

## Kenya: A Case Study on How Centrally Funded CSHGP Grants Contribute to National Programming and Mission Priorities

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May, 2013

***Cover photos:***

Left: Community Health Worker

Source: Stakeholders meeting for Busia Child Survival Project

MTE Presentation

November 2008

Right: Busia Child Survival Project

LLIN distribution

Source: Mid-term evaluation results presentation

November 2008

## INTRODUCTION

International nongovernmental organizations (INGOs) supported through the Child Survival and Health Grants Program (CSHGP) have contributed to and influenced the development of national policy in Kenya by demonstrating what works in community-based programming. The Government of Kenya first introduced a national community health strategy in 2005, and the Ministry of Health (MOH) partnered with INGOs at district level to first test and later roll out key elements of this strategy. The MOH recognized that small-scale projects (district or sub-district level) with sufficient rigor could help determine how and where it should invest resources to implement its national strategy, and what needed to be addressed to ensure that the strategy would be sustainable. By working collaboratively with CSHGP grantees to pilot the National Community Strategy, these projects offered substantive contributions to the MOH and further

Through the Child Survival and Health Grants Program (CSHGP), USAID's Bureau for Global Health (BGH) leverages the development assets and "know-how" of international NGOs to advance public health policies and strategies. At the same time, it improves access and coverage of high-impact maternal, newborn, and child health (MNCH) interventions in marginalized and underserved communities. With a strategic focus on innovation and operations research, the CSHGP has developed effective partnerships with civil society and built technical and institutional capacity, generating practical evidence on the design, implementation, and evaluation of innovative community-oriented approaches. This has positioned its partners to contribute to the global and national evidence base for advancing innovative solutions that address critical bottlenecks in community-oriented health. The program's structure (direct cooperative agreements with NGOs), technical assistance<sup>1</sup>, and collaboration for learning and action<sup>2</sup> effectively harmonize global, national, and local priorities to advance primary health care and community health strategies.

strengthened their credibility as technical assistance partners of USAID. This case study aims to highlight seven CSHGP NGO partners in Kenya implementing projects from 1999–2010. It depicts how the effective collaboration between USAID, INGOs, and the Kenyan MOH influenced and supported the development, implementation, and refinement of Kenya's community health strategy. More in-depth information is provided on the three most recent projects, which tested the community health strategy following its introduction in 2005.

1. The influence of the CSHGP can be seen through the facilitated interaction and coordination of the Kenyan MOH and INGOs working on and articulating community health strategies. The National Community Strategy was shaped in large part by INGO experience in community-based programming, particularly the fostering of a cadre of Community Owned Resource Persons (CORPs), who served as volunteer community health workers (CHWs). Much of this experience came through CSHGP projects in Kenya in the early part of the last decade. CARE Kenya implemented a child survival grant from 1999–2003 that piloted the new structuring of CHWs, the model ultimately adopted in the National Community Strategy.<sup>3</sup> This cadre was initially supervised by Public Health Technicians or Enrolled Community Nurses, and they provided health education and basic services directly in communities. Other CSHGP projects implemented during this period used the CORP model and piloted additional innovated approaches in community based programming. These include PLAN International (1999–2003) in Kwale District, World Vision (2001–2006) in Teso District, and Catholic Relief Services (2002–2007) in Mbeere District.

CSHGP grantees, including those working in Kenya, contributed their community health program findings in an international workshop on Community IMCI in January 2001. That workshop led to the development of an "implementation framework for household and community integrated management of childhood illness". The framework, endorsed by members

<sup>1</sup> For example, from the Maternal and Child Health Integrated Program (MCHIP).

<sup>2</sup> For example, from the CORE Group.

<sup>3</sup> Olowe, M. 2003. *Integrated Management of Childhood Illnesses (IMCI): The Case of Siaya District, Kenya*. Nairobi, Kenya: Tropical Institute of Community Health Publication.

of the CORE Group<sup>4</sup> Network of INGOs, served as a reference tool for describing, sharing, and coordinating future community child health activities in the field, and as a guide for designing appropriate behavior change strategies.<sup>5</sup> The Mbeere Child Survival Project implemented by Catholic Relief Services utilized this framework, and the project was instrumental in developing the Community IMCI training program officially adopted by the MOH Division of Child Health. The CRS project also utilized a successful mother-to-mother approach to scale up exclusive breastfeeding practices, which are now used in a variety of health programs in Kenya.

During the period from 2004–2010, three additional CSHGP-supported projects piloted the National Community Strategy of the Kenyan Ministry of Health’s National Health Sector Strategic Plan II. The three projects were implemented by Plan International (2004–2009), AMREF (2005–2010), and HealthRight International (2006–2010). By exploring a variety of approaches to address major implementation challenges, these organizations demonstrated how the strategy can be adapted to varying local contexts.

The designs of these CSHGP projects reflected the convergence of both USAID and government priorities to improve community health programming. The USAID Mission to Kenya played an important role in facilitating collaboration between its bilateral projects (APHIAs), the Ministry of Health, and CSHGP grantees to further that goal. In addition, USAID Kenya played a key role in disseminating lessons learned on the innovative approaches demonstrated in the district-level projects. As a result, it ensured that the successes of the NGOs extended well beyond the geographic and time boundaries of their individual projects.

## COMMUNITY HEALTH IN KENYA

Since it achieved independence in 1963, Kenya has enacted several reforms to its health system to improve coverage and quality of services. These reforms ranged from mandating free, universal coverage in the 1960s, to decentralizing management of the health system in the 1990s, and more recently to attempting to coordinate efforts of the public and private sectors under a common framework and goals. Despite these reforms, access to quality health services in rural communities remained poor due to uneven distribution of health services and resources. In response to decentralization challenges,

### Policy Timeline

- 1965: **Sessional Paper No. 10** mandates free, universal health care and centralized from counties and municipalities to the Ministry of Health headquarters.
- 1978: **WHO framework for Primary Health Care** for all by the year 2000.
- 1983: **District Focus for Rural Development (DFRD)**, health and other government services are decentralized.
- 1986: **National Guidelines for the Implementation of Primary Health Care in Kenya** focuses on decentralization, community participation, and inter-sectoral collaboration.
- 1992: **Public Health Act** amended to establish the District Health Management Board (DHMB) as the main, district-level decision-making structure, and user charges are introduced.
- 1994: **Kenya Health Policy Framework Paper** (1994–2010) comprehensive policy mandating quality health care that is acceptable, affordable and accessible to all.
- 1999: **National Health Sector Strategic Plan (NHSSP I) 1999-2004** operationalizes the Health Policy Framework of 1994.
- 2005: **NHSSP II for 2005–2010** refines the implementation guidelines of the initial Plan. It introduces a Community Health Strategy (CHS) that recognizes and decentralizes health service delivery to community level (Level 1).
- 2006: **Health SWAp and Joint Program of Work and Funding (JPWF)**. The JPWF is a consensus document formulated by all stakeholders (government, NGOs, private sector) to set their project activities under a common framework that reflects the goals of the NHSSP.

<sup>4</sup> CORE Group fosters collaborative action and learning to improve and expand community-focused public health practices for underserved populations around the world. Established in Washington, D.C., in 1997, CORE Group is home to the Community Health Network, which convenes its INGO member organizations, associates, scholars, advocates, and donors to support the health of underserved mothers, children and communities around the world. Through volunteer-led technical working groups, CORE Group advances community health by developing consensus-based technical resources, tools, best practices, and partnerships that increase impact and sustainability of maternal and child health programs worldwide. For more information see <http://www.coregroup.org>

<sup>5</sup> Winch, PJ; LeBan, K; Casazza, L; Walker, L; Percy, K. 2002. An Implementation framework for household and community integrated management of childhood illness. *Health Policy and Planning* 17 (4): 345–353.

worsening maternal and child health indicators in the 2003 national Demographic and Health Survey (DHS), and widening health disparities, the Government of Kenya developed a new National Health Sector Strategic Plan (NHSSP II: 2005–2010) that included a comprehensive approach to engage “households and communities [to] take an active role in health and health-related development issues.” AMREF Kenya was one of the key technical partners that worked with the MOH to develop the national Community Strategy. Based on years of experience in community programming, including the Child Survival and Health Grants Project it implemented in Busia District in Western Kenya, AMREF Kenya contributed to the development of systems and models.

The USAID Mission provided both financial and technical support to Kenya’s NHSSP II and its Community Strategy, primarily through health systems strengthening (health policy, logistics, human resources, and monitoring and evaluation) and its AIDS, Population, and Health Integrated Assistance Project (APHIA II), which was implemented from 2006–2010 in seven of Kenya’s eight provinces. APHIA II worked to strengthen the National Community Strategy through increasing demand for, and availability of, key HIV, family planning, reproductive health, and maternal/child health services.

However, Kenya still struggled with a shortage of resources to support community-level activities, and APHIA II had limited funding for maternal and child health. In response to this limitation, PVOs and District Health Offices formed partnerships for the initial rollout and testing of key elements in the Community Strategy, particularly with regard to training and support of community structures and volunteers, community mobilization, and the community-based health information system. To leverage these local partnerships for broader national impact, the USAID Mission began to foster networking collaborations between NGOs, the Ministry of Health, and donors on community health issues of joint interest. This networking contributed to replication and expansion of successful strategies, productive partnerships, and capacity building.

## CSHGP PROJECTS INFORMING AND TESTING NATIONAL STRATEGIES

The aim of the National Community Strategy unveiled in Kenya’s NHSSP II is to promote health and prevent disease in communities. The strategy proposes the empowerment of communities to adopt healthy lifestyles and strengthened linkages with the formal health sector through community health workers, who are supervised and supported by community health extension workers. The National Community Strategy called for the establishment of community units composed of 1,000 households. The policy called for volunteer CHWs<sup>6</sup> to be instituted within each community unit, a cadre that was to be supported by MOH Community Health Extension Workers (CHEWs) and Community Health Committees (CHCs), which were also to be established. The CHCs function as the community unit’s management team, a counterpart to the existing Health Facility Management Committees at each health facility.

The MOH categorizes the health care system into six levels, and the community strategy is intended to focus on Level 1 services:

- Level 1: Community – Village/Household/Family/Individuals
- Level 2: Dispensaries/Clinics
- Level 3: Health Centers, Maternity and Nursing Homes
- Level 4: Primary Hospital
- Level 5: Secondary Hospital
- Level 6: Tertiary Hospital

<sup>6</sup> CHWs are often referred to as CORPs (Community Owned Resource Persons), a general term for a volunteer.



**CSHGP Influence on the Development of the National Community Strategy:** The final strategy was influenced strongly by NGO experience in community-based programming, including their work with CHWs, the behavior change strategies they employed, and their well-developed community mobilization/organization approaches.

**CSHGP Projects Testing the National Community Strategy:** While the new strategy was comprehensive and well-thought out, the practical aspects of implementation were challenging. Human resources, such as hiring enough CHEWs to supervise CHWs, transportation for CHEWs to support communities, community mobilization and coordination between various structures, and

motivation of volunteer CHWs are a few of the issues the MOH faced. Due to resource limitations and a recognition of NGO expertise in community-based health programming, the MOH recommended that districts formally partner with experienced NGOs to carry out the National Community Strategy.<sup>7</sup> Beginning in 2006, Plan, AMREF, and HealthRight's CSHGP projects each served as learning models for the Kenya MOH's National Community Strategy. All three projects implemented the core components of the National Community Strategy—training and supporting CHWs, establishing and training CHCs, implementing Community-Based Health Information Systems, mobilizing the community around health, and communicating for behavior change. Because the Plan project started before the National Community Strategy was final, its model was slightly different. For example, it did not formally establish community units.

#### Key Components of the Community Strategy

- One Level 1 unit will serve 5,000 people and will require 50 CHWs and 2 CHEWs.
- One CHW will serve 20 households or 100 people.
- One CHEW (retrained Public Health Technician, Enrolled Community Nurse or any other similar cadre) will supervise and support 25 CHWs. These are paid employees of the health system.
- CHWs are volunteers and provide services at the household level; these include a community-based information system, dialogue-based information, health promotion, disease prevention, and simple curative care.
- A Community Health Committee in each unit is responsible for planning, coordinating, and reporting on community health activities.

**Project Descriptions:** The Plan Kilifi District Coastal Area Replication and Evolution (KIDCARE) Project worked in four divisions of Kilifi District, Coast Province, from 2004–2009. The goal of the project was to sustainably reduce maternal and child morbidity and mortality through improved household behaviors, improved IMCI services, increased access to quality MCH services, and improved capacity of local partners, systems, and structures. Its primary interventions included the establishment of a community-based health system linked to MOH service providers and the strengthening and expansion of IMCI services at community and facility levels. Both of these intervention areas strongly resembled the National Community Strategy, which was released halfway through the project cycle.

[CSHGP Grantees] are very important because they provide lessons about what can be done in small areas. What could be done if all things are put in place. They have assisted in informing policy or developing materials for child survival programs like C-IMCI, mother to mother support groups, or improving breast feeding.

Dr. Santau Migiro, MOH Department of Child Health

AMREF implemented the Busia Child Survival Project in two divisions of Busia District,<sup>8</sup> Western Province, from 2005–2010. The MOPHS asked the project to serve as a pilot area for the implementation of the National Community Strategy, with the goal of generating lessons to inform replication and scale-up at national level. AMREF designed a community-based maternal and newborn care (CBMNC) intervention package and implemented it within the framework of the Community Health Strategy. The project aimed to empower women, men, families, and communities to make healthy decisions. It applied a social and behavior change

<sup>7</sup> National Community Strategy—Body, page 7.

<sup>8</sup> One of the divisions was later relocated into Samia District.

strategy to enable community members to respond to obstetric and neonatal needs and emergencies and to strengthen community action. In addition, the project took steps to strengthen referral linkages between service delivery Levels 1 (community unit), 2 (dispensary), and 3 (health center).<sup>9</sup>

In Greater West Pokot,<sup>10</sup> Rift Valley Province, HealthRight International targeted one sub-location in each of the five divisions in its Partnership for Maternal and Neonatal Health (PMNH) project, which ran from 2006–2010. Through the project, it supported the DHMT to roll out a similar intervention package following the National Community Strategy in each of the project's target sub-locations, supporting the selection and training of five community units comprising 253 CHWs, five CHEWs, and 45 CHC members.

The three projects made significant contributions to the National Community Strategy, which include showing different requirements for the CHS in different contexts. Some of these lessons learned are highlighted in the table below:

Contribution	Plan	AMREF	HealthRight
Testing effectiveness in enhancing uptake of health services	Substantial increases in vaccination, vitamin A supplementation, exclusive breastfeeding, ITN use, care-seeking for fever, and VCT	Coverage for facility births and postpartum care doubled; LLIN use, IPT, and HIV testing also increased	Dramatic increases in postpartum care, neonatal care, breastfeeding, and knowledge indicators
Costing strategy components	Tracking cost of trainings for CHWs and CHEWs	Aggregated overall costs of implementing the strategy in two divisions	
Developing/adapting training materials		Manual for CHWs on maternal and newborn care	Adapted CHW training schedule and included participatory work to increase retention and engagement
Supporting community structures, volunteers, and health workers/facilities	Integrated care groups into system with CHWs and CHCs	Organized mother-to-mother and child-to-child support groups to facilitate community mobilization; developed chalkboard system to share data with CHCs	Improved linkages between communities and health facilities through CHW referral system
Identifying human resource gaps		Found DHMTs did not have experience supporting community-level activities and that demand for clinical skills of CHEWs kept them from supervising CHWs effectively	Need to help HFMCs fully understand roles and responsibilities
Exploring motivation for CHWs	Found need for defined career paths for CHWs	Studied motivators and quantified time commitment	In-depth study on CHW incentives
Adapting strategy to local contexts	Varied ratio of CHWs to households based on geography and population density		Reduced household visits from monthly to quarterly; adapted CHW criteria and materials to include semi-literate/illiterate volunteers
Identifying needs in supplies and transportation	Supplied transport (motorbikes) for those supervising CHWs	Bicycles necessary for CHWs	Bicycles for CHWs (motivators); training, funds, and recommendations for CHW kits

<sup>9</sup> Wangalwa, G; Bennett, C; Wamalwa, D; Machira, Y; Ilako, F; Ofware, P. 2010. "Community-Based Maternal and Newborn Care: Effectiveness of Kenya's Community Health Strategy for Maternal and Newborn Health Care in Butula and Samia Constituencies, Busia County, Kenya". Nairobi, Kenya: AMREF.

<sup>10</sup> The government divided the area into three districts during the project's first year: West, Central, and North Pokot Districts.

## LEVERAGING LESSONS LEARNED WITH MISSION SUPPORT

While the CSHGP projects produced valuable information for promising practices and potential pitfalls of community-based health programming, the projects were small and covered only parts of selected districts. Additionally, sharing successful experiences between districts is often challenging due to decentralization. Recognizing that these important lessons might be lost without intentional efforts to share their experiences with others, the USAID Mission began sponsoring CSHGP and MOH partner meetings in 2005. These later expanded to biannual partners meetings in 2006 and included the bilateral APHIA II partners. The meetings—one in Nairobi and one at a field partner's location—are held for the purpose of facilitating cross-learning and collaboration among USAID partners. They provide a forum where USAID/Kenya, the MOH, and USAID partners implementing MNCH/FP/HIV activities meet to ensure coordination of activities in line with MOH strategies and relevant policies, disseminate and familiarize participants with current best practices for MNCH/FP/HIV, and discuss challenges in implementing these programs. They also provide an opportunity for grantees to participate more actively and contribute to national health dialogue by utilizing their project platforms as testing labs for national discussions.

The Nairobi-based meetings allow for participation of government partners based in Nairobi. The field-based meetings provide an opportunity for staff at the DHMT level in the region to attend along with local implementing partners supported by the Mission. These meetings have been hosted by USAID and AMREF on various occasions. The field-based meetings always feature an opportunity to observe the partner programs in the host setting. In 2007, AMREF hosted the September meeting in Busia; HealthRight International hosted the fall 2008 partners' meeting in West Pokot; Plan International hosted the 2009 meeting in Kilifi; and Path's APHIA II project hosted the 2010 meeting in Kakamega.

We (the Mission) expect collaboration—it is not an option. Mission funded and centrally funded programs are all using USG resources and we believe it's our responsibility to create the forum for this collaboration. This approach also makes it easier for the DHMT and MOH to work with us, and ensures that we are reinforcing government priorities. This model allows a forum for the government to express its priorities, and ensures that we leverage every US dollar that goes toward serving the Kenyan population.

Sheila Macharia, USAID Kenya

Through these meetings, the Mission has been able to interface with the local, in-country NGO expertise that has been built through the CSHGP grantee community. Since the majority of the Mission's health budget is dedicated to addressing the HIV epidemic, this experience-sharing in maternal and child health programming is particularly important. This collaborative model has also exposed the Mission and its partners to other innovations pioneered by CSHGP grantees in cross-cutting areas such as monitoring and evaluation. Examples of the collaboration resulting from these meetings include:

1. **Contribution to the APHIA Project:** The Mission examined the experience and designs of CHSGP projects to plan its APHIA bilateral projects. USAID specifically considered experiences of AMREF, HealthRight, and CRS in terms of how the bilaterals would work with the government to implement the National Community Strategy. For example, the APHIA Eastern project was just beginning as the CRS CSHGP project was ending, and it scaled up some of the components of that grant. NGOs with previous CSHGP grants were well-positioned to contribute on a much larger scale as the Mission expanded through its APHIAplus programs. AMREF participated as a key partner serving Eastern and Central regions, addressing the social determinants of health and the orphans and vulnerable children (OVC) result area; and World Vision as a key partner to PATH in Zone 1 (Nyanza and Western)—a megazone where most of the APHIAplus funds are committed in Kenya. USAID Kenya recently funded AMREF as the lead for an expansion of the APHIAplus



program into the North Eastern Province through the North Arid Lands (NAL) project. This is an integrated service delivery project that covers HIV/FP/MNCH and water, sanitation, and hygiene (WASH).

2. **Collaboration to Increase Coverage and Coordination of Services:** The partners' meetings allowed AMREF and the APHIA II Western teams to reach an agreement about which services would be covered by each: APHIA II covered early infant feeding, home-based care of HIV, community IMCI, and sanitation and hygiene—components not covered by the AMREF Program. HIV/AIDS and malaria prevention (especially ITN distribution) was greatly aided by the contributions of other programs, such as APHIA II, AMPATH, MSF Spain, and PSI, that were working in the area. AMREF's Final Evaluation, for example, found that knowledge about HIV prevention was strong among community members, and all interviewed mothers had been tested while they were pregnant. AMREF's CSHGP Grant worked in partnership with these organizations to reduce duplication and offer a wider range of services to the population.
3. **Lot Quality Assurance Sampling:** The Mission also benefited from learning about new methodologies in monitoring and evaluation, such as the use of Lot Quality Assurance Sampling (LQAS) for routine monitoring. The Plan KIDCARE Project trained Kilifi DHMT staff in LQAS for regular monitoring on a set of standard indicators. These routine surveys were conducted every six months over the life of the project, and results were regularly shared with key stakeholders in the district. AMREF also had a longstanding capacity in LQAS monitoring for its programs. When the USAID Mission saw the value of LQAS that was being carried out through CSHGP grantees, it decided to utilize the same method to conduct an evaluation of its APHIA projects, and engaged one of the key staff from Plan as a consultant to that process. Plan worked with the GOK National Council of Population and Development (NCPD) and the Division of Child and Adolescent Health (DCAH). Because PLAN, HealthRight, and AMREF had all utilized LQAS extensively and built DHMT capacity in this area, they were able to demonstrate to the Mission and the MOH that the strong LQAS capacity at the district level could help with further expansion and utilization of the methodology. Since 2009, the NCPD and the DCAH have worked with the Mission's new bilateral partners under the APHIAplus program to conduct LQAS in all the Kenyan provinces.
4. **CHW Policy:** Cognizant of the National Community Health Strategy and the need to operationalize it, AMREF developed a CHW training curriculum on maternal and newborn care that the MOH adopted nationally. Plan, AMREF, and HealthRight all examined motivators for CHWs and made recommendations on improving retention (including considerations of the CHW-to-population ratio) and managing the CHW kit. The MOH has subsequently modified the Community Strategy to allow for a CHW stipend, adapted CHW coverage standards according to population density of various regions, and made changes to the contents of the CHW kit.<sup>11</sup>
5. **MCH and HIV Integration:** HealthRight's HIV/AIDS project partnered with Family Health International, the lead agency of APHIA II in the Rift Valley. This partnership allowed for expansion and better integration of HIV/AIDS activities into three new geographical areas. HealthRight's expansion of the USAID/Kenya APHIA II project into six districts in the North Rift Valley in 2009 overlapped with its PMNH project in Pokot District and contributed to additional HIV testing. In four years, the project achieved nearly a three-fold increase in the percentage of women tested for HIV during antenatal care (ANC) visits (from 28% to 76%). The project also facilitated early entry into treatment by having HIV site managers immediately link HIV-positive women after ANC testing to treatment services, an integration modality that is often logistically challenging. The APHIA projects also

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<sup>11</sup> "Policy Shift on Community Strategy": Memorandum from the MOPHS Director, March 2011.

supported HIV training for 253 CHWs and voluntary counseling and testing (VCT) so that counselors could travel with mobile clinics to offer ANC HIV testing in the rural villages.

6. **DHMT Capacity Building:** All three of the CSHGP projects described in the previous section partnered with their respective DHMTs and focused on building their capacity. HealthRight supported the three DHMTs in Greater Pokot to take responsibility for implementing the project activities, and at the time of the project's Final Evaluation in 2010, the DHMTs were overseeing all aspects of the project including quality improvement, supervision of facilities, health information system capacity building, and implementation of the National Community Strategy. Six months after project activities ended, Quality Assurance Committees continued to meet each month in facilities previously supported through the PMNH project. In addition, Central Pokot District was recently recognized as the best district in the entire Rift Valley for its completeness and timeliness in reporting health data to the province level.

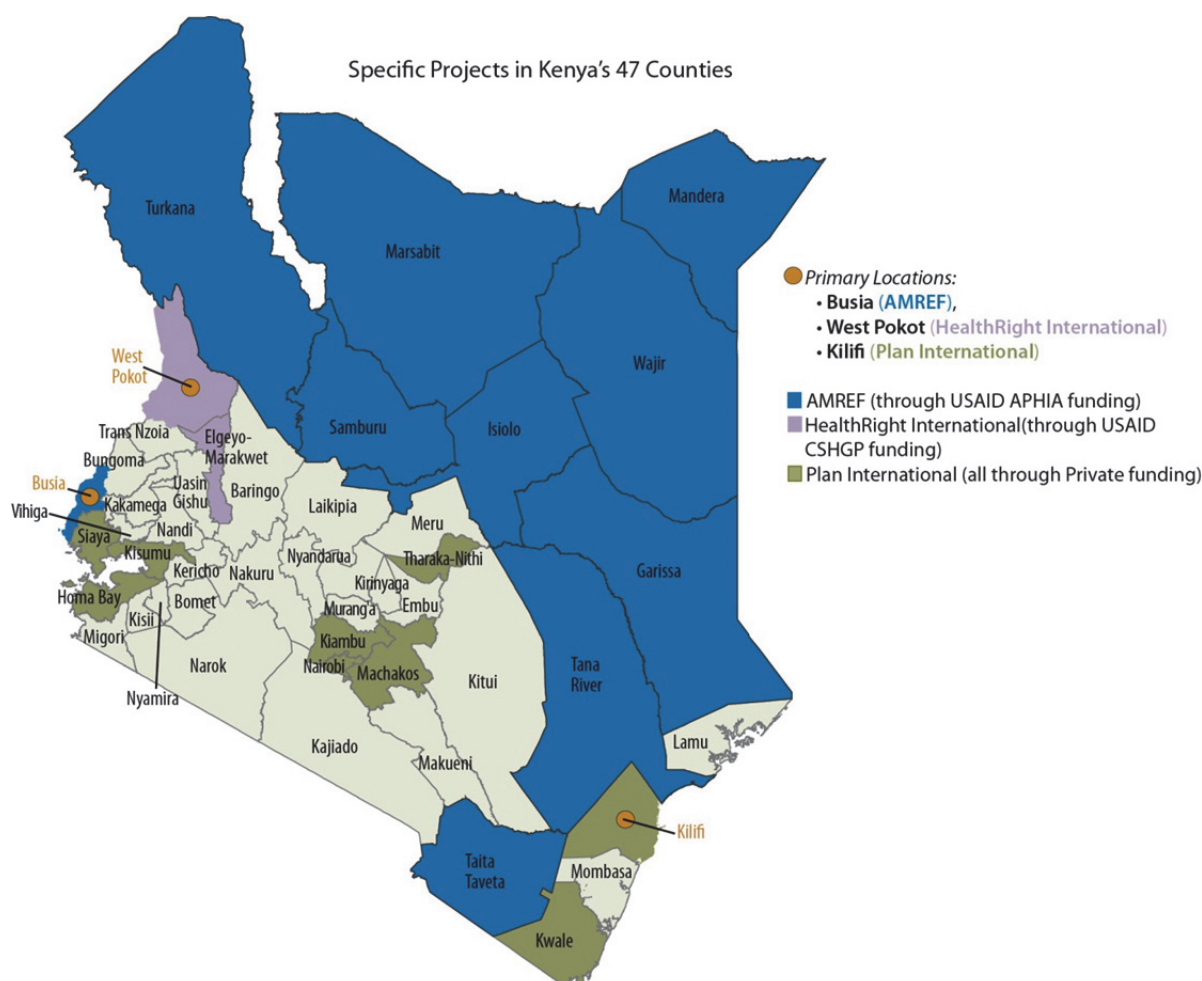
The Health Systems Strengthening of Plan's KIDCARE has resulted in the Kilifi DHMT being recognized as a national "Learning Center" for effective MCH strategies, including capacity to measure impact using LQAS without outside assistance. Recognition of Kilifi District's high performance by the National and Province MOH established Kilifi District as a model DHMT and DMOH for the rest of the country. The AMREF project worked with the DHMT to develop facilitative supervision checklists in health facilities. Even after the end of the project, DHMT staff continued to use these checklists at least four times a year, indicating that this expanded capacity and commitment to supervision will be sustained in the longer term.

## SCALING UP STATE-OF-THE-ART COMMUNITY HEALTH WORK IN KENYA

CSHGP seeks to leverage NGO entrepreneurship in countries, and grants directly influence other health programs being implemented in countries. In Kenya, NGOs like AMREF, HealthRight International, and Plan have a substantial geographical footprint. Their CSHGP grant projects did influence uptake of lessons learned directly to their broader health programs within the country and those of the national ministry and other key implementers. For example, using private funding, Plan KIDCARE was able to scale up the use of women care groups and LQAS for program monitoring from one district, Kilifi, to eight additional districts (HomaBay, Kiambu, Kisumu, Kwale, Machakos, Nairobi, Tharaka, and Siaya). HealthRight International was able to scale up community health strengthening activities for MNCH into Elgeyo Marakwet through a back-to-back USAID CSHGP project. AMREF, by virtue of being awarded the NAL Project covering several counties in Kenya, had the limited opportunity to engage partners through this platform on community service delivery, borrowing a little of what was learned from Busia. Below is a graphic representation of this organization-led scale-up, with the disclaimer that the county coverage depicts activity presence in at least a small portion of that county and not universal county coverage.

Furthermore, Kenya offers a promising example of how projects implemented through the CSHGP can inform and test national strategies for community-based programming before scale-up, and how a USAID Mission can leverage the maximum impact of resulting lessons learned by proactively seeking to involve all partners. The CSHGP had a definitive impact on the design, testing, and scale-up of the Kenya National Community Strategy at multiple points along its development. It accelerated country ownership to oversee, manage, and deliver a health program responsive to the needs of its people to achieve and sustain health outcomes. Each of the seven projects described in this case study contributed in some way to the policy and its rollout, defining new ways of working at the community level and new ways of feeding lessons learned at the community level up to national- and global-level stakeholders. By collaborating and coordinating closely with the district, province, and national level MOH, and through

strong support from the Mission and USAID/Washington, the CSHGP projects exchanged their implementation experience and conveyed key findings from operations research activities.



The experience in Kenya demonstrates that CSHGP grants are of sufficient size and scale to allow for testing of community strategies, increasing technical capacity within INGO organizations, and sharing valuable experience with governments and other organizations for further opportunities for partnership and collaboration to improve health. This example also offers important lessons for USAID Missions, USAID Washington, and other CSHGP grantees. USAID Kenya effectively involved CSHGP grantees in its work, which enhanced bilateral projects, leveraged existing funding, and improved partnerships with government stakeholders. Other Missions can benefit from implementing this collaborative model, especially as development actors in general are challenged to maximize the use of valuable financial resources. USAID Washington can recognize that while the CSHGP is a very small portion of its overall health portfolio, it is a key component of the Global Health Initiative and has expanded influence well beyond the boundaries and timelines of individual projects.

To read the full project evaluation reports of these and other CSHGP Grantees worldwide, search for the projects you'd like to learn more about at:  
[http://www.mchipngo.net/controllers/link.cfc?method=project\\_doc\\_search](http://www.mchipngo.net/controllers/link.cfc?method=project_doc_search)