based management of LEVEL ONE SERVICES.
- Clinical updates (safe motherhood, IMCI, malaria treatment, prevention and control).

5.2 Recruitment and Training of CORPs

CORPs are at point in the delivery of KEPH at level 1 and as such they should be able to accompany the households in their struggle for health improvement. This is possible when the providers overlap adequately with the target community in terms of experience and context. Since the core of level 1 service provision rests on key household practices, CORPs are likely to be more effective in dialoguing with households for actions for health as they share a common context and experience. And because communication is essential to their effectiveness, the selection criteria for those to be trained as CORPs should include literacy in the local language, along with respectability in the community and a "good heart". Those interested in being trained should be encouraged to offer themselves if they satisfy the literacy criterion, but they would have to be voted for by members of the village under the leadership of the village elders.

5.2.1 Recruitment

The village, sub-location and district teams should collaborate in recruitment of the CORPs and their coaches (CHEWs) for training, one for each village, according to recruitment guidelines set by the communities. The coaches, depending on their area of expertise, should be hired by the location development committee or the health facility committee. They could be at the level of a PHT or ECN, but financed through a financial allocation by the state. The same fund should be used to compensate the CORPs for work actually done and costs incurred.

It is envisaged that the training would take place in the respective contexts of those to be trained, and be done in phases to reduce the time that people are taken away. Since they are volunteers, prolonged training away from their base may disable the livelihood mechanisms they depend on. Thus, although the training would eventually cover nine months, the course would be spread in phases over three years. Each phase of the training would be linked to specific implementation activities to enable the programme to take off. The outcome of the training should be a team of competent community-based providers for service provision at level 1.

5.2.2 The Scope of Training

The course would equip the CORPS with the skills they need to undertake the tasks assigned to them, such as:

- Recognizing a health problem, classifying it and deciding on appropriate action.
- Promoting inter-sector action for health, working with various extension workers.
- Facilitating good health promotion through advocacy, social mobilization and interactive communication.
- Functioning as link person between communities and the health system.
- Developing and maintaining household registers, collecting data from households regularly as a method of health promotion, collating data on chalkboards, and using it for dialogue at household and village levels.
- Educating and motivating community members on key household practices based on agreed communication strategy, such as safe motherhood, C-IMCI, adolescent health, screening for chronic conditions.
- Carrying out immunization, family planning, antenatal care, disease surveillance, treatment of malaria, prevention and control of HIV/AIDS and STIs, monitoring TB treatment, promoting school health, and ensuring continuity of services.

- Providing first aid treatment for minor illness and injuries, and referring patients to health facilities.
- Managing resources and storing and distributing commodities and supplies.
- Raising awareness through appropriate IEC and behaviour change interventions on disease causation, control and prevention, environmental sanitation, safe water supply, housing, hygiene, community IMCI (nutrition, maternal care, immunization, malaria, etc.).
- Mobilizing communities and their leaders on LEVEL ONE SERVICES to take appropriate action.
- Facilitating and participating in planning, implementation, monitoring and evaluation of LEVEL ONE SERVICES.
- Carrying out baseline survey, compiling survey data.
- Registering households, keeping population and household data of the villages, and recording events based on regular household visits.
- Keeping records of daily activities of services delivered, producing reports and submitting them to LDC/HFC.
- Organizing documentation and filing system.

Where there are ECNs as CHEWs, they could conduct home deliveries with the support of traditional birth attendants (TBAs). The content of the various levels of training is summarized in Table 3 by category and required skills.

Table 3: Summary of training content by category and tasks

Category trained	Required skills/Tasks	Training content
The national and provincial managers/ trainers	▪ Programme development and management ▪ Resource mobilization and allocation ▪ Development of guidelines, training materials ▪ Training of managers and trainers ▪ Planning ▪ Development and testing of models ▪ Networking, dissemination, advocacy	▪ Concepts in health and development ▪ NHSSP II, KEPH, LEVEL ONE SERVICES and the life-cycle approach ▪ Programme development and management ▪ Resource management (human, financial) ▪ Evidence-based planning, implementation, monitoring, evaluation, feedback ▪ Communication strategy, dialogue for behaviour change ▪ Competency based training
The district and sub-district trainers and supervisors	▪ Policy dissemination and implementation ▪ Programme management ▪ Community, entry, mobilization, organization ▪ Participatory planning ▪ Monitoring and evaluation ▪ Advocacy and dialogue for change ▪ Training of the health extension workers and supporting them in training CORPs ▪ Development of learning aids	▪ Concepts in health and development ▪ (including rights based approach) ▪ NHSSP II, LEVEL ONE SERVICES and the life-cycle approach ▪ Governance, management and leadership ▪ Planning, implementation, monitoring, evaluation, feedback and the wheel of change ▪ Community-based management information system

Continued

Table 3, continued

Category trained	Required skills/Tasks	Training content
	▪ Supervision of extension workers ▪ Logistical support ▪ Ensuring accountability and integrity ▪ Leading change, support to governance	▪ Community-based education and competency-based training ▪ Communication strategy, dialogue for change ▪ Management of resources and activities
CHEWs	▪ Community entry, mobilization, organization and sensitization ▪ Establishing the information system, and the planning, implementation, monitoring, evaluation and feedback process ▪ Report writing ▪ Training of committees and CORPs ▪ Recognition and classification of common conditions and decision for action (treatment or referral) ▪ Home visiting ▪ Communication through evidence-based dialogue ▪ Growth monitoring ▪ Supervision	▪ Concepts in health and development ▪ NHSSP II, LEVEL ONE SERVICES and the life-cycle approach ▪ Community partnership (entry, etc.) ▪ Community-based education and competency-based training ▪ Updates on recognition and classification of disease and taking appropriate action based on KEPH (treatment or referral) ▪ C-IMCI, handling essential drugs and supplies ▪ Nutrition, growth monitoring ▪ Home care, home visiting ▪ Counselling ▪ Recordkeeping, data gathering and use ▪ Planning, implementation, monitoring, evaluation, feedback ▪ Communication strategy and dialogue ▪ Health and management information system ▪ Planning for community-based health initiatives
CORPs	▪ Community entry, organization, sensitization ▪ Registering households, data gathering ▪ Collation of data on chalkboards ▪ Community dialogue for change ▪ Record keeping and report writing ▪ Health promotion ▪ Recognition and classification of common conditions and decision for action ▪ Home visiting ▪ Training and supporting home caregivers	▪ LEVEL ONE SERVICES ▪ CBIS ▪ Community dialogue for change ▪ Recognition and classification of common conditions and decision for action (treatment or referral) ▪ Home visiting ▪ Keeping drugs and supplies

6: Monitoring and Evaluation

In the development of structures for the district health plans, which in future will be based largely on the intelligence developed at level 1, we defined monitoring and evaluation – M&E – as a continuum of observation, information gathering, analysis, documentation, supervision and assessment. This applies equally at community level. The purpose is to keep activities on track towards goals and objectives and to support decision making. Effective M&E thus contributes to accountability on current activities (reporting and assessing impact) and helps improve planning and implementation of future activities.

6.1 Issues in Monitoring and Evaluation

To carry out monitoring and evaluation activities, the critical issues are goals, clear objectives, targets, inputs, outputs and indicators. Monitoring is the process of regularly reviewing achievements and progress towards the goal. In this context monitoring is the process of measuring, coordinating, collecting, processing and communicating information on the implementation of the planned KEPH activities. It also involves tracking the use of resources to support management and decision making by the stakeholders. In a word, it involves comparing what is actually happening with what was planned.

Effective M&E contributes to accountability on current activities (reporting and assessing impact) and helps improve planning and implementation of future activities.

Evaluation itself implies judging and appraising. It can take place during or after implementation. It involves determining the worth, merit, value or quality of ongoing or completed activities in terms of relevance, effectiveness, efficiency and sometimes impact. In a nutshell, evaluation asks whether we succeeded or failed, whether we used resources appropriately, and whether our actions will have long-term results.

An effective M&E system needs monitoring structures with appropriate staff, a good information network system, and appropriate reporting formats/registers and procedures. Fundamentally, monitoring should be established from the beginning as part of the planned activities. The purpose is to ensure that KEPH activities are implemented according to the set plan, that lessons are derived from the way the programme is implemented, and that health extension programmes are effectively implemented.

6.2 Implementing Monitoring and Evaluation

M&E methods derive from the key issues that inform the process. These include the quality of the information used for tracking progress, changes in objectives/activities, timeliness of programme/project activities, timeliness/ effectiveness of communicating results, and the capacity of the implementers and managers of the activities. To facilitate M&E, there should be regular collection and analysis of data that are directly relevant to programme objectives and management.

Monitoring involves comparing what is actually happening with what was planned.

6.2.1 M&E Methods

Monitoring and evaluation should be participatory and built into community processes. The community should be guided to take control of activities. Feedback should always be given to the community for monitoring progress and for re-planning programme activities.

Both qualitative and quantitative methods can be used to evaluate health programmes. Qualitative methods are used to measure success in participation, collaboration, changes in views of people, policy development and implementation. Qualitative data provide crucial information on values, norms, knowledge, attitudes, behaviours, experiences, practices and social interactions in the implementation of the health extension package. Tools or techniques used in collecting qualitative data include observations, in-depth interviews, and group or focus group discussions.

Quantitative methods provide precise measurements of activities and services – how many, how often, how much. Quantitative tools include large surveys for programme evaluations. Both quantitative and qualitative data are used together to give a clearer picture of the situations about the performance of the programme.

6.2.2 Community-Based Information System

It is critical that the management of health action be evidence-based, beginning at the community level. Yet at present most of the information used in health services delivery is derived from health facilities at levels 2, 3 and 4. Health and health-related information and data generated in the communities are rarely linked with those higher levels. This makes health reports less comprehensive than they should be and inadequate for effective monitoring, evaluation and planning.

At community level, the evidence is grounded in the community-based information system, which refers to information required, gathered, analysed and used by the community and other levels for planning, monitoring and decision making related to KEPH at the community level. The system enables the community to follow up on the progress of implementation of planned activities, to determine their success and constraints in achieving their objectives. Because there is not likely to be an elaborate management information system in very many communities, it is important that a system be designed and established for the collection, analysis, reporting and use of realistic health and health-related information. In order to make this information complete there is a need to establish reasonably uniform community-based information systems across the sector. Similar efforts must be taken to link or integrate this information to the present HMIS

Evaluation asks whether we succeeded or failed, whether we used resources appropriately, and whether our actions will have long-term results.

in the health facility. Table 4 summarizes the categories and types of information to be collected at community level, and identifies possible sources of the information.

There are a number of steps that can be taken to link the community and health facility information systems. Members of the health facility committees, community leaders, CHEWs and CORPs should be trained on the importance of data collection, analysis, storage and utilization. The DHMT should facilitate the availability of data collection tools. The committee should be responsible for the overall management of their community-based information system (CBIS).

CORPs, with the support of the village elders, are expected to be responsible for collecting routine/day-to-day data in the services they provide using the available

Table 4: Types of health information to be collected in community by category and source

Category	Types of data	Collection/Source
Demographic	▪ Population by age and sex ▪ Births and deaths (with cause) ▪ Migration in and out	▪ Village register ▪ Birth and death register ▪ Village health worker
Nutrition	▪ Under one year registered weight ▪ One to five years registered weight ▪ Moderate and severe malnutrition	▪ Under-five register
Immunization	▪ Under one year registered, vaccinated against BCG, DPTHB ▪ Polio (3 doses), measles, fully immunized children ▪ Women protected against tetanus with at least 3 doses of tetanus toxoid	▪ Under-five register ▪ Household survey ▪ Visit form, registers ▪ National immunization
Malaria	▪ Under five sleeps under ITN	▪ Village register, survey
Reproductive and child health	▪ ANC visits, ANC referrals, causes of referrals ▪ Deliveries, referrals during delivery, complications ▪ Mother and child outcome, deaths and causes ▪ New and current family planning users by method ▪ IEC/BCC session conducted	▪ ANC register ▪ Delivery register ▪ Family planning register ▪ Household/catchment area survey form
Health status	▪ Under-fives with fever, diarrhoea, measles, chest tightness, HIV/AIDS	▪ Household survey/visit form
Environmental sanitation/Water	▪ Latrines, housing type, safe waste disposal methods, safe water sources	▪ Household survey/visit form
School	▪ School visits, health education, health screening on disease conditions, immunization status, first aid, guidance and counselling, referral system, safe water, latrines, school meals, mass treatment, class one enrolment by gender, dropouts by gender	▪ School visit form
Socio-economic	▪ Number of orphans, disabled children exempted	▪ Household visit form

CBIS tools, e.g., village registers and household visit forms. The collected data are presented to the CHEW and Assistant Chief, or entered in the sub-locational chalkboard.

Health facility in-charges should use the information as a basis for discussion during their review and planning meetings. They should provide immediate feedback to CHEWs and CORPs during supervisory visits and meetings. CHEWs and CORPs and other leaders should use the information to monitor progress of planned LEVEL ONE SERVICES. In addition, data are used for monitoring, identifying vulnerable households, targeting outreach services and deciding appropriate health education lessons.

Feedback to the village will be ensured through representation by CORPs and elders in the health facility committee meetings. The District M&E officer should be responsible for processing and analysing data by sub-location and disseminating at the district level. Data can also be obtained from other institutions such as schools, churches and mosques.

7: Activities and Inputs for Implementing the Community Strategy

The implementation process will kick off with the identification and establishment of task forces at national, provincial and district levels. The national team of managers drawn from both national and provincial levels will go through a five-day orientation workshop followed by commencement of activities at the district and community levels. Each province will be required to start off with a minimum of four districts with the most enthusiastic champions and partners to encourage early success stories. In this way it should be possible for the programme to reach all the districts in the country by the second year.

The following sections provide an outline of the tasks, outputs and expected inputs in introducing LEVEL ONE SERVICES countrywide.Table 5, at the end of the section, provides a timetable for pulling together all the pieces detailed in the previous sections.

7.1 Assembling Key Implementation Partners

Experienced partners identified in each province could spearhead mobilization, organization, planning, training, monitoring and evaluation activities. Such partners could be contracted by the MOH for the task.

7.1.1 Specific Tasks

- Carry out a rapid inventory of agencies and individuals with experience in community-based approaches to health care and development by province and district.
- Identify key partners and champions and convene them into task forces at national, provincial, district and community levels for LEVEL ONE SERVICES implementation.
- Identify lead partners with proven capacity to spearhead the implementation of LEVEL ONE SERVICES at national and provincial levels.
- Hold a five-day national orientation workshop followed shortly by provincial orientation workshops, but building on existing initiatives and processes.
- Establish national and provincial secretariats and identify a district focal person for LEVEL ONE SERVICES.
- Establish coordination and collaboration mechanisms/committees at national, provincial and district levels to spearhead evidence-based planning, monitoring and evaluation (quarterly meetings at each level).

- Hold annual LEVEL ONE SERVICES meetings for review, as well as share innovations, discuss progress and find solutions to problems.
- Run training workshops on emerging critical elements.
- Recognize excellence, celebrate progress and publish results.

7.1.2 Expected Outputs

- An inventory of experienced LEVEL ONE SERVICES agencies and champions undertaken and a report presented to the LEVEL ONE SERVICES task force.
- A national task force convened and oriented through a five-day workshop attended by national and provincial managers sector-wide.
- A lead partner identified at national level and in all provinces and contracted to spearhead LEVEL ONE SERVICES.
- All eight provinces hold orientation workshops attended by all district teams, sector-wide.
- Coordinating committees meet quarterly.
- Secretariats established and focal point persons identified at the three levels.
- All districts submit LEVEL ONE SERVICES plans, 30 in the first year and 50 in the second year.

7.1.3 Required Inputs

- National, provincial and district managers assigned to spearhead operations as counterpart facilitators alongside the expert facilitators from contracted partner agencies.
- The identified lead agencies provide two experienced facilitators to facilitate activities at national and provincial levels.
- Transport and travel for fieldwork, orientation workshops and coordination meetings.
- Daily subsistence allowances for fieldwork, orientation workshops and coordination meetings.
- Stationery and other workshop materials.
- Report production at national, provincial and district levels.

7.2 Building the Human Resource

People are the foundation of LEVEL ONE SERVICES, and we considered earlier some of the issues of recruitment and training of the large cadre of service providers that will be required. Here we apply that discussion to recap the specific tasks, outputs and inputs.

7.2.1 Specific Tasks

- Identify and train the national team of trainers, with all provinces represented.
- Identify and train provincial teams, with all districts represented.
- Recruit the team of health extension workers, animators, CHEWs and CORPs.
- Train the health extension workers as they initiate the LEVEL ONE SERVICES implementation steps, supported by trainers, applying the partnership approach to health personnel education.
- Identify trained CORPs and orient them to LEVEL ONE SERVICES on the basis of their learning needs.
- Work with the community structures to identify and train additional CORPs based on the number of households per sub-location, one CORPs for 20 households.
- Develop a training curriculum and training materials based on the learning needs.

7.2.2 Expected Outputs

- 32 national trainers trained, all in the first year.
- 400 provincial trainers trained (5 from each district), at least 150 in the first year.
- 5,100 CHEWs (PHTs, ECNs or equivalent) recruited and trained, one for each sub-location: 2,000 recruited and commence their action linked training in the first year, the rest recruited and started on training by the second year.
- 225,000 CORPs (who can read and write but nominated by their communities) trained: 50,000 trained in the first year in 30 districts and the rest identified and trained in the second year, therefore covering all the districts.

7.2.3 Required Inputs

- National (8), provincial (400) and district trainers.
- The identified lead agencies provide two experienced trainers to accompany the MOH teams at national and respective provincial levels.
- Transport and travel for fieldwork supervision, follow up and training workshops.
- Daily subsistence allowances for fieldwork, supervision, follow up and workshops.
- Curriculum and training materials development.
- Stationery and other training materials.
- Report production at national, provincial and district levels.
- 5,100 CHEWs (PHTs, ECNs or equivalent) and 225,000 CORPs (50 per sub-location).

7.3 Introducing and Sustaining Service Delivery at Level 1

The launching of service provision at level 1 should follow the community entry and participatory planning process described earlier, as well as the training of CHEWs and CORPs. The actual package and hence the content of the sub-location kit should be worked out by the DHMT in consideration of prevailing local diseases/conditions. The health facility committees should be responsible for the provision of the kits including regular replenishment of drugs and supplies therein.

7.3.1 Specific Tasks

- Establish the level 1 service package for each implementing district on the basis of community plans collated into the district master plan.
- Distribute supplies according to guidelines and controls.
- Promote early service seeking behaviour.
- Facilitate health promotion: IEC on control and prevention of common diseases (particularly malaria and HIV/AIDS) using the dialogue method at household and community levels to ensure disease prevention and control.
- Facilitate environmental sanitation and safe water supply and encourage good personal hygiene.
- Provide first aid and treatment of common ailments.
- Establish a referral mechanism and identify and refer clients.

7.3.2 Expected outputs

- Level 1 service package established for each implementing district.
- Equipment, drugs and supplies distributed according to the package, guidelines and controls to 5,100 sub-locations.
- 900,000 household visits for health promotion, disease prevention, care and support, and data collection.

- 600,000 packets of IEC materials distributed to CHEWs, CORPs, schools and worship sites on control and prevention of common diseases (particularly malaria and HIV/AIDS).
- 1,800,000 people receive treatment.
- 1,200,000 people referred.
- 900,000 women cared for and referred to health facility to deliver; 600,000 cared for but delivered at home.

7.3.3 Required Inputs

- Preventive and promotive materials and supplies (ITNs, water guard, condoms, contraceptives).
- Health promotion supplies (IEC materials according to priorities, e.g., C-IMCI, safe motherhood, community nutrition and supplements).
- Drugs and supplies for first aid and treatment of common ailments (first aid kit and supplies, anti-malarials, analgesics, de-worming medicines, oral rehydration salts).
- Referral mechanism, e.g., communication and transport (phones, air-time, bicycle, forms).
- 5,100 CHEWs, 225,000 CORPs, trained caregivers, trained teachers, trained parents.
- Antenatal care equipment and supplies.
- Indoor residual spray equipment and supplies.
- Expanded programme of immunization equipment.
- Home delivery kits.
- Growth monitoring equipment and cards.
- Gender and age sensitive recreation facilities, including comprehensive community-based youth-friendly centres.
- Home-based care equipment and supplies.

7.4 Strengthening Linkage between the Health System and the Communities

Fundamental to KEPH is the recognition that at the community level people do not access health facilities, for a variety of reasons ranging from cost to questions about service and quality of care. A trip to a formal sector health facility may be made only as a last resort and frequently when it is too late for effective treatment – thus contributing to the spiral of discontent. This has a major impact on the health status at community level. One purpose of KEPH is to renew services on the ground and restore people's confidence in the formal health sector. It is therefore critical to build and strengthen linkages between the two avenues of health care.

7.4.1 Specific tasks

Following orientation and training workshops, participants with the support of facilitators will:

- Create awareness among the district leaders by written communication followed by a visit and leaders workshop.
- Carry out community entry starting at the district level and continuing down to the community (sub-locational level).
- Disseminate the relevant portions of the NHSSP II and LEVEL ONE SERVICES guidelines to all key stakeholders.

- Orient key stakeholders on LEVEL ONE SERVICES and launch the initiative in 30 districts in the first year and the rest in the second year.
- Support interested health committees to strengthen the health facility community.
- Develop guidelines and procedures to promote evidence-based governance, management and service delivery to translate policies, plans and human capital into long-term health improvement.
- Sensitize, mobilize and organize the community, and enhance leadership support, for rights and responsibilities for health.
- Bridge the gap between health workers and the communities they serve, seeking to:
  - Improve communication and relations with communities.
  - Show genuine respect and concern for community problems and aspirations.
  - Work with communities to promote health and improve their health status.
  - Increase availability of health workers to the communities.

7.4.2 Expected Outputs

- Entry process undertaken in all 80 districts in Kenya, 30 of which will be done in the first year covering a minimum of 1,000 sub-locations, and the rest in the second year.
- 300 copies of LEVEL ONE SERVICES guidelines distributed in all 80 districts in the country.
- Orientation for key stakeholders on LEVEL ONE SERVICES and launch of the initiative in 30 districts in the first year and the rest in the second year.
- 2,000 community-based structures reviewed and briefed for involvement in LEVEL ONE SERVICES.
- Orientation for 5,000 village health committee members on their LEVEL ONE SERVICES functions and relevant policy documents made accessible to them.
- 80 districts will have LEVEL ONE SERVICES plans, at least 30 of them in the first year.
- Health facility committee guidelines reviewed and re-oriented in the light of LEVEL ONE SERVICES in 80 districts, 30 covered in the first year, with 20% of level 2 and 3 health facilities.
- Linkage mechanisms (committees, staff and CORPs) established in at least 30 districts in the first year and the rest in the second year.
- 400 facilities have plans including LEVEL ONE SERVICES with at least 100 in the first year, and the rest to be done by the second year.
- 400 facilities monitoring and discussing client satisfaction, with 100 commencing in the first year.
- 400 committees with established referral mechanism, with 100 in place the first year.
- 400 committees holding evidence-based discussions regularly, with 100 having started in the first year and 20% of facility committees involved in the practice of displaying and discussing information to inform improvement.

7.4.3 Required Inputs

- Transport and subsistence allowance for team conducting entry process in 80 districts, and 5,100 sub-locations.
- 5,000 copies of LEVEL ONE SERVICES guidelines.
- Three-day orientation workshops for 50 participants per district in 80 districts.
- Transport and subsistence for two-day dialogue sessions at district level quarterly in each district (320 sessions).
- Transport and subsistence for one-day evidence-based dialogue sessions at health facility level quarterly in each district (3,200 sessions).

- Stationery and supplies for the linkage structures for 1,000 health facility committees.

7.5 Monitoring and Evaluating Level 1 Activities

To be effective, M&E must be built into a programme from the very beginning, and that is the case here. Specific timetables, deliverables and budget lines for tracking and assessing LEVEL ONE SERVICES will ensure that the community process is ingrained into the implementation of service delivery.

7.5.1 Specific Tasks

- Carry out assessment and baseline surveys, as well as identify structures for inclusive participation in evidence-based dialogue at community level.
- Establish evidence-based participatory planning, implementation, monitoring and action for health, starting with initial district implementation plan for LEVEL ONE SERVICES followed by quarterly reviews.
- Register and map households by villages and sub-locations.
- Establish CBIS with chalkboards at strategic sites for local collation and use of data.
- Hold monthly local health days for collective action as well as evidence-based dialogue for health, with supervisory support.
- Hold quarterly divisional health days for sharing, recognition and celebration through situation analysis, participatory planning and action for health.
- Establish regular evidence-based dialogue, planning, implementation, monitoring, evaluation and feedback meetings, based on the CBIS and HMIS at all levels.

7.5.2 Expected Outputs

- Household registration and baseline surveys in at least 30 districts and aiming to cover 20% of the sub-locations in the first year. The rest of the districts would be covered in the second year.
- 80 districts launch quarterly evidence-based dialogue sessions based on CBIS and HMIS, building on the baseline survey data, with at least 30 districts covered in the first year and the rest in the second year and at least 1,000 sub-locations reached in the first year.
- 1,000 chalkboards functioning and the same number of facilities displaying data on immunization and maternity delivery, based on the KEPH assessment framework.
- Regular evidence-based dialogue, planning, implementation, monitoring, evaluation and feedback meetings, based on the CBIS and HMIS, at all levels in 30 districts in the first year and scaled up to the rest in the second year.

7.5.3 Required Inputs

- District assessment and survey teams to cover 30 districts in the first year and 50 districts in the second year (10 research assistants and 15 enumerators for six days per district).
- Data cleaning, entry and analysis.
- Report production at national, provincial and district levels.
- 5 computers per district to facilitate data processing.
- 80 statisticians.

Table 5: Programme timetable, April 2006 – March 2009

Activities	Apr-Jun06	Jul-Sep06	Oct-Dec06	Jan-Mar07	Apr-Dec07	Jan-Dec08	Jan-Mar09
1. Launching LEVEL ONE SERVICES implementation countrywide							
Carry out a rapid inventory of agencies, individuals & programmes	**						
Convene national & provincial task forces	*	*	*	*	***	****	*
Identify and contract lead partners	*						
Hold national & provincial orientation workshops	*********						
Establish national & provincial secretariats and focal persons for LEVEL ONE SERVICES	*****	****					
Hold annual LEVEL ONE SERVICES meetings	*				*	*	
Conduct training workshops for updates	*	*	*	*	***	****	
Assess & recognize performance					*	*	
Publish results					*	*	
2. Training service providers' and the community for LEVEL ONE SERVICES implementation							
Develop training curricula & materials	**						
Identify & train the national team of trainers	*						
Identify & train provincial teams	*****	***					
Recruit & train CHEWs	**	***	***	***	***	***	
Identify & train CORPs	**	***	***	***	***	***	
3. Strengthening the linkage between the health system and communities for LEVEL ONE SERVICES implementation							
Create awareness at district level	*						
Carry out community entry	**	***					
Disseminate LEVEL ONE SERVICES guidelines	**	**					

Continued

Table 5, continued

Activities	Apr-Jun 06	Jul-Sept06	Oct-Dec06	Jan-Mar 07	Apr-Dec 07	Jan-Dec08	Jan-Mar 09
Carry out assessment & baseline surveys	**	*****				**	
Register and & households	**	*****	*****	*****			
Establish CBIS	**	*****	*****	*****			
Monthly health days	***	*******	*********	*******	*******	*******	***
Hold quarterly divisional health days	*	*	*	*	***	****	*
Establish evidence-based planning, imple-mentation, monitoring, evaluation & feedback	*	*	*	*	***	****	*
Strengthen HMIS	**	*****	*****	*****	*****	*****	
Monitor client satisfaction	***	*******	*********	*******	*******	*******	***
4. Providing services at level 1							
Carry out home visiting regularly	***	*******	*********	*******	*******	*******	***
Provide preventive, promotive & simple curative care on demand	***	*******	*********	*******	*******	*******	***
Assess performance of households quarterly	*	*	*	*	***	****	*
Conduct dialogue sessions at barazas, churches, mosques & schools	***	*******	*********	*******	*******	*******	***
Hold divisional community days	*	*	*	*	***	****	*
Hold regular dialogue sessions	***	*******	*********	*******	*******	*******	***

* = Number of weeks required to complete the task.

8: Budget

This section contains two separate approaches to the financial data. Following a statement of the assumptions behind the budget allocations, the section first presents a budget organized according to objectives and activities. This is followed by a summary budget for LEVEL ONE SERVICES calculated on an annual basis.

8.1 Budget Parameters

Budget allocations are estimated according to the parameters detailed below. These relate to contracting and consultants, drugs and supplies, transport and travel, office space and equipment, documentation and publication, training, and workshops and meetings.

1. ***Contracting and consultants:*** The identified lead agencies provide experienced facilitators for national and provincial level activities, including assembling key partners, recruiting and training personnel, strengthening linkages between health facilities and the community, and conducting baseline surveys. All human resources required for these activities, except in the case of government staff involvement, will be paid for under the contracting and consultants budget line. A detailed analysis of consultancy cost and daily subsistence allowance (DSA) for each activity is contained in the budget.

2. ***Drugs and supplies:*** These will include:

- Preventive and promotive materials and supplies (ITNs, water guard, condoms, contraceptives)
- Health promotion supplies (IEC materials according to priorities, e.g., C-IMCI, safe motherhood, community nutrition and supplements)
- Drugs and supplies for first aid and treatment of common ailments (first aid kit and supplies, anti-malarials, analgesics, deworming medicines, oral rehydration salts)
- Referral mechanism, e.g., communication and transport (phones, air-time, bicycle, forms)
- Antenatal care equipment and supplies
- Indoor residual spray equipment and supplies
- Expanded programme on immunization equipment
- Home delivery kits

- Growth monitoring equipment and cards
- Equipment for gender and age sensitive recreation facilities
- Home-based care equipment and supplies

3. ***Transport and travel:*** Transport and travel will include hired vehicles for project and consultant staff travels, bus fares, taxi hires and bicycle hires, among other travel means that will be applicable.

4. ***Office space and equipment:*** Office space will include cost for hire of space where government may not have space for the coordination of activities at provincial levels. Communication costs including telephones, e-mails, fax, etc., are budgeted under this line. Equipment will include procurement of office equipment such as computers, printers, and telephone and fax equipment among other small office machines.

5. ***Documentation and publication:*** This will include the cost of documenting and publishing the project results and best practices arising there from. The cost of circulating copies to all stakeholders is also included under this budget.

6. ***Training Costs:*** These will include costs for
- Transport and travel for fieldwork supervision, follow up and training workshops
- Daily subsistence allowances for fieldwork, supervision, follow up and workshops
- Curriculum and training materials development
- Stationery and other training materials
- Report production at national, provincial and district levels

7. ***Workshops and meetings:*** Three types of budget lines are covered here: community process and governing structures development; planning, implementation, monitoring, evaluation, feedback and information systems; and dissemination workshops and meetings. The costs will include:
- Transport and travel
- Daily subsistence allowances
- Materials development
- Stationery and other materials
- Report production for national, provincial and district levels

8.2 Budget by Objectives and Activities, 2006-2009

Table 6: Summary of budget by objectives and activities, 2006-2009 (in US$)

	Output	Inputs	Unit cost	Total
1. Launching LEVEL ONE SERVICES implementation countrywide				
Carry out a rapid inventory of agencies, individuals and programmes	Inventory of community-based programmes, people and agencies undertaken in 8 provinces	A consultant, travel, daily subsistence allowance (DSA), stationery	2,500	20,000
Convene LEVEL ONE SERVICES task forces at national & provincial levels	9 task forces meet quar-terly (25 members each attend 10 meetings)	Transport, travel, DSA	6,000	540,000

Continued

Table 6, continued

	Output	Inputs	Unit cost	Total
Contract agencies to spearhead LEVEL ONE SERVICES implementation	8 agencies contracted	16 consultant advisors	216,000	1,728,000
Hold national & provincial LEVEL ONE SERVICES orientation workshops	9 workshops attended by 30 participants each	Transport, travel, DSA	8,000	72,000
Establish national and provincial LEVEL ONE SERVICES secretariats & a focal person	9 secretariats established	Staff, computers, stationery, communication facilities	108,000	972,000
Convene annual LEVEL ONE SERVICES meetings	3 annual meetings held	Staff, stationery, communication facilities	150,000	450,000
Conduct training workshops on emerging issues	3 refresher workshops on emerging issues	Staff, facilitators stationery, communication facilities	50,000	150,000
Assess & recognize performance	30 people recognized	Awards for excellence	2,000	60,000
Publish results	3 monographs published, 1,500 copies	Editing, printing	35,000	105,000
			Subtotal	***4,097,000***
2. Training health providers and community leaders for LEVEL ONE SERVICES implementation				
Develop training curricula & training materials	3 sets of curricula & materials developed	2 consultants, stationery, printing	6,000	18,000
Identify/train national team of trainers	32 trainers trained	Transport, travel, stationery,trainers	2,000	64,000
Identify/train provincial teams	400 trainers trained	Transport, DSA, stationery,trainers	1,500	600,000
Recruit/train community health extension workers, animators, coaches	5,100 CHEWs trained	Transport, DSA, stationery,trainers	400	2,040,000
Identify/train CORPs	110,000 CORPs trained	Transport, DSA, stationery,trainers	100	11,000,000
			Subtotal	***13,722,000***
3. Strengthening linkages between the health system and communities for LEVEL ONE SERVICES and the provision of services at level 1				
Create awareness at district level through contact and workshop	80 districts reached	Animators, facilitators, transport, DSA, stationery	3,000	240,000
Carry out community entry	Entry process undertaken in 80 districts and 5,000 sub-locations	Animators, facilitators, transport, DSA, stationery	30,000	2,400,000

Continued

Table 6, continued

	Output	Inputs	Unit cost	Total
Disseminate LEVEL ONE SERVICES guidelines	300 copies of guidelines distributed	Transport	50	15,000
Carry out assessment and baseline surveys	Assessment and follow-up surveys in 80 districts	Facilitators, transport, enumerators, stationery, data analysis, DSA,	10,000	1,600,000
Brief & orient community leaders	5,000 committee members orient on policy documents	Animators, facilitators, transport, DSA, stationery	50	250,000
Develop district LEVEL ONE SERVICES plans	80 districts have LEVEL ONE SERVICES plans	Facilitators, transport, DSA, stationery	100	8,000
Establish evidence-based planning, implementation, M&E and feedback and quarterly reviews	20,000 dialogue sessions (4 per site)	Animators, facilitators, transport, DSA, stationery	10	200,000
Register and map households by villages and sub-locations	25,000 households registered in 5,000 sub-locations	Staff, CHEWs, CORPs, GIS, stationery	50	250,000
Establish CBIS with chalkboards at strategic sites	2,000 chalkboards & facilities displaying progress data	Chalkboards, animators, facilitators, transport, DSA, stationery	100	200,000
Hold monthly local health days	50,000 local health days	Animators, transport, DSA, stationery	10	500,000
Hold quarterly divisional health days	1,200 divisional health days	Facilitators, transport, DSA, stationery	400	480,000
Restructure health committees to strengthen community linkage	800 committees restructured	Animators, transport, DSA, stationery	100	80,000
Establish evidence-based planning, implementation, M&E and feedback at committee levels	Established at 800 health facilities	Animators, transport, DSA, stationery	100	80,000
Orient key stakeholders on LEVEL ONE SERVICES and launch the initiative	800 committees trained	Animators, transport, DSA, stationery	1,000	800,000
Distribute CHEW & CORP kits according to guidelines and controls	187,500 kits distributed	Antimalarials, ITNs, Vit. A, worm tablets, water guard, etc., in kit	556.8	104,400,000
Hold regular evidence-based dialogue with households	5,000,000 reached	CORPs, bag, learning materials	3	15,000,000
			Subtotal	***161,303,000***
			Grand total	**179,122,000**

8.3 Annual Budget Summary for LEVEL ONE SERVICES

Table 7: Summary yearly budget for LEVEL ONE SERVICES, 2006-2009 (in US$)

Item	2006	2007	2008	2009	Total
1. Contracting & consultants	2,800,500	3,734,000	3,734,000	933,500	11,202,000
2. Drugs & supplies	26,100,000	34,800,000	34,800,000	8,700,000	104,400,000
3. Transport & travel	150,000	600,000	600,000	300,000	1,650,000
4. Office space & equipment	900,000	934,500	394,500	202,000	2,431,000
5. Community process & governing structures development	1,000,000	1,000,000	960,000	-	2,960,000
6. Planning, implementation, monitoring, evaluation, feedback & information systems	1,333,000	1,000,000	500,000	500,000	3,333,000
7. Documentation & publication	20,000	20,000	20,000	30,000	90,000
8. Workshops & meetings	800,000	2,200,000	600,000	1,000,000	4,600,000
9. Training	5,000,000	5,000,000	3,000,000	872,000	13,872,000
Grand total	**38,103,500**	**49,288,500**	**44,608,500**	**12,537,500**	**144,538,000**

Note: Budget period is April 2006 to March 2009.

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Republic of Kenya

Reversing the trends

The Second

NATIONAL HEALTH SECTOR

Strategic Plan of Kenya

Taking the Kenya Essential Package for Health to the COMMUNITY

A Strategy for the Delivery of LEVEL ONE SERVICES

Ministry of Health

June 2006

Taking the Kenya Essential Package for Health to the Community:
A Strategy for the Delivery of LEVEL ONE SERVICES

Communities are the central focus of affordable, equitable and effective health care. Representing the first level of health care, they are the core of the Kenya Essential Package for Health defined in Kenya's second National Health Sector Strategic Plan. The goal of this strategy is to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, and child and maternal deaths, as well as improve education performance across all the stages of the life cycle.Service provision at level 1 is organized in three tiers starting with household-based caregivers, adult members of the household who provide the essential elements of care for health in all dimensions and across life-cycle cohorts. These household-based caregivers are supported by volunteer community-owned resource persons - CORPs - who are in turn supported and managed by a range of community structures to be established or strengthened through the implementation of this strategy. It is anticipated that the community focus will reach the entire country, district by district, within two years.

Ministry of Health
Health Sector Reform Secretariat
Afya House
PO Box 3460 - City Square
Nairobi 00200, Kenya
Email: secretary@hsrsmoh.go.ke
www.hsrs.health.go.ke