Integrating Community Health Program

KENYA COUNTRY SNAPSHOT

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REPUBLIC OF KENYA

MINISTRY OF HEALTH

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LAST MILE HEALTH

Acknowledgments

Contents

Acronyms

CHA	Community Health Assistant
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHU	Community Health Unit
CHV	Community Health Volunteer
HFMC	Health Facility Management Committee
HFMT	Health Facility Management Team
HSICF	Health Sector Intergovernmental Consultative Forum
iCCM	Integrated Community Case Management
ICH	Integrating Community Health
KHSSIP	Kenya Health Sector Strategic and Investment Plan
KQMH	Kenya Quality Model for Health
LMH	Last Mile Health
LSTM	Liverpool School of Tropical Medicine
MOH	Ministry of Health
NHIF	National Hospital Insurance Fund
PHC	Primary Healthcare
SCHMT	Sub-County Health Management Team
SDG	Sustainable Development Goal
SQALE	Sustaining Quality Approaches for Locally Embedded Community Health services
WHO	World Health Organization
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WIT	Work Improvement Team

Preface

Accelerating the Integration of Community Health Worker Programs through Institutional Reform

Approximately half of the world's population do not have access to essential health services. A growing emphasis on the roles of communities recognizes community engagement, including community health workers (CHWs), as a means of realizing the full potential of the primary healthcare (PHC) system.[1] High performing CHW programs at scale are an integral component of responsive, accessible, equitable, and high-quality PHC.

Recognizing the potential for community health to address gaps in coverage, improve financial protection, and support access to quality care, the Declaration of Astana in 2018 committed to strengthening the role of community health in PHC as a means to accelerate progress toward universal health coverage (UHC). Before the Declaration of Astana, the transition from the Millennium Development Goals to the Sustainable Development Goals (SDGs) also helped to reposition communities as resources for health systems strengthening and sources of resilience for individuals and families.

The United States Agency for International Development (USAID) initiated a collaboration with the United Nations Children's Fund (UNICEF) and the Bill & Melinda Gates Foundation in 2016 to advance country commitments toward communities as resources in PHC systems to accelerate progress towards the achievement of the SDGs. The Integrating Community Health (ICH) collaboration fueled a global movement with more than twenty countries to elevate national priorities and progress for institutionalizing community health in primary health care systems. USAID, in collaboration with UNICEF, invested in catalytic partnerships with governments, their trusted NGO partners, and communities across 7 countries (Bangladesh, the Democratic Republic of Congo

(DRC), Haiti, Kenya, Liberia, Mali, and Uganda) to institutionalize reforms and learning, with a focus on CHWs. In alignment with these efforts, the Bill & Melinda Gates Foundation supported the development of new evidence and knowledge regarding performance measurement, advocacy and pathways to scale in the seven focal countries via the Frontline Health Project with Population Council and Last Mile Health as lead partners. Using Last Mile Health's Community Health Reform Cycle framework, the Country Snapshots highlight the ICH collaboration's catalytic partnerships to strengthen national CHW programs as an essential component of PHC and to place these programs within the context of institutional reforms and political commitment needed for national progress in health outcomes.

Re-envisioning health systems to achieve UHC requires leadership and political commitment from within countries. Countries must mobilize the whole society—both public and private sectors as well as communities—as essential resources in this effort. The community component of PHC must be designed to enable the health system to reach the most underserved, respond to pandemics, close the child survival gap, and accelerate the transformation of health systems. Without a major expansion of support for national CHW programs, the measurable acceleration urgently needed to reach the health-related targets of the SDGs by 2030 is unlikely. With a decade remaining to achieve the SDGs and faced with the challenge of the COVID-19 response, building global political momentum with countries and funders is critical to support urgent national priorities, evaluate progress, and develop and share new knowledge to inform bold political choices for a whole of society approach to health systems strengthening.

Community Health Institutionalization as a "Reform Cycle"

The Country Snapshots featured in this series highlight the seven ICH countries' reform efforts within a framework for institutional reform: the Community Health Systems Reform Cycle (often referred to here as the "reform cycle").[2] Countries experience community health systems reform as a process and pathway to institutionalizing community health. The likelihood that any particular reform is successfully institutionalized in an existing policy environment depends on political will and buy-in from key stakeholders, the technical design of the policy, the available capacity and resources to launch and govern the intervention, the ability to learn, and the willingness to adapt and improve the program over time.

The reform cycle framework has guided—and been refined through—a descriptive analysis of the ICH countries' reform journeys. Country Snapshots, reflecting the ICH investment on community health systems reform, demonstrate the practical linkages between available literature and specific country experiences. This framework provides health systems leaders with an approach to plan, assess, and strengthen the institutional reforms necessary to prioritize community health worker programs as part of national primary health care strategies to achieve universal health coverage.

The reform cycle traces several stages of institutional reform, which are summarized below. Reforms may encompass an entire community health worker program or target specific systems components, such as health information systems. While reforms may not always follow each stage in sequence and timing can vary depending on the complexity of the program or activity, deliberate and comprehensive planning can strengthen buy-in and overall effectiveness.

THE COMMUNITY HEALTH SYSTEMS REFORM CYCLE

MANAGEMENT & LEARNING
Key stakeholders regularly review program data to inform problem-solving at the national or subnational level.

PROBLEM PRIORITIZATION
Actors identify a meaningful and relevant problem.

COALITION BUILDING
A group is formed around a compelling problem or vision.

GOVERNANCE
Stakeholders establish a project governance framework, which includes key leadership and decision-making bodies, clear roles and responsibilities, and explicit decision rights.

SOLUTION GATHERING
Potential solutions are gathered, drawing from existing local and international programs.

LAUNCH
New policies, processes, and organizational structures are implemented, and key actors execute their new roles.

READINESS
Coalition members and champions prepare for launch by getting buy-in from actors instrumental to the launch, rollout, and maintenance of the program.

DESIGN
Key decision makers, stakeholders and planners map out different options for program design.

PROBLEM PRIORITIZATION

Actors identify a meaningful and relevant problem. They diagnose pain points and unmet needs, and connect them to priority areas for reform, where possible. Actors acknowledge the need for reform within the community health system and commit to a joint vision for addressing gaps.

COALITION BUILDING

A group is formed around a compelling problem or vision. Members define the coalition's goals, roles, size, and composition. Diverse members fill critical roles in the reform effort (e.g., leaders, connectors, gatekeepers, donors, enablers, change champions, and liaisons to key players outside the coalition).

SOLUTION GATHERING

Potential solutions are gathered, drawing from existing local and international programs. Actors define criteria and metrics to assess solutions, and specific ideas for reform are piloted, where possible. Promising solutions are prioritized for integration into the health system.

DESIGN

Key decision makers, stakeholders, and planners map out different options for program design. Where possible, evidence about the options, expected cost, impact, and feasibility are identified. Through consultations, workshops, and other channels, stakeholders offer feedback on options, and decision makers select a design. This may include operational plans, training materials, job descriptions, management tools, data collection systems, and supply chain processes.

READINESS

Coalition members and champions prepare for launch by getting buy-in from actors instrumental to the launch, rollout, and maintenance of the program. Stakeholders also translate program design into costed operational plans that include clear strategies and tools for launch and rollout. Investment plans for sustainable financing and funding mechanisms are put in place. Stakeholders are prepared for their new roles and responsibilities, and potential areas of policy/ protocol conflicts are addressed.

LAUNCH

New policies, processes, and organizational structures are implemented, and key actors execute their new roles. As these shifts progress, learning is gathered to demonstrate momentum and identify challenges to achieving scale. Particular attention is paid to issues around rollout, and timely design and implementation shifts are made as needed.

GOVERNANCE

Stakeholders establish a project governance framework, which includes key leadership and decision-making bodies, clear roles and responsibilities, and explicit decision rights. Processes for risk and issue management, stakeholder engagement, and cross-functional communication are established. Actors monitor program progress to advance clear decision-making and address critical issues or challenges.

MANAGEMENT & LEARNING

Key stakeholders regularly review program data to inform problem-solving at the national or subnational level. Stakeholders engage in continuous learning and improvement, identifying challenges and changes to program design and other systems bottlenecks.

Country Snapshots of Institutional Reform

PURPOSE AND GOALS OF COUNTRY SNAPSHOTS

- Describe the community health landscape within each country
- Present the country's vision for community health reform and situate progress to-date within the framework of the reform cycle
- Articulate the primary community health institutionalization challenges that the country is or was facing at the outset of the ICH investment
- Trace the policy and advocacy process taken by country stakeholders to move reform forward, using the ICH investment as a catalyst
- Identify lessons learned and opportunities for strengthening existing reforms arising out of the ICH investment

The Country Snapshots complement other resources generated within and beyond the ICH investment, such as the countries' Community Health Acceleration Roadmaps, ICH Country Case Studies, and Frontline Health Project Research Studies. The Country Snapshots place a unique emphasis on tracing the process of policy choice, advocacy, and implementation. Together, these complementary initiatives are catalyzing community health systems reform and advancing efforts towards a strong primary health care system and UHC.

APPROACH AND METHODS

The Country Snapshots highlight examples of a country's reform journey through the specific stages of institutionalization outlined in the framework. Country Snapshots both demonstrate the features of each stage within the country context and elevate salient examples of countries' learning and success. The Country Snapshots reflect a process of desk reviews and consultations with country stakeholders. Stakeholders include but are not limited to current and former ministry of health representatives, leaders from non-governmental and technical organizations, and members of multilateral and bilateral institutions. The Country Snapshots elevate both existing

insights captured in policy and strategy documents that are often difficult for those not working within the country to access, as well as novel perspectives gained through methods such as workshops or in-depth interviews with key stakeholders. Where the Country Snapshots draw on existing materials, citations are noted. Insights and country stakeholder recommendations on the reform cycle's application serve not only to validate the framework, but also to highlight ways in which the framework can help trace powerful narratives of reform and accelerate community health systems policy and advocacy efforts.

These narratives reveal opportunities to accelerate the prioritization of community health worker programs and primary health care strategies with the goal of UHC. The Country Snapshots reflect valuable feedback from stakeholders on how the framework can help advance community health systems policy and advocacy.

Key Resources

- USAID Vision for Health Systems Strengthening 2030
- Astana Declaration
- CHW Resolution
- CHW Guidelines
- Exemplars—Community Health Workers
- Community Health Roadmap
- Institutionalizing Community Health Conference 2017
- Institutionalizing Community Health Conference 2021
- Community Health Community of Practice
- Global Health: Science and Practice Supplement 1: March 2021
- Journal of Global Health: Advancing Community Health Measurement, Policy and Practice

Kenya's Health Landscape
Health Access and Outcomes

In 2008, Kenya launched a radical new agenda, Vision 2030, seeking to establish the nation as a "middle income country providing high quality life for all its citizens by the year 2030." Shortly after, in 2010, the country introduced constitutional reforms that aimed to fulfill the needs and rights of all, and enshrined the right to the highest attainable standard of health for every Kenyan. The constitution introduced sweeping governance reforms in 2013, splitting the country into 47 political and administrative counties with the goal of promoting democracy, accountability, national unity, recognition of diversity, self-governance, community leadership, and equitable sharing of resources.[3]

In 2014, Kenya achieved a critical milestone in the Vision 2030 agenda, gaining classification as a middle-income economy.[4] Strong economic performance has coincided with drastic reductions in poverty for Kenya's more than 52 million inhabitants. The proportion of Kenyans living in poverty has decreased from 43.6% in 2005-2006 to 35.6% in 2015-2016.[5] The country has matched economic growth with substantial improvements in health indicators. Among the seven ICH-supported countries, Kenya now has the second-lowest rates of maternal and child mortality, trailing only Bangladesh. The table below highlights Kenya's performance relative to key health indicators.

Despite these population-wide improvements, in recent years government healthcare spending as a percentage of gross domestic product (GDP) had begun to flag even as the country faced a daunting triple burden of communicable diseases, noncommunicable diseases, and injury.[6,7] Furthermore, significant disparities persist in the wealth and health of Kenyans across multiple dimensions. As described in a recent analysis of devolution, "Inequities in Kenya are rooted in the historical and social structural forces originating from colonization, and contribute to widely varied levels of poverty, education, development, resource allocation, and investment for infrastructure and human resources."[8] Significant contextual differences also exist between settled agrarian, urban, and pastoralist areas. Health inequities are often greatest for: those living in rural areas or historically marginalized counties; vulnerable groups such as those living with HIV/AIDS; and those with lower socioeconomic status, in particular residents of vast "informal settlements" around Kenya's major cities and towns. These disparities are both caused by and contribute to barriers in access to care. For example, 46.1% of all Kenyan women surveyed as part of Kenya's 2014 Demographic Health Survey reported that they have a serious problem in accessing healthcare. These barriers are experienced disproportionately among rural women (54.4%) and women in the

INDICATOR [DEMOGRAPHIC HEALTH SURVEY]	1989	1993	1998	2003	2008-9	2014
Infant Mortality Rate (per 1,000 live births)	60	62	74	77	52	39
Under-Five Mortality Rate (per 1,000 live births)	89	96	112	115	74	52
Maternal Mortality Ratio (per 100,000 live births)	--	--	590	414	488	362
Children Completely Vaccinated (%)	44.1	79	65	57	77	79
Children with Diarrhea Treated with ORS (%)	21.1	31.6	36.9	29.2	38.8	53.8
Unmet Need for FP Among Married Women (%)	--	36.4	24	24.5	25.6	17.5
Delivery with Skilled Personnel (%)	50	45	44	42	44	61.8
ANC 4+ (%)	--	63.9	60.8	52.3	47.1	57.6

country's bottom two wealth quintiles (68.1% and 61.1%). For women in all groups, getting money for treatment is the most often cited barrier in accessing healthcare.
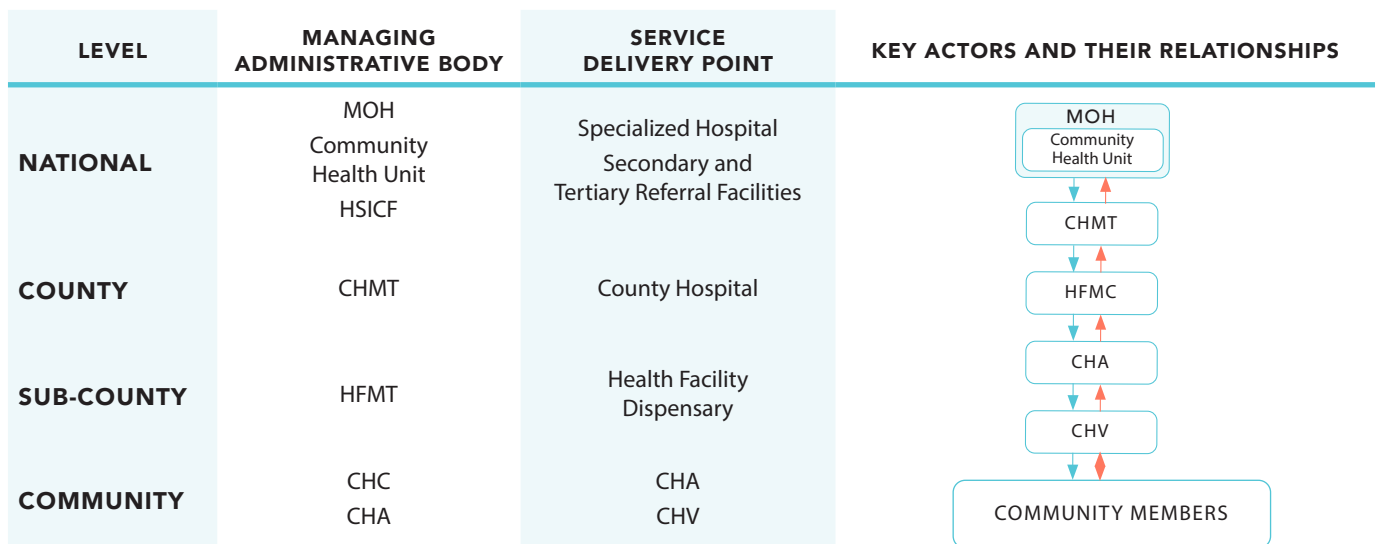
Experts warn that the country will need to promote higher and more inclusive growth, and enact progressive, cross-sectoral reforms in order to eradicate poverty by 2030 Sustainable Development Goal 1 (SDG1) and to improve the overall health and wellbeing of all Kenyans (SDG3).[5] Recognizing this need, after his reelection in 2018, President Uhuru Kenyatta launched a new mid-term plan for Vision 2030. The plan has four pillars for reform, known as the "Big Four": manufacturing, food security, UHC, and affordable housing. Overall, the success of UHC reforms will rely not only on political will but also the ability of Kenya's newly devolved governance structure to provide "quality, accessible, affordable, and acceptable health services for its entire citizenry."[7] This is a daunting prospect, as the country currently lacks the skilled health workforce to manage and deliver these services. The WHO has recommended that in order to achieve the Sustainable Development Goals (SDGs), countries will require 44.5 physicians, nurses, and midwives per 10,000 population. Kenya's ratio is only 13.8 per 10,000 population, and coverage is further strained by rapid population growth and geographic disparities.[9]

In response, the country is renewing and rapidly scaling up investment in primary healthcare as a cost-effective strategy for achieving UHC and is placing community health at the center of this agenda. The country is increasingly viewing community health workers and their supervisors—in Kenya, called Community Health Volunteers (CHV) and Community Health Assistants (CHAs), previously known as Community Health Extension Workers (CHEWs)—as a critical component of the workforce. Leaders expect them to be vital to both expanding access to quality services at the community level and supporting a shift towards health prevention, promotion, and early detection and treatment of illness.

These high-profile global and national commitments have generated strong momentum for translating political will into both policy and practice. Imminent milestones include the 2020 launch of the country's first Primary Health Care Strategic Framework 2019-2024 and Community Health Policy 2020-2030. These policy foundations are expected to serve as the basis for rapid, nationwide scale-up of community health services. Kenya aims to revitalize and deploy a cadre of Community Health Volunteers who are: remunerated through domestic resources; delivering a package of preventive, promotive, and basic curative services; working as part of Community Health Units (CHUs); supervised by CHAs; and connecting communities with primary healthcare facilities. If successful, 100% of Kenyans will have access to primary healthcare through CHUs, as highlighted in Figure 1.[10]

FIGURE 1: Health System Structure

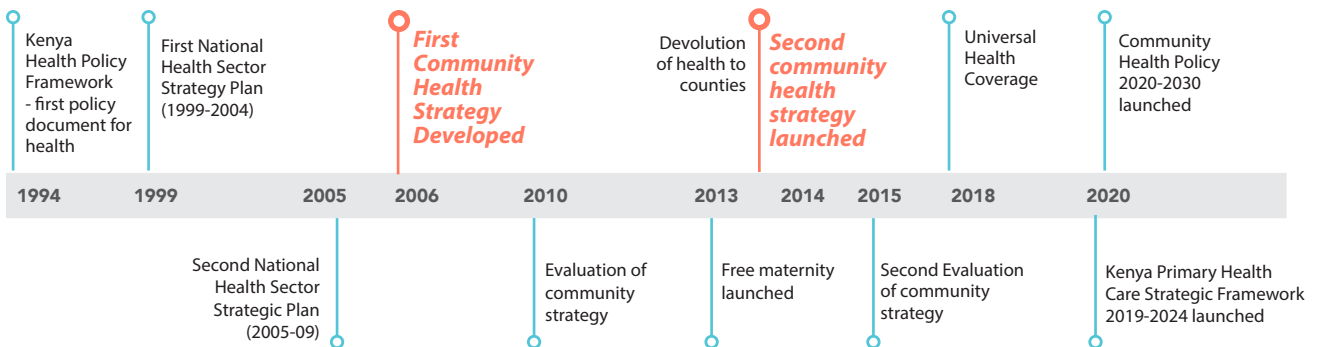| LEVEL	MANAGING ADMINISTRATIVE BODY	SERVICE DELIVERY POINT	KEY ACTORS AND THEIR RELATIONSHIPS
NATIONAL	MOH Community Health Unit HSICF	Specialized Hospital Secondary and Tertiary Referral Facilities	
COUNTY	CHMT	County Hospital	
SUB-COUNTY	HFMT	Health Facility Dispensary	
COMMUNITY	CHC CHA	CHA CHV	

Kenya's Community Health Reform Foundations

Kenya's roots of community health reform go back to the first Alma Ata declaration in 1978 and the Bamako Initiative in 1987. During that period in Kenya, family planning services were provided via community distributors. In the early 2000s, despite increasing health sector funding, the country was experiencing a rapid rise in poverty accompanied by a "downward spiral of deteriorating health status" and "unacceptable disparities."[11,12] In response, the country underwent two periods of reform between 2005 and 2016.

The Community Health Systems Reform Cycle (detailed in the Preface) provides a helpful framework for analyzing Kenya's reform journey during these phases, revealing insights into its foundations, strategies, and challenges. The sections below will outline two reform cycles that have taken place in Kenya—a national policy level cycle and a health system reform cycle.
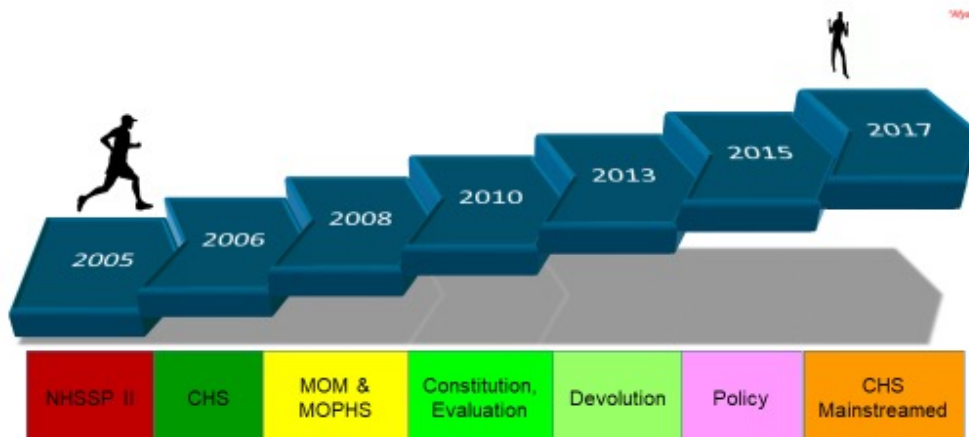
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READINESS
Coalition members and champions prepare for launch by getting buy-in from actors instrumental to the launch, rollout, and maintenance of the program.

FIGURE 2: Evolution of Community Health Strategy in Kenya[13]

1994	1999	2005	2006	2010	2013	2014	2015	2018	2020

Above timeline:
- **1994** — Kenya Health Policy Framework - first policy document for health
- **1999** — First National Health Sector Strategy Plan (1999-2004)
- **2006** — *First Community Health Strategy Developed*
- **2013** — Devolution of health to counties
- **2014** — *Second community health strategy launched*
- **2018** — Universal Health Coverage
- **2020** — Community Health Policy 2020-2030 launched

Below timeline:
- **2005** — Second National Health Sector Strategic Plan (2005-09)
- **2010** — Evaluation of community strategy
- **2013** — Free maternity launched
- **2015** — Second Evaluation of community strategy
- **2019** — Kenya Primary Health Care Strategic Framework 2019-2024 launched

Progression of CHS in Kenya

Development of Community Health Policy and Integration of Community Health Services— National Health Policy Reforms

STRENGTHENING KENYA'S COMMUNITY HEALTH SYSTEM (2006)

Opportunities emerged to strengthen the relationship between the community and the formal health system, particularly in areas that had geographical access challenges. As a result, the health system offered "infrequent, irrelevant, and inadequate response to community health needs."[12] Until that point, the government had largely based most of its decisions on data collected at health facilities. Without directly engaging communities, it had no way of understanding the factors that were influencing care seeking and contributing to negative health outcomes. The studies' chief recommendations were to extend the country's primary healthcare approach beyond the facility and to create a formal interface between the community and the health system. At the time, some partners and local governments had introduced informal community health initiatives, but fragmentation had hindered their ability to achieve and demonstrate impact at scale.[15]

In 2003, Kenya came together with other African countries to seek strategies to establish the community health system and achieve the Millennium Development Goals. The resulting 2006 Addis Ababa Declaration on Community Health in the African Region marked a turning point for community health and coincided with a number of major reforms in Kenya:

1. The launch of Vision 2030 by then-President Mwai Kibaki

2. The establishment of community health as the first tier of the formal health system to deliver the Kenya Essential Package for Health (KEPH))

3. The start of a community health strategy development process

4. The creation of a Community Health Services Unit within the MoH to oversee community health and drive the design, launch, and implementation of the strategy.[16–18] Technical working groups and interagency coordinating committees were established to inform strategy implementation.

Following a participatory development process—which involved CHWs and CHEWs—Kenya's first community health strategy in 2006 set this vision:

> "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...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."[19]

The strategy boldly sought to scale up community health services to reach 16 million Kenyans, approximately 40% of the population, in four years. The strategy also established the core cadres, structures, and systems that, with some adaptations, continue to shape the country's community health system today.

GENERATING EARLY EVIDENCE FOR THE COMMUNITY STRATEGY (2006-2010)

Thanks to the 2006 strategy, community health was recognized as a formal part of the health system. However, community health advocates needed to prove that the approach would be successful, following previous efforts in the 1990s. Starting in 2006, the country began to establish its first pilot CHUs. One of the first and most prominent programs to introduce the approach was the USAID-funded Busia Child Survival Project, implemented by Amref in partnership with the MoH. Covering 360 villages and nearly 1,000 CHVs, the program served as a learning center to generate the evidence needed to advocate for increased investment and uptake of the community strategy. Program evaluations demonstrated that, where properly supported, the approach could bring about drastic improvements in health indicators.

The importance of establishing these early reform foundations came into stark relief as violence erupted around the contested presidential elections in 2007-2008. The growing tension drove the country to revise its constitution in 2010 and introduce a devolved system of government in the years that followed.[8] It was a time of drastic change, and county governments started to scrutinize policies that were originally supported at the national level.

Ministry leaders seeking to preserve the community health strategy in the new political landscape commissioned an evaluation of its effectiveness, relevance, efficiency, and sustainability. The 2010 study found that sites supported by the community health strategy performed significantly better than comparison sites across a range of critical health and development indicators. Evaluators concluded:

> "The strategy has significantly reversed the negative health indicators observed before the implementation of the programme…[It has] clear benefits in improving health service coverage and quality leading to a more productive living…[and is] a powerful tool for social transformation towards improved quality of life at the community level."[20]

The strategy was not without its challenges, however. A primary concern was that implementation to date had been almost exclusively donor-reliant and project-based, making it unsustainable in the long term. The national government had not allocated a budget for the strategy, apart from employment of CHAs and other MoH staff. All other costs—such as trainings, CHV stipends, and CHV kits (including commodities)—fell to donors and partners. This diminished the government's ability to promote implementation fidelity, quality, and scale. Indeed, assessments showed that by 2010 the government had achieved only 7% coverage for the strategy—far short of its 40% target.

These learnings provided an important point of analysis as national and county governments revised policies after devolution. Encouraged by overall results and determined to address challenges, external funders increased financing for the strategy, and the MoH engaged counties to advocate for the prioritization of community health.

RECOMMITTING AND ADAPTING THROUGH DEVOLUTION (2010-2015)

Devolution shifted the locus of control in Kenya from the national to the county level. The country had high expectations that devolution would "strengthen democracy and accountability, increase community participation, improve efficiency, and reduce inequities."[8] The transition of functions was originally slated for a three-year period, but pressure from newly elected county governments in 2013 expedited the timeline to just four months. The process raised a great deal of uncertainty around the future of community health. On the one hand, there was fear that devolution would "erode the gains" made since 2006. This was especially concerning in the early stages of devolution when the parameters of the new system were unclear, transfers of resources to counties were grossly insufficient, and county capacity was lacking. On the other hand, there was hope that shifting decision making to county governments and rolling out equity-oriented country revenue allocations would boost county-level investment in community health.[8,16]

What ultimately worked in favor of the community health agenda was that the county governments were now facing the same fundamental challenge as the national government before them: how to meet the health needs of their citizens in ways that responded to community priorities, and addressed financial and human resource constraints. While the legal and institutional frameworks governing the health sector were shifting,[21] health access and outcomes for the majority of Kenyans remained deficient. Under devolution, leaders continued to recognize that they simply could not achieve Vision 2030 or UHC without investing in community health.

Accordingly, in 2013, national and county governments set about adapting the community strategy for devolution in conjunction with broader health and development reforms.[16] These included the National Health Bill (drafted and introduced for parliamentary debate in 2014 and passed in 2018 as the Kenya Health Laws Amendment Bill),

the Second Medium Term Plan for Vision 2030, the Kenya Health Policy (2014-2030), and the Kenya Health Sector Strategic and Investment Plan (KHSSIP 2012-2017). Devolution had a major impact on the nature of these processes. The national government retained responsibility for setting health policies, standards, and regulations; however, county engagement was paramount, both to ensure that guidelines could be effectively contextualized by counties and to promote county buy-in as the ultimate decision makers around implementation.[8,16,21]

The new community health strategy they crafted, covering 2014-2019, integrated lessons learned from the first strategy and included four strategic objectives. It aimed to strengthen:

1. The delivery of integrated, comprehensive, and quality community health services for all population cohorts
2. Community structures and systems for effective implementation of community health actions and services at all levels
3. Data demand and information use at all levels
4. Mechanisms for resource mobilization and management for sustainable implementation of community health services[17]

The shared buy-in for the strategy was reflected in the ambitious targets put forward in the KHSSIP. The inclusion of community health in KHSSIP was crucial, as it translated the country's vision into action through strategic resource allocation, annual planning, and performance contracting. The KHSSIP tracked CHU scale-up as a priority indicator and set a target to establish 8,000 CHUs and train 250,000 CHVs in five years, covering a population of 40 million people. At the 2013 Global Human Resources for Health forum in Brazil, Kenya similarly pledged to scale from a baseline of 2,511 CHUs in 2012 to 9,294 CHUs by 2017, to recruit the requisite 40,000 CHAs, and to establish a community health insurance scheme to boost access to CHU services.[11]

Kenya's Institutionalization Challenge and Policy Opportunity

Leaders began to draw attention to the fact that Kenya had yet to establish a formal community health policy. To remedy this, in 2015 the MoH commissioned a full situation analysis to help set "a clear policy direction" for the country.[11] Although the country would take five years to officially establish the resulting policy,[11] the situation analysis provided valuable insights for the policy makers and managers supporting community health's transition through devolution. A key finding centered around the gap between the community health strategy and practice. CHAs and CHVs felt that national and county governments had not done—and were still not doing—enough to support the implementation of the strategy. Primary areas of concern were resource mobilization and what was termed the strategy's primary challenges—the financial incentivization of CHVs. National-level stakeholders echoed this viewpoint, stating that "for a long time, the [community health strategy] has been a 'strategy on paper rather than in action.'"[16]

However, the 2015 situation analysis made it clear that the strategy's performance remained inadequate, and its institutional foundations were vulnerable. Among the challenges identified were lack of prioritization of the strategy (in some counties), inadequate human resources for health, fragmented supervision, weak partner alignment, insufficient governance and management of the program, and problematic retention and attrition of CHVs. The analysis's assertion that the community health strategy remained a strategy on paper only provided a powerful indication that Kenya's previous reforms had largely failed to proceed from policy and program design to later stages of institutionalization.

Community health advocates recognized that the priorities set by new county governments would orient community health under devolution for years to come. At the same time, in 2017 the country was readying itself for its first presidential elections under devolution, and candidates were developing the platforms that would drive political prioritization through 2022. Advocates understood that this was the time to solidify community health reform. They began to ask what would need to be done differently—in this upcoming cycle of reform—to truly deliver on the country's vision of extending high-quality health services to each and every Kenyan and what associated leadership, management, and governance systems would need to be in place within the community health system to effectively institutionalize the program.

As a result of their efforts, in the five years since devolution, many counties have already achieved between 80-100% coverage of community health services,[11] and the country is now preparing for full national scale-up.

The following sections explore the strategies that these advocates have employed to strengthen and accelerate community health reforms both within and beyond the ICH program. Their insights serve as a powerful resource for informing ongoing investment and reform in Kenya as well as global best practice.

Embedding the Community Health Strategy in the Universal Health Coverage Agenda

The ICH and other in-country investments also helped to catalyze broader community health reforms led by the MoH, county governments, and key stakeholders—including UNICEF, USAID, WHO, LVCT Health Kenya, Amref, Living Goods, Population Council, World Vision, and Lwala Community Alliance. Adopting the reform cycle framework helps to illustrate Kenya's progress towards the institutionalization of community health and shows how various initiatives and strategies can advance reforms towards UHC. Accordingly, stakeholders' immediate efforts focused primarily on the stages of the reform cycle that would lay the groundwork for effective program mobilization and rollout, while also anticipating and paving the way for later stages of program management, governance, learning, and institutional refinement. Together, their efforts created the reform foundations, pathway, and momentum that engendered the impressive gains that followed.

From 2015 to 2017, as Kenya committed to the SDGs and incumbent President Uhuru Kenyatta moved to secure reelection, UHC reemerged as a national priority under the President's Big Four Agenda. However, at the outset it was not evident if national and county decision makers would view community health as central to that agenda. A theme identified in previous election cycles has been that "Kenyan county governments have often prioritized visible health interventions which appeal to their electorate, leading to over-emphasis on curative health services with neglect of preventive services, including community health approaches."[8]

Rather than waiting in a state of uncertainty, community health advocates proactively came together to demonstrate how community health could drive the UHC agenda forward. They understood that in order to be successful, they would need to make their case for community health in terms that resonated with political leaders.

They knew that affordability of health services was a top priority for President Kenyatta. During his first term, he had introduced free maternity services at all public health facilities—now known as the Linda Mama program. Coming into his second term, he set financial protection as a priority within the UHC agenda. He moved to strengthen the country's health insurance system, particularly the National Hospital Insurance Fund (NHIF) and its administration of the Linda Mama program.[22] The viability of NHIF and Linda Mama depended on strong enrollment, and the President sought recommendations on how to establish better touchpoints between NHIF and everyday Kenyans.

Community health advocates recognized this as an ideal leverage point. They knew that the community health strategy offered a unique interface between the government system and Kenyans at the household level. In fact, several counties independently proposed the approach, noting that mobilizing CHVs for enrollment would also give them an opportunity to "map communities, identify health inequities, and formalize the community health cadre."[23] Leaders working in community health made this argument at every opportunity; and they linked the message to their own health sector targets for scale-up of CHUs, and the associated workforce of CHAs and CHVs. They recollect, "The drumbeat became, 'We can achieve 100% enrollment through 100,000 CHVs.'"[23]

COALITION BUILDING

A critical moment in Kenya's reform journey was the 2017 Institutionalizing Community Health Conference (ICHC) in Johannesburg. A large Kenyan delegation was led by the head of the Ministry of Health's Community Health and Development Unit, and included representatives from Nairobi, Kisumu, and Migori county governments, USAID, UNICEF, WHO, LVCT Health Kenya, Living Goods, and AMP Health. The conference was a critical step in the coalition building stage of reform as it solidified Kenya's community health coalition and created opportunities for intensive exchange both within and beyond the delegation. Through this dialogue, the coalition crystallized the country's reform agenda and established concrete commitments that

they would carry forward together post-conference. These were:

1. To finalize the community health services policy
2. To re-evaluate the community health services program through an evidence driven approach
3. To increase visibility of community health services
4. To strengthen the leadership and coordination of the Community Health Section

In the years since the conference, the delegation and the broader in-country coalition have far surpassed these targets and achieved remarkable reform milestones.

Following ICHC 2017, a MoH steering committee—led by the Community Health Services Division and including key partners who had been at the ICHC—was established to advocate for prioritization of community health in Kenya. The committee served as an organizing force and accountability mechanism for the broader country agenda. Post-ICHC, they defined a terms of reference and action plan, and gained buy-in by briefing influential stakeholders, including the Community Health Interagency Coordinating Committee, the Principal Secretary, and the Council of Governors—a leadership body of county representatives established as part of devolution.

Since the steering committee's launch, each stakeholder has contributed resources in strategic areas that played to their respective institutional strengths, and UNICEF has played a consistent role in providing direct financial, technical, and operational support to the Community Health Services Division. The committee has worked particularly closely with Professor Miriam Were, Kenya's Goodwill Ambassador for Community Health who's widely known as the mother of community health in Kenya and was part of the Kenyan ICHC delegation.

The steering committee's advocacy has been a critical component of Kenya's reform successes. Their efforts have been driven not just by a shared vision to institutionalize community health, but also by a willingness—even a desire—to establish a harmonized, scaled system owned not by their branded organizations but by the government and

people of Kenya. These actors have developed an in-depth understanding of Kenya's unique stakeholder landscape, enabling them to deploy sophisticated, long-term advocacy strategies that leverage champions and navigate challenges at all levels of the system. To effectively position champions, the steering committee has prepared targeted talking points that reflect priorities within the current community health agenda. The committee is also finalizing a national Community Health Advocacy Toolkit based on tested models from Amref and other members.

Cultivating high-level buy-in through strategic representation at high-profile international convenings has been a particularly effective strategy. The steering committee has found that creating opportunities for leaders to hear in-country advocacy messages reflected by the global community has been valuable. Two strong examples come from Kenya's representation at the 2018 Astana Global Conference on Primary Health Care and the 2019 Women Deliver Conference in Vancouver. Upon returning from Astana, the Cabinet Secretary for Health increased pressure for the development of a Primary Health Care Strategic Framework and Community Health Policy, and she began to champion the role of CHVs in reaching the President's NHIF/Linda Mama enrollment targets. At Women Deliver, Amref organized a joint panel—with President Kenyatta, Amref's CEO, the Deputy Chair of UHC at the WHO—to highlight connections between community health and Kenyatta's UHC agenda. Based on this experience, the President began to engage stakeholders to create additional space for community health within the national budget and installed indicators for delivery of primary healthcare (PHC) and community health within the Cabinet Secretary for Health's performance contract.

Other successful tactics during this coalition building stage of the reform cycle have included positioning community health as a political legacy initiative; developing policy briefs for priority issues; intensifying advocacy during transitions of power; generating data to address areas of concern; and building bottom-up community demand.

PROBLEM PRIORITIZATION AND SOLUTION GATHERING

The steering committee recognized that Kenya's lack of a community health policy was a critical institutional weakness that left counties without clear guidelines for funding and implementation decisions. Furthermore, some key decision makers remained unsupportive and cited the absence of a community health policy as a justification for their resistance. In response, the committee revitalized the process for developing the policy and revising the strategy. The group agreed that in order to be successful, any new guidelines would need to: reflect the current status of community health in the country, link with the President's UHC agenda, and build on available evidence and innovation. These would be critical steps in the problem prioritization and solution gathering stages of the reform cycle.

RE-EVALUATING THE STATUS OF COMMUNITY HEALTH SERVICES

In 2018, Kenya launched a Community Health Services Evaluation, with funding from UNICEF and guidance from steering and technical committees. The evaluation sought to understand why and how certain counties were prioritizing community health, what impact these decisions were having on health outcomes, and what lessons could be gleaned to inform national scale-up. Among other analyses, the evaluation compared two counties with high and low coverage (Siaya with 100% and Kericho with 34%). Across nearly all indicators, Siaya outperformed the national average while Kericho fell well below. The evaluation also identified clear human resource gaps that would need to be addressed. National CHU coverage had still reached only 59%, and an additional 4,292 CHUs would be needed to reach full scale. The evaluation further confirmed what many already knew: that many "established" CHUs weren't functional or meeting designated standards. For example, while coverage of CHUs was reported at 59%, coverage of CHAs had reached only 15%.[11] The evaluation revealed similar gaps in financing: Although 69% of counties had allocated funds for community health, only 32% had disbursed them from the county treasury. This left the community health strategy underfunded and largely donor-dependent. Nonetheless, the value of the strategy was evident, and the evaluation positioned the steering committee to make a clear case for how it could accelerate the country's UHC agenda.

INTEGRATING COMMUNITY HEALTH INTO THE PRESIDENT'S BIG FOUR UHC PILOT:

Issued in 2017, the President's UHC initiative was slated to be piloted in late 2018 and scaled-up nationally beginning in 2019. The Government of Kenya established a national UHC Secretariat to oversee the process. The MoH and Council of Governors selected four counties to implement a defined UHC approach over a one-year period. When the UHC approach was initially designed, it did not include community health. However, building on the evaluation findings and other coalition efforts, including persistent advocacy by the Cabinet Secretary for Health, community health became a flagship component of the approach. The national and county governments entered into an Intergovernmental Participatory Agreement articulating their respective roles, such as recruitment and payment of the requisite community health workforce and procurement of CHV kits. The pilot demonstrated that community health services would be critical for achieving UHC, and the UHC Secretariat recommended that community health be further rolled out and institutionalized through legislation.

FOSTERING INNOVATION TO STRENGTHEN AND EXPAND COMMUNITY HEALTH SERVICES AND SYSTEMS

One of Kenya's growing advantages in community health is its openness to strengthening systems and services through innovation. Seeking to validate global best practice in the Kenyan setting and generate local evidence for decision making, the MoH has opened pathways for community health innovators to identify problems, test solutions, and channel successful approaches into policy and program design. The Ministry's thematic technical working groups have served as entry point for the process. Efforts have been particularly successful when government and partners have co-designed and co-implemented approaches. The adoption of Sustaining Quality Approaches for Locally

Embedded Community Health services (SQALE) as the Kenya Quality Model for Community Health is one prominent example. Others include the integration of case management with amoxicillin for uncomplicated pneumonia into the CHVs' iCCM package, and the testing of community-administered injectable contraceptives with support from Living Goods and other partners. The President's prioritization of technology as an enabler for UHC has also created new opportunities for further innovation and institutionalization of community health, such as the digitization of the community health information system and integration of community data into PHC dashboards.

DESIGN

As the UHC pilot gathered momentum, pressure mounted to ensure that scale-up would rest on solid policy and program foundations. Given their prominence in the UHC agenda, PHC and Community Health received particular attention. Returning from the Astana Global Conference on PHC in 2018 and anticipating the need for strong management and governance as reforms progressed, the MoH established a dedicated PHC Department. It also moved the Community Health Services Unit from under the Family Health Department to become its own division within the PHC Department. The rationale was that it would better position Community Health to function not as a program but as a tier within the PHC structure.

The MoH and UHC Secretariat has tasked the Department of Family Health and evolving PHC Department with developing, through a consultative process, Kenya's first Primary Health Care Strategic Framework 2020-2024. The framework currently being implemented emphasizes that PHC-oriented health systems deliver better health outcomes and can respond to 80-90% of individuals' health needs over their life course. The approach involves a paradigm shift away from curative services and towards preventive and promotive services. It also aims to reduce demand for commodities, minimize costs, and better respond to the increasing burden of noncommunicable illnesses. The framework aims to strengthen each of the health system's building blocks and reorganize fragmented PHC structures into PHC Networks run by multi-disciplinary teams and comprised of PHC referral facilities, PHC facilities, and CHUs. Each network is expected to ensure that it achieves the prescribed number of CHUs. With this framework, Kenya has solidified community health's position at the center of the PHC and UHC agendas.

ESTABLISHING KENYA'S FIRST COMMUNITY HEALTH POLICY

In conjunction with the PHC Strategic Framework, in 2020, Kenya finalized its first and long-awaited Community Health Services Policy 2020-2030. The policy development team organized a participatory process with broad coalition engagement, and intensive financial and technical support from UNICEF. Leaders drew on insights from the previous community health strategies and integrated best practices from emerging implementation research. In particular, the policy sought to define and strengthen the community health system across each pillar of the health system and create linkages with the PHC strategic framework. The team also reviewed all relevant program materials—including CHV curriculum modules and data collection tools—and established certificate- and diploma-level training for CHEWs/CHAs at the Kenya Medical Training College.

READINESS AND LAUNCH

The steering committee identified the program readiness stage as a critical bottleneck in previous community health reforms. While some solutions seemed ready for implementation—such as ensuring the dissemination of policies and program materials—others appeared to have less movement. Determined to remedy the situation, the coalition identified a number of strategies for accelerating reform. This included building an investment case, exploring systems for sustainable financing, and establishing legal frameworks for community health.

BUILDING AN INVESTMENT CASE:
The steering committee viewed an investment case as an essential tool for resource mobilization and advocacy, a clear link to readiness and

launch stages of the reform cycle. Without it, they would continue to miss, as one analysis cited, "opportunities to include [community health] financing in insurance packages or in new global funding mechanisms, such as the Global Financing Facility."[6] In 2018 the committee, with stewardship from Living Goods and Johnson & Johnson, commissioned the investment case. It showed that the community health strategy could deliver a 9.4 to 1 return on investment, one of the "best buys in healthcare." The analysis also generated funding targets to guide the resource mobilization, set recommendations for building cost-efficiencies, and drew attention to the urgency of financing CHV stipends. The findings provided "a compelling justification for National and County Governments in Kenya as well as development partners and other stakeholders…to increase investments towards [community health]."[6] Recognizing the value of this data, the coalition is rapidly disseminating results and making plans to support counties to develop county-specific investment cases.[6]

EXPLORING SYSTEMS FOR SUSTAINABLE FINANCING

Responding to the need for a sustainable funding mechanism to mobilize and manage funding for community health, Kenya developed The Sustainable Financing and Certification Guideline towards achieving Universal Health Coverage. Under the guidelines, the national government will allocate funds for costed UHC implementation plans, including earmarked funds for the community health strategy, and disburse them to the MoH and county governments through the national treasury. Recognizing that domestic resources are not yet sufficient, national and county governments will seek supplemental funding from external sources, local revenue, and in-kind contributions. To manage these funds, the government plans to establish pooled funding mechanisms at the national and county level. The national level will be responsible for policies, regulations, standards, and capacity building, while counties will cover the implementation of community health services, including CHV stipends and supervision, CHV kits and data collection tools, logistical support, and

community engagement. The formal inclusion of CHV stipends is a historic milestone and is expected to finally address the long-standing challenge of the community health strategy. In conjunction with these efforts, the steering committee and focal points within government are also pursuing reforms of the Public Finance Law to facilitate health financing and public private partnerships within Kenya's devolved government structure.

ESTABLISHING LEGAL FRAMEWORKS FOR COMMUNITY HEALTH

Despite these advances, the steering committee was concerned that Kenya still did not have a legally binding agreement for mutual accountability between CHVs and the government. Even counties moving to introduce community health line items had run into difficulties because the program was not institutionalized in any laws. In response, the committee began to support counties to introduce community health bills. Once passed by the county assembly, these bills establish a legal framework to hold the country's treasury accountable for dedicating and disbursing funds for the community health platform. As of 2018, AMREF, LVCT Health Kenya, and UNICEF had supported Nairobi and Turkana in successfully passing bills, and an additional 18 counties had bills in progress. These successes have generated nationwide momentum for the passage of a National Community Health Bill, which stands at an advanced stage in Parliament, awaiting public participation as part of Kenya's constitutional process. Once passed, it will supersede county regulation, unlock additional resource allocation from the national level, free up donor funds for other program elements, and set a national standard for an institutionalized community health system.

Taken together, these program mobilization efforts are—for the first time in Kenya's history—establishing a pathway for the full and sustained institutionalization of community health. Critically, the steering committee has received strong buy-in from the Council of Governors, an essential component for effective institutionalization within the devolved government context.

Kenya's ICH Investment as a Catalyst for a Health System Reform

The USAID SQALE Project Integration of Quality Improvement in Community Health

With the scale-up of CHUs and NHIF/Linda Mama engagement secured, advocates had succeeded in establishing a unified strategy for community health's contribution towards two of the three drivers of universal health coverage recognized by the MoH: scale and financial protection. However, it was still uncertain exactly how Kenya, and its community health system, would address the third and final driver: quality. The government's inclusion of quality as a driver of universal health coverage underscored their conviction that there would be little value in scaling up services and positioning people to access them financially if service quality were ultimately insufficient to improve health outcomes. However, the balance between the three drivers was a delicate one.

In particular, advocates identified "a tension between adding numbers of people reached by community health workers and investing in quality".[23] In addition, poor community data quality often meant it was not used to inform programs or quality. These tensions were felt even amongst the most committed universal health coverage and community health champions. As the universal health coverage agenda gained momentum, some felt that Kenya was on the brink of further scaling-up community health programs, but there was concern that rapid scale-up will compromise quality, equity, and sustainability.

UNICEF's role in championing quality community health services and the UHC agenda during the administration of Linda Mama helped lay a critical foundation to address the tension between quality and scale. It is against this backdrop that Kenya, in partnership with USAID and UNICEF, introduced the Integrating Community Health (ICH) investment. The ICH program in Kenya, awarded in 2016 to the Liverpool School of Tropical Medicine and LVCT Health Kenya, aimed to address the quality gaps in the country's community health system; cultivate bottom-up demand for quality through heightened provider motivation and active community involvement; and test advocacy strategies to navigate tensions between quality and the other drivers of UHC. It also sought to prioritize and bolster community health through devolution and to enhance overall coordination of community health reform. The box below provides a short overview of Kenya's ICH investment.

A QUICK LOOK AT THE ICH INVESTMENT

PROJECT: USAID SQALE: Sustaining quality approaches for locally embedded community health services

IMPLEMENTING PARTNER: Prime: Liverpool School of Tropical Medicine (LSTM) Sub: LVCT Health Kenya, URC (2016-2017)

DATES: April 4, 2016 – April 3, 2019

OBJECTIVES:

1. Embed leadership and communities of quality improvement at national and county levels, resulting in strengthened national and county coordination for improved quality of community health programs
2. Increase capacity of county decision-makers to prioritize and budget for community health programs in an equitable manner
3. Improve community health program performance in Reproductive, Maternal, Neonatal, and Child Health
4. Strengthen community engagement and increase community participation in decision-making

GEOGRAPHIC FOCUS:

- National-level policy, advocacy, and coordination
- Nairobi County (sub counties Embakasi West, Kasarani, and Langata)
- Kitui County (sub counties Kitui Central, Kitui East, and Mwingi North)
- Migori County (sub counties Suna West, Nyatike, and Kuria West)

SCALE: In each intervention county, trained 3 Sub-County QI Teams and 9 CHU Work Improvement Teams (WITs). A total of 27 units were trained and implemented the model.

The need for such a program was clear. Quality improvement (QI) foundations were strong at the health facility level in Kenya but did not extend to the community level. As a result, not enough was known about the actual quality of services provided within the CHUs, and studies frequently revealed weaknesses in contributory program systems such as training, supervision, supply chain, and health information. In 2015 the Ministry of Health's Department of Standards and Community Health Services Unit (now the Community Health Services Division) collaborated with partners to revise the Kenya Quality Model for Health (KQMH) to include all levels of the health system. However, at the outset of the ICH investment the new KQMH community health standards and guidelines had not been broadly disseminated for county buy-in, nor had they been piloted and tested at the community level to ensure their feasibility, acceptability, and effectiveness.[23]

LSTM and LVCT Health Kenya recognized that beyond service quality, data quality was also deficient. Stakeholders recognized that CHVs have "the potential to be the eyes and ears of the health system and [to serve as] a mechanism for reporting new and emerging health challenges."[23] However,

prior to the ICH investment, leaders considered community-level data to be of such poor quality that it simply wasn't used. As with service quality, available evidence highlighted a similar range of factors contributing to poor data quality. Early assessments conducted by SQALE revealed a lack of coherence and clarity among available tools and approaches to collect data at the community level. This was compounded by an absence of indicators around quality, methods for including provider and community voices, and adaptation to the needs of CHVs.[23,24] The government began to recognize that without addressing the problem, it would undermine its ability to make effective decisions around the emerging community-driven approach to UHC.

THE SQALE APPROACH

To this end, the SQALE project sought to collaborate with the Ministry of Health and key stakeholders to disseminate, test, and revise the community components of the KQMH based on evidence and insights from SQALE-supported intervention counties. SQALE received strong buy-in from county leadership, a prerequisite for introducing and sustaining programming within the devolved context.

Based on best practices drawn from Kenya and other countries, the SQALE approach followed seven key principles: "1) Alignment with existing Ministry of Health standards, models and tools; 2) Data collection for data use; 3) Focused, small set of quality indicators; 4) Simple, jargon-free training materials; 5) Clearly defined roles and responsibilities for quality improvement at all levels; 6) Recognition of good practice and celebration of success; and 7) Incorporation of community voices."[23,24]

In line with these principles, SQALE conducted an assessment of existing QI structures within the health system and introduced adaptations only where necessary. SQALE organized the existing Ministry of Health staff and community health cadres within the health system into sub-county and CHU WITs. These WITs would be responsible for identifying and addressing challenges within community health systems and services. Representation on WITs was strategically designed to promote dynamic interaction and advocacy between the different levels of the health system. Primary healthcare facility staff sat on CHU WITs and CHU WIT representatives sat on sub-county WITs. WITs received support from QI coaches within county and sub-county health management teams. WITs used adapted, simplified versions of existing MOH tools—with the addition of a Community Follow-up Tool—to measure community perceptions and satisfaction with CHU services.

SQALE used a phased approach, represented in the figure below. At each phase, WITs received supplemental training and had an opportunity to assess progress and plan for the next stage of implementation. Between phases, WITs implemented their QI change plans with support from county and sub-county QI coaches. SQALE provided regular capacity building support for coaches on data use, advocacy to higher levels of administration, and teamwork. QI coaches also identified QI champions from WITs and engaged them for peer-to-peer support in the rollout of QI trainings in new counties. Teams had the opportunity to apply for QI awards, which created avenues for the funding and testing of community-led QI innovations. In addition, SQALE convened bi-annual learning events, which provided an interactive forum for exchange among WITs, policy makers, managers, QI coaches, supervisors, providers, and community members. Learning events recognized best practices, celebrated successes, created an environment for shared learning and innovation, and elevated the voices of communities to higher levels of the health system.

INSTITUTIONALIZING QUALITY IMPROVEMENT

Over the course of the award, the MoH, SQALE team, and key stakeholders identified that the KQMH manual and tools required significant adaptation to function optimally at the community level. SQALE offered an opportunity to introduce, test, and refine those adaptations. SQALE's robust research and learning agenda also ensured that decision makers' questions and concerns were addressed throughout the process, generating rich evidence on data quality, community satisfaction, community health service coverage and equity, WIT functionality, as well as the cost and sustainability of embedding QI into the health system. The strategic engagement of leaders during this process and targeted dissemination of these results led the MoH to adopt the SQALE model as the Kenya Quality Model for Community Health (KQMCH) in 2019.[25]

Key results and lessons learned from SQALE include insights into the tensions between quality, scale, and financial protection. SQALE demonstrated that empowering sub-national managers, providers, and communities to engage in local QI processes improved health outcomes and strengthened the health system through responsive, cost-efficient solutions. In many cases, WITs resolved problems around data quality and facility-based delivery that had previously been intractable or for which leaders had assumed cost-intensive approaches would be required. Observing the successes of WITs in SQALE-supported areas, new sub-counties and counties gained interest and confidence not just in KQMCH but the community health strategy itself. Many have even gone on to incorporate QI for community health services QI into their annual work plans, a marker of sustainable institutionalization. Under the leadership of these national and county decision makers, Kenya is now poised for widespread uptake of KQMCH.[23]

Opportunities and Next Steps for Kenya

Through the dedication of its community health coalition, Kenya has achieved comprehensive reform of community health's place within the health system. Community health has been institutionalized within the President's UHC agenda and PHC Strategic Framework, which are being driven forward by the country's highest office.

Despite these successes, a sense of urgency remains. Community health leaders are eager to ensure that the unique, potentially once-in-a-lifetime opportunity presented by the President's UHC agenda is successful. Further, they are anxious to institutionalize the UHC agenda so that it is not viewed as a short-term project when President Kenyatta closes out his second and final term in 2022. As Kenya moves into this next phase in its community health journey, the reform cycle continues to serve as a useful framework for analysis, helping to highlight achievements and areas for further reform.

POLICY AND DESIGN

REVISION OF THE COMMUNITY HEALTH STRATEGY:
With the finalization of the community health policy, the Community Health Services Division and steering committee turned their attention to the revision of the community health strategy. The committee established working groups for each health systems area. The working groups made strategic recommendations based on the 2018 evaluation and prioritized areas for integration of innovation and digital technology. The process was enriched by a new consultative process with national and county stakeholders, involving field visits to learn from implementation experiences across different counties. The new Community Health Strategy in Kenya was formally validated and launched in March 2021.

READINESS, LAUNCH, GOVERNANCE, MANAGEMENT AND LEARNING

INTENSIFYING HIGH-LEVEL ADVOCACY FOR LEADERSHIP TRANSITION:
In January 2018, the President appointed the Honorable Sicily Kariuki as Cabinet Secretary for Health. After her appointment, the steering committee and other community health leaders engaged her in extensive discussions to make the case for community health. She emerged as one of the country's strongest community health champions on the national and international stage. During her term in office, she has facilitated many of the sweeping community health reforms outlined in these sections. In February 2020, the President shifted the current Cabinet Secretary for Health to head the Ministry of Water, Sanitation, and Irrigation and appointed the Honorable Mutahi Kagwe, as the new Cabinet Secretary for Health. The steering committee is working to set advocacy priorities for the incoming MoH leadership, and continues to support the community health agenda as a key component of PHC and UHC.

SCALING UP THE UHC AGENDA:
Under devolution, counties have the opportunity to opt in or out of the UHC initiative, despite its positioning as a national agenda. To encourage buy-in, the national government is using its

resources as leverage, offering to unlock national funds if counties allocate at least 30% of their budgets to health, including a specified percentage for PHC and community health. As with the UHC pilots, the arrangements will be governed by Intergovernmental Participatory Agreements between national and county governments. Currently 45 out of 47 counties have opted in and, prior to COVID, were expecting to reach 100% CHU Coverage by May 2020.

STRENGTHENING SYSTEMS FOR MANAGEMENT AND GOVERNANCE OF THE UHC AGENDA

UHC is a high-stakes opportunity for Kenya to shape systems of management and governance under devolution. The national government has a constitutional right to set and enforce policies and standards and to provide technical assistance. However, when devolution was first launched, national staff report being phased out of some counties when they would go for monitoring. Tensions have since subsided, and both national and county governments are focusing on how to effectively mobilize, rollout, manage, govern, and institutionalize UHC—and how to engage the national MoH in that process. This is of particular relevance with regard to ensuring fidelity and quality relative to national standards. UHC's common monitoring and evaluation framework will help to synergize these efforts, but they will not be sufficient. Effective implementation and monitoring of UHC will also require sufficient human resources, capacity, and budget within the national MoH and County or Sub-County Health Management Teams (CHMTs or SCHMTs), particularly given expectations for a rapid, concurrent rollout across counties. Some key funders, such as USAID, are exploring ways to integrate national- and county-level support for the UHC agenda within their upcoming five-year strategy.

ADDRESSING FRAGMENTATION:

Another critical institutionalization challenge in Kenya has been the fragmentation of the implementation environment surrounding community health and the health sector more broadly. At the national level, the Ministry of Health is still in the process of establishing integrated systems for management of UHC, PHC, and community health. For example, it will be important to set expectations for how the Community Health Services Division will collaborate with the National Standards Department to set and monitor standards for community health, and how it will work with various service delivery programs to prioritize training areas, rationalize indicators, and set targets. Fragmentation has also been an issue at the field level. For example, historically verticalized funding, such disease-specific Global Fund investments, has fueled verticalized implementation. Partners have often opted to train their supported CHVs in select technical modules (e.g. HIV or TB) without first training them in the required set of basic modules.

Furthermore, many partners select and support new CHVs for their own programs without engaging CHMTs/SCHMTs and determining whether CHVs were already operational. As a corrective measure, the government recently relocated various vertical programs, such as Malaria, TB, and the National AIDS and STI Control Program, that had previously operated as separate entities under the umbrella of the MoH.

The Ministry expects to carry this integration forward into future funding proposals, including an upcoming Global Fund application, to help ensure that programming factors in community health systems strengthening. Many public health advocates are calling for a number of additional reforms, such as:

- Setting and reinforcing clear implementation standards
- Advocating that all CHVs be trained using standard technical training modules
- Conducting resource and partner mapping exercises; expanding domestic resource contributions to boost government leverage
- Introducing pooled funding and integrated contracting mechanisms; strengthening county planning processes
- Establishing partner engagement frameworks, including empowerment of CHMTs/SCHMTs to provide feedback and guidance to funders and partners as necessary

Looking Forward to Future Reform

Kenya's remarkable achievements are bringing the country ever closer to realizing its vision of affordable, high-quality healthcare for each and every Kenyan. The steering committee's prioritization of institutionalization in lieu of small-scale, project-based implementation is also raising the possibility that community health will truly take hold as part of the fabric of Kenya's health sector and society. Fulfilling the promise of community health rests on continued investment and commitment—to advancing and refining reform; adapting and scaling interventions based on learning and evidence; and encouraging innovation to improve the delivery of essential services across Kenya.

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