Republic of Kenya

Reversing the trends

The Second
NATIONAL HEALTH SECTOR
Strategic Plan of Kenya

Community Strategy Implementation Guidelines

for

Managers of the Kenya Essential Package for Health at the Community Level

Ministry of Health

March 2007

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.

Community Strategy Implementation Guidelines for Managers of the Kenya Essential Package for Health at the Community Level

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Sector Planning and Monitoring Department
Afya House
PO Box 3469 - City Square
Nairobi 00200, Kenya
Email: secretary@hsrsmoh.go.ke
www.hsrs.health.go.ke

Contents

List of Tables and Figures

Tables

Figures

List of Abbreviations

AFB	Acid fast bacilli
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
AOP	Annual operational plan
ART	Anti-retroviral therapy
ARV	Anti-retroviral drug
BCC	Behaviour change communication
CBD	Community-based distributor/ distribution
CBHIS	Community-based health information system
CBO	Community-based organization
CHC	Community health committee
CHW	Community health worker
CHEW	Community health extension worker
DDC	District development committee
DHMB	District health management board
DHMT	District health management team
DMOH	District Medical Officer of Health
DHS	District health system
DHSF	District health stakeholder forum
DMS	Director of Medical Services
DC	District Commissioner
ECN	Enrolled community nurse
FBO	Faith-based organization
FP	Family planning
GOK	Government of Kenya
IEC	Information, education and communication
HCMC	Health centre management committee
HF	Health facility
HFMC	Health facility management committee
HIV	Human immunodeficiency virus
HMB	Hospital management board
HMIS	Health management information system
HQ	Headquarters
HR	Human resource
HSCC	Health Sector Coordinating Committee
HSR	Health sector reform
IBP	Individual birth plans
IMCI	Integrated management of childhood illness
IHI	Institute for Health Improvement
ITN	Insecticide treated (bed) nets
IVC	Integrated vector control
JICC	Joint Interagency Coordinating Committee
KDHS	Kenya Demographic and Health Survey
KEPH	Kenya Essential Package for Health
MCH	Maternal and child health
MDGs	Millennium Development Goals
MOH	Medical Officer of Health
NDP	National Drug Policy
NGO	Non-government organization
OPD	Outpatient department
OVCs	Orphans and vulnerable children
NHSSP II	Second National Health Sector Strategic Plan 2005–2010
PDW	People with disability
PHT	Public Health Technician
PHO	Public Health Officer
PLHA	People living with HIV and AIDS
PMO	Provincial Medical Officer
PMTCT	Prevention of mother-to-child transmission (of HIV)
RH	Reproductive health
STI	Sexually transmitted infection
STD	Sexually transmitted disease
TB	Tuberculosis
TBA	Traditional birth attendant
VCT	Voluntary counselling and testing

Foreword

The Kenya Essential Package for Health (KEPH) is the new approach through which the goals of the National Health Sector Strategic Plan 2005-2010 (NHSSP II) will be accomplished. Realizing the importance of empowering households and communities in the delivery of the KEPH at level 1, the Ministry of Health and sector partners developed and launched a Community Strategy in 2006. The strategy outlined the type of services to be provided at level 1, the type of human resources required to deliver and support level 1 services, the minimum commodity kits required, and the management arrangements to be used.

The development of the Community Strategy guidelines contained in this book is an important milestone in the implementation of the Community Strategy as they outline the "how" of the strategy. The guidelines discuss the establishment of community health service linkage structures, as well as the launch and management of the Community Strategy at the local level. They provide direction for building the capacity of the community health extension workers (CHEWs) and community health workers (CHWs), establishing a communication strategy that effectively improves health seeking behaviour, and providing level 1 services. Importantly for future monitoring and evaluation, they detail the mechanisms for evidence-based dialogue informed by community- and facility-based information systems.

These guidelines are for use by frontline health sector managers who have primary responsibility for managing the implementation of KEPH at level 1 of the health system. The guidelines are neither prescriptive nor restrictive. They are, rather, facilitative and enabling, as they set a firm foundation for *Taking the Kenya Essential Package for Health to the Community.* They seek to help the managers to get the necessary skills to work with clients, households and communities within the proposed partnership approach.

It is my own hope – and that of the Ministry – that the use of these guidelines will improve the delivery of KEPH at level 1 and will contribute to the realization of the health sector vision of "reversing the trends" in Kenya's impact and outcome indicators.

Dr. T. Gakuruh
Head, Sector Planning and Monitoring Department
Ministry of Health

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The Ministry would like also to acknowledge our development partners, especially the World Health Organization (WHO), the Department for International Development (DFID) and the Swedish International Development Cooperation Agency (Sida) for the technical and financial assistance provided during the manual development process.

1. Introduction to the Community Strategy

Communities are at the foundation of affordable, equitable and effective health care. The community, in fact, represents level 1 in the Kenya Essential Package for Health (KEPH) proposed in the second National Health Sector Strategic Plan 2005–2010 (NHSSP II). It is so important to the success of NHSSP II that a specific strategy was developed for rolling out the strategic plan at community level: *Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of LEVEL ONE SERVICES*[1] (hereafter referred to as the Community Strategy).

The overall goal of the Community Strategy is to enhance community access to health care in order to improve individual productivity and thus reduce poverty, hunger, and child and maternal deaths, as well as improve education performance. This goal is to be accomplished by establishing sustainable level 1 services aimed at promoting dignified livelihoods across all the stages of the life cycle, and throughout the country through the decentralization of services, as well as enhanced accountability and responsibility among all concerned partners.

The community-based approach, as set out in the Community Strategy, *is the mechanism through which households and communities strengthen their role in health and health-related development* by increasing their knowledge, skills and participation. The intention is to strengthen the capacity of communities to assess, analyse, plan, implement and manage health and health-related development initiatives so that they can contribute effectively to the country's socio-economic development. The approach recognizes that all communities are already actively engaged in health activities for the survival of their households. Their actions for health could be strengthened through an increased knowledge and skills base as well as by better planning of their activities.

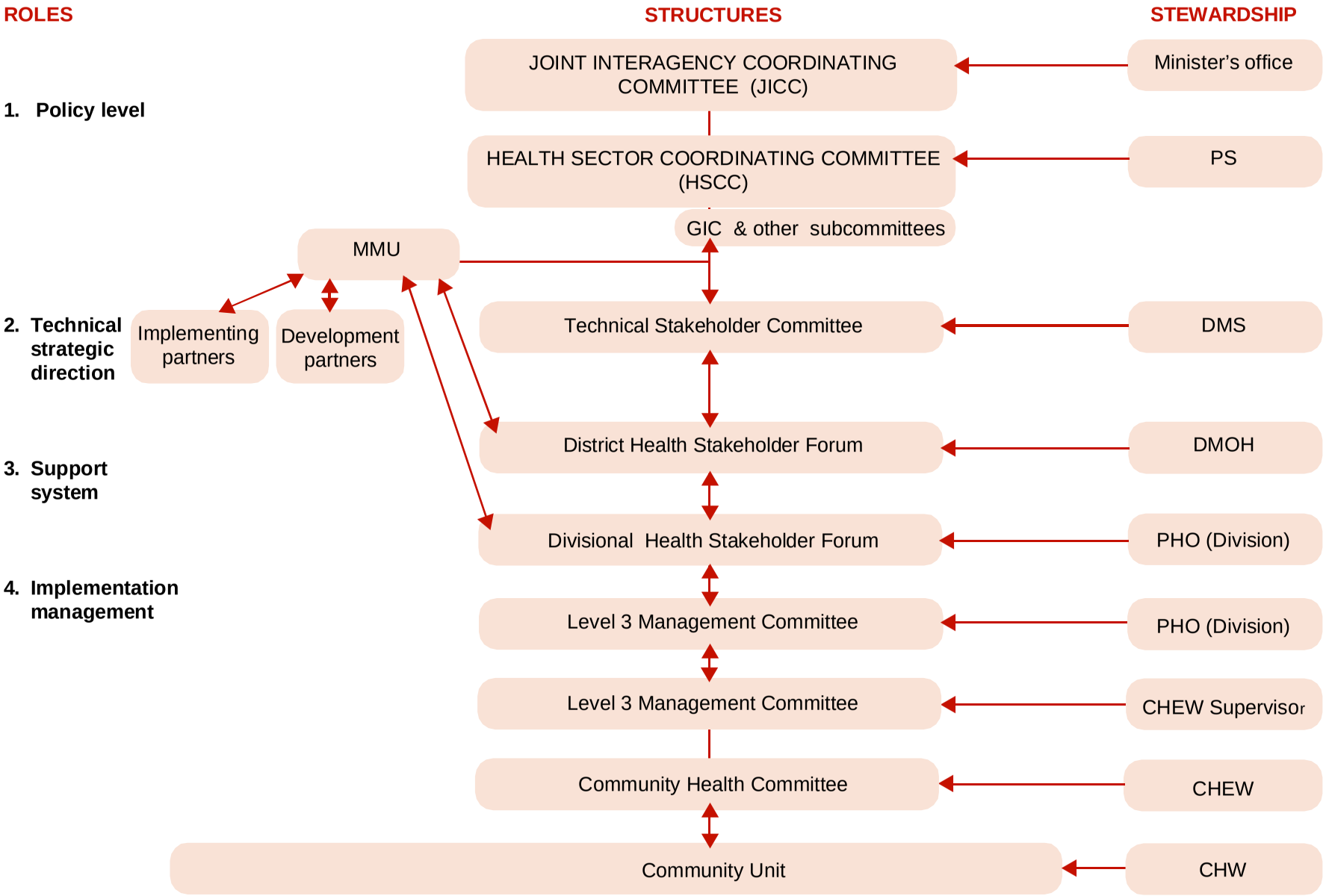
In addition, the approach recognizes the pivotal role of the health system in supporting community efforts. It is through partnership between the system and the communities that improvement can be realized and sustained. It is therefore critical to integrate level 1 health activities by all stakeholders into the health care system. The integration requires mechanisms and structures that provide the necessary linkage. Such structures would enhance and enable effective participation of communities in health-related decision making processes at the community level, as well as at the interface between level 1 and levels 2 and 3. This is the intention of the decentralization policy that is key to Kenya's ongoing health sector reform, NHSSP II and KEPH. Figure 1.1 illustrates NHSSP II's vision of the decentralized coordination of the health sector overall. As can be seen in the diagram, the community is the foundation of the coordination structure.

The community-based approach is the mechanism through which households and communities strengthen their role in health and health-related development by increasing their knowledge, skills and participation.

The Community Strategy spells out the linkage structures at district, divisional, health facility and community levels that are expected to provide citizens with sufficient representation and voice in all issues affecting service provision at level 1. The health facility in-charges (supported by the district health management team –

[1] Published by the Ministry of Health in June 2006.

Figure 1.1: Health sector coordinating structure



DHMT), community health extension workers (CHEWs), community health workers (CHWs), village elders and chiefs, and other extension workers are the sinews that bind these structures and enable sustained community leadership in addressing health problems, through the formation of linkage committees at all these levels.

Since this is a new approach, health care managers and providers accustomed to the older top-down way of operating may require insights into how to make the strategy work. This volume therefore spells out the guidelines for ensuring the equitable and effective operation of the Community Strategy. This introductory chapter presents the objectives and purpose of the guidelines and how the book is organized.

1.1 Objectives of the Community Strategy Guidelines

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. This document provides guidelines for:

- Establishing community health service linkage structures through effective decentralization and partnership for the implementation.
- Launching and managing the Community Strategy.
- Building the capacity of the community health extension workers (CHEWs) and community health workers (CHWs) to provide services at level 1.
- Establishing a communication strategy that effectively improves health seeking behaviour.
- Providing level 1 services.
- Establishing mechanisms for evidence-based dialogue informed by community and facility-based information systems.

1.2 The Purpose and Overview of the Guidelines

These guidelines target frontline managers, including district managers, responsible for enhancing the linkage between the health system and the communities. The target group includes the frontline managers from the district health managers to the sub-district down to local levels who have the task of oversight of the linkage structures and their functions as well as support for service delivery at levels 1, 2, 3 and 4. It also includes the CHEWs, and members of the linkage structures, including local leaders at community and administrative structures.

These guidelines describe the processes and structures for empowering both communities and health care providers to improve health at the front lines, working as partners in action.

1.2.1 Why the Guidelines

Because most service providers act top-down according to training and experience, they may not have given an alternative approach adequate consideration. For this reason, not all professionals will have the necessary skills to work with clients, households and communities *as partners* rather than simply recipients of services. These guidelines intend to help facilitators and managers work within the proposed partnership approach to enable clients, households and communities to increase their control over their situation through more informed and effective actions.

In this way the guidelines hope to empower both communities and providers to improve health at the frontlines, working as partners in action. The communities will also be able to exercise effective demand for quality care, with mutual accountability and responsibility for better health for all across all cohorts. This will be achieved through community—health system linkage, enhanced ownership of facilities, enhanced community control and greater personal responsibility for health. The guidelines describe the processes and structures for including communities in the governance of health facilities and related resources. This will increase people's self-esteem, capacity for informed dialogue and control. The guidelines introduce and strengthen the culture of assessment, dialogue, planning and action throughout the country to ensure sustained improvement at level 1.

1.2.2 What Methods Are to Be Used

It is best to use participatory methods that encourage the active involvement of individuals in group processes, no matter their background,

leading to informed decision making and planning. The methods enhance trust and respect among participants and between levels of control. The principles are those of participatory learning for change. The methods are designed to build the confidence of people in themselves and their ability to improve their situation. As they make changes, there are improvements, which build confidence even further. Using participatory methods is rewarding to communities and to facilitators alike.

1.2.3 How the Guidelines Are Organized

Following this introduction, the guidelines are organized into six chapters:

- Chapter 2 presents the linkage structures, their formation and functions.
- Chapter 3 discusses the launch and management of the strategy.
- Chapter 4 presents the criteria for the identification and training of the workforce.
- Chapter 5 outlines the communication strategy – the basic health messages to be shared with families and communities.
- Chapter 6 summarizes service delivery at level 1.
- Chapter 7 details the information system for monitoring and evaluation.

2. The Essential Elements of the Community Strategy

This chapter defines and outlines the structures and mechanisms that link the community with the health system at all levels needed to support level 1 services. The specific committees and forums are described in terms of their composition, formation, roles and responsibilities.

2.1 The Linkage Mechanisms and Structures

Community linkages are important points of emphasis in NHSSP II. The strategic plan recognizes that the health facilities at levels 2 and 3 will improve the effectiveness of their service delivery if they work closely with their catchment communities through various committees in the community strategy framework that link to service delivery at the household level. The structures provide opportunity to generate informed dialogue between the health system and the community, to create demand for quality services on the part of the community, and to enhance their responsibility for action for health at level 1. For this to happen, the committee structures must be inclusive in terms of administrative areas as well as interest groups. The structures defined in the sections below and illustrated schematically in Figure 2.1 are key to the Community Strategy framework.

It is the members of households and families who are both the primary targets and the primary implementers of level 1 services.

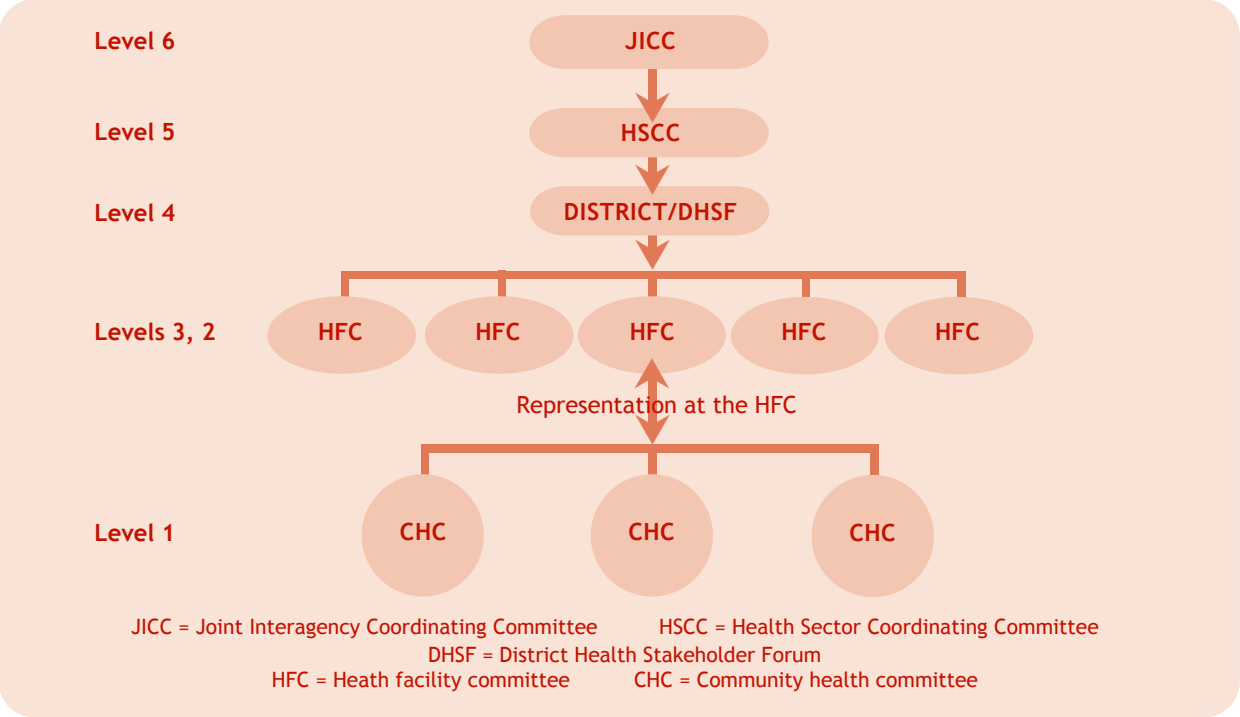
2.1.1 Community Units

The "community unit" as defined in this context comprises approximately 1,000 households or 5,000 people who live in the same geographical area, sharing resources and challenges. In most rural areas such a unit would be a sub-location, the lowest administrative unit. The number of households in a community unit will determine the number of community health workers to be selected, so that 1 CHW serves approximately 20 households.

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

The community units are organized in villages and other interest groups that are responsible for identifying and supporting the CHW. The CHWs report to the community health committee (CHC) through the community health extension worker (CHEW), who is the secretary to the committee. All the villages within the community unit should be represented on the CHC. 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 nurturing economic empowerment and transformation, enhancing access to the means of production and marketing, and paying

Figure 2.1: Community Strategy linkage structure



attention to the social determinants of health. All these sectors and actors should be represented on the CHC to the extent possible.

2.1.2 Community Health Committee (CHC)

The health governance structure closest to the community is the CHC, elected in such a way that all the villages in the community unit are represented. The CHC should be elected at the Assistant Chief's *baraza* under the chair of the Assistant Chief. The committee is chaired by a respectable member of the community. It is recommended that a CHW should be elected treasurer and that the CHEW should be the secretary. There should be nine additional members, to include representatives of: youth, faith groups, women's groups, NGOs, people living with HIV and AIDS (PLWHAs), people with disability (PWDs), and relevant others. At least one-third of the committee members should be women.

Role and Functions

The role and functions of the CHC will include:

- Identifying community health priorities through regular dialogue.
- Planning community health actions.
- Participating in community health actions.
- Monitoring and reporting on planned health actions.
- Mobilizing resources for health action.
- Coordinating CHW activities.
- Organizing and implementing community health days.
- Reporting to level 2 on priority diseases and other health conditions.
- Leading community outreach and campaign initiatives.
- Advocating for good health in the community.

Meetings and Agenda

The committee should meet at least monthly to receive reports from the villages to enable the CHEW to compile monthly reports for level 2 or 3 management committees. The standing agenda should include:

- Review of actions agreed on in the previous meeting and progress made in their implementation.
- Review of the chalkboard records of key indicators by village (immunizations, deliveries, cases of fever and diarrhoea in children, the chronically ill, use of insecticide treated nets [ITNs], maternal and child mortality).
- Identification of and dialogue on areas needing improvement and planning action to improve.

- Advocacy issues to be taken up to the next level.
- Recognition of the CHW of the month, based on data.

2.1.3 Level 2 Management Committee

This committee should have 12 members with equal representation of the community units served. The chair and treasurer should be elected from among members, while the secretary should be the facility in-charge. The CHEW should be included and eight other members appointed by CHCs. The election of the level 2 committee chair and treasurer should be supervised by the DHMT, and they should come from the different community units. Each CHC will nominate amongst themselves up to five people to serve on the level 2 committee.

Role and Functions

- Establishing the linkage between the health system and the community, helping to market the health facility to enhance its credibility based on quality of care so as to promote people's confidence in services beyond level 1.
- Planning, implementing, monitoring and evaluating health actions at the facility and in the community units served.
- Providing feedback on LEVEL ONE SERVICES.[1]
- Facilitating regular dialogue between the community and the health service providers based on available information.
- Mobilizing resources for development of the health facility as well as supporting outreach and referral activities.
- Participating in community health days, outreaches and campaigns.
- Strengthening community involvement in decision making.
- Promoting inter-sector collaboration.
- Overseeing the community unit's processing of community-based and facility-based health information systems (CBHIS and FBHIS, respectively), displaying and discussing the data for action, addressing facility-based and community-based issues that cause gaps indicated in the data so as to ensure specificity of responsibility.
- Facilitating budgeting, budget controls and accountability to ensure availability of resources needed for LEVEL ONE SERVICES.
- Listening to and addressing complaints of clients expressed through a suggestion box or client satisfaction questionnaire.
- Coordinating the recruitment of CHEWs.
- Liaising with CHCs in convening monthly community health days for joint health action.

Meetings and Agenda

The committee should meet at least monthly to receive reports from the community units to enable the in-charge to compile the monthly report to the level 3 management committee. The standing agenda should include:

- Review of actions agreed on in the previous meeting and progress made in implementation.
- Review of service and community-based data presented by community units on key indicators such as completed immunization of <1's, health facility deliveries, the chronically ill, use of ITNs, maternal and child mortality.
- Review of client satisfaction records.
- Identification of and dialogue on areas needing improvement and planning action to do so.
- Advocacy issues to be taken up to level 3.
- Recognition of the 3 top CHWs, CHEWs and service providers of the month based on data.

The community health committee is the health governance structure closest to the community. Its members should be elected in such a way that all the villages in the community unit are represented.

2.1.4 Level 3 Health Facility Management Committee

The committee should have 14 members representing level 2 units served within the catchment area. The level 3 facility in-charge and the Public Health Officer (PHO) in the division will be *ex officio* members (that is, members by reason of their position). The chair and treasurer will be popularly elected, while the level 3 facility in-charge will serve as the secretary.

Election of the 14 level 3 committee members should be held at the District Officer's (DO) baraza supported by representation from the District Health Management Team (DHMT). There should be 2–3 members from each level 2 committee in the catchment area, paying

[1] 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 activities.

attention to the principle of representation of all community units served.

Role and Functions

The Level 3 health facility management committees should meet at least monthly to review progress from the indicators generated through the CBHIS and FBHIS and to make decisions for continued actions for health at facility, community, household, political and administrative levels. The facility in-charge should collate the data obtained from the CHEWs and the health facility in order to share the information with the other sectors by displaying it on boards, disseminating summaries and presenting the summaries at stakeholder forums. Specifically, the committee has responsibility for:

- Supervising activities at level 2 and immediate catchment area CHC.
- Organizing quarterly performance review meetings for all facilities in the catchment area and facilitating corrective measures.
- Preparing quarterly reports and submitting progress reports to the DHMT, DO, level 2 and CHCs.
- Overseeing the functioning of the health centre in support of level 1 service provision.
- Ensuring implementation of policy guidelines.
- Training trainers and CHEWs on LEVEL ONE SERVICES and overseeing training of CHWs.
- Providing technical and professional guidance through supportive supervision.
- Coordinating CBHIS and FBHIS and divisional experience sharing and dialogue forums.
- Disseminating information to relevant levels.
- Managing relationship with divisional level stakeholders.
- Mobilizing resources for development of the health facility as well as supporting outreach and referral activities.

Meetings and Agenda

The committee should meet at least monthly to receive reports from the community units to enable the in-charge to compile the monthly report for the level 3 management committee. The standing agenda should include:

- Review of actions agreed on in the previous meeting and progress made in implementation.
- Review of service and community-based data presented by community units and level 2 facilities on key indicators such as completed immunization of <1's, health facility deliveries, the chronically ill on treatment, patients completing TB treatment, use of ITNs, maternal and child mortality.
- Review of client satisfaction records.
- Identification of and dialogue on areas needing improvement and planning action to improve.
- Advocacy issues to be taken up to level 4.
- Recognition of the top CHW, CHEW and service provider of the month based on data.

2.1.5 Divisional Health Stakeholder Forum

The membership should include: the District Officer as chair and the PHO as secretary, with representatives of CBOs, FBOs, NGOs, and other sectors such as agriculture, education, water, social services, roads, environmental services.

Role and Functions

- Sharing information and areas of coverage amongst partners.
- Identifying gaps in divisional health interventions.
- Mobilizing any additional resources to address the gaps.
- Proposing areas of harmonization of CHC, level 2, level 3 and stakeholder plans.
- Participating in selection of district health management board (DHMB) members.
- Submitting reports to district health stakeholder forum.

Meetings and Standing Agenda

The forum should meet at least once in four months to receive reports from level 3 as well as other stakeholders in the health sector. The standing agenda should include:

- Review of actions agreed on in the previous meeting and progress made in implementation.
- Reports from various stakeholders as well as health facility management committees.
- Review of service and community-based data presented by management committees in the catchment area on key indicators such as completed immunization of <1's, health facility deliveries, the chronically ill, use of ITNs, maternal and child mortality.
- Review of client satisfaction records.
- Identification of and dialogue on areas needing improvement and planning action to improve.

- Advocacy issues to be taken to the district health stakeholder forum.
- Recognition of 10 top CHWs, 5 top CHEWs and 3 top service providers of the quarter based on data.

2.1.6 The District Health Stakeholder Forum

Within the district, the organization and management of LEVEL ONE SERVICES should be integrated into the health sector and local government reform frameworks. The DHSF draws its membership from all the organizations involved in the provision of curative, promotive, preventive and rehabilitative health care services within the district, including NGOs, FBOs, CBOs, private sector institutions (such as hospitals, nursing homes, clinics and pharmacies), government line ministries, development partners in the district, civil society, the media, constituency development committees, women's welfare associations (such as Maendeleo ya Wanawake), health partners and provincial administration (DCs, DOs and chiefs).

Linkages between the DHSF and the district health management team and board are summarized in Table 2.1. Types of management meetings and their timetable are shown in Table 2.2.

Formation and Composition

All organizations that are implementing programmes within the district are members of the general assembly of the stakeholder forum. Sector district officers whose functions have direct or indirect impact on the management and effectiveness of health service delivery in the district – e.g., treasury, education, agriculture, etc. All members have the right to be eligible for election to the steering committee of the DHSF as a representative of their respective constituency – e.g., CBO, NGO, FBO representative.

The DHSF steering committee will be composed of the following:

- Chair – District Commissioner
- Vice Chair – DHMB Chair

Table 2.1: Linkages of the DHSF with DHMT and DHMB

No.	Functional linkages			
	Function	DHMT	DHSF	DHMB
1.	Leadership	▪ Provides technical leadership in health service delivery in the district	▪ Assists the DHMT and DHMB to focus on joint programming and implementation, including resource mobilization	Oversees all the health service delivery in the district
2.	Needs identification and priority setting	▪ Identifies health priorities by scanning both the internal and external environments	▪ Discusses the priorities and provides recommendations to be included in the district's annual operational plans	Approves the priorities for implementation
3.	Implementation	▪ Coordinates the implementation of programmes ▪ Identifies bottlenecks, recommends and takes appropriate actions ▪ Ensures that programme activities are executed according to the plan	▪ Ensures that all actors are implementing their plans as contained in the district health plan (DHP) and reporting to the DHMT on a agreed timelines	Ensures programme implementation is in line with stipulated rules, procedures and regulations
4.	Monitoring and evaluation	▪ Collects and produces summarized quarterly implementation reports ▪ Organizes review meetings with the steering committee ▪ Undertakes follow-up actions based on the outcomes of review meetings	▪ Submits monthly and quarterly implementation reports to the DHMT for consolidation and analysis ▪ Discusses the quarterly implementation report and provides recommendations on appropriate actions ▪ Takes stock of actions carried out to improve performance by individual members of the forum ▪ Compares district performance in health with the set targets based on district's annual operational plans	Approves the quarterly reports

Table 2.2: Summary of timing and types of health care management meetings

Type of meeting	Time line	Possible issues to be discussed
General stakeholders	**First quarter** First week of October	▪ Confirmation of previous minutes. ▪ First quarter monitoring and evaluation report. ▪ Resource mobilization for the first joint health activities. ▪ Information sharing and reporting. ▪ Emerging health issues.
General stakeholders	**Second quarter** Second week of January	▪ Confirmation of previous minutes. ▪ Taking stock of actions carried out since quarter one. ▪ Six-month progress report. ▪ Resource mobilization for joint health activities in the second quarter. ▪ Adjusting DHP targets based on achievement, if necessary. ▪ Agreement on timetable for planning and submission of programme and resource envelope. ▪ Information sharing and reporting. ▪ Emerging issues
	Third quarter Second week of April	▪ Confirmation of previous minutes. ▪ Planning for the annual elections. ▪ Resource mobilization for the third joint health activity. ▪ Nine-month progress report. ▪ Appraisal of the integrated DHP and recommendation for change and approval. ▪ Information sharing and reporting. ▪ Emerging issues.
Annual General Meeting	**Annual** Second week of July	▪ Confirmation of previous minutes. ▪ Election of new office bearers (after two years). ▪ Taking stock of the achievements and lessons learnt for better planning, implementation and coordination. ▪ Monitoring and evaluation reports of the joint health activities. ▪ Presentation of annual reports by the DHSF. ▪ Emerging issues.

- Secretary – DMOH
- Members
  - CBO representatives
  - NGO representatives
  - FBO representatives
  - Other sectors

Role and Functions

- Reviewing divisional health stakeholder forum reports and providing appropriate feedback and guidance on the operations of divisions.
- Discussing the health priorities in the district with the DHMT and agreeing on programmatic interventions.
- Providing input into the district health planning process.
- Facilitating collection, collation and deliberation on implementation progress reports by all stakeholders.
- Participating in resource mobilization and allocation by presenting and discussing partners' programmes and resource envelopes (including the MOH's) and aligning the same with agreed prioritized interventions.
- Participating in joint planning and budgeting to develop integrated district health plans.
- Reviewing the comprehensive district health plans and other reports and advising the DHMB to approve as appropriate.
- Agreeing on the modalities for joint performance monitoring mechanisms, reporting, review meetings, joint supervision and follow-up action.
- Sharing information on best practices, new developments or emerging issues, and policy and strategy development.
- Submitting reports to DHMB.

Meetings and Standing Agenda

The forum should meet at least once in four months to receive reports from divisional forums as well as other stakeholders in the health sector. The standing agenda should include:

- Confirmation of previous minutes.
- Review of actions agreed on in the previous meeting and progress made in implementation.
- Reports from various stakeholders as well as health facility management committees.

- Review of service and community-based data presented by Divisions on key indicators such as completed immunization of <1's, health facility deliveries, the chronically ill, use of ITNs, maternal and child mortality.
- Review of client satisfaction records.
- Identification of and dialogue on areas needing improvement and planning action to improve.
- Advocacy issues to be taken to the district health stakeholder forum and the DHMB.
- Recognition of the 10 top CHWs, 5 top CHEWs and 3 top service providers of the quarter based on data.

2.1.7 District Health Management Board

The DHMB provides leadership and accountability in support to level 1 activities. The board receives reports from the DHSF and provides feedback to facilitate monitoring of overall district activities according to the annual operational plan (AOP). The DHMB is in turn linked to the district development committee (DDC) but focuses on health issues.

Formation and Composition

The membership is drawn from representatives of community units, with up to 16 members to include: the chair and the secretary (DMOH) as *ex officio* members and 14 others. The members are nominated during the selection process for level 2 and level 3 committee members. Each divisional health stakeholder forum elects 1–2 people from the CHC submitted list and submits to the DHMT. The DHMT submits names to the DHSF for the purpose of selecting the 14 DHMB members.

Role and Functions

- Coordinating district health services in collaboration with stakeholders.
- Approving plans and budget.
- Receiving implementation progress report.
- Supervising level 1 – level 4 committees.
- Mobilizing resources and allocates to various levels and units.
- Submitting reports to facilities, community, provincial and national level structures.

Meetings and Standing Agenda

The Board should meet at least once in four months to receive reports from the DHSF as well as other members of the Board. The standing agenda should include:

- Review of actions agreed on in the previous meeting and progress made in implementation.
- Implementation reports from the DHMT.
- Review of service and community-based data presented by Divisions on key indicators such as completed immunization of <1's, health facility deliveries, the chronically ill, use of ITNs, maternal and child mortality.
- Review of client satisfaction records.
- Identification of areas needing improvement and planning action to improve.
- Advocacy issues to be taken up to the Provincial Health Board.

2.2 The Management Structures

Some of the structures described above have management as well as implementation responsibilities. These include the district health management team and the provincial health management team. Other management structures are the technical stakeholder committees and the Health Sector Coordinating Committee (HSCC). The relationships among these organs are illustrated in Figure 2.2 and summarized below.

2.2.1 District Health Management Team

The DHMT provides technical support to level 1 activities that includes planning, implementation, monitoring and supervision. The DHMT has eight functional clusters, taking into consideration the implementing role of the district. These clusters are shown in Table 2.3.

2.2.2 Provincial Health Management Team

The PHMT roles are clustered into three, taking into consideration the coordinating and supervisory role of the district. The roles are summarized in Table 2.4.

2.2.3 Technical Stakeholder Committees

These committees are chaired by the respective heads of departments, while heads of divisions serve as secretary. The members should include representatives of NGOs, FBOs, private and other government sectors as the committee decides.

The committees have the following roles and functions:

- Sharing information and areas of coverage amongst partners.
- Identifying gaps in specific area interventions.
- Proposing areas for policy improvement.
- Reviewing, adopting strategies and guidelines for the specific area of concern (e.g., malaria).
- Reviewing DHSF reports and providing feedback.
- Submitting reports to the Health Sector Coordinating Committee (HSCC).

Figure 2.2: MOH implementation structure

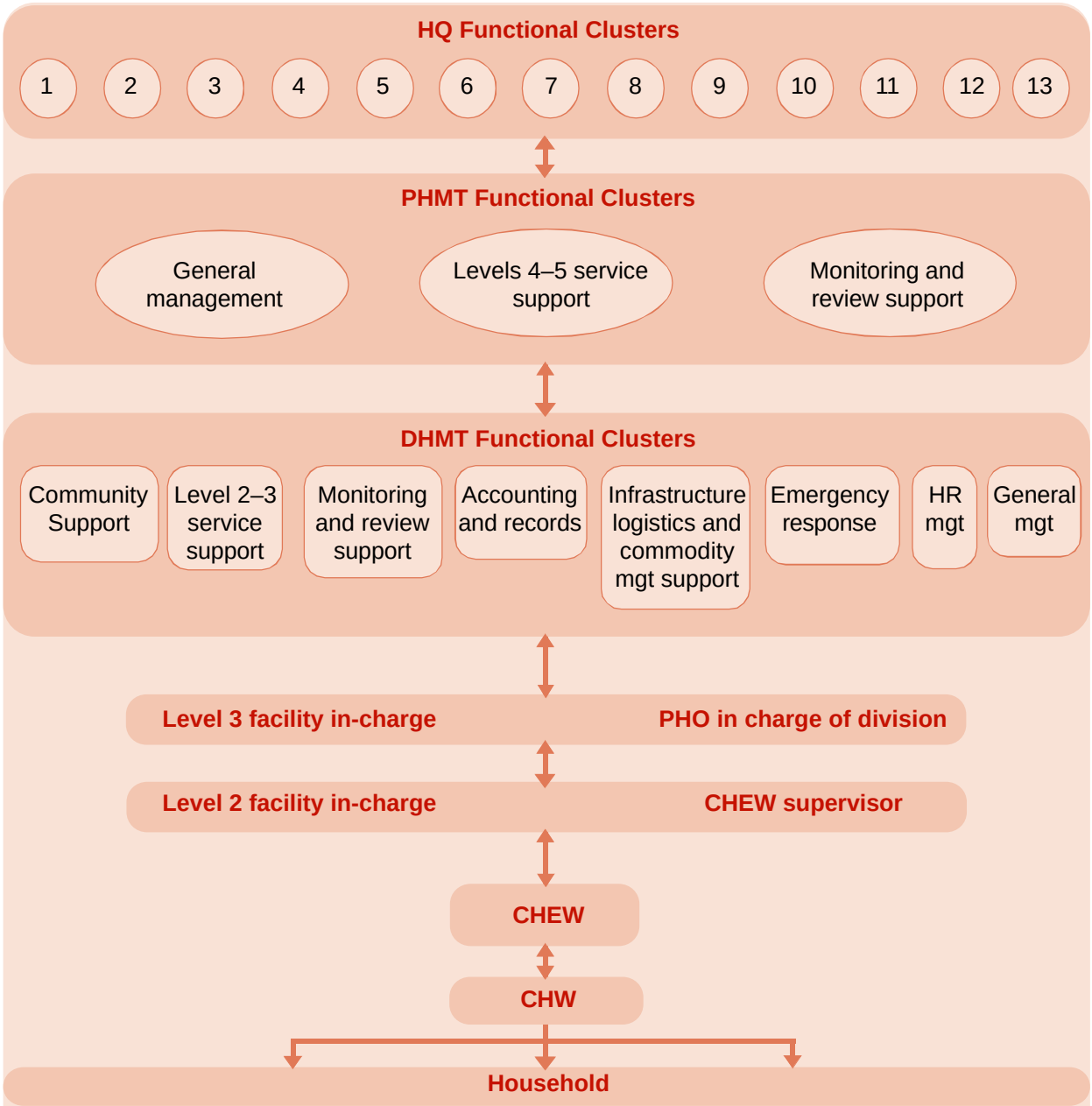


Table 2.3: Role and functions of the DHMT

DHMT role	Community support	Levels 2-3 service support	Monitoring & review support	Accounting & records	Infrastructure logistics & commodity mgt support	Emergency response	HR mgt	General mgt
Training PHO div	✓							
Training level 2-3 service providers		✓						
Support and regulatory supervision								✓
Report writing			✓					
District planning								✓
Monitoring/evaluation			✓					
Reporting & feedback								✓
Secretariat to DHMB, DHSF								✓
Personnel management							✓	
Accounting and record keeping				✓				
Information management			✓					
Commodity management					✓			
Infrastructure and logistics mgt					✓			
Emergency response						✓		
Cluster coordination								✓
Operational research			✓					

2.2.4 Health Sector Coordinating Committee

This is a committee of 20 members, chaired by the Permanent Secretary with the Ministry Monitoring Unit (MMU) as Secretary. The members will include representatives of various GOK ministries (HOD finance, education, agriculture, water, social services), two NGO representatives, three FBO representatives and one private sector representative, plus two DHMB chairs at any one time, rotated on provincial basis.

The committee has the following functions:

- Approving and adopting AOPs.
- Reviewing and developing health sector policy documents.
- Approving global initiative proposals.
- Mobilizing and allocating resources.
- Receiving AOP implementation status reports and conducting regular reviews.
- Facilitating harmonization/alignment of plans to the Joint Programme of Work and Funding (JPWF) and reporting to joint implementation coordinating committees (JICCs).

Table 2.4: Roles and functions of the PHMT

PHMT role	General management	Levels 4-5 service support	Monitoring and review support
Training DHMT		✓	
Training levels 4 - 5		✓	
Supportive supervision	✓		
Report writing			✓
Provincial plan	✓		
Monitoring and evaluation			✓
Reporting and feedback	✓		
Selection of HMB	✓		
Personnel management	✓		
Financial management	✓		
Commodity management		✓	
Infrastructure and logistics management		✓	
Emergency response	✓		
Cluster coordination	✓		
Guidelines and tools dissemination		✓	
Operational research			✓

3. Launching the Community Strategy – Community Entry

Recognizing the central role of the people in making decisions and taking actions that influence their health, the Community Strategy acknowledges that the community is indeed in charge of their own health and development whether appreciated by the formal sector or not. Community members are in fact already actively involved in taking care of their own health needs according to their capacity. The Community Strategy thus aims to develop linkages into that existing household/ community-based care system in order to learn from as well as influence it to ensure the adequacy and effectiveness of health actions. This can best be done through partnership, which requires recognition of community systems and a careful process of engagement to build a relationship with the community-based service providers.

This chapter outlines the steps in the launch of the Community Strategy at the district level, where most of the activities will take place in initiating and managing the strategy.

In order to build partnership with the community, it is necessary to gain entry through a structured, step-by-step approach that involves creating awareness, conducting situation analyses, forming linkage structures, training teams, and establishing monitoring and evaluation mechanisms. Effective community entry must be based on a process of engagement that recognizes the need for the health system to negotiate its way into the community agenda and care system as a way of addressing their health and development issues. The entry process involves a number of distinct steps as described below.

Steps in community entry

1: Create awareness
2: Conduct situation analysis and household registration
3: Plan actions for improving health status
4: Establish information systems to monitor change

3.1 STEP 1: Creating Awareness

Awareness creation among district leaders is undertaken through the existing structures and officials 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 first step. This can be undertaken in a 1—3-day workshop that ends in the formation or confirmation of the district health stakeholder forum (DHSF). During this workshop the Community Strategy is introduced, focusing on the linkage structures, their formation, composition and functions, as described in Chapter 2.

In addition, the workshop would outline a district-level Community Strategy implementation plan and identify officials to spearhead it. This workshop should be followed by workshops and meetings at divisional and health facility levels, and cascading down to community unit levels, repeating the same exercise of awareness creation, formation of structures and planning the implementation process, and thus launching the strategy at all levels.

3.2 STEP 2: Situation Analysis and Household Registration

Implementing divisions will conduct situation analyses using participatory approaches. The participatory assessment and household registration are intended to provide information for planning. The situation analysis will include:

1. Exploration: This sub-step entails a relatively low-key fact finding mission to enable the service providers, particularly the CHEWs, coming into the community to gain an understanding of life as it is lived in the community. The findings should be written up and shared with the community, highlighting the facts that community people speak about with emotions such as fear, frustration, anger, joy, hope and anticipation.

2. Protocol: This sub-step entails identifying the gatekeepers (formal and informal leaders) in order to formalize the process and gain authority to work with the community. The facilitators introduce the Community Strategy idea to the leaders in order to involve them in the rest of the community process. Together the group clarifies the objectives and identifies all the target groups to ensure that they are included. This process should lead to identification of task groups to spearhead the actual situation analysis and detailed implementation planning.

3. Participatory assessment: This process starts with discussions with the key individuals at every level and control point down to the household. This ensures that the introduction of the Community Strategy takes full cognisance of what is going on in the community. The idea has to be negotiated through the gatekeepers at every level, down to the level of individuals concerned. In this process the community is asked to define the issues to be included in the assessment, and thus set objectives for it.

Under each objective the assessment and planning task group defines indicators/key questions, identifies the sources of reliable information, and determines the most appropriate methods of gathering the information. They then develop information gathering tools (checklists, interview guides, etc.). The scope of the assessment should include:

- The population size and structure
- Community structures
- Any existing community information systems
- Resource availability, access and management (money, manpower, material)
- Service delivery and the package of care and support
- Communication strategy, networking, collaboration and linkages
- Coping mechanisms, innovations and best practices
- The status of health and wellbeing, 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)
- Identified dialogue centres and groups (religious institutions, schools, civic leaders, youth groups and other sectors), their roles and responsibilities

In the participatory process the community is asked to define the issues to be included in the assessment, and thus set objectives for it.

The assessment methods may include transect walks, direct observation, mapping of the availability and access to resources, and a seasonal calendar of events, activities, diseases, food availability, etc., and daily activities by gender. Other tools might be Venn diagrams to understand stakeholders, key informant interviews of individuals from the community and focus group discussions. During this process the task group may also carry out household registration and mapping to create village registers to be kept by frontline health providers, the CHWs. Specific activities may include:

- ✓ **Activity 1:** Review the history of the community over ten years – events, achievements and challenges.
- ✓ **Activity 2:** Carry out household registration and mapping, creating the village register.
- ✓ **Activity 3:** Review community resources, assets, manpower, networks, etc.
- ✓ **Activity 4**: Map the community health situation and the causes, thus summarizing the community profile, based on the household register (population structure, environment, immunization, place of delivery, ITNs, use of family planning, diseases, births and deaths by age and sex, education, food, income)

3.3 STEP 3: Planning Actions for Improving Health Status

Once obtained and processed, the findings are used for dialogue in the established structures to prioritize issues and decide on action. 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. The same task group as well as additional working groups, identified according to priority issues, 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 relevant actions are already in place in order to add doable options that are lacking. Planned actions must be based on available resources for action.

The activities may include:

- ✓ **Activity 5:** Facilitate dialogue on the community health situation (why, what has been done, what more can be done).
- ✓ **Activity 6:** Identify action options, select doable options.
- ✓ **Activity 7:** Outline actions by time frame for various groups and individuals.

The plans from the different interest groups should be harmonized into one community unit plan. The CHEW, local NGOs and CBOs, and other extension staff within the community unit provide technical assistance throughout this process of assessment and planning, with the CHEW as the responsible technical person. The integrated community unit plans are submitted to the health facility committees where they are discussed and approved by the committees, based on resource implications. Finally, the community unit plans are consolidated into one integrated divisional health plan for level 1 activities and submitted to the DHMT.

3.4 STEP 4: Establishing Information Systems to Monitor Change

As described further in Chapter 7, the information system for monitoring change will be set up in the following way:

- ✓ **Activity 8:** Analyse the information gathered by the CHWs and supporting task groups.
- ✓ **Activity 9:** Facilitate regular evidence-based dialogue and community days.
- ✓ **Activity 10:** Disseminate analysed information for dialogue, advocacy and social mobilization.

4. The Workforce

People make any strategy work. This chapter aims to provide information about the workforce charged with the responsibility of providing health care services in the community. The chapter looks at their roles and responsibilities, how they link up with the rest of the formal health system, and how the volunteer segment of the workforce is to be motivated and sustained. The chapter also describes their training in terms of objectives, content and organization.

4.1 The Categories

Essentially, NHSSP II calls for two categories of personnel promoting health at the community level. These are community health workers (CHWs), who work on a volunteer basis, and community health extension workers (CHEWs), who are MOH employees. The community health committees (CHCs) manage the two. The functions of these categories are described below and summarized in Table 4.1.

4.1.1 Community Health Workers

Community health workers are expected to be mature, responsible and respected members of the community, men or women chosen by the community to provide basic health care. They should be good communicators and leaders who have shown signs of healthy practices as a parent or caregiver in their own household. In many communities there are community-based resource persons such as community-based distributors (CBDs), TB ambassadors and others. All these resource persons at the community level should be incorporated into the strategy as CHWs, if they have the characteristics described in this section.

The Roles and Functions of CHWs

CHWs have several functions in the community that are influenced by community priorities and the availability of health services to the community. Their main role is to promote good health by:

- Teaching the community how to improve health and prevent illness by adopting healthy practices.
- Treating common ailments and minor injuries, as first aid, with the support and guidance of the CHEW.
- Tending the CHW kit with supplies provided through a revolving fund generated from users.
- Referring cases to the nearest health facilities.
- Promoting care seeking and compliance with treatment and advice.
- Visiting homes to determine the health situation and dialogue with household members to undertake the necessary action for improvement.
- Promoting appropriate home care for the sick with the support of the CHEWs and level 2 and 3 facilities.
- Participating in monthly community unit health dialogue and action days organized by CHEWs and CHCs.

Community health workers (CHWs), who work on a volunteer basis, and community health extension workers (CHEWs), who are MOH employees, are the front line of the Community Strategy. The community health committees manage the two.

- Being available to the community to respond to questions and provide advice.
- Being an example and model of good health behaviour.
- Motivating members of the community to adopt health promoting practices.
- Organizing, mobilizing and leading village health activities.
- Maintaining village registers and keeping records of community health related events.
- Reporting to the CHEW on the activities they have been involved in and any specific health problems they have encountered that need to be brought to the attention of higher levels.

How a CHW Is Selected

To the extent possible CHWs should be accepted by the whole community as they are the link-pin between the household system and the health system. It is therefore critical that the community be briefed on the functions of the CHW to enable them to select persons who can work effectively with them in promotion of good health among households. Village leaders will organize meetings to inform the people about the CHWs' functions in the community, linked to the launching workshops described in Chapter 3.

At a village meeting convened by the elders, consenting nominees are presented for consideration by the villagers. In this forum the villagers select the individual of their choice on the basis of on the following criteria:

- A permanent resident in the area.
- Able to read and write, and enthusiastic to learn more.
- Concerned about the welfare of the people.
- Willing to volunteer.
- Physically fit.
- Willing to visit all village members.
- Respected by villagers as an example of healthy behaviour.
- Having demonstrated attitudes valued by the community.
- Backed by immediate family members (particularly the spouse).

How a CHW Is Motivated

Because they are volunteers, CHWs may require specific incentives to remain motivated to serve their communities. Years of experience working with CHWs has revealed the following motivating mechanisms:

- Continuous lifelong training based on the needs expressed by CHWs.
- Religious commitment, giving meaning to service to others.
- Having responsibility over households to which they belong and cultural, religious or economic ties permitting permanent loyalty and reciprocal giving and receiving from members.
- Organizing their work into fixed number of days in a quarter/year, beyond which they must be financially compensated (e.g., one household visit for two hours for 20 households per quarter and one dialogue meeting/*baraza* or health day per month).
- Supportive supervision and coaching as individuals or groups based on need, giving them regular feedback on performance and improvement being made.
- Giving them priority when there are paid jobs for health campaigns and mass treatments, for example, or distribution of communities (if they have served the community for two years after initial training).

Table 4.1: Summary of functions of the Community Strategy workforce

Function	Level 1 CHW	Level 1 CHEW	Level 2 In-charge	Level 3 PHO	Divisional PHO	District DHMT
Registers and record keeping	✓					
Report writing	✓	✓	✓	✓	✓	✓
Facilitating HH and comm. dialogue	✓	✓	✓	✓	✓	
Facilitating evidence-based planning		✓	✓	✓	✓	✓
Action monitoring and follow up	✓	✓	✓	✓	✓	✓
Coordinate CHWs activities		✓				
Distribute CHW kits		✓	✓			
Training of CHWs		✓	✓	✓		
Training of CHCs		✓	✓	✓		
Training of level 2 and 3 committees				✓	✓	✓
Supervision and follow up		✓	✓	✓	✓	✓
Training of CHEWs and PHOs					✓	✓

- Encouraging them to take up paid jobs when such opportunities are available and accepting them back when such assignments end (it may be necessary to train an alternate counterpart CHW per village when the first one has been serving for more than two years).
- Logistical support, regularly providing working materials (transport, basic kit)
- Evidence-based output linked to rewards at regular celebrations.
- Organizing them into savings and credit associations to enhance their own income earning capacity as well as linking them to other CHWs through exchange visits and meetings.
- Training them in productive skills according to their own interests and capacities, beyond health issues.
- Attending relevant conferences.

4.1.2 The CHEW

Community health extension workers (CHEWs) are trained health personnel with certification in nursing or public health. They will supervise CHWs and will be Ministry of Health employees.

The Roles and Functions of CHEWs

As provided for in the Community Strategy implementation framework, CHEWs constitute a new cadre of health worker. Their function is to facilitate the provision of quality services by CHWs and to ensure a smooth referral mechanism linking the community to level 2 and 3 facilities. The CHEWs' main functions therefore include:

- Overseeing the selection of CHWs.
- Organizing and facilitating CHW training.
- Monitoring the management of the CHWs' kit.
- Supporting the CHWs in assigned tasks and coaching them to ensure achievement of desired outputs and outcomes.
- Collating information gathered by the CHWs to display summaries at strategic sites to provide relevant feedback as well as material for dialogue at household and community levels.
- Compiling reports from CHWs and forwarding to level 2 and 3 management committees.
- Receiving feedback from level 2 and 3 facilities and passing it on the CHCs and CHWs through dialogue and planning that leads to actions to improve identified issues.
- Following up and monitoring actions emerging from dialogue and planning sessions to ensure implementation.

How a CHEW Is Selected

The DHMT will take the lead in the recruitment of the CHEWs with the support of level 3 management committees. Community health committee (CHC) members will be informed about the roles and functions of CHEWs by the DHMT to enable them to make informed decisions on the type of persons they elect as CHEWs for their community, as described in Chapter 3. The CHEW should be received by the community at a community unit meeting that is open to all members. Selection criteria should include:

- Having suitable qualification in nursing or public health.
- Being a mature and responsible person.
- Being acceptable to and respected by the whole community.
- Being a good communicator.
- Being able to work with people of diverse backgrounds.
- Being willing to teach and mentor others.
- Being able to be available to the service consumers according to demand.

4.1.3 The CHC

A community health committee (CHC) is a group of people who are charged with the responsibility of leading community health action at the community unit level. The committee is composed of 8–12 people selected from the community. Membership must be sensitive to gender balance and equal representation of villages and all interest groups in the community. The CHC elects officials from among the members: Chair (a respected community member), secretary (the CHEW) and treasurer (a CHW). The CHC has regular meetings that relate to the 100-day improvement cycle as well as community dialogue and action days. When they meet they discuss health-related community issues and review progress of households, CHWs and CHEWs on the basis of planned action for health guided by available data. Village and activity specific data are presented for dialogue and planning to ensure adequate targeting of areas and specific interventions.

The Roles and Functions of CHCs

- Leading monthly dialogue sessions at community unit level on the basis of data presented by villages and activities, leading to planning action.

CHEWs are a new cadre of health worker whose function is to facilitate the provision of quality services by CHWs and ensure a smooth referral mechanism linking the community to level 2 and 3 facilities.

- Providing structures for community action for health, emphasizing key household health practices.
- Providing a channel for external assistance to be continued where necessary.
- Providing a channel of communication with the levels 2 and 3 management committees, divisional health forum and the district health stakeholder forum.
- Facilitating community change by actively advocating the CHWs' work, backing them up in their tasks.
- Monitoring trends of key community health data and reporting to level 2 and 3 management committees for quarterly dialogue, planning and action.
- Overseeing CHW activities and appraising CHWs in preparation for recognition during community health days or forums at various levels.
- Seeking and mobilizing local human and financial resources for health action, on the basis of priorities identified by available data.

How a CHC Is Selected

The selection of members to the CHC is led out by the administrative head of the community unit, an Assistant Chief. The respective level 3 management committee facilitates the process by sending representatives to attend meetings organized by the administrator for the purpose of selecting CHC members. The characteristics of people to be identified are explained and then consenting nominees are identified for consideration by the *baraza*, with attention to inclusive representation as described in Chapter 3. The following characteristics are considered in the selection:

- Residency in the area.
- Ability to read and write.
- Demonstrated leadership qualities.
- Demonstrated role model in positive health practices.
- Representative of a constituency in the community (village, faith communities, youth, disabled, women, etc.).

4.2 Training Service Providers for Level 1

The implementation of the Community Strategy requires training or orientation for all the people involved so they can acquire the necessary skills to initiate and manage the linkage structures described in Chapter 2. These skills are critical for the success of the strategy in delivering services at level 1. The orientation of personnel in a cascade of training workshops from the provincial teams to the districts down to the community levels should be followed immediately by the launch of activities at the respective levels. The programme should begin in at least four districts and two divisions in each district, based on the enthusiasm and availability of champions, scaling up to the rest of the country by 2008. Training for each batch at every level should be a continuous exercise applying formal, informal and non-formal approaches to learning.

4.2.1 Community Health Extension Workers' Training

The training of the CHEWs intends to enhance their capacity to serve as extension health workers in the community working with and through the CHWs. The CHEWs have the overall technical and managerial responsibility of the CHWs with the support of the community health committees, which they serve as secretaries. Besides their certification in health (nursing, public health, etc.), CHEWs require skills on how to organize, manage and support the implementation of community-based activities initiated by the community and the CHW.

Objectives

The aim of the training is to enhance the CHEWs' capacity to supervise, monitor, manage and support the implementation of the Community Strategy. They are also expected to collate information from the villages in order to present for dialogue and planning at the CHC as well as give feedback to the community health workers who gather the information. The CHEW should be trained to carry out the following tasks:

- Organizing and facilitating the training of CHWs.
- Monitoring the use of simple drugs and preventive materials used by CHWs.
- Organizing and facilitating community animation and mobilization.

- Practising evidence-based management of service delivery at level 1, based on the continuous improvement strategy.
- Supporting the CHWs in the community motivation process by encouraging them to carry on with their planned activities and dialogue with the community.
- Providing supportive supervision to CHWs in the course of their activities.
- Playing a leadership role among the CHWs in their jurisdiction.
- Initiating community mobilization and awareness sessions for identified priorities in the community.
- Collating health data records from CHWs and forwarding this to the health facilities through the level 2 and 3 management committees.
- Providing a link between the community and the health committees.
- Assisting in the selection of CHWs.
- Facilitating evidence-based dialogue sessions at community unit level.
- Communication through advocacy, social community mobilization and interactive communication.
- Supporting CHWs in recognition of health problems, classification and action.
- Promoting inter-sector action for health, working with various extension workers.
- 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, STIs, TB and school health.
- Facilitating assessment, planning, implementation, monitoring and evaluation of LEVEL ONE SERVICES.
- Establishing and managing the community-based health information system, which includes data collation, storage, analysis, interpretation and utilization, in dialogue for continuous improvement.
- Leading CHW teams in household registration and mapping.
- Carrying out baseline survey and analysing the data.
- Keeping records of daily activities of services delivered and producing and submitting reports.
- Organizing documentation and filing system.

Training Content

The CHEW training will cover the following topics:

- An overview of the training course
- The function of the CHEW as a facilitator
- Concepts in health and development
- Population structure, distribution and functions
- Components of NHSSP II, focusing on the KEPH strategy
- Community entry process
- Group dynamics
- Community-based education and competency-based training
- Communication strategy with emphasis on interactive dialogue
- Personal and environmental hygiene
- Clinical and technical updates (reproductive health, HIV/AIDS, safe motherhood, integrated management of childhood illness - IMCI, malaria, TB, nutrition, disability).
- How to assess, classify and identify appropriate action for a sick person
- Referral
- Community- and facility-based information systems to enable evidence-based management of LEVEL ONE SERVICES, monitoring and evaluation.

4.2.2 Community Health Workers' Training

The training of CHWs aims at building the capacity of the CHW to work, on part time basis, directly with communities to promote their health, through involvement and participation. The CHWs will support the households in their efforts to identify and solve their problems within their context. They will provide information and strengthen the knowledge of the community, essentially through dialogue.

The training will therefore provide the relevant knowledge and skills that CHWs should have in order for to influence key household practices for health in the village of responsibility. The training is intended to be problem based and life long, applying formal, informal and non-formal approaches to learning.

CHEWs will support the CHWs in the motivation process by encouraging them to carry on with their planned activities and dialogue with the community.

Objectives

By the end of the training the CHWs will be able to do the following:

- Mobilizing and organizing the community for health action.
- Promoting good health practices and educating the community on the same.
- Recognizing common ailments and taking appropriate action (advise, treat or refer).
- Referring cases to the health facilities.
- Advising on compliance with treatment and advice.
- Facilitating community dialogue for health status improvement with the support of the CHEWs.
- Responding to any questions from community members.
- Carrying out home visits to assess the health issues of families based on evidence and dialogue with the households towards action for change.
- Being an example and model of recommended health practices.
- Keeping the village household register and other records of community health events.

Training Content

- Concept of development
- Concept of health
- Community organization, mobilization and participation
- Group dynamics
- Leadership
- Communication (dialogue)
- Adult learning
- Evidence-based dialogue for action for change at household and community levels
- The KEPH by cohort at the community level
- Personal and environmental hygiene and related health problems
- Pregnancy and childbearing (reading and applying the ANC card to household dialogue)
- Common conditions and their role in dealing with them (malaria, worms, conjunctivitis, skin infections, wounds, scabies, STIs/STDs, HIV/AIDS)
- Immunization (reading and applying the child health card to household dialogue)
- Nutrition
- Monitoring and evaluation: the village register/map, record keeping, use of data

5. Key Health Messages by Cohorts for Level 1

A selection of key messages is intended for use by the CHWs in promoting important household and community practices for health improvement, through dialogue. Published in a separate reference manual and summarized below, the messages become a reference for the CHWs to refer to for needed information for every household and cohort under their care. They are a tool for effective home visiting and dialogue grounded in the situation of the household visited and the set of information available. The mechanisms of communication should be multiple, taking advantage of opportunities that may trigger behaviour change at household or community levels. This chapter briefly reviews approaches to effective communication, then outlines the key messages by cohort.

The objective of these messages is to enhance key household practices for health improvement relating to each cohort. The messages go beyond providing people with information; they aim at triggering respectful dialogue that ensures interest and relevance through an interactive, two-way process of sharing ideas, knowledge and opinions.

The **Kenya Essential Package for Health** defines six life-cycle cohorts:

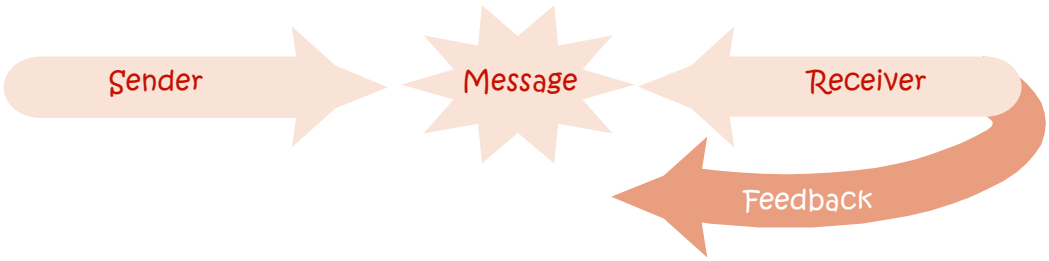
- Pregnancy, delivery and the newborn (first 2 weeks of life)
- Early childhood (2 weeks to 5 years)
- Late childhood (6 to 12 years)
- Adolescence (13-24 years)
- Adult (25-59 years)
- Elderly (over 60 years)

5.1 Communicating the Messages

Effective communication requires a message, the sender of the message, the receiver of the message, and feedback from the receiver to the sender and back again. There are many different ways of communicating, but whether you are working person-to-person within a community, advocating with political leaders or developing messages to be publicized in the mass media, the basic principles are the same:

1. Know who needs the information and find out about their living conditions, language, customs and level of knowledge. This helps to identify the messages that are most relevant, most easily understood, and most likely to be accepted and acted upon.
2. When adapting or translating the messages, use language that people understand. Do not overload the messages with too many actions or technical details. Keep to the verified information in the reference manual. If the messages are adapted, their accuracy should be verified.
3. Make sure the audience understands the information and knows how to put it into practice. This can be done by sharing the draft messages and visual materials with parents and other caregivers in the community, asking them open-ended questions and encouraging discussion to determine whether the intended message is both clearly understood and feasible. Utilize their feedback to adjust the messages and visual aids.
4. Make the message relevant to people's lives, addressing them, through dialogue, in the context in which they live. Find ways to make the messages interesting and

Figure 5.1: Effective communication is a two-way process



meaningful to each household and community, such as by illustrating them with local examples and stories.

5. Select the communication channels and media that are most effective at reaching the target audience. Pay particular attention to existing media and use these media as much as possible. Do not rely on a single means of communication but instead use a mix of channels and media so that the audience receives the message repeatedly and in many variations.
6. Repeat the information to reinforce it.

5.2 COHORT 1: Pregnancy, Delivery and Newborn

- Know the warning signs during pregnancy and childbirth and have plans and resources for getting immediate skilled help.
- Remind community members that physical abuse of women for any reason is dangerous and unacceptable.
- Encourage pregnant women to attend at least four ANC visits before delivery.
- Encourage all pregnant mothers to sleep under insecticide treated nets (ITNs) to prevent malaria.
- Help a pregnant woman prepare a birth plan, that is, what to do when the time comes.
- Encourage all pregnant women to deliver with the assistance of skilled medical personnel.
- Recognize the following risk factors in pregnancy:
  - An interval of less than two years since an earlier birth.
  - A girl who is under 18 or a woman who is over 35 years of age with first pregnancy.
  - The woman has already had four or more deliveries.
  - The woman has had a previous premature birth or baby weighing less than 2 kilograms at birth.
  - The woman has had a previous difficult or Caesarean birth.
  - The woman has had a previous miscarriage or stillbirth.
- Recognize the following warning/danger signs during pregnancy and take action:
  - Anaemia, paleness inside the eyelids, or being tired or easily out-of-breath.
  - Swelling of legs, arms or face.
  - The foetus moves very little or not at all.
  - Spotting or bleeding from the vagina during pregnancy (or profuse or persistent bleeding after delivery).
  - Severe headaches or abdominal pains.
  - Severe or persistent vomiting.
  - High fever.
  - The water breaks before due time for delivery.
  - Convulsions.
  - Prolonged labour.
- Encourage mothers to get immunized against tetanus.
- Immunize all newborn children against the preventable diseases.
- Ensure all births are notified and registered.
- Remember that the child health card is an important document that must be kept safely to monitor growth and immunization and other services to the child.
- Wash hands before feeding or breastfeeding, after cleaning the baby's faeces, and after using the toilet.
- Breastfeed your baby within an hour of birth.
- Follow instructions given at the health facility FOR EACH SERVICE.
- Involve fathers in the reproductive health of the family.

Girls who are under 18 and women who are over 35 with first pregnancy are at risk.

5.3 COHORT 2: Early Childhood (2 Weeks to 5 Years)

- Immunize all children during the first year of life to protect against diseases.
- Give all children Vitamin A supplementation.
- Monitor the child's growth every month from birth to age two, and thereafter when a child has a health problem.
- Recognize warning signs showing that the child's growth and development are faltering.
- Give the child proper mix of foods in three meals a day.
- Provide stimulation and affection to ensure social, physical and intellectual development.
- Provide exclusive breastfeeding to the infant for the first six months.
- Introduce weaning foods to infants from the age of six months, but continue breastfeeding through the child's second year and beyond.
- Keep the child health card safe. It is an important document that has all the information about child immunization and growth.
- Remember that diarrhoea kills children by draining water from the body, thus dehydrating the child. As soon as diarrhoea starts, give the child extra fluids as well as regular foods.
- Give the child an extra meal a day for at least two weeks while recovering from diarrhoea.
- To prevent diarrhoea, wash hands thoroughly with soap or ash and water after contact with faeces and before touching food or feeding children.
- Keep a child with cough or cold warm and continue normal feeding and drinking.
- Ensure children sleep under ITNs to prevent malaria.
- Have a child with a fever examined immediately by a trained health worker and receive an appropriate anti-malaria treatment as soon as possible.
- Watch young children when playing and keep their environment safe to avoid accidents.
- ***Do not use*** drinking bottles to store poisons, medicines, bleach, acid or liquid fuels such as paraffin. All such liquids and materials should be kept in clearly marked containers out of children's sight and reach.
- Involve fathers in the care of their children.

Abstinence is the safest way to prevent STDs and HIV infection and has no side effects.

5.4 COHORT 3: Late Childhood (6—12 Years)

- Ensure all children attend primary school.
- Ensure children receive an adequate balanced diet, three meals a day.
- Respond to child's need for care by playing, talking with and providing a stimulating environment to promote mental and psychological development.
- Seek health care as soon as an illness appears or is suspected.
- Insist that children sleep under ITNs to prevent malaria.
- Treat all drinking water at the point of use.
- Wash hands after visiting toilets and before eating in school and at home.
- Introduce sexuality education at focal points (home, church and school).
- Follow the instructions given at the health facility for each service.

5.5 COHORT 4: Adolescence and Youth (13—24 Years)

- Seek health care as soon as an illness appears or is suspected.
- Sleep under ITNs to prevent malaria.
- Treat water at point of use.
- Remember that abstinence is the safest way to prevent STDs and HIV infection.
- Delay sexual activity as long as possible.
- Use protection during sex if one must have sex.
- Follow all the instructions given at the health facility for each service.
- Avoid the use of alcohol, cigarettes and drugs.
- Involve both parents in the care of their adolescents and in reproductive health of the family.
- Encourage parents to discuss sexuality issues with their adolescent children.
- Prevent unwanted pregnancy through family planning.

5.6 COHORT 5: Adults 25—59 Years

- Remember that all people are at risk of HIV/AIDS; use condoms to reduce this risk.
- If you suspect that you might be infected with HIV, contact a health worker or a VCT centre to receive confidential counselling and testing.
- Reduce the risk of getting HIV through sex by not having sex at all or by being faithful to one partner, whose only partner is you.
- Parents and teachers, help young people protect themselves from HIV/AIDS by talking with them about how to avoid getting and spreading the disease.
- Discuss sexuality and HIV/AIDS with children early enough.
- Get information on lifestyle related illnesses.
- Check regularly for non-communicable illnesses like diabetes, hypertension, cholesterolaemia, etc.
- Seek health care as soon as illness appears or is suspected.
- Sleep under ITNs to prevent malaria.
- Treat drinking water at the point of use.

5.7 COHORT 6: Elderly Persons (over 60 Years)

- Seek health care as soon as illness appears or is suspected.
- Use ITNs when sleeping to prevent malaria.
- Treat drinking water at point of use.
- Follow instructions given at the health facility for any service.
- Take regular exercise to the extent of ability.
- Go for regular medical check ups.

6. Service Delivery at Level 1

NHSSP II organizes health services into six levels of delivery recognizing the Kenya Essential Package for Health (KEPH) over the six stages in the life cycle of human development. The five key policy objectives of the strategy highlight equity, access, effectiveness, efficiency, partnerships and resource mobilization as the pillars of improved health care. Through the strategy, the Government of Kenya focuses on human capital development as well as human rights principles in recognition of health care as a basic human right. Priority interventions include those that must be provided at the household and community levels by individuals and CHWs. It is envisaged by MOH that the implementation of KEPH requires effective decentralization of governance, management and service delivery, bringing decision making and health action as close as possible to households, which are both consumers and providers of care.

This chapter details the services needed at level 1 according to the service providers (household caregivers, CHWs and CHEWs). The chapter describes how level 1 services are linked to the rest of the service delivery system and explains the referral mechanisms.

6.1 Levels of Service Delivery

The Community Strategy framework describes the critical interface between the community and the health care system, which is further elaborated in these guidelines to facilitate implementation (see Figure 6.1). Tables 6.1—6.3 provide an additional glimpse, respectively, at service delivery structures, required expertise by level, and the service delivery matrix by cohort and level.

Figure 6.1: Levels of service delivery under KEPH

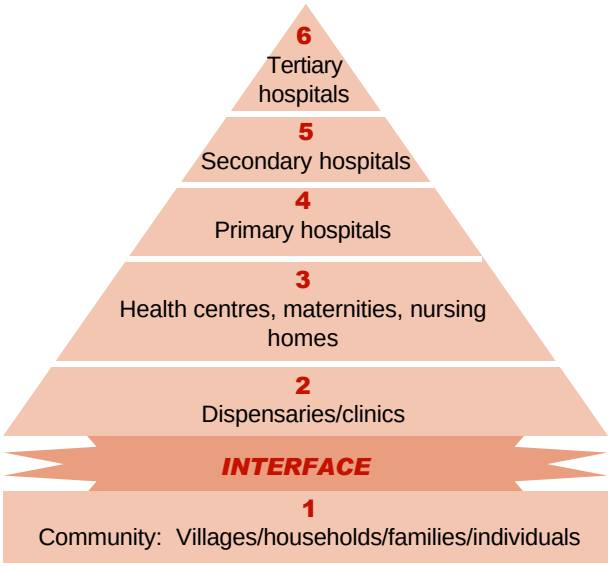


Table 6.1: Description of services at community levels (1-3)

Service level	Administrative unit	Service delivery unit
Level 1	Community/ Village	• Personal, family, household & community practices • Pharmacies
Community-System Interface		
Level 2	Sub-location	• Dispensary • Clinic
Level 3	Location	• Health centre • Nursing/ maternity home

Table 6.2: Expertise by level of services

	Promotive & preventive	Curative & rehabi-litative
Level 1: Community health services	+++	—-
Level 2+3: Primary health services	+++	+—
Level 4+5: Referral hospitals (public)	+—	+++
Level 6: Teaching hospitals	—-	+++

6.2 Key Components of KEPH at Level 1

At the community level, level 1, the main focus is to promote positive health behaviours and to create demand for health services that are provided at other levels of health care. The corollary is to equip communities with comprehensive information on practices leading to improved health through resource persons at the community level, the CHWs. In this way KEPH brings basic health services close to the people and provides a

Table 6.3: KEPH service delivery matrix by cohort and level

Cohort	KEPH level 1	KEPH levels 2 and 3
1. Pregnancy and newborn	▪ IEC on early recognition of danger signs; referral ▪ Birth preparedness ▪ Health promotion ▪ Community midwifery	▪ Focused ANC, IPT for malaria ▪ VCT, PMTCT or referral ▪ Basic emergency obstetric care, post-abortion care, referral services ▪ Oversight of CHW services ▪ Maternal death review
2. Early childhood	▪ Behaviour change communication (BCC) to promote key household care practices in prevention, care of the sick child at home, service seeking and compliance, promoting growth and development ▪ Community dialogue and action days ▪ Referral services	▪ Immunization, growth monitoring, treatment of common conditions (pneumonia, malaria, diarrhoea) ▪ Community dialogue ▪ Oversight of CHW services ▪ Essential drugs list ▪ Referral services
3. Late childhood	▪ School enrolment, attendance and support ▪ Support for behaviour formation and good hygiene	▪ Screening for early detection of health problems
4. Adolescence and youth	▪ BCC and IEC ▪ Community-based distribution (CBD) services ▪ Peer education and information ▪ Supply of preventive commodities ▪ Referral services	▪ All basic youth-friendly services, BCC and IEC ▪ Syndromic management of STIs ▪ Lab diagnosis of common infections ▪ Essential drugs list ▪ Referral services ▪ Oversight of CHW services
5. Adulthood	▪ BCC and IEC, community dialogue ▪ CBD services; home care, treatment compliance (TB, ART) ▪ Supply of preventive commodities ▪ Water and sanitation ▪ Referral services ▪ Promotion of gender and health rights	▪ BCC and IEC, VCT, ART and support groups ▪ Syndromic management of STIs ▪ Diagnosis and treatment of common conditions; TB treatment ▪ Essential drugs list ▪ Manage clients' satisfaction ▪ Referral services
6. The elderly	▪ IEC and BCC to reduce harmful practices ▪ Referral services	▪ Advocacy; management and rehabilitation of clinical problems ▪ BCC and IEC ▪ Screening, early detection of disease and referral

mechanism for easy referral for those who need more specialized care. This will ensure coverage of physically, socially and economically vulnerable and disadvantaged groups by making services affordable, with adequate safety nets for the economically disadvantaged. The outputs of KEPH at the community level must include basic services that are available, accessible, appropriate, acceptable, affordable, effective and efficient.

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 based on their own capacities. The conditions identified and included in their plan are those in which LEVEL ONE SERVICES can make the most significant contribution to the improvement of the health and the well being of Kenyans.

At the community level the activities focus on effective communication aimed at behaviour change, access to safe water/sanitation and basic care. Among the key issues are reproductive health, malaria, tuberculosis, HIV/AIDS and integrated management of childhood illness (IMCI).

6.2.1 Reproductive Health

Maternal mortality remains unacceptably high in Kenya (414 maternal deaths per 100,000 live births), with almost all of the deaths being the result of well-known and preventable causes such as haemorrhage, eclampsia, obstructed labour and puerperal sepsis. These common causes of maternal and neonatal deaths have been observed to be due to unsafe traditional practices during delivery. Such practices need to be checked to ensure that clean hands, clean delivery and clean instruments for cutting the cord are maintained in order to minimize complications. The other contributing factors are the three delays:[2]

1. Delay by the pregnant mother in deciding to seek care for pregnancy related complications. This occurs for several reasons, including late recognition that there is a problem, fear of the health facility or the cost that will be incurred in seeking care, or lack of an available decision maker (e.g., the husband, mother-in-law, etc.).

2. Delay in actually reaching the care facility, which is usually caused by lack of transport or unfavourable infrastructure. Many communities have very limited transportation options and poor roads.

3. Delay in being examined and receiving appropriate definitive treatment once at the health facility. This is one of the most tragic issues in maternal mortality. Often women will wait for many hours at the referral facility because of poor staffing, prepayment policies, or difficulties in obtaining blood supplies, equipment or the operating theatre.

The three delays boost maternal mortality

1. Delay in seeking care for pregnancy related complications.
2. Delay in reaching the care facility.
3. Delay in being examined and treated at the health facility.

Evidence from a number of studies globally has shown a reduction in maternal and perinatal mortality when women have skilled attendants present at every birth. This must be assured at level 1 service delivery through effective birth plans and availability of service delivery points.

The present policy requires that all pregnant women should have access to skilled care throughout the pregnancy-delivery-postnatal continuum, yet many community units grapple with gaps in service availability and must identify workable alternatives to meet the needs of pregnant women. With regard to safe motherhood, traditional birth attendants can be empowered to educate, encourage and assist women, their partners and families to anticipate and recognize signs of life-threatening complications, to know when and where to refer cases, to encourage development of birth preparedness plans including emergency transport, and where possible to accompany women coming for delivery at health facilities (Reproductive Health Policy Draft 3, 2005).

[2] United Nations Population Fund, *State of the African Population Report: Population and the Poverty Challenge*, Addis Ababa, Ethiopia, 2004.

6.2.2 HIV/AIDS Prevention and Care

At the community level the major obstacle to effective HIV/AIDS care and control is lack of access to different services, e.g., voluntary counselling and testing (VCT), laboratory services and anti-retroviral therapy (ART). Services are restricted to major hospitals and big urban health institutions. The standard care in ART requires laboratory monitoring of response, yet these tests are expensive and available only at a limited number of health facilities. Recent legislative amendments by GOK aimed at enhancing access to ART, together with dramatic price reductions, have seen the number of deserving patients on ART increase significantly. This has resulted in improved health outlook and reduced mortality. The net result is to convert HIV/AIDS to a chronic disease that if properly managed can allow sufferers to continue living and fulfilling their life goals and remain productive for the family, community and nation. The role of care at level 1 is critical in realizing this goal.

ART is a help but not a cure. The person can be re-infected with the virus and can infect others.

Services to prevent mother-to-child transmission (PMTCT) of HIV are being systematically integrated into maternal and child health (MCH) and family planning services, and thus guided by standards of care that have been developed, including codes and ethics of practice, clinical guidelines, and guidelines for operational procedures. The goal of the PMTCT programme is to increase access to PMTCT by developing capacity of health workers, expanding facilities, encouraging utilization of services, and strengthening information and reporting systems. These objectives will not be achieved without adequate information, education and communication (IEC) at household and community levels.

MCH/FP programmes are in a unique position to assist in HIV/AIDS control as well as care. There is long experience within MCH/FP programmes dealing with such matters as sexuality, counselling, contraception methods, care during pregnancy and childbirth, and breastfeeding, all of which are closely related to risk and prevention of HIV transmission. Greater impact of MCH/FP programmes on HIV/AIDS entails expansion of services to include IEC and counselling on a variety of sexuality, fertility and relationship issues. Routine infection control procedures need to be strengthened, while IEC aimed at changing knowledge, attitudes and practices related to sexual behaviour could be most effective at level 1.

Providers at level 1 are involved in clinical care, nursing care, nutrition, counselling and psycho-spiritual support, social support to clients with HIV/AIDS or TB, and support to orphans and children made vulnerable by AIDS.

6.2.3 Malaria

The greatest burden of malarial disease and death lies with the poor, who also have the least access to interventions against malaria. Effective interventions against malaria are available, yet the burden persists, because most people at risk of malaria have little or no access to them for reasons including those of distance and affordability. Poor access to public health facilities is a recognized constraint to the provision of early treatment. A large proportion of people who are ill with malaria are treated at home, with medicines from shops – often inappropriate medicines.

Since the majority of children who die from malaria do so within 48 hours of the onset of illness, and often at home, the early use of effective malaria medicines at or near the home will reduce the burden of malaria in endemic areas. This acknowledged time element is critical to saving child lives in stable malaria areas, and to reducing mortality in non-immune older children and adults in areas that are prone to epidemics. Recognizing these constraints, one aim of the Community Strategy must be to make treatment available as near the home as possible, be that in the community or in the home itself. The strategy must ensure early recognition of, and prompt and appropriate treatment for, malaria illness in the home or community. Specifically the strategy must:

1. Enable communities and ***caregivers*** to recognize malaria illness promptly and take early appropriate action at home and within the community.
2. Ensure that ***service providers***, including shopkeepers and CHWs, have adequate knowledge and capacity to respond to malaria illness.
3. Promote integrated vector control (IVC) according to endemicity type.

6.2.4 Community IMCI

The community component is well developed in the concept of integrated management of childhood illness (IMCI). The households are engaged in the 20 key care practices that have been identified and agreed upon and hence introduced to the households through dialogue with CHWs. The households are thus strengthened to improve the health status of their children, mostly those in the second cohort. The critical components include: disease prevention, care of the sick child, care seeking and compliance, and promotion of early childhood growth and development.

6.2.5 Tuberculosis

It is estimated that 35% of the Kenyan population is infected with the TB bacillus (*Mycobacterium tuberculosis)*, the causative agent of TB. The majority of these people will never develop disease because their immune (defence) systems are able to prevent the bacillus from multiplying and causing disease. If the immune system is weakened, for example by HIV infection, the TB bacilli begin to replicate and eventually lead to disease. Since an estimated 7% of Kenyans are currently infected with HIV, it follows that a significant proportion of Kenyans are concurrently infected with both HIV and the TB bacillus. These individuals have a considerably higher risk of developing TB disease.

Tuberculosis is a disease that usually attacks the lungs (80%), but can affect almost any part of the body except the hair and the nails. The TB bacteria usually enter the body through the lungs and may reside there without causing any disease. TB is spread through the air by a sick person through coughing, sneezing, singing or even speaking to a healthy person who inhales the TB bacilli. TB patients with bacteria in their sputum (smear positive TB) are the sources of infection.

Recognition of TB

Cough that lasts for two or more weeks, loss of appetite, weight loss, chest pains, shortness of breath, and night sweats may indicate that a person has TB. Some people may present with bloodstained sputum. All patients presenting with pulmonary TB and a cough should have three sputum samples collected for microscopic examination for acid fast bacilli (AFB). A chest x-ray is also useful but not diagnostic for TB.

TB is not HIV and HIV is not TB. They are two different diseases and of them TB is ***curable***.

TB Treatment

TB is curable even in people living with HIV, as long as the diagnosis is made early and treatment is prescribed and taken adequately. The treatment is free at all government facilities and in some designated health facilities, e.g., mission hospitals, where TB services are offered. The duration of TB treatment ranges from 6 to 8 months. The preferred approach is referred to as directly observed treatment, short course (DOTS), meaning that the service provider observes the patient taking the drugs.

For better adherence to TB treatment, it is recommended that every TB patient should have a treatment supporter. TB patients can get their drugs daily from the nearby health facility or from the community (community-based DOTS).

Links between HIV and TB

HIV/AIDS and TB are so closely connected that the term "co-epidemic" or "dual epidemic" is often used to describe their relationship. HIV affects the immune system and increases the likelihood of people acquiring new TB infection. It also promotes both the progression of latent TB infection to active disease and the relapse of the disease in previously treated patients. Tuberculosis kills up to half of all AIDS patients and is the most important cause of death among people living with HIV. An estimate one-third of the 40 million people living with HIV/AIDS worldwide are co-infected with TB. In Kenya the national average stands at 50-60%, but in some regions it is much higher; in Nyanza, 80-90% of TB patients are also infected with HIV.

Each disease speeds up the progress of the other and TB considerably shortens the survival of people with HIV/AIDS. People who are HIV-positive and infected with TB are up to 50 times more likely to develop active TB in a given year than people who are HIV-negative. Furthermore, without proper treatment, approximately 90% of those living with HIV die within months of contracting TB.

Key TB Information for the Community

Crucial information to be shared with community members includes the following:

- A cough lasting two weeks or more could be TB, so one should go for a check up as early as possible.

Households have important responsibilities for addressing health needs at all stages in the life cycle. Among these are health promotion, disease prevention, care seeking and participation in governance of health care services.

- Treatment to cure TB is available free of charge at all government health facilities and other designated health facilities like mission hospitals.
- Early treatment prevents the spread of TB to healthy people/ community.
- TB patients who are taking their medication properly are not likely to spread the disease.
- Patients who adhere to their treatment completely get cured even if they have HIV infection.
- Patients can lead perfectly normal lives.
- Community participation in TB control activities will help to win the fight against TB, and fewer people will die from the disease.
- TB is not HIV and HIV is not TB. They are two different diseases and of them TB is ***curable***.

Role of CHEW in TB Control

The key role of the CHEW is to ensure that the CHWs carry out the tasks assigned to them. They:

- Create awareness in the community on TB control and prevention.
- Identify suspected TB cases.
- Refer the TB suspects to the health facility for screening.
- Ensure that the TB treatment supporter observes the patient take/swallow the medicine (DOTS)
- Ensure that the appointment card is ticked by the treatment supporter after observing the swallowing of medicine.
- Follow up the TB cases to ensure that they are taking the drugs correctly.
- Act as the link between the community and the health facility.
- Ensure proper recording and reporting of both the TB suspects and patients.
- Carry out defaulter tracing.

6.3 Service Provision at Level 1

This section lists the services to be provided by households and communities, as well as CHEWs and CHWs, and the process of supportive supervision. The section then summarizes the basics of referral mechanisms, including essential elements of a referral system and the steps to take in making a referral.

6.3.1 Service Provision by Households and Communities as Partners in Service Delivery

The households have important responsibilities for addressing health needs at all stages in the life cycle. Among these are health promotion, disease prevention, care seeking and participation in governance of health care services.

Health Promotion

- Eating a healthy diet for people at all stages in life in order to meet nutritional needs.
- Building 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 for early detection of problems for timely action.
- Exercising regularly.
- Ensuring gender equity.

Disease Prevention

- Practising good personal hygiene in terms of washing hands, using latrines, etc.
- Treating drinking water.
- Practising integrated vector control measures (e.g., cutting brush and draining stagnant water to control mosquitoes).
- Preventing accidents and abuse, and taking appropriate action when they occur.
- Promoting dialogue on responsible sexual behaviour to prevent transmission of sexually transmitted diseases.

Care Seeking and Compliance with Treatment and Advice

- Providing home care for the sick members.
- Completing scheduled immunizations of infants before first birthday.
- Recognizing and acting on the need for referral or seeking care outside the home.
- Complying with 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.
- Giving feedback to the service system either directly or through representation.

6.3.2 Service Provision by CHEWs and CHWs

The service functions of CHEWs and CHWs include a wide range of activities, from health promotion to disease prevention and control, to hygiene and compliance with treatment, among others.

Health Promotion

- Demonstrating a healthy diet for people at all stages in life in order to meet nutritional needs.
- Providing guidance on social capital to ensure mutual support in meeting daily needs as well as coping with shocks in life.
- Encouraging demand for health and social entitlements as citizens.
- Observing health status to ensure early detection of problems for timely action.
- Providing guidance on gender equity.
- Encouraging emergency preparedness.

Disease Prevention and Control to Reduce Morbidity, Disability and Mortality

- Promoting the control of communicable disease through behaviour formation, modification and change towards healthy practices (HIV/AIDS, STIs, TB, malaria).
- Providing/demonstrating first aid and emergency preparedness, treatment of injuries and common ailments.
- Demonstrating good personal hygiene in terms of washing hands, using latrines, etc.
- Ensuring access to water treatment for safe drinking water.
- Demonstrating and encouraging integrated vector control measures.
- Enhancing prevention of accidents and abuse, and taking appropriate action when they occur.

Expanding Family Planning, Maternal, Child and Youth Services

- Promoting/facilitating MCH/FP, maternal care, seeking trained obstetric care, immunization, nutrition, C-IMCI.
- Promoting enhanced adolescent reproductive health through household and community-based dialogue, targeting behaviour formation, modification and change.
- If appropriate, organizing community-based day-care centres.
- Organizing community-based referral system, particularly for emergencies.
- Encouraging payment for first-contact health services provided by CHWs.

Hygiene and Environmental Sanitation

- Providing IEC for water, hygiene, sanitation and school health.
- Ensuring proper excreta/solid waste disposal.
- Improving water sources to ensure access to safe drinking water.
- Practising/promoting proper food hygiene.
- Practising/promoting good personal hygiene.
- Developing kitchen gardens.
- Organizing community dialogue and health days.

Care Seeking and Compliance with Treatment and Advice

- Training and supporting home caregivers.
- Facilitating availability of and access to vaccines.
- Training caregivers to recognize health problems and on the need for referral or seeking care outside the home.
- Encouraging compliance with recommendations given by health workers in relation to treatment, follow-up and referral.
- Ensuring 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.
- Giving feedback to the service system either directly or through representation.

Claiming Rights

- Promoting the 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.

6.4 Supportive Supervision

The health system should be able to provide supportive supervision to the LEVEL ONE SERVICES frontline personnel. Supervisory teams should have an appropriate, multidisciplinary skills mix so as to ensure standards in terms of quantity and quality of work. Other components of effective supervision are regular performance appraisals based on checklists to measure performance; good communication and discussions; and appropriate rewards to CHWs.

During supervisory visits, the team should:

- Discuss with CHEWs and CHWs 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 and wind up with an agreed plan of action.

The team should then prepare a field report and send it to the CHC, HFC and the DHMT for follow up and needed action. Such action may include: in-service training, continuing education and improvements in the supply of materials provided by the health centre (HC) or district health office.

6.5 Referral Mechanisms

A referral system is an interlinked network of service providers and facilities that provide a continuum of care for acute and chronic health conditions. The network may include both individuals and organizations working to provide care and support to people who are unwell. There are typically four levels to a health referral network: the community, primary, secondary and tertiary levels. This section focuses on the community level. The community level consists of household caregivers, CHWs and CHEWs, linked to levels 2 and 3. These providers should be trained to recognize illness and gauge its severity in order to provide prompt treatment (if they have the necessary capacity) or refer, when they are unable to treat, to the next appropriate level of care.

It is the responsibility of the one initiating referral to document the referral activity and follow up with clients to ensure they received the necessary attention at the level of care to which they were referred.

The objectives of a referral system are to improve the access of clients to services, reduce the time it takes for them to receive required care and avoid unnecessary delays. Achieving these aims requires a collective effort of many individuals at various levels to strengthen access to existing services as well as linkages among the providers, including formal referral arrangements, proper communication, transport and the use of standard tools.

Effective supervision requires multi-sector coordination and collaboration at various levels in creating a supervisory system made up of staff with technical and management skills working as a team.

This obviously demands coordination, communication and arrangements to ensure that access to required services is as quick as possible, that confidentiality is maintained, and that referrals can be easily traced and followed up. It also means that referral outcomes can be documented, feedback from clients on the services they received can be noted, gaps in the system can be identified and steps can be taken to improve service provision.

6.5.1 Essential Elements of a Referral System

The following elements need to be put in place to build and maintain an effective referral system and ensure positive outcomes for clients, their families and the entire community:

- ***Service availability:*** The foundation of the system is the availability at the next level of care of services that are accessible and affordable to the general community, on the basis of prevailing local health problems.
- ***Coordination of referral activities:*** Specific individuals should be designated at the community level to coordinate the referral activities and provide feedback as necessary.

- ***Relationships:*** Ideally level 3 facilities should take the lead in establishing and maintaining referrals by supporting community level providers. Both providers and clients should work as partners in the system.

- ***Communication and transport:*** Effective communication and transport arrangements are crucial for the completion of effective referrals. Identification of the cheapest means of transport should be done and if possible discussed by the key partners in the referral system. One possible solution would be to choose members of the community who have access to transport to assist other community members with transport during referrals.

- ***Feedback mechanism:*** A feedback system should be established to help with the tracking of referrals from the point of initiation to the point of delivery. This will provide evidence that the client completed the referral process and whether the client is satisfied with the services received.

- ***Monitoring and evaluation:*** The referral system should be included in the monitoring and evaluation mechanisms at this level to ensure continuous assessment and improvement of the referral system, process and outcomes.

All health care providers should be knowledgeable about all the service providers within their areas. This can be done by developing a list of all providers in the area and where they are located. The list should include different types of services provided by each service provider. Health providers should to the extent possible develop good relationships with other service providers and establish a means of communication with each of them. Each facility or service group should have a contact person with means of communication. This will enable the providers to enhance each other's work, leading to improved care of patients within the system.

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

6.5.2 Steps in the Referral Process

The referral process should be carried out through a dialogue between the provider and the client, with the goal of addressing the perceived needs of the client and the client's caregivers. The following steps are undertaken:

1. ***Assess needs:*** Discuss with the client to identify their immediate needs.
2. ***Determine alternatives:*** Discuss what the client would have to do to reach the next level of care and assess the adequacy of or gaps in proposed action.
3. ***Identify options:*** Brainstorm with both the client and the caregiver to come up with options.
4. ***Appraise options:*** Select the most doable option based on available resources.
5. ***Commit to action:*** Discuss the consequences of taking or not taking the agreed action.
6. ***Develop a plan of action:*** Map out what is to be done, fill out the referral documents to enable follow-up and tracking.
7. ***Take action:*** Move on the option as planned and follow up.
8. ***Assess the action and provide feedback:*** Assess the action and through regular meetings inform the caregivers and the relevant members of the referral network about the results of the action.

7. Community-Based Health Information System

When it is working properly, a functioning community-based health information system (CBHIS) makes an important contribution to improving the provision of basic health care services to communities. This chapter describes the CBHIS and its role in providing information for regular dialogue, monitoring and evaluation for informed health-related decisions at the community level. The chapter:

- Defines a community-based health information system.
- Outlines how a community-based health information system is established.
- Describes the scope of a community-based health information system.
- Summarizes the qualities of a good community-based health information system.

Measurement of the effectiveness of service delivery at level 1 is based on the essential care package, organized by life-cycle cohort, as described in Chapter 6. Among the critical elements of care are focused antenatal care, newborn care, nutrition, breastfeeding, prevention of mother-to-child transmission of HIV, delivery by trained midwives and family planning. Other aspects of the essential package are family and community support, water and sanitation, community IMCI, education, food availability, and screening. All these elements are – or should be – reflected in the CBHIS.

All stakeholders must be involved in designing and implementing a community-based health information system if it is to be successful.

Evaluation asks whether we succeeded or failed, whether we used resources appropriately, and whether our actions will have long-term results. We can't know unless our information system provides the means to monitor our progress.

7.1 Why a Community-Based Health Information System

Back in 1993, the World Bank's *World Development Report* proposed that health status could be substantially improved without the investment of a large amount of financial resources if priority setting, planning, and action were based on the evidence of disease burden. It predicted that by reaching 80% of the population with cost-effective packages of essential interventions, the burden of disease could be reduced by 32%. Experience in various areas has confirmed this proposition.

At individual and community levels, information is needed for assessing the extent to which services are meeting the needs and demands of the communities. Better availability and use of information can cut costs, reduce system inefficiencies and improve health outcomes.

The Community Strategy recognizes that all stakeholders must be involved in designing and implementing a CBHIS if it is to be successful. The system must include indicators for assessment that relate to outcomes people care about. These are indicators that are likely to

trigger a strong response from the community and the health system while paying attention to the assessment of progress towards NHSSP II objectives and the Millennium Development Goals (MDGs).

7.2 Definition of Community-Based Health Information System

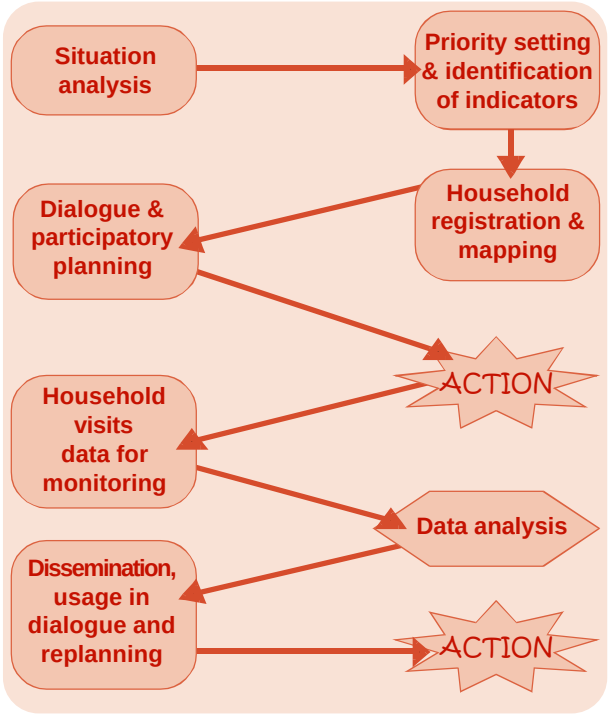
Simply put, the system is described by its name: It is a system that generates health-related information through sources at the community level. It has potential to be comprehensive because it has the possibility of covering everyone in a health unit under the responsibility of a CHC, according to their need for care. This type of system is able to collect information even about illnesses that are stigmatized like disability and various chronic conditions because the people who do the collecting are from within the community. More importantly, the system captures information from both those who visit and those who do not visit health facilities.

7.3 Setting up a Community-Based Health Information System

The system collects information to help the CHC plan and manage health activities at the community level. Within parameters set by MOH, each CHC should decide on the scope of their CBHIS, guided by the CHEW. On the basis of their experience and available information from the community, the CHC prioritizes the problems that determine the indicators to be included. Figure 7.1 outlines how an information system is established.

After prioritization and agreement on possible courses of action, the CHC with the support of the CHEW plans specific actions to improve the community health situation. To monitor and evaluate the actions and the level of improvement achieved, the CHC identifies the type of information to be collected, who collects it and what tools are necessary. In addition, the committee has to describe how the information will be collected, analysed, disseminated, utilized and stored for future use.

Figure 7.1: The process of establishing a community-based health information system



7.3.1 The Type of Information Collected and Who Collects It

In order to have an effective CBHIS, the community must be involved in its design, implementation and evaluation. This increases the acceptance and use of the system's output. Ideally the system will collect data based on the activities of CHWs, CHEWs and CHCs, as well as general information on community development issues, socio-economic and demographic indexes of households, community resources, diseases, etc. The information is collected mostly by the CHWs, supported by the CHEWs and CHC members. Typically, the following as indicators normally apply:

- Births and deaths
- Children with child health card
- Children who have completed immunization

A good information system captures all the events being monitored and in all households and individuals within the area of responsibility.

- Number of pregnant women attending antenatal clinics
- Mothers using oral rehydration salts for diarrhoea in their children
- Children under five sleeping under insecticide treated mosquito nets
- Households having latrines
- Households treating drinking water
- Households with food items in stock

7.3.2 How the Information Is Collated and Analysed

The information is collected through simple formats that the CHC, CHWs and CHEWs agree on, such as tally sheets or simple questionnaires. The CHC agrees on the frequency of data collection, linked to their health plan, and monitors data collection, compilation and analysis. It also decides on the format in which the information is presented for dissemination and utilization within the community – reports, posters or chalk boards placed in strategic places within the community like schools, dispensaries or chiefs' offices.

7.3.3 Use of Community-Based Health Information System

The information collated through the CBHIS can be used for many purposes, among which are:

- Contributing to dialogue, planning, action and assessment processes to fuel continuous health improvement.
- Informing the participating community about their health situation and progress being made towards improvement.
- Comparing efforts by different communities in terms of health improvement.

7.3.4 Characteristics of a Good Community-Based Health Information System

The following are some of the marks of a good health information system:

- The information collected is accurate, reliable and timely.
- The information gathered is complete in terms of capturing all the events being monitored and in all households and individuals within the area of responsibility.
- The data are easy to collect, analyse and interpret.
- The information collected is useful to the person who is collecting it and to the participating community because it reflects issues that the community is concerned about.
- The system provides feedback to all the households in the participating community.
- The system uses simple data collection tools.
- The system is inexpensive, requiring limited resources for it to function effectively.
- The information available can be and is referred to frequently.
- All data are updated twice a year.

Notes

Notes

Republic of Kenya

Reversing the trends

The Second
NATIONAL HEALTH SECTOR
Strategic Plan of Kenya

Community Strategy Implementation Guidelines

for

Managers of the Kenya Essential Package for Health at the Community Level

Ministry of Health
March 2007

Community Strategy Implementation Guidelines for Managers of the Kenya Essential Package for Health at the Community Level

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 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. 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 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 the strategy. This book provides a guide for bringing communities on board, to ensure the full involvement and ownership by community members.

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