PRIMARY HEALTH CARE

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Introduction

Health care:

- It is defined as multiple services rendered to individuals, families or communities by the agents of health services or professionals for the purpose of promoting, maintaining, monitoring or restoring health.

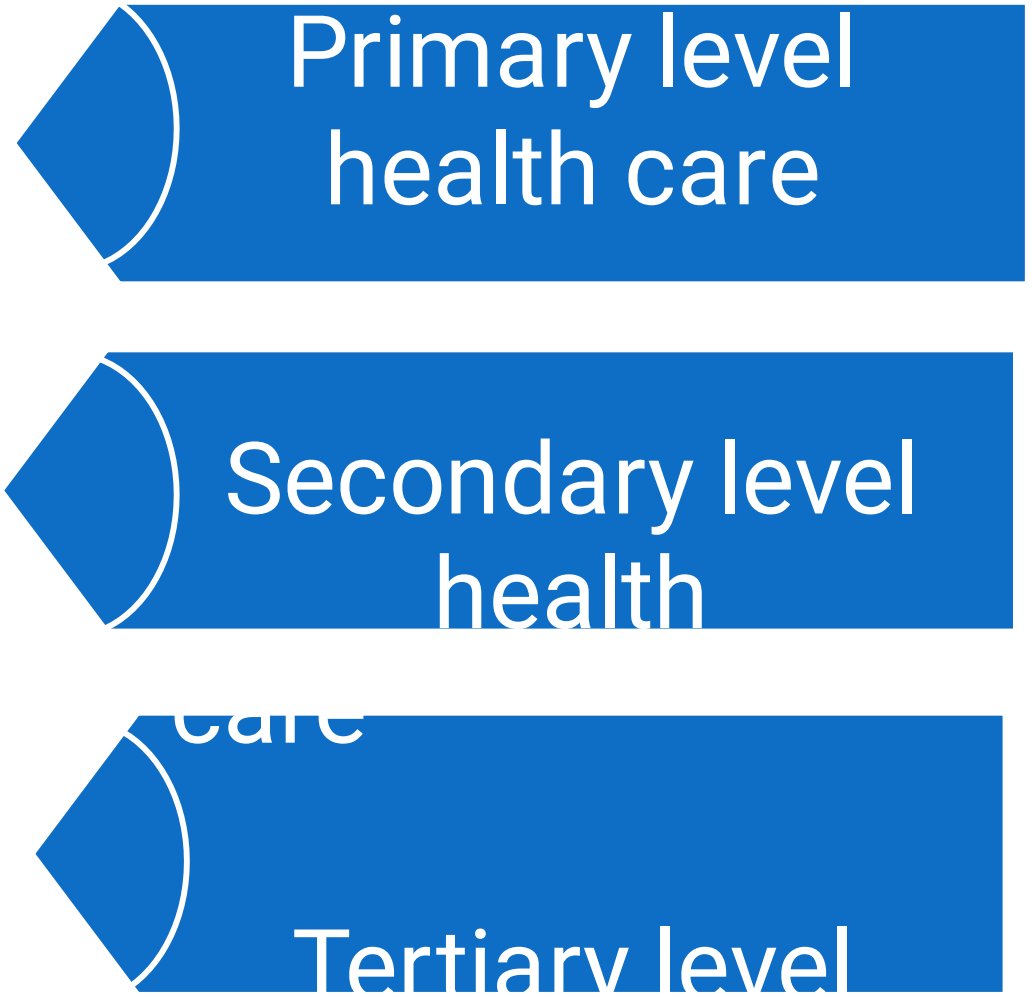
Health for all :

- Attainment of a level of health that will enable every individual lead a socially and economically productive life

Primary health care

- Primary health care refers to essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost that the community and country can afford.
- Primary Health Care is different in each community dependi ng upon:
  - Needs of the residents;
  - Availability of **health care** providers;
  - The communities geographic location; &
  - Proximity to other **health care** services in the area.

LEVELS OF HEALTH CARE



Primary level Health Care

- This is the first level of contact between the recipient of care and the health care delivery system.
- Essential health care (PHC) is provided.
- The closest to the people.
- Majority of the problems at this level are solved by the people with some assistance and guidance of health workers.
- Provided by the primary health

Secondary Level Health Care

- At this level, more complex problems that require secondary level of preventive services and curative services are taken care of.
- It is the 1st referral level.
- These services are provided at sub-county hospitals.

Tertiary Level Health Care

- This level of health care is provided at the state/regional/central level institutions.
- Offers super-specialist care

- These institutions serve as a referral units for primary and secondary levels.

- They also serve as a teaching institution for education and training of various categories of health care professionals.

Concept of PHC

- The concept of primary health care was introduced at international level jointly by WHO and UNICEF at the Alma Atta conference in 1978 to achieve the goal of HFA by the year 2000A.D

- The commitment to global improvements in health, especially for the most disadvantaged populations, was renewed in 1998 by the World Health Assembly. This led to the ‘Health-for-All for the

- These c0ncepts are as follows:

1. **Universally accessible**
   - This accessibility refers to continuing and organized supply of HC that is geographically, financially and culturally within easy reach of the whole community.

- **2. Socially acceptable**
  - PHC acceptable to all implies that care has to be appropriate and adequate in quality to satisfy the health need of people and how to be provided in method acceptable to them with their social cultural norm.

- **3. Affordable**
  - Affordable PHC implies that whatever the method of payment used with service should be affordable in the community and country.

- **4. Available:**
- This means that the structure and services are easily available to the community members but they only help them to assume responsibility in their own health.

- **5. Appropriate technology**
- Refers to the utilization of appropriate methods and techniques together with the people using them and can contribute significantly to solving health problems.

- **6. Full participation**
- It means that individual, families and community assume the responsibility in promoting their own welfare and health.

- Assignment: History Background of Primary Health Care

Pillars of Primary Health Care

1. Health system
2. Priority
3. Science
4. Culture
5. Equity
6. Participation
7. Sustainability

Health system

- Primary health system is the first element of a continuing health care process sustained by integrated, functional and mutually support referral systems, leading to progressive improvement of the comprehensive health care for all and giving priorities to those in most needs.

Priority

- Essential health problems
- Address main health care problems in the community providing promotive, preventive, curative and rehabilitative services.

Science

- Practice scientifically sound
- Based on application of the relevant results of social biomedical and health services research.

Culture

- Socially acceptable method and technology.
- Reflect and evolves from the economic condition and social, cultural and political characteristics of the country and communities.

Equity

- Made universally accessible to individual and family by solving the gross equality in peoples health states.

Participation

- People have the right and duty to participate in planning and implementing of health care

Sustainability

- Being able to maintain at every stage of developing in the spirit of self reliance and determination

Principles

Equitable distribution:

- It means primary health care services must be shared equally by all the people.

Accessibility:

- Primary health care aims to provide health care to all the population living in any geographical area.

Community participation/involvement:

- Community participation is the process by which individuals and families assume responsibilities for their own health and welfare and for those of the community and develops the capacity to contribute to their country nt

Multi-sectoral approach:

- For achieving the goals, co-ordination with the other sectors is necessary because no sector can achieve its goals in isolation.

Appropriate health technology:

- It implies the use of methods, techniques and equipment which are scientifically sound but simple.

Intersectoral function/ collaboration

- Intersectoral function is essential for many health related programmes like water, sanitation prog, housing prog, food supplies and education progs.
- For raising general social economic standards of whole population.

Decentralization

- Refers to transfer of authority for planning decision making and management including some financial management from a higher level to lower level and the aim is to make this services responsive to the local needs.

Referral system:

- The patients with severe condition unable to treat at the primary level should be referred to the higher/ specialised centre for the proper treatment.

Logistics of supply:

- It includes planning and budgeting of the supplies required, procurement or manufacture, storage, distribution and control.

Integration of health programmes

- Means that individual pt., families or community must understand how to use health care system when they need it.
- It should be friendly and accessible without wasting money and time in accessing the services.

Effectiveness

- Implies that the technology and the strategy used in health care must do work at which they are intended e.g. they reduce the risk.

Efficiency

- It means methods used to achieve a given result should involve minimum resources e. g. facilities, manpower, money and time required to do the job.

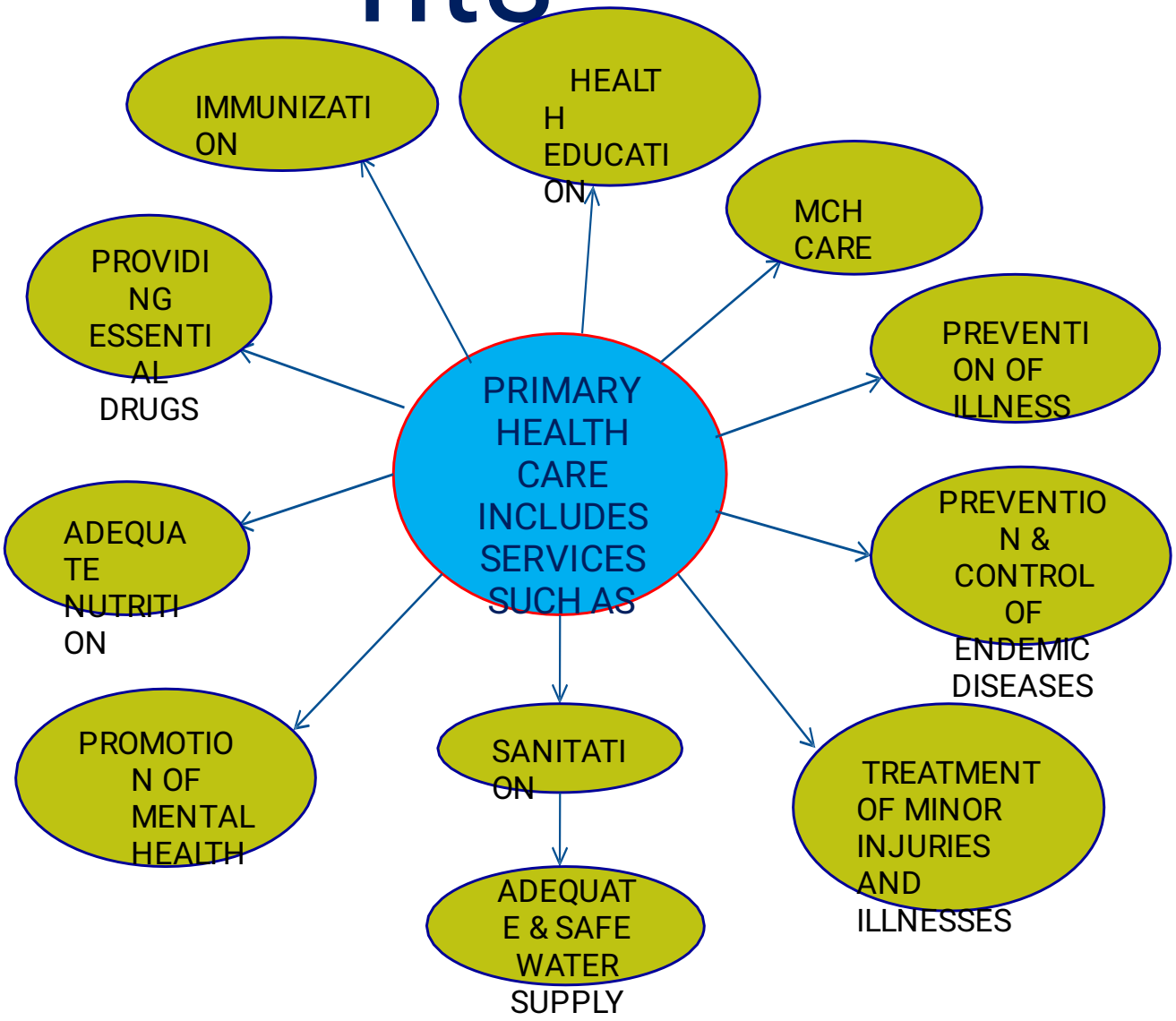
Health promotion and disease prevention

- This includes behaviour change in relation to activities such as nutrition, environment and reaction rather than prevention of specific diseases.

Characteristics of PHC

- It is essential health care which is based on practical, scientifically sound and socially acceptable methods and technology
- It should be rendered universally, acceptable to individuals and the families in the community through their full participation.
- Its availability should be at a cost which the community and country can afford to maintain at every stage of their development in a spirit of self reliance and

Elements


PRIMARY HEALTH CARE INCLUDES SERVICES SUCH AS
IMMUNIZATION
HEALTH EDUCATION
MCH CARE
PROVIDING ESSENTIAL DRUGS
PREVENTION OF ILLNESS
ADEQUATE NUTRITION
PREVENTION & CONTROL OF ENDEMIC DISEASES
PROMOTION OF MENTAL HEALTH
SANITATION
TREATMENT OF MINOR INJURIES AND ILLNESSES
ADEQUATE & SAFE WATER SUPPLY

Essential Elements of Primary Health Care (PHC)

E– Education concerning prevailing health problems and the methods of identifying, preventing and controlling them.

L– Locally endemic disease prevention and control.

E– Expanded programme of immunization against major infectious diseases.

M– Maternal and child health care including family planning.

E– Essential drugs arrangement.

N– Nutritional food supplement, an adequate supply of safe and basic nutrition.

T– Treatment of communicable and non-communicable disease and promotion of mental health.

S– Safe water and sanitation.

Extended Elements in 21st Century:

1. Expended options of immunizations.
2. Reproductive health needs.
3. Provision of essential technologies for health.
4. Health promotion.
5. Prevention and control of non-communicable diseases.
6. Food safety and provision of selected food supplements.

Policies of WHO/ Sets of PHC reforms

- **Universal coverage:**
  - Reducing exclusion and social disparities in health
- **Service delivery reform:**
  - Organizing health services around peoples needs and expectations
- **Public policy reforms:**
  - Integrating health information to all sector
- **Leadership reforms:**
  - Perusing collaborative models of policy dialogue Increasing stakeholders participants

Strategies of PHC

1. **Reducing excess mortality of poor marginalized populations**:

PHC must ensure access to health services for the most disadvantaged populations, and focus on interventions which will directly impact on the major causes of mortality, morbidity and disability for those populations.

2. **Reducing the leading risk factors to human health**:

PHC, through its preventative and health promotion roles, must address those known risk factors, which are the major determinants of health outcomes for local populations.

Strategies contd.

3. Developing Sustainable Health Systems:

PHC as a component of health systems must develop in ways, which are financially sustainable, supported by political leaders, and supported by the populations served.

4. Developing an enabling policy and institutional environment:

PHC policy must be integrated with other policy domains, and play its part in the pursuit of wider social, economic, environmental and development policy.

LEVELS OF PRIMARY HEALTH CARE IMPLEMENTATION

Family Level

- Maintaining a home environment conducive to health maintenance and personal development.
- Making decision about seeking health care
- Maintaining reciprocal relationship with the community and all health institutions.
- Providing nursing care to sick, disabled or dependent members of the family.
- Recognizing interruptions of the health development such as illness or a child’s failure to thrive.
- Dealing efficiently with health and non health crisis

Responsibilities of the community

- To recognise priority problems relating to health
- Decide on what needs to be done to overcome the problems
- Decide on what the community itself can do to solve the problems.
- To organise and implement whatever they themselves can do on their own or with the support of the government or non-govt. agencies.
- To monitor and evaluate their activities as necessary. Community meets this through; community participation, awareness and involvement.

Responsibility of the Government; National Level

- Ensure a consistent policy and strategy base for PHC activities throughout the country.
- Recommend activities that should be undertaken to overcome communities problems.
- Avail resources to address these problems from other sectors, NGOs and international sources.
- Ensure collaboration among the different government sectors in planning activities that have a bearing on health.
- Ensure the coordination of inputs from both bilateral and multilateral sources in accordance with the national plan for PHC development
- Provide overall coordination of PHC activities in the country

- Review and evaluate PHC activities with a view to identify areas in need of strengthening.
- Provide technical and financial support for PHC
- Promote Intersectoral collaboration in PHC at all levels
- Maintain a database on PHC development and provide quarterly and annual report of programme.

Govt resp. at County

- Responsible for all PHC activities
- Technical support in the planning and management of PHC at the sub-county level through necessary materials and training people.
- Monitoring and evaluation of the health activities in all levels.

Government responsibilities at sub-county

- Identifying the existing health problems in the subcounty
- Identifying what actions need to be taken to reduce these problems
- Identifying the resources available within the community from other govt. sectors with NGOs to deal with the identified problems.
- Preparing plans to use the resources available in a coordinated manner to improve health.
- Providing technical support to PHC activities in the community
- Monitoring the implementation of the sub-county plan both in terms of activities carried out by each of the actors in the plan and their effect on the health.

Government at community level

- Ensure training of CHVs, CHEWs, TBAs
- Providing essential drug to the health centres
- Support control of endemic diseases in the community such as Malaria.
- Ensure constant supply of vaccines and the cold chain is well managed (support)
- Provide training on HIV/AIDs and STI/TB prevention

Government at community level

- The government has assisted the communities to set up village health development committee.
- The responsibilities of the village health development committee include:
- Assist with the identification of health problems in the community and setting of priorities.
- Assist with the identification of community resources and coordinating them in planned activities aimed at overcoming specific health problems.
- Assist the community to select CHWs and to provide administrative supervision of their work.

- Provide a channel of communication between the community and the health as well as development committee at the ward level.
- Assist with monitoring of the health of the community
- Initiate and participate in communal income generating activities.

Roles of NGOs

- Involved in community based health care project
- Collaboration with the ministry of health to improve population health status
- Formulation of rational guidelines and implementation of PHC
- Provision of funds to support PHC programmes
- Initiate medical and research foundation

Examples FBO

- Catholic missions medical board
- Christian Health Association in Kenya (CHAK)
- Baraton
- AIC-Kapsowar
- UZIMA
- Kenya Methodist university

Responsibilities

- Coordinate all health services held for churches
- Have a great impact of taking care of orphans
- Also deals with employment and training health workers
- Collaboration with the ministry of health to improve population health status.

Reading assignment on the role of a nurse in implementing PHC elements

Achievements of PHC

1. There was a shift from curative programmes which has led to a reduction of morbidity and mortality rates . These have been achieved through programmes like KEPI, MCH/FP, nutrition, control of communicable diseases etc.
2. There has been a widespread acceptance of PHC among govts, ministries, NGOs and international agencies.
3. PHC has had considerable influence in promoting a more equitable distribution of health resources and in development of new types of health workers in the country e.g. Community Owned Resource Persons, CHEWs, CHAs, CHVs.
4. There has been extensive expansion in coverage of several PHC elements.

- 5. Epidemiology of childhood diseases e.g. poliomyelitis, tetanus, pertussis has resulted to an overall decline of infant and child mortality rates.

- 6. PHC has led to encouraging achievement especially in global targets to eradicate and control selected diseases.

- 7. PHC has made an improved contribution to greater social justice and equity by reducing the gap to those who have an appropriate level of health and those who don’t.

Challenges of primary health care

1. The main source of morbidity and mortality in Kenya still remain disease that can be prevented through immunisation, improved personal hygiene and environmental manipulation.
2. Curative services remains an expesive aspect of Kenya's health care delivery.
3. Most funds remain at tertiary and secondary level facilities and the least at the peripheries.
4. There has been an increase in the burden of diseases due to emerging and reemerging diseases as well as human disasters

5. Up to 55% of Kenya's lack access to safe water and sanitation, this puts the population at risk of contracting diarrhoea and other communicable diseases and also there's air pollution and poor waste management
6. Malaria and respiratory conditions accounts for 50% of all reported diagnosis in public health facilities, diarrhoeal cases to 60%.
7. There's a challenge of maintaining the present level of coverage achieved by many PHC programmes e.g. EPI has remained dependant on support from donors.
8. Despite the 1970s system in health care delivery, there's no clear guidelines on how patients can be referred from one health facility to another.

The Challenges of changing World

- Unequal growth, unequal outcomes
- Adapting to new health challenges
- Trends that undermine the health systems' response
- Changing values and rising expectations
- PHC reforms: driven by demand

The Basic Requirements for Sound PHC (the 8 A's and the 3 C's)

- Appropriateness
- Availability
- Adequacy
- Accessibility
- Acceptability
- Affordability
- Assessability
- Accountability
- Completeness
- Comprehensiveness
- Continuity

Declaration of the Alma Ata

- In 1978, ministries from 134 countries met at the Alma- Ata conference in the former USSR to declare a common mission for governments, international organizations & health workers worldwide (**health for all by the end of year 2000**), they thus declared the **strategy of PHC** as the key to realize this vision.
- It consisted of ten fundamental principles for effective comprehensive primary health care service delivery
- Principles were in response to the broader community and social issues leading to poor population health

Alma- Ata Declaration:

- There was a call for urgent & effective local, global efforts to develop & **implement PHC** through out the world particularly in developing countries.
- Iraq firstly adapted this strategy and started PHC programs in different sectors in 1978 in about 80-82 districts over the country.
- Thus Primary health care (PHC) became a **core policy** for the WHO with the Alma-Ata Declaration in 1978 and the 'Health-for-All program by the Year 2000'.

- The commitment to global improvements in health, especially for the most disadvantaged populations, was renewed in 1998 by the World Health Assembly.

- This led to the **'Health-for-All for the twenty-first Century' policy and program**, within which the commitment to PHC development is restated.

The Ottawa Charter

- Building healthy public policy
- Creating environments which support healthy living
- Strengthening community action
- Developing personal skills
- Reorientating health care

Models of primary health care

	Comprehensive	**Selective**	**Medical model**
View of health	Positive wellbeing	Absence of disease	Absence of Disease
Locus of control over health	Communities and individuals	Health professionals	Medical practitioners
Major focus	Health through equity and community development	Health through medical interventions	Disease eradication through medical interventions
Health care providers	Multidisciplinary teams	Doctors plus other health professionals	Doctors and nurses
Strategies for health	Multi-sectoral collaboration	Medical interventions	Medical interventions

Rogers W. & Veale, B. (2000).

Resolution made during 1978 meeting at Bamoko (Mali)

- The key to accessible health care for all
- The govt. must decrease the scarcity to provide essential drugs
- The govt. must ensure more equitable, accessible health care and equitable use of resources.
- The govt. must have integrated health services in all facilities

Evaluation of Health For All : 1979-2006

- Reasons for slow progress:
  - Insufficient political commitment
  - Failure to achieve equity in access to all PHC components
  - The continuing low status of women
  - Slow socio- economic development
  - Difficulty in achieving inter sectoral action for Health
  - Unbalanced distribution of resources

FIVE COMMON SHORT COMINGS OF HEALTH CARE DELIVERY

- Inverse care
- Impoverishing care
- Fragmented and fragmenting care
- Unsafe care
- Misdirected care

COMMUNITY STRATEGY

contd

Community is;

Social group of any size whose members reside in a specific locality, share government, and often have a common cultural and historical heritage.

cont

Strategy is;

1. A method or plan chosen to bring about a desired future, such as achievement of a goal or solution to a problem.
2. The art and science of planning and marshalling resources for their most efficient and effective use. The term is derived from the Greek word for generalship or leading an army.

COMMUNITY STRATEGY

BACKGROUND

- Communities are at the foundation of affordable, equitable and effective health care, and are the core of the Kenya Essential Package for Health (KEPH) proposed in the second National Health Sector Strategic Plan 2005–2010 (NHSSP II). This strategy document sets out the approach to be taken to ensure that Kenyan communities have the capacity and motivation to take up their essential role in health care delivery. The overall goal of the community strategy is to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, and child and maternal deaths, as well as improve education performance across all the stages of the life cycle.

cont

- This will be accomplished by establishing sustainable community level services aimed at promoting dignified livelihoods throughout the country through the decentralization of services and accountability. Throughout this document, where LEVEL ONE SERVICES appears in all capital letters, it refers to the entire community-based component of the Kenya Essential Package for Health.

cont

- A large proportion of Kenyans continue to carry one of the highest preventable burdens of ill health in the world. Much of this burden can be lifted and prevented with existing knowledge and resources.
- Despite having well defined national health policies and a reform agenda whose overriding strategies are focused on improving health care delivery services and systems through efficient and effective health management systems and reform, there has not been a breakthrough in improving the situation of households entrapped in the vicious cycle of poverty and ill health

cont

- Poverty compounds powerlessness and increases ill health, as ill-health increases poverty. Both have become progressively worse since the 1990s, with appealling disparity within and between provinces. The situation is further complicated by the emergence of new and resurgence of old communicable diseases. The community systems are faced with the challenge of coping with the growing demand for care, in the face of deepening poverty and lack of resources.

cont

- The result has been deteriorating trends in health status throughout the country with unacceptable disparities between and within provinces. In addition, the cost of health services has escalated well beyond the financing capacity of the Ministry of Health. This is in part the premise for the evidence-based, life-cycle approach to health care introduced in NHSSP II.

cont

- The approach is critical in order to insure the NHSSP II goals of equity, effectiveness and efficiency. The worsening indicators include the following:

✓ Rising infant mortality rate from 64 per 1, 000 live births in 1993 to 72 in 1998, 74 in 2000 and 77 in 2003 (KDHS 2003).

✓ Rising under-five mortality rate from 90.9 per 1,000 live births in 1989 to 115 per 1,000 live births in 2003 (KDHS 2003)

✓ High maternal mortality rate of 590 per 100,000 in 1998 and 414 in 2002 per 100,000 live births (MOH 2005).

The 2003 Kenya Demographic and Health Survey also revealed that:

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

cont

- Both the health sector reforms (HSRs) and the primary health care (PHC) concept have advocated for better health for Kenyans through people's active initiative and involvement. HSR expanded the community-based health care (CBHC) principles by decentralization to formalize people's power in determining their own health priorities and to link them with the formal health system in order to reflect their decisions and actions in health plans.

cont

- In addition, people themselves would also participate in resource mobilization, allocation and control. This approach is well articulated in NHSSP II and supported by local government reforms that would ensure the effectiveness of decentralization, as power is shifted to the councils, and governing structures that enhance transparency and accountability.

cont

- The community-based approach, as set out in this strategy, *is the mechanism through which households and communities take an active role in health and health-related development issues.*

Initiatives outlined in the approach target the major priority health and related problems affecting all cohorts of life at the community and household levels – level 1 of the KEPH-defined service delivery.

cont

- It is envisioned that the households and communities will be actively and effectively involved and enabled to increase their control over their environment in order to improve their own health status. The intention, therefore, is to build the capacity of communities to assess, analyse, plan, implement and manage health and health related development issues, so as to enable them to contribute effectively to the country’s socio-economic development.

cont

- The second major intended impact of the approach is that the communities will thereby be empowered to demand their rights and seek accountability from the formal system for the efficiency and effectiveness of health and other services.

Community Strategy

- A mechanism through which household and community take an active role in health and health related developments.

Reasons for targeting communities

- Communities are a foundation of affordable, equitable and effective health care.
- Communities are a core of the Kenya Essential Package of Health

Goals of Community Strategy

- Enhance community access to health care in order to improve productivity so as to reduce poverty, hunger, child and maternal deaths, improving educational performance across all the stages of life cycles.
- How the goals were to be achieved :

1. Establishing sustainable community level service aimed at promoting dignified livelihood throughout the country
2. Through decentralisation of services
3. Through accountability

Reasons for initiating Community strategy

- A large proportion of Kenyans continued to carry one of the highest preventable burden of ill health and yet this could be solved using available resources and knowledge.
- Despite having well defined national health policies and reform agenda whose overriding strategies was focused on improving health care delivery services and systems through efficient and effective health management systems, there was still no break through and households were still entrapped with a vicious cycle of poverty and ill health.
- There was still emergence and resurgence of all communicable disease like TB, Polio, Ebola

- They had realised that only 2.5% of children were being exclusively breastfed in 2003 while 56.8% were breastfed for up to 3 months.
- 61.5% of under 5 yrs. had poor health, 59.2% of children in the second year of life were fully immunized (2003)
- 0nly 4.3% of under 5 and 4.5% of pregnant mothers were sleeping under insecticide treated nets.
- Only 40.8% of deliveries were assisted by health professionals and out of 40.8%, 39.4% occurred in health facilities

Team members that were to help in implementation of community strategy (key players)

- Community Health committees
- Health care givers
- CORPS(community owned resource persons)
- CHEWS(community health extension workers)

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.

cont

- 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

- 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.

Key roles of Households and Communities as Partners in level one services

- **Health promotion:**
- Ensuring a healthy diet for people at all stages in life in order to meet nutritional needs.
- Building healthy social capital to ensure mutual support in meeting daily needs as well as coping with shocks in life.
- Demanding health and social entitlements as citizens.
- Monitoring health status to promote early detection of problems for timely actions.
- Taking regular exercises
- Ensuring gender equity

- Using gender equity
- Using available services to monitor nutrition chronic conditions and other causes of disability.
- **2. Disease prevention**
- Practicing good personal hygiene in terms of washing hands, using latrines etc.
- Using safe drinking water.
- Ensuring adequate shelter and protection against vectors of diseases.
- Preventing accidents and abuse and taking appropriate action when they occur.
- Ensuring appropriate sexual behaviour to prevent transmission of STDs

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

- **4. Governance and management of health services**
- Attending and taking an active part in meetings to discuss trends in coverage, morbidity , resources and client satisfaction and giving feedback to the services system either directly or through representation
- **5. Claiming rights**
- Knowing what rights communities have in health
- Building capacity to claim these right 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 citizens health charter.

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.

cont

- 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.

cont

- 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.

Role of Nurse

- Assessing the health status of individuals and communities.
- Mobilising community involvement.
- Providing integrated health care including the treatment of emergencies, and making referrals.
- Maintaining epidemiological surveillance.
- Training and supervising health workers.
- Collaborating with other development sectors.
- Monitoring progress in primary health care.

How Care Workers were to be identified

They were to be identified by the community because the organized in functional groups e.g. villages and sub locations , functional units select the one they want with the following qualities:

- One who has high intelligence
- Community interest at heart
- One who lives permanently in the community
- One who’s able or ready to do a volunteer work
- One who has an interest in health

Once selected they are introduced to the following community based system:

- Introduced to dialogue based on the information on health promotion. Disease prevention and simply curative care using drugs supply through receiving funds.
- Introduced to referral systems established by local heath committee.
- They are paid incentives that tends to be limited to uniforms, the embracement of direct cost and period reward for excellent performance an such incentives are taken care of by local health committee.

Factors influencing level of community involvement in implementation of PHC

- Favourable political atmosphere
- Education status of community may involve the speed at which full participation and involvement is achieved
- Community infrastructure such as communication networks
- Economic factors
- Level of Intersectoral coordination at the community level.

- **Service personnel at level 1 (community)**
- According to community strategy, community is designed into community unit.
- Each unit is designed to serve 5000 people and its supposed to work with volunteer CORPS, identified by the community, trained and supported by the CHEWs / CHAs
- **Norms and standards for health delivery at level 1 services**
- 1 CORP to serve 20 households
- One CHEW support and supervises 25 CORPS (CHVs) one level one unit serves 5000 people and requires 50 CORPS and to CHEWs/CHAs.

Guiding principles in providing level 1 services

- Communities are organized into functional unit of 20 households
- CORPS should be voluntary but paid as stipend on the basis of work actually done and this payment is done through committee to enhance loyalty and accountability.
- CORPs are nominated by the community on the basis of criteria.
- CHEWs are to be on the government payroll and be facilitated in the activities e.g. transport.'
- The community play a leading role in joint health action.
- A strong coordination structure to be established to bring in all actors at all levels.
- Communication to be strengthened through advocacy, social mobilization and informative dialogue.

Level one services as organized by committees may include:

1. Disease prevention and control to reduce morbidity, disability and mortality e.g. communicable disease control like malaria, TB
- Provision of first aid and emergency preparedness such as treatment of injury.
- Health promotion where information, education and community is shared on health promotion and disease prevention.

2. Family health services to extend FP, maternal, child and youth health.
- It includes issues of MCH/FP where the community is taught on maternal health, obstetric care, immunisation IMCI

- Adolescent/ RH
- Non communicable disease control e.g. cancers., diabetes, malnutrition.
- Other common diseases of local priority within that area e.g. eye conditions, oral health, community day care centres.

3. Community based referral system especially when there are emergencies.
4. Hygiene and environmental sanitation

- At all community level, there should be information or communication on use of safe water, hygienic practices, sanitation, school health and also on incinerator and solid waste disposal in school and households

5. Water supply and safety, including protection of springs
6. Food hygiene; organize services such that there is control of rodent and insects, personal hygiene, healthy warm environment including sanitation around the house, kitchen garden.

Support supervision

- There is need to be a multidisciplinary supervisory team having appropriate skills, needs to measure that standards of quantity and quality of work are met.
- There should be a multi-sectoral collaboration and coordination at all levels.
- They are supposed to carryout regular performance appraisal based on a checklist that is meant to measure performance appraisal, promote good communication and discussion and determining appropriate reward.
- For this services to occur at this level, there are 6 cohorts.

Level of action to support level one services

- Households
- Community
- Churches
- Organized groups like women and youth groups
- Sub-location
- Dispensaries
- Division health centres
- District hospitals
- Referral hospitals

Responsibilities of households

1. Day to day up keep of household affairs e.g. taking children to facility for immunisation or when sick.
2. Seeking health services- identifying their health problems
3. Participation in community working days (health action)
4. Disease prevention e.g. personal hygiene, safe water.

Entry steps for community strategy

- Involves the step by step approach which includes; awareness creation, formation of district level working groups and training teams, establishing formal monitoring and evaluation mechanism.

The Entry Steps

1. Define a clear implementation guideline:
2. Create awareness among sub-county leaders, including the District Commissioner (DC), the District Development Committee (DDC) and relevant line ministries:
3. Form and equip district-level multi-sector working groups and training team:
4. Launch the programme in the communities
5. Follow up, monitor and evaluate:

- In the second phase of implantation, you prepare working groups for:

a) Follow up, monitoring and evaluation

b) Launching the programme in the community population and community structure, process of governance of resources available, service delivery points, care seeking behaviours of community members, coping mechanisms.

Structures

- **In level 1:**
- Village health committee reports to the health facility committee.
- VHC is made of people from the given village whose activities are coordinating health services of that village then makes a monthly report, every VHC has a representative who will advocate for them.
- Health facility committee is accountable to the counties.
- Sub-county health committee (SCHC), County health committee (CHC), VHC, oversees the operation of level one and households.
- It has a chairperson who reports to HFC on matters of level one.

Functions of VHC

1. Representing villages in various health committees
2. Endorses requirements of CORPS
3. Plan, implement, monitor and evaluate health activities with level one as well as giving feedback.
4. Mobilise resources for health activities including outreach and referral.
5. Facilitate regular dialogue within community
6. Organise community for collective health actions and addressing priority problems.
7. Ensure community involvement in decision making.
8. Gather community based health information for use at that level and other higher levels.
9. Listen to and address chief complains as they arise in level one.

- 10. Facilitate provision of specific education
- 11. Make contact with partners for technical support and resources
- 12. Promote equal opportunities for decision making and control of resources.
- 13. Promote gender equality and empowerment of women.

Monitoring and evaluation

- Implies a continuum of information gathering, documentation, supervision and assessment.
- Monitoring and evaluation is done to support decision making and to obtain set goals.
- Effective monitoring and evaluation contributes to accountability on current activities, therefore to carryout monitoring and evaluation clear objectives, targets, inputs (materials, other resources, time) and indicators must be spelt.

- In monitoring, achievement and progress towards the set goals are reviewed regularly. It involves tracking the use of resources to support management and decision making by stakeholders.
- Evaluation implies making judgement and appraisal.
- It takes people during and after implementation.
- It involves determining the work, merit, value or quality of ongoing or completed activities in terms of relevance, effectiveness, efficiency and impact.
- Evaluation looks at whether you have succeeded or failed.

Implementation methods of monitoring and evaluation

- Monitoring and evaluation should be participatory and built into community processes,
- The community should be guided to take control of activities.
- Feedback should always be given to the community about progress and preplanning.
- **There are two methods:**
  - Qualitative method
  - Quantitative method

- Both can be used to evaluate health program
- Both qualitative and quantitative data are used to give a clear picture of the health status in the community.

Qualitative method

- Used to measure success in particpation, collaboration, changes in view of people, policy development and implementation.
- Qualitative data provides, crucial information on values, norms, knowledge, attitudes, behaviours, experiences, practices and social interactions.
- The tools/ techniques used in collecting data include; observation checklist, depth interviews and focused group discussions (FGDS).

Quantitative methods

- Provides precise measurement of activities and services.
- They answer such questions as how many, how often, how much etc.
- Quantitative tools include large surveys of program evaluation.

Community based information system

- Any action taken should be evidenced based from the beginning at the community level
- Information used for guiding health services implementation, is derived from level 2,3 and 4.
- Community strategy stresses on information that is based within the community and therefore this will be the work of the CHEWs and CORPs forwarded to the facility.
- This is done by orientating CHEWs and CORPs on documentation which will involve what services they are preferred to a health facility.

Types of information collected from community

- **1. Demographic information:**
- It constitutes the births, deaths, and their causes, any migration in and out.
- It can be collected through village registers, birth and death registers, VHW can collect this information.
- **2. Nutrition:**
- It look at the types grown in the village, staple food used in the community weaning practices for children and babies. Sources includes under one year registers, under 5s registers, check for moderate to severe malnutrition, CHWs can provide this information from the under one registers.

3. **Immunization:**

- Assess the immunization uptake within the community, women who have received at least three doses of T.T.
- Sources include; under 1 year registers, permanent registers. CHW provide this information.

4. **Malaria cases:**

- Collect data on malaria cases, how many people sleep under long lasting insecticide treated mosquito nets. Village registers and survey provide this information.

5. **Reproductive and child health:**

- Check on ANC visits how many have been referred for ANC and whether they reached the facilities of referral and causes of referral.
- No. of deliveries, referrals and their causes
- **FP service utilization**: this done per method

- **IEC Session that has been carried out on reproductive and child health:** information is from ANC register, delivery registers, FP registers, CHW registers, household survey forms.

6. **Health status:**

- Morbidity and mortality cases especially morbidity of the under 5, those who have fever, diarrhoea, signs of the measles, chest tightness, information on HIV/AIDs. Can be obtained from household surveys/ visits forms.

7. **Environmental sanitation and water:**

- How many latrines are in that village in relation to the households, type of housing, source of water and if safe, safe waste disposal services. Information from household survey/ visit forms.

8. **School data:**

- The no. of visits made by CHEWs and CORPS to schools (school health programmes) those who were screened for diseases, immunization, those offered first and, guidance and counselling any referrals any safe water systems, information on latrines/toilets in the school, waste disposal in the school, class one enrolment by gender. Information can be got from school visit forms.

9. **Socio-economic data:**

- No. of orphans in the community, no. of the disabled by type, widows and widowers , the aged, information is from house visits forms and the village men.

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 mechanism for easy referral for those who need more specialized care.

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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.

cont

- 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).

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.
- The other contributing factors are the three delays:

cont

- 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.

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).

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.

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.

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 (defense) 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.

Life cycle cohorts

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

i. Pregnancy, delivery and the newborn (first 2 weeks of life)

ii. Early childhood (2 weeks to 5 years)

iii. Late childhood (6 to 12 years)

iv. Adolescence (13-24 years)

v. Adult (25-59 years)

vi. Elderly (over 60 years)

Pregnancy, delivery and the newborn (first 2 weeks of life)

- 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.

cont

- 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.

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.

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.

cont

- 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.

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.

cont

- 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.

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.

cont

- 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.

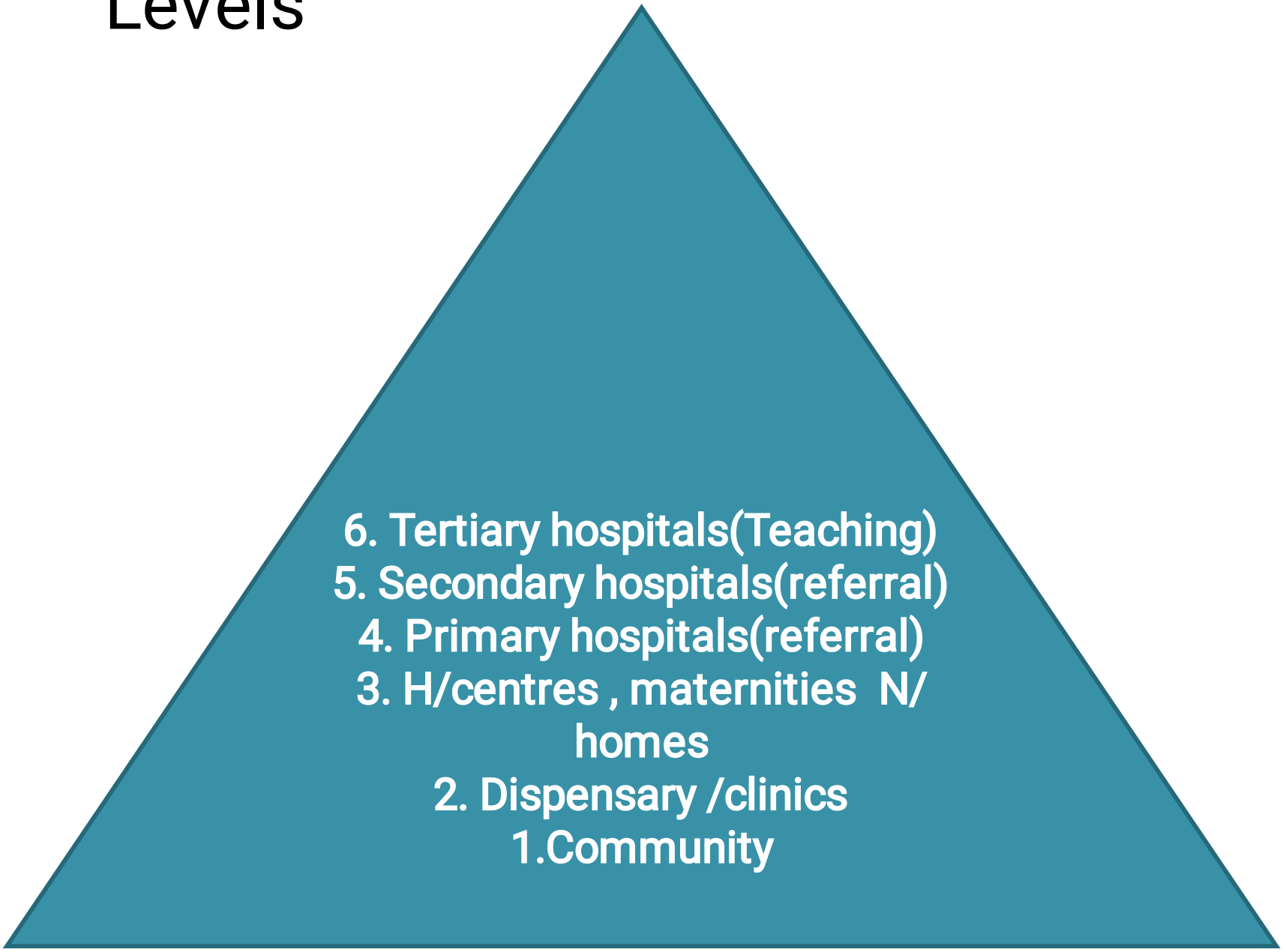
COHORT 6: Elderly Persons

(60 Years and above)

- 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.

Level of health care delivery

- Levels



Description of services at community levels (1–3)

Service level	Administrative unit	service delivery unit
Level 1	Community / village	1. Personal ,family ,house hold & community practices 2. pharmacies
Community system interface		
Level 2	Sub- location	1. Dispensary 2. clinics
Level 3	location	Health centre ,nursing / maternity homes

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	➢ 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

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

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.

Essential Elements of a Referral System

- ***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.

cont

- ***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.

cont

- ***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.

cont

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

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.

cont

- ***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.

The Essential Elements of the Community Strategy

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 that link to service delivery at the house hold level.