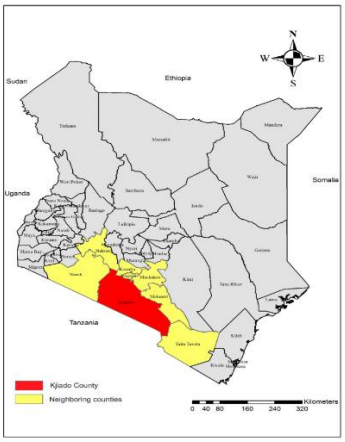
WOODS' ROOTS OF HEALTH
KAJIADO HEALTH SYSTEM

PROGRAMME PROPOSAL, May 2021.



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Acronyms and abbreviations

WRoH	Woods' Roots of Health
CMF	Christian Mission Fellowship
CEmOC	Comprehensive Emergency Obstetric Care
CCC	Comprehensive Care Centre
CHEW	Community Health Extension Worker
COPM	Community Outreach Programme Manager
CHSP	County Health Strategy and Investment plan
CHV	Community Health Volunteer
CLTS	Community Led Total Sanitation
CU	Community Health Unit
EMR	Electronic Medical Records
FGM	Female Genital Mutilation
FGD	Focused Group Discussions
HIV	Human Immune Deficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information System
KEPH	Kenya Essential Package for Health
KCO	Kenya County Office
KDHS	Kenya Demographic Health Survey
KHSWAp	Kenya Health Sector Wide Approach
MCH/FP	Mother and Child Health and Family Planning
MOH	Ministry of Health
NGO	Non-Governmental Organisation
NAYS	National Adolescent and Youth Survey
NHIF	National Health Insurance Fund
SWOT	Strength Weakness Opportunities and Threats
TB	Tuberculosis
TBA	Traditional Birth Attendant
UHC	Universal Health Coverage
UNICEF	United Nations International Children's Emergency Fund
WASH	Water, Sanitation and Hygiene

Glossary of terms

Terminology	Definition
Community health Strategy (Community-based care)	A method for delivering the Kenya Essential Package for Health (KEPH) at the Community (Level 1 of Care)
Community Health Worker	A person trained on public health, community health and licensed to practice community medicine or primary healthcare in the community
County/Sub-County Health Management Team	A multi-disciplinary team of health officials in charge of all healthcare activities within a County/Sub-County
Early Child Marriage	A harmful, illegal (mostly traditional and forced or lured into) marriage before a child attain the age of 18 years
Female Genital Mutilation (FGM)	An outlawed practice that involves the removal of the clitoris, inner-and-outer lips of the vagina, and sometimes the sewing or stapling together of the two sides of the vulva leaving only a small hole to pass urine and menstruate – depending on the type.
Gender Prejudice	A practice that had long been woven into the fabric of most societies. It was driven by a universal belief that women were the weaker of the sexes.
Inpatient	The care of patients whose condition requires admission to a hospital.
Level of Healthcare	Organization of the Kenya Health System where the lowest level 1 is the community and the highest level 6 are the National Referral Hospitals (tertiary care facilities)
MoH Norms and Standards	The standard operating procedure for guiding the public health interventions on all pillars of health service.
Outpatient	A patient who receives medical treatment without being admitted to a hospital.
Partnership Defined Quality (PDQ)	Is an approach for improving the quality and accessibility of services whereby communities are involved in defining, implementing, and monitoring the quality improvement process.
People living with HIV/AIDS (PLWHA)	Someone infected with HIV and symptomatic or asymptomatic of AIDS
Programme Steering Committee	Is a "governing device" used to organize key programme/project stakeholders and empower them to "steer" a project to successful conclusion.
Traditional healers	A person in a traditional society who uses long-established methods passed down from one healer to another to treat a person suffering from various illnesses, many of which have psychological underpinnings.
Universal Health Coverage	Is a health care system which provides health care and financial protection to all citizens of a particular country.
Water, Sanitation and Hygiene (WASH)	Several interrelated public health issues that are of particular interest to international development programs. Affordable access to WASH is a key public health issue, especially in developing countries.

REVIEW AND RECOMMENDATION

This proposal lays out the purpose, need and justification for establishment of a self-sustainable health system in Kajiado for the Maasai community in the area. The initiative with the management structure outlined, will be helpful in bringing a long-term safe, affordable, accessible and Christ centered healthcare.

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Organization:…….

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Executive summary

The Maasai community inhabit Central, Southern Kenya and Northern Tanzania, they are the most renowned community due to the distinctive culture and dress. **CMF-International** was among the pioneer missionaries to spread the Gospel of Jesus Christ in the community early 1980's, this has tremendously transformed the community's life style including renouncing their worship of Oloibon (witchdoctors) to church planting and now predominantly Christians. Kajiado county, southern Kenya, is a vast region that spans an area of 21, 300 sq. Km (8,200 sq. miles) with Maa population of about 750,000. The county boarders Narok County to its West and Tanzania to the south which also have large Maasai Population. Various reports have severally reported poor and dismal levels of healthcare for the communities living in this area.

Dr. Daniel Koitatoi.

The CMF Missionaries helped in supporting to start basic primary education institutions in several areas and paying fees to a number of the less fortunate children to acquire basic

education. One of the greatest beneficiary of CMF's Missionaries generosity is Dr. Koitatoi, a young Maasai boy who hails from Inkiito Village, a deeply rural remote village of Kajiado county, and rose from living in a cow dung Manyatta house to being the only medical doctor in the region and passionate to help the community attain desperately needed safe health care. His achievement was fueled by friends; *First Christian Church in Decatur Illinois, CMF, Fellowship of Associates of Medical Evangelism (FAME), and several other Individual Friends from the USA*. The link below leads to a testimonial documentary of Dr. Koitatoi's journey to become a doctor.

https://www.cmfi.org/blog/dr-daniel-koitatoi-we-are-so-proud-of-his-faith-and-focus/ .

Dr. Koitatoi wishes to extend the Love and generosity of Jesus Christ received from the Missionaries through his medical training to his Maasai community in Kajiado by **establishment of safe self-sustainable healthcare system and medical evangelism in kajiado.**

He therefore embarked on developing a Health system proposal with a vision to providing safe, affordable and sustainable healthcare to the Maasai population of Kajiado, Kenya and Tanzania by extension.

The proposal seeks to raise money from well-wishers; individual donors, corporate funding, for the implementation as per the attached budgets (***detailed into hospital, Dispensaries and community health components***).

Phase one of the programme will be expected to achieve self-sustainability in 5 years and able to run with minimal support from the donors.

For more details about this programme, contact the proposal developers through the contacts provided in the annexes.

1 Background

Kenya, like many countries of the developing world, is faced with the challenge of providing adequate health services to all her people. Available resources especially finance are insufficient to implement this mammoth task. Consequently, the government works with a number of other agencies to help realize this goal, also allowing private and faith-based hospitals to operate independently.

The Maasai Community of Kajiado County in Kenya live in deeply rural and remote areas and face a myriad of socioeconomic challenges that not only impede their socioeconomic development but threaten their sheer survival.

The target regions (areas where ***Community Christian Curches*** which were planted and supported by CMF missionaries), spans Matapato North, Matapato South and Lodokilani wards in Kajiado county (henceforth referred to as Divisions in this proposals).

Inadequate access to safe healthcare and practices that pose health risk are the key challenges that this pastoral community has been contending with.

A **Self Sustaining Health System in Kajiado** is a vision held by Dr D. Koitatoi following his desire to serve his community and extend the love of Christ through medical evangelism.

2 Overall goal and Project description

The proposal aims to establish a self-sustainable health system in Kajiado county, so as to enhance effective preaching of the gospel through medical evangelism and ameliorating overall health standards of the community by improving the health indicators for women, children and youth, through integrated **safe curative**, **promotive** and **preventive** health strategies in Reproductive and Child Health, HIV/AIDS, Malaria, Tuberculosis, other medical and surgical conditions, and WASH services among the Maasai Community of Kajiado County.

To attain self-sustainability, the proposal envisions to

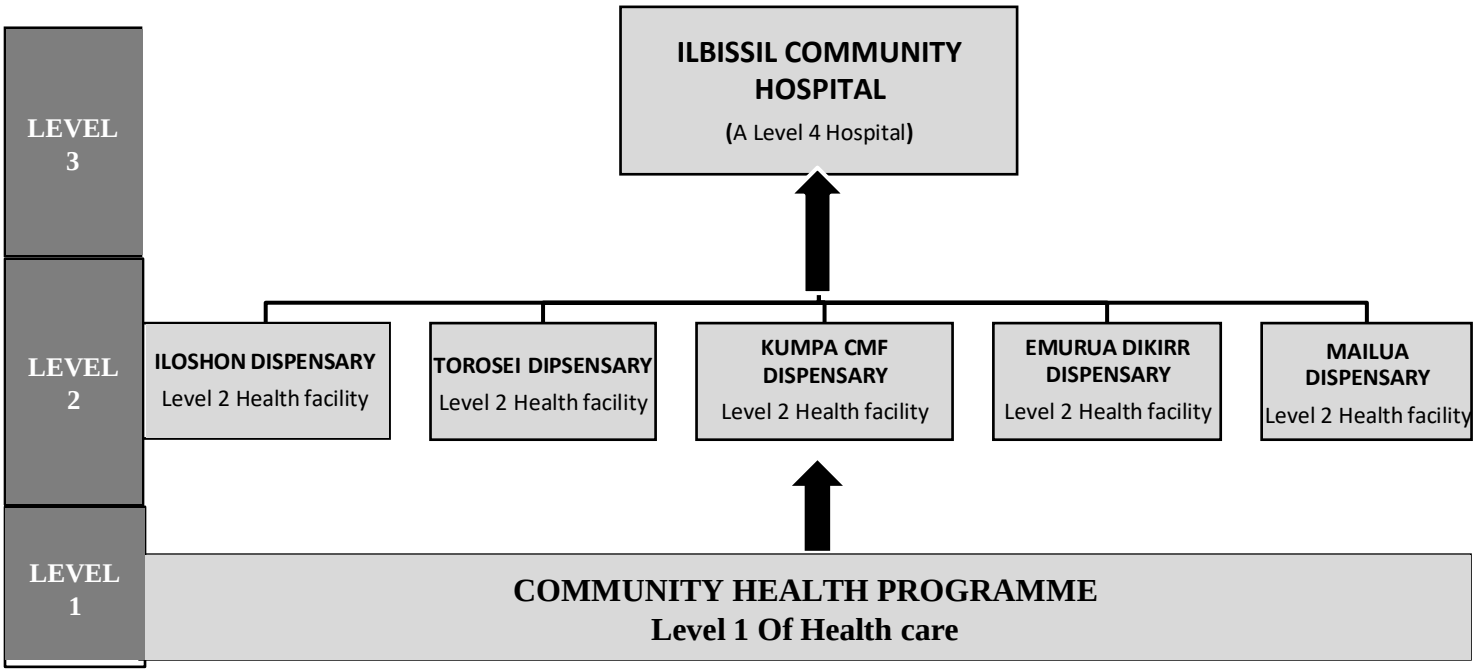
First, rally healthcare donors and other well-wishers to establish infrastructure, acquire medical instruments and finance for operational cost.

Second, the established System shall adopt an affordable commercial revenue generating model of safe healthcare delivery where services offered are duly paid for by the patient.

The programme aims at developing **three (3) levels of healthcare** service delivery as per the guidelines of the Countrys' Ministry of health, and to ease both ***accessibility, sustainability*** and gospel ministry by medical evangelism through community health programme.

The levels of healthcare are illustrated in the model below.

The Proposed Health System Model.



I) LEVEL 1: ***A Community Outreach programme:*** *(Annex)*

This aims to

- To enhance healthy lifestyles by promoting diseases preventive measures in the community.

- Promote better health seeking attitude and behavior change to rally community to abandon health-risky cultural practices including FGM, and use of traditional herbal medicines to adopt healthy living practices at home
- Establishing mobile clinics and camps to hard-to-reach villages, and the rural clinics to occasionally offer free medical consultation to the community members who cannot afford to pay for the subsidized dispensary fee.
- Ease gospel preaching during community outreaches and other household support programme.
- Establishes preventive and promotive healthcare services like community health Education to create awareness, Water Sanitation and Hygiene (WASH) and Menstrual Health Management (MHM)
- Services offered at this level are *free of charge* and do not generate any revenue to the system but rather form the basis of the **corporate social responsibility** (CSR) of Woods' Roots of health ministry.

II) LEVEL 2: Five (5) Rural dispensaries.

The health system establishes THREE (3) rural Dispensaries and support TWO (2) of the already existing dispensaries in the regions of interest (through a Memorandum of understanding with the local county government, MOU):

This aims to

- Enable the community to have access to adequate, safe and affordable primary healthcare services especially for preventive and/or curative of non-complicate medical conditions requiring only outpatient services.
- The three (3) rural dispensaries primarily owned by Woods' Roots of Health shall serves as revenue generating entities for the health system by offering fee for service outpatient healthcare services.
- Link up patients and other community emergency referrals to the Level 4 hospital.

III) LEVEL 3: *A level 4 General Hospital at Ilbissil town:*

- This facility shall be located in a cosmopolitan urban set-up (**Ilbissil town**), for enhanced accessibility from the vast Kajiado county, other parts of the country and also from the neighboring Tanzania.
- The facility shall offer safe affordable and Christ-centered outpatient services to its neighborhood and advance inpatient healthcare services for those requiring inpatient care.
- It Serve as the health systems referral hospital.
- Links up the community to the level 6 hospitals in the country's city when necessary, for tertiary

level of care.

- Shall serve as the main revenue generating hospital for the health system.

3 Communities' profile.

(Annex 5)

4 THE HEALTH CONTEXT AND JUSTIFICATIONS

1.1 CONTEXT

The health sector partnership in Kenya is guided by the Kenya Health Sector-Wide Approach (KHSWAp) introduced in 2005. KHSWAp provides a framework through which all sector agencies can engage to improve effectiveness of health actions. In this regard, the **Woods' Roots of Health system** shall partner with Kajiado County Government and the local community.

For survival, livelihoods rely on pastoralism, which often exposes the population to a number of zoonotic diseases and poor hygiene standards.

Male gender retains and controls the income generated from the livestock, leasing and sell of land. Women and children's access to healthcare and the community economic power has remained very low. Further, women are largely excluded from conventional and economic activities with about 90% of young girls still being subjected to the illegal practices of Female Genital Mutilation (FGM) and 20% face child marriage (UNICEF, 2019).

The Maasai of Kajiado county region, which forms almost the entire Kenya's south region has a large foot-print in the world map for its rich natural resources. It is widely known by the world for the famous Mt. Kilimanajaro and Amboseli National game reserve.

Despite this natural wealth, the community's poverty level is high with approximately 80% of households living without access to essential primary healthcare, water, and basic sanitary hygiene, and over 60% of homes practicing open defecation (NAYS, 2018).

Elementary education levels are very low, especially for women, which is reflected by the 75% illiteracy and innumeracy rate (KDHS, 2019). This high levels of illiteracy greatly affects the health situation as, the community members have poor health seeking behavior and also are mainly still attracted to traditional herbalist and Traditional Birth Attendant (TBAs) for women of child bearing age.

Further, Adolescent Sexual and Reproductive Health Report (MoH, 2018) calculated child pregnancy at Kajiado County to be 40%.

Kajiado County - formerly Kajiado District - (Annex 1) has a population of 1,117,840 in the

recently conducted 2019 population and housing census. The population grows at a rate of 5.5% per annum thus the projected population for the year 2023 is 1,418,871 and the population density is 51 people per km2.

A large proportion of the population (70%) travels over 10 kilometers to access the nearest facility. Some patients face challenges in accessing health facilities due to poverty and poor impassable roads.

There is therefore need to improve health infrastructure and access to health facilities to cater for the large population without access to health care services (C – AWP, 2016/2017). Further, according to NAYS (2015), the average number of children per woman in Kajiado County is six (6), which is one and a half times the national average of 3.9.

This high fertility rate is as a result of the low proportion of married women using contraception estimated at only 48% compared to 58% at the national level. The result is a large and an increasing population of young people; 10.5% growth rate per annum with 66% of the population being the youth (MMWCA, 2015). According to (NAYS 2015), the major health problems affecting young people in the County are STIs and HIV/AIDS and Sexual and Gender-Based Violence (SGBV).

These young people are sexually active and are under pressure to indulge in early sex and do not use condoms as most do not have access to and they get HIV and other STI infections and unwanted pregnancy.

NAYS (2015), further noted that estimated number of deliveries was 4.37% and estimated live births was 3.79% and unskilled delivery is one of the contributing factors to high infant and maternal mortality. The proportion of births attended by skilled providers in Kajiado County is 32%. This is remarkably lower than the national average of 62%.

The proportion of children (12-23 months) who have received all basic vaccines is 59%, again lower than the national target of 80%. The county HIV prevalence is 5% which is also almost as high as the national HIV prevalence of 6%.

These poor reproductive health indexes are as result of low and poor education and health standards. Reduction in fertility and mortality rates and general improvements in quality of life are dependent on education which is also of poor quality. Although the county has a high Primary School net enrolment rate of 85%, a large number of primary school-age children (36,656) are out of school.

1.2 Justification (Priority Gaps)

A **rapid needs assessment** was piloted by Dr. Daniel Koitatoi, with an objective of validating the above County wide situational context and narrowly identify priority pressing gaps to be intervened. Generally, the study revealed the health systems situation at the Southern Maasai

of Kenya in Kajiado County to be comparatively worse.

Specifically, the study established the following priority gaps that this programme intends to intervene.

1.2.1 Access to health facilities

Interviews with locals portrayed a community that is ravaged by a heavy burden of preventable diseases and yet access to primary health care services is limited. It also established that the deeply rural areas are poorly connected to the healthfacilities due to poor road networks and poor condition of roads, strained by infrastructural, staffing and medical supplies gaps. Kajiado County Referral Hospital is about 100km away with bad roads and limited public transport complicating access.

The situation has worsened the healthcare seeking behavior of the locals, since many of the patients would wait until the illnesses are quite advanced demanding extensive resources to manage. Also, it makes some of the households desperately depend on traditional healers and herbal medicines and, much worse, leads to a proliferation of ***unregulated, unsafe backstreet clinics*** within local market centers.

The poor road qualities and lack of adequate health care facilities, is a main challenge when the community is faced with dire emergency situation like maternity delivery complications among others, hence a worrying gap.

The public national referral hospital (KENYATTA NATIONAL HOSPITAL) is located in Nairobi, Kenya's capital city, which is about 150 km northwards from Ilbissil town and significantly inaccessible to the rural resident of Kajiado county, who reside further in the deep rurals of Kajiado with road networks. Many other well-functioning private hospitals are located in Nairobi as well, and offer services at outstandingly expensive prices which makes it

financially inaccessible to the Maasai of Kajiado.

The level 2 health centers in the WRoH ministry, shall be put up in strategic rural areas, market places, to achieve better maximum catchment of the population to provide accessible primary health care and a good referral system for patients who will need to be referred for secondary medical services at the systems level 4 hospital.

1.2.2 Poor sustainability of health care.

- **Inadequate or lack of essential medical equipment and understaffing:**

Working with Kajiado county referral Hospital Dr. Koitatoi notes that **e**ssential medical equipment and services are lacking, thus limiting provision of the scope of services expected at a county's referral hospital. Such equipment includes laboratory diagnostics biochemistry machines and hematology machine, new-born incubator machines, autoclave sterilizer and fridges.This always delayed service delivery as patients have to take blood samples to Kitengela (60km away) or Nairobi (106Km) then wait for results.

Also noted that 80% of the newborns admitted to New-born unit at the referral hospital, suffer from Birth asphyxia with resultant cerebral palsy and/or convulsive disorders, and Low- Birth weight. These conditions pose severe health risk to the children growing up in the already resource constrained community.

This necessitates an intervention comprising of services like active management of labor up to including emergency caesarian section, and adequate Newborn care.

Also noted is that a large number of patients on chronic illness follow-up are lost to follow-up due to long distance they have to travel to visit clinic checkup regularly and reappear later with emergency situations of the condition and often terminal illness.

The linkage of the rural dispensaries shall ensure that patients can refill their medications and have regular medical checkups closer to them.

- **Recurrent Healthcare workers strikes (industrial action) and often lack of resources in government clinics, and community based Health centers.**

The government is always faced with a challenge of providing adequate remuneration and proper working conditions for its

health workforce and also failure to fully equip the health facilities. This results in recurrent industrial actions by medics leading to frequent closure of hospitals, which breaks the consistency of provision of healthcare services.

- **Collapse of NGO and Government owned medical clinics.**

The research also reveals that most health clinics begun by NGO's/Local government and managed by community committees often face challenges following misunderstandings and conflicts in the community. In the survey contacted by the Dr. Daniel Koitatoi, an interviewee says"*community members often differing on opinions of leadership and use of finance, often end up,making the projects redundant"*. In addition, community members many times do Not duly pay for services received from community and government owned facilities because of political interference and corruption.
The WRoH ministry envisions that the level 2 dispensaries and the level 4 hospital shall adopt a **privatized commercial aspect** to **maximize integrity** and optimize revenue collection to achieve consistent provision of affordable primary and secondary healthcare. In this way, the system shall be independed and immune from community conflicts. The management shall entirely lie with Woods' RoH board of directors and a team of experts hired by the organization in the programme.

- **Poor Health seeking behavior in the community.**

The survey also reveals that most community members are not concerned about their health problems as long as they are able tɒgo about their daily activities, they often wait until the illnesses are quite advance, or acquire pain medications from local clinics without adequate treatment, thus muffling symptoms. It's also noted that a significant proportion of the communities depend on herbalist, and traditional medicine.
This hugely contributes to morbidity and mortality from preventable and curable illnesses like TB, Pneumonia, Malaria, Diarrhea and the non-communicable diseases like hypertension and caner.
The proposed Community Outreach programme in the Woods' RoH Kajiado Health System Programme proposal, shall be the focus in educating the communities to abandon health risky cultural behaviors and create awareness of good health care seeking attitude.

- **Inadequate water supply & storage:**

The communities mainly depend on boreholes drilled by government, wells or Dams as sources of water. Most households use 20 liter jericans to store water. This poses a challenge to watersanitation and treatment of water for drinking.
The community outreach programme shall help in educating the populations on benefits of WASH and also providing water treatment kits.

1.2.3 Local socio-cultural practices posing a risk to health

The socio-cultural practices are gaps identified during the assessment as posing a risk to health of the community are as outlined below:

- **Low awareness on the value to utilize conventional health services:**

The rural government facilities available records showed that uptake of services especially preventive and promotive care such as antenatal care, skilled care at birth, postnatal care, immunization and family planning is 50% of expected. Dropout rate is high for services that require multiple re-visits. For instance, the drop out between first antenatal care visit and the recommended fourth visit was estimated to be 44%. Similarly, approximately 38% of children from the community are not fully immunized.

It was also found that 70-80% of mothers give birth at home under the care of Traditional Birth Attendants (TBA). The local community trend of utilization of curative care was foundto be when one is sick they resort to self-medication over the counter from shops or seek traditional and herbal medicine and only appears to the local health centers when they are seriously sick.

Generally, health awareness was reportedly low and misinformation and myths around certain illnesses are common.

Access to health information is limited because few health education and promotion interventions exist. Late recognition of disease symptoms and myths around some of the symptoms resulted in delays in seeking treatment. Particularly, children are often brought to the health facility at a severe stage of illness because mothers did not recognize the illness early, and did not seek prompt treatment or because home remedies were attempted first.

Woods' RoH proposes to tackle this problem by regular free medical camps and the use of medical education and health talks through its level 1 Community Outreach Programme.

- **Female Genital Mutilation (FGM):** The community is still among those with over 90% FGM prevalence. According to some local informants, the practice has gone 'underground' meaning it is practiced in secret to avoid arrest and prosecution. Its therefore advised that interventions aimed at fighting FGM should be culturally- sensitive and bring on board community "gate keepers' and other influencers such as religious leaders, traditional healers and birth attendants.

- **Child marriage:** The Community still has one of the highest rates of child marriage of about 60%. The girls are married off before reaching 18 years of age, the official age of consent in Kenya. Many families that cannot afford formal schooling for all their children, prioritize to educate boys while marrying off the girls as a source of family income. Generally, education for girls is not valued as a priority for family or community investment. Thus, girls tend to perform at a lower level than their male peers and are unable to continue education beyond the primary level.
- **Gender prejudices:** The study found that men control the family resources and decision-making. Women and girls are socialized to be passive – they often have little decision making power even on health matters. Maasai girls are not taught to speak up for themselves, to cultivate dreams for the future, or to develop leadership skills. Rather, they are instructed from a young age by their parents and elders that their future is to become a wife and mother upon reaching puberty. In addition, women's and girls' family duties and social roles may limit their availability to attend to healthcare needs of themselves and their children. This limited access to financial resources and decision-making has direct implications on the health of the women and their children.

  WRoH aims at transformation of the mindset of the society members by actively engaging them through health education in the Community health programme, to enable the community be custodians of their state of health.

5 Proposed Strategic interventions.

5.1 Health Facilities/Hospital based interventions

Buildings a level 4 Hospital which shall be the systems' referral hospital in **ILBISSIL town**, a cosmopolitan area with predominantly the Maasai community. It is a location that is strategic to tap the whole southern Maasai region, including maasai and other communities from the neighboring towns and from across the border in Tanzania. With a larger population coverage, the systems is remarkably increased chances of attaining self-sustainability. **Ilbissil town** is located along the **Nairobi-Namanga Highway.** The hospital fully adopts a privatized aspect of health care provision to maximize revenue collection for the health system.

Services to be offered at the *Ilbissil Community hospital*. Include

- Outpatient
- Maternal Child Health, ANC.
- Accident and Emergency
- At least Sixty Bed (60) capacity for Inpatient care which comprises of,

- **5** Beds in A&E
- **13** Beds in Maternity (**10** beds for ANC+PNC, and **3** Delivery Beds in Labour ward.)
- **15** Beds in Paediatric ward (**10** general ward + **5** New-born Unit, along with 5 incubators for new-born care.)
- **15** Beds for General Male Ward
- **15** Beds for General Female Ward.
- **5** Beds (Rooms) for Prime care/Amenity wards.

- Blood transfusion services.
- Theater services, be able to perform Emergency Caesarian Section, and other minor and major surgical procedure to be contacted by both medical doctors and specialized surgeons.
- Endoscopy services (Following an increased incidence of throat Ca among the maasai population of Kajiado – which demands for timely diagnosis)
- Comprehensive Care Center (For PLWHA)
- Laboratory services.
- Radiology (U/S, X-ray) for a start.

It is also proposed that three (3) dispensaries are built in strategic rural regions identified, then support 2 other government rural clinics through a Memorundum of understanding (MOU) with the government.

These interventions' budgets are elaborated in separate excel document.

5.2 Community Outreach Programme.

a) Community Units

- Initiating and supporting Community Health Units (CU)
- Initiating and supporting Community Health Committees (CHC).
- Revitalizing mobile clinics and medical camps to hard-to-reach villages.
- Carry out Family Planning (FP)
- Initiating and supporting Community dialogue days
- Advocating for health seeking attitude and behaviour change to rally community to abandon health-risky cultural practices.

b) Reproductive Maternal Neonatal Child Adolescent Health

- Initiating and support self-help groups for key population like People Living with HIV/AIDS (PLWHA), Pregnant and lactating women
- Train Community on Community Maternal Neonatal Care (CMNC)
- Integrated Community Case Management (ICCM)

- Advocate and initiate Alternative Rights of Passage (ARP)
- Initiating and supporting school health specific activities like deworming, menstrual hygiene and others.
- Prevent teenage pregnancy through Sexual &Reproductive Health (S&RH)

c) Water, Sanitation and Hygiene (WASH)

- Protect community springs and water sources
- Construct rain water harvesting tanks (roof catchment)
- Promote House Hold Water Treatment & Safe Storage (HWTS)
- Promote Sanitation and Hygiene in households, schools and community through Community-Led Total Sanitation (CLTS), SanMark, Hygiene promotion and Menstrual Hygiene Management (MHM)
- Support Health Facilities in Infection Prevention and Control (IPC)
- Support Community in Vector & Vermin control

These interventions are elaborated in a technical document – KAJIADO COMMUNITY OUTREACH PROGRAMME STRATEGY – which is attached to this proposal as a separate document.

5.3 Phased implementation of programmes

The programmes will be implemented in three (3) phases.

a) Phase Zero

This involves idea conceptualization by the development partners, needs assessments, hiring of project manager to drive the programme development through feasibility studies, analysis for Strength, Weaknesses and Threats (SWOT), designs and formulate programme implementation strategy based on funding available.

b) Phase One (5 years)

This involves distribution of proposal to potential donors to secure the required finances, stakeholder engagement, implementation of projects and programmes work plan, continuous monitoring and phase one end-term evaluation.

c) Phase Two (5 years)

This involves incorporating Phase One Monitoring, Evaluation and Learning (MEAL) recommendations, the ***Ilbissil Community hospital*** and the health system transitions to Self-sustainability.

Securing the capital required for phase two

- Construction of Hospital Mortuary,
- Construction of a nursing college and hiring Medical specialist.

Phase two will focus majorly on building and maintaining sustainability.

6 Work plan budget and schedule of activities

Detailed budget and work plan is illustrated in the attached excel sheet.

7 Oversight and management

7.1 Oversight

The programme structure is displayed visually in annex 3.

7.1.1 WOODS' ROOTS OF HEALTH (WRoH)

The top organ of the programme shall be Woods' RoH. The Organization's **Board of management** establishment comprises of a team of experts; in **Medical knowledge**, **project management and community health & development**, **Human resource management** and **Finance**.

This is the leading Organization which coordinates the programmme implementation process and linking donors to the programme.

Programme Director.

The Chief executive director of the organization shall be the programme directror and secretary to the Board.

The BoM shall be responsible for programme strategy and direction. This is accomplished through the Programme director, who reports to the board for approval of budgets and expenditures, assess programme and or its' projects progress, and review periodical reports.

7.2 Management

7.2.1 Management Team

The Programme director shall be having the overall responsibility over management of personnel, resources including budgets and finances, programme schedules, reporting, monitoring and evaluation. This is achieved with heads of department: **Clinical services, Human resource, Finace** and **community outreach programme manager,** who shall all be employees of the hospital and repots to the director.

7.2.2 Community Health Strategy team (CHST)

The Woods' RoH shall establish a Community Health Strategy Team (CHST) lead by the Community Outreach programme manager (COPM), drawing membership from the respective community members, local churches and community leadership.

The CHST will support the organization specifically to implement the Community Health Strategy in every community health unit.

8 Monitoring, Evaluation & Learning

8.1 Monitoring and Evaluation Indicators

The following performance indicators would be used to monitor and evaluate programme's projects progress, outcome and impact. This will however be refined by the programme management team when phases start.

- Percentage of Phase 1 construction completed on time.
- Percentage of MCH average score during assessment for quality & safety of care.
- Percentage of MCH departmental score during assessment for quality & safety of care.
- Percentage of pregnant women from the catchment attending 4 ANC visits.
- Percentage of TB patients completing treatment
- Percentage of eligible HIV clients on ARV's and achieving viral suppression.
- Percentage of PLWH who are MCH clients attaining optimal viral suppression
- Percentage of women of Reproductive age from the catchment receiving a family method planning.
- Percentage of deliveries conducted by skilled attendants.
- Percentage of infants under 6 months on exclusive breastfeeding.
- Percentage of population with access to safe clean water.
- Percentage of households with latrines.
- Percentage of functional CUs (As recommended – approximately 3,000 people per CU)
- Percentage of children completing all under 12 months' immunization schedule.
- Percentage reduction of young girls undergoing FGM.
- Percentage of households enrolled for health insurance scheme.
- Percentage of household using ITN for malaria prevention.
- Percentage of cases rated to have severe illness due to late seeking of health.

8.1.1 Monitoring activities

Detailed monitoring systems and processes will be put in place to enable tracking of progress and results. The monitoring team will collate field data, conduct quality assurance and verification checks, and provide statistics to stakeholders with updates on performance against targets. Quarterly review meetings will be conducted to review achievements and challenges in relation to the set targets. Monitoring activities will also be carried through monthly and

quarterly progress reporting, quarterly joint meetings among partners, and regular field visits. Community feedback will be collected through bi-annual client exit interviews (at the health facility) and focus group discussions with community members (men, women, and youth).

8.1.2 Evaluation activities

Detailed evaluation system and processes has been put in place to enable end of phases evaluation. Annual evaluation meetings will be conducted to review achievements and challenges in relation to the set targets. Some of the key evaluation activities are outlined below;

- **Baseline survey:** The programme need assessment report and situation analysis as reported in proposal context will be used, for formative assessment phase, to provide data for refining the strategy and budget. That's pre-intervention status for the programme key performance indicators can be based on the needs assessment and this proposal contextual reports.
- **Mid-term evaluation:** At the end of Phase one (five years), a midterm evaluation will be conducted to measure progress and inform the refinement of Phase two strategies and budget.
- **End-term evaluation:** Five years after commencement of Phase two and "end-term evaluation" will be conducted to determine the achievements and impact of the programme.

8.1.3 Learning activities

Evidence based learning will be an on-going activity and the main objective will be to improve and contribute to the Kenyan and wider health sector body of knowledge. This objective will be achieved through the effective capturing and analysis of lessons emerging from the programme but also through special operational research in partnership with national and local research institutes.

Weekly Continued Medical Education (CME's) shall always be conducted at the Ilbissil Community Hospital to refresh skills and knowledge of the health care providers in the ministry.

9 Feasibility and sustainability

9.1 Feasibility

The programme is being implemented by the Woods' RoH, a local Non – Profit Organization conceptualized and founded by Dr. Daniel Koitatoi a local medical doctor from the targeted area, along with consulted experts in healthcare management.

This brings vast knowledge and experience of the doctor who is a bona fide member of the community, supported by the missionaries to achieve his medical degree, and driven by his passion to give back to the community. He also understands the dynamics of his community. One of the sustainability focused measures was carrying out a SWOT analysis, at phase zero, for the proposed interventions in relation to programme location and strategy. The

analysis gave the programme a good "feasibility rating". The analysis (Annex 5) shall guide the mitigation of few foreseeable challenges.

For instance, sourcing and retaining high caliber programme personnel will require additional motivation as the location is one of the remotest in Kenya. The poor roads network and or floods may pose unprecedented costs from maintenance of programme vehicles or delayed timelines.

9.2 Sustainability

The privatization model of the health system shall ensure adequate revenue collection and prudent management of projects finances. Training that will be offered to Community health committees, CHVs and the general public shall strengthen local capacity and skills in adopting and becoming enterprising and patronize the Heath Facilities.

Construction work will, to the extent possible, utilize local materials, skilled and unskilled labor thus setting the right basis for local tenure for future repairs and maintenance.

Perhaps the **most fundamental aspect** of sustainability will be the social change that will be triggered by community education, mobilization, sensitization and empowerment. This need for financial sustainability shall be given high priority by the programme strategy. It has been projected that the Health System phase one need to become self-sustainable before phase two is commenced.

10 Budget

10.1 Summary of programme budget

NB: The Hospital is expected to generate revenue which maintains the above operating cost. Please make reference to the separate business plan (Annex 10) and the respective Health facilities' budget on the excel sheet (Annex 7) for details on the projections and deficit required as the operating gap.

10.2 Detailed programme budget

Annex 7 (See attached Excel sheets for ILBISSIL COMMUNITY HOSPITAL, RURAL CLINICS AND THE COMMUNITY OUTREACH PROGRAMME.)

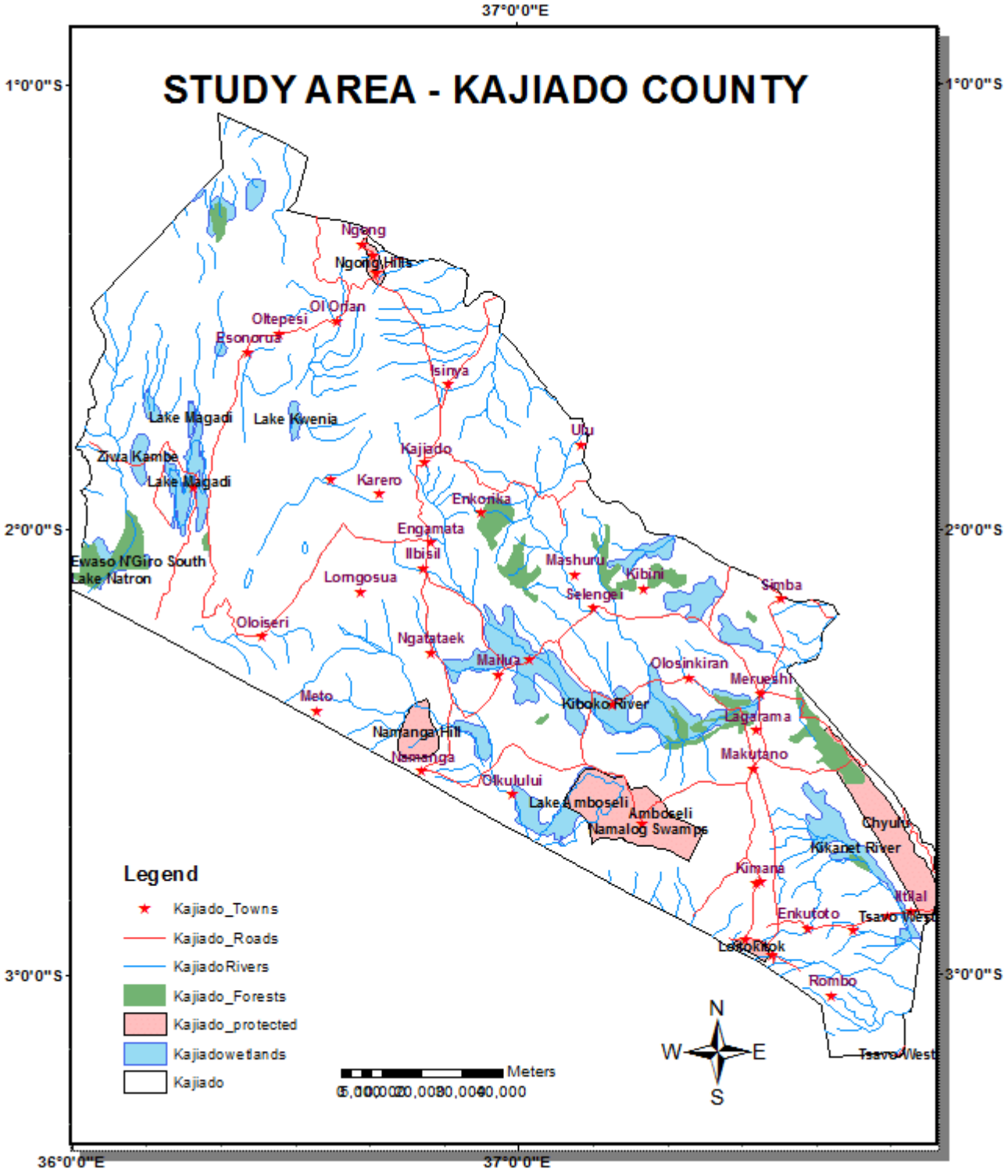
11 References

1. County Government of Kajiado (2014). County health strategic & investment plan 2014/2014- 2017/2018. Unpublished.
2. Kajiado County Integrated Development Programme 2018-2022.
3. Health sector service delivery team (2006). A guideline on Norms and standards for health service delivery. Ministry of health, Kenya. Unpublished.
4. Kenya Subsidiary legislation (March 2016). Checklist for inspections of public and private providers by health regulatory bodies under the ministry of health. Kenya gazette supplement No. 31.
5. Kajiado county government department of health and sanitation (2016). Annual performance report and plan for implementation of health services 2017/2018. Unpublished.
6. National Council for Population and Development (2017).
7. Kenya National Adolescents and Youth Survey (2015) Nairobi, Kenya: NCPD.
8. The public health Act, CAP 242. Laws of Kenya.

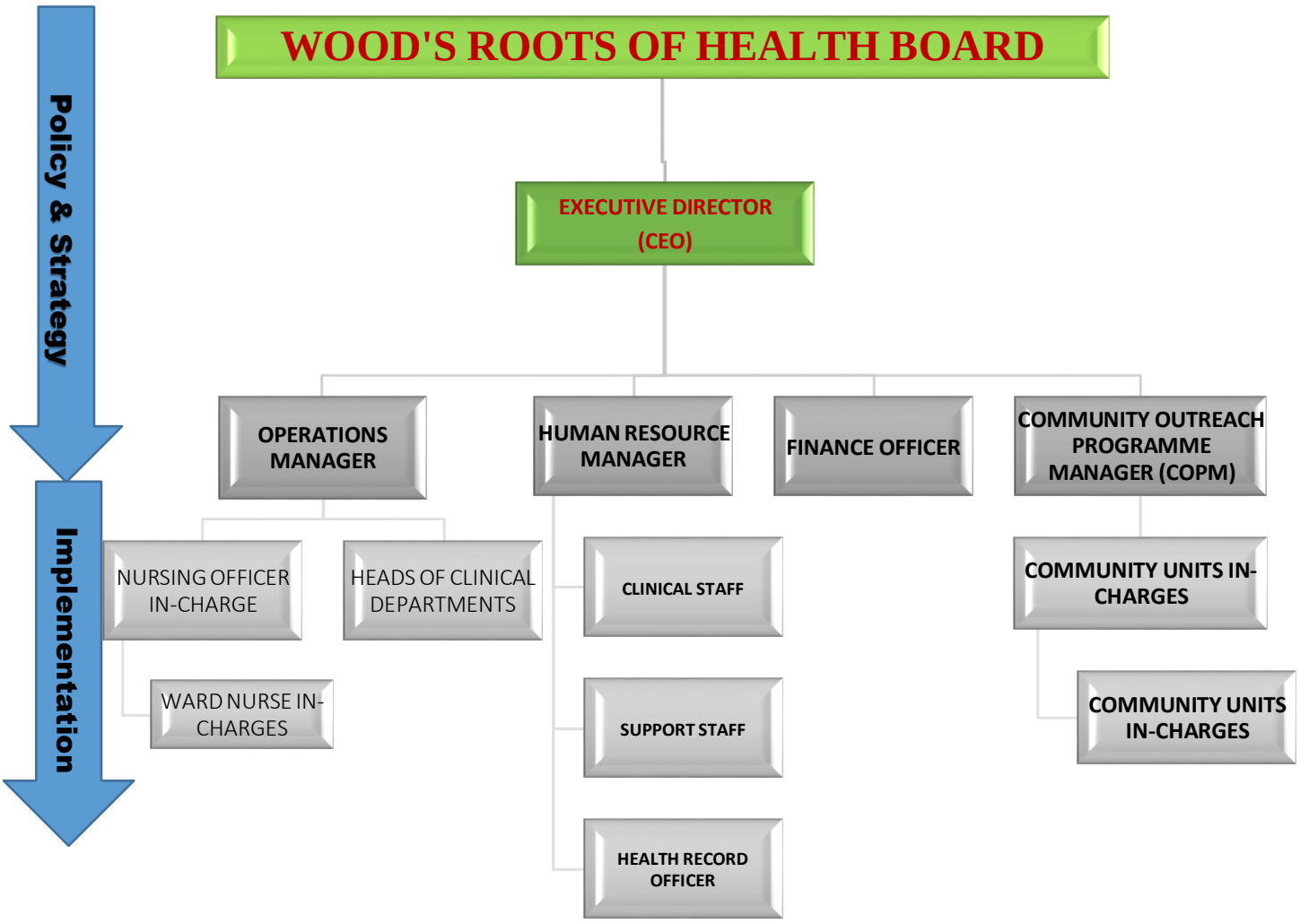
12 Annexes

Annex 1: Map showing details of Kajiado County (formally Kajiado District) and its relative location in Kenya

Annex 2: Map showing Kajiado Health System Location, Kajiado central sub-county.



Annex 3: Program Management structure



Community Outreach Programme (COP)

(Annex 5 of Master Proposal)

May, 2021

Contacts:

Dr. Daniel M. Koitatoi

Email: dkoitatoi@gmail.com – cellphone +254729-092-478

Contents

1 Introduction

This Annexure describes the **Kajiado Health System, Community Outreach Programme (COP)** component.

It's a method for delivering the Kenya Essential Package for Health (KEPH) at the Community level (Level 1 of Care).

Woods' RoH has a vision of Lasting Health Change among the Masai of Kajiado County in Kenya. The Community Outreach Programme is a paramount aspect when transforming the health of the targeted community.

Following the baseline research contacted by *Dr Daniel Koitatoi* in the region, it's evident that there is a myriad of challenges in community that extremely affects the health of the society. Including and not limited to cultural practices and ignorance. Working closely with the community structures, county and national governments, and other stakeholders, **Woods' RoH** shall use this programme to offer health education among other level 1 health services to the community in the effort to achieving sustainable safe health care to the community.

Other Level 1 services that Woods' RoH plans to use are; supporting HIV prevention, care and treatment, working with CHVs to identify, diagnose, and treat/refer children, women and men with Malaria, diarrhoea, malnutrition in the community, Supporting CHVs with skills to enable them find and refer missing cases of TB in the communities, provide women with modern Family Planning methods.

2 Community Units

A Community Unit (CU) refers to a small community-based (Level 1) health systems comprising of community people or volunteers trained for basic public health interventions at the villages levels like first aid and making referrals and follow-ups. This level uses basic equipment like weighing scales, thermometer, charts etc. The staffs at a CU comprises CHVs & CHEWs and work through close supervision of qualified public health staff. The specific activities to be deployed by the Kajiado Health System, Community Outreach Programme under a CU interventions are as follows:

- Initiating and supporting Community Health Units (CU)
- Revitalizing mobile clinics and medical camps to hard-to-reach villages.
- Carrying out Family Planning (FP)
- Initiating and supporting Community dialogue days
- Advocating for health seeking attitude and behaviour change to rally community to abandon health-risky cultural practices.

3 Communities' profile.

Community name	No. of CUs	No. of Households	No. of persons per HH	No. Primary. schools	Estimated Population per school	Community Population
ILOSHON (ELANG'ATA WUAS)	3	870	7	6	200	6800
TOROSEI	2	820	8	5	250	6500
KUMPA & INKIITO	3	920	6	3	300	6400
MAILUA	3	750	7	3	250	5200
EMURUA DIKIRR	1	300	8	2	200	2300
TOTAL	**12**	**3,660**		**18**		**25,600**

4 Reproductive Maternal Neonatal Child Adolescent Health (RMNCAH)

RMNCAH is a World Health Organization (WHO) wide focus on Reproductive and family health. It is a strategy for delivering health indicators for women, neonates and adolescents. RMNCAH has demonstrated to be effective in improving maternal, newborn and child health and survival by addressing the main causes of mortality. It's delivered along the continuum of care for women and children – from the reproductive years, through pregnancy, birth, the newborn period, infancy and childhood. The Strategy is suitable for implementation in low- and middle-income countries and delivered at all levels of the health system: community/home, first level and outreach, and referral-level services selected based on systematic data reviews and meta-analyses.

The specific activities to be deployed by the Kajiado Health System, Community Outreach Programme under the RMNCAH interventions are as follows:

- Initiating and support self-help groups for key population like People Living with HIV/AIDS (PLWHA), Pregnant and lactating women
- Training Community on Community Maternal Neonatal Care (CMNC)
- Implementing Integrated Community Case Management (ICCM)
- Advocating and initiating Alternative Rights of Passage (ARP)

- Initiating and supporting school health specific activities like deworming, menstrual hygiene management (MHM) and others
- Preventing teenage pregnancy through Sexual and Reproductive Health (S&RH) education.

5 Water, Sanitation and Hygiene (WASH)

WASH refers to several interrelated public health issues that are of particular interest to international development programs. Affordable access to WASH is a key public health issue, especially in developing countries.

The specific activities to be deployed by the Kajiado Health System, Community Outreach Programme under WASH interventions are as follows:

- Protecting community springs and water sources.
- Promoting House Hold Water Treatment & Safe Storage (HWTS)
- Promoting Sanitation and Hygiene in households, schools and community through Community Led Total Sanitation (CLTS), Sanitation Marketing, Hygiene promotion and Menstrual Hygiene Management (MHM)
- Constructing rain water harvesting (rock or roof catchment) and drilling boreholes.
- Supporting Health Facilities in Infection Prevention and Control (IPC)
- Supporting Community in Vector & Vermin control.

6 Roles and Responsibilities of Community Outreach Programme Manager (COPM).

The COPM is personnel trained in Community health and/or Public Health, recognized by the Ministry of health practitioners as a Community Health Extension Worker (CHEW) in recognition of the need for professionally trained health workers to supervise and monitor the progress of health care at level 1.

Their main roles and responsibilities are:

- Facilitating Community—Health Facility linkage structures.
- Participating in the selection, training and support of Community Health Volunteers (CHVs)
- Providing technical and logistical support to caregivers (CHVs) at level 1.
- Managing the community-based health information system (CBHIS), using it to influence continuous improvement in health status at the community units.
- Monitoring the use of CHV Kit (simple drugs, water guard, thermometer and other supplies) and Providing supportive supervision and coaching to CHVs.

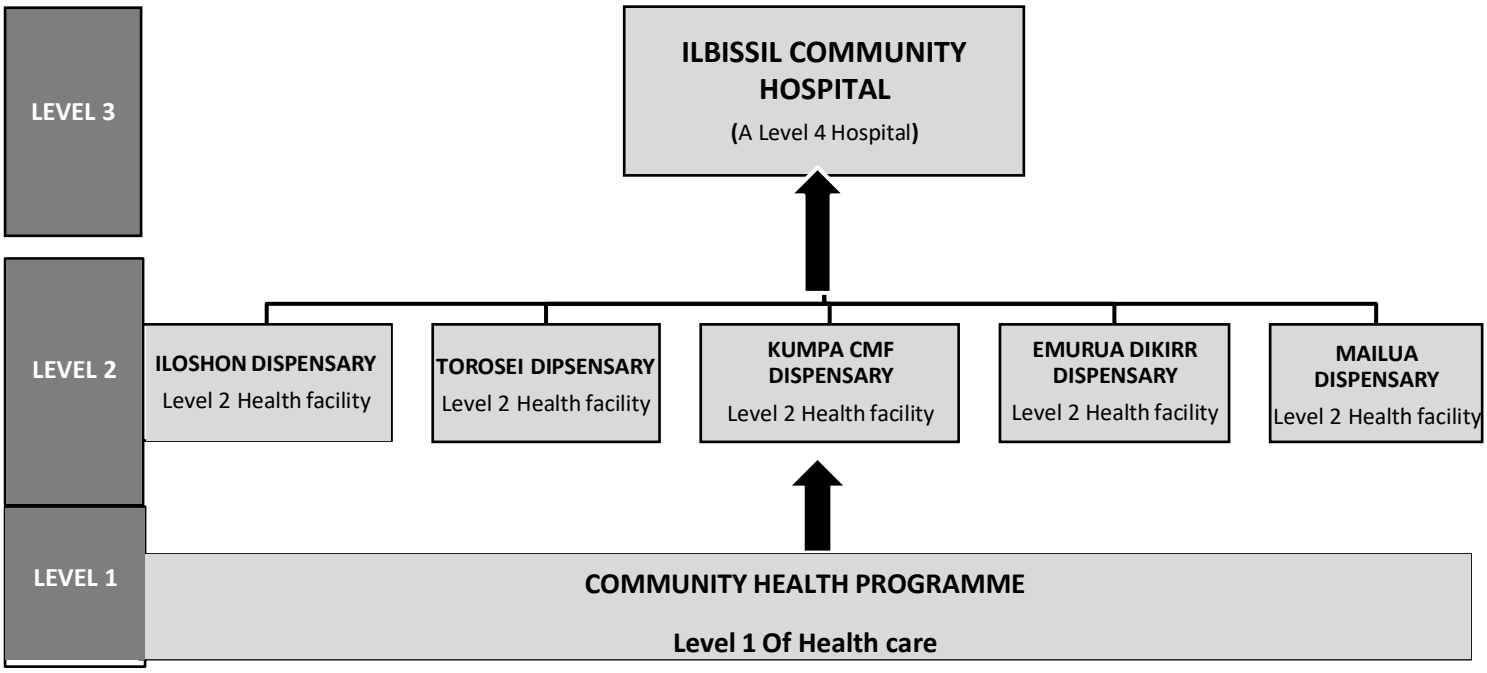
7 Roles and Responsibilities of Community Health Volunteers (CHVs).

The followings are Roles and Responsibilities of CHVs as defined in Community Health Strategy guidelines:

- Guiding the community how to improve health and prevent illness by adopting healthy practices
- Treating common ailments and minor injuries, as first aid, with the support and guidance of the CHEW
- Managing and keeping inventory of the CHV kit supplies
- Referring cases to the nearest health facilities
- Promoting care seeking and compliance with treatment and advice
- Visiting homes to determine the health situation and initiating dialogue with household members to undertake the necessary action for improvement
- Promoting appropriate home care for the sick with the support of the CHEW, level 2 health facilities and the leading programme Doctor.
- Participating in monthly community unit health dialogue and action days organized by the COPM/CHEW.
- Being available to the community to respond to questions and provide advice.
- Being an example and model of good health behaviour.
- Motivating members of the community to adopt health promoting practice
- Organizing, mobilizing and leading village health activities.
- Maintaining village registers and keeping records of community health related events.
- Reporting to the link Health Facility and COPM on the activities they have been involved in and any specific health problems they have encountered that need to be brought to the attention of higher levels.

8 References

1) The Kenya Essential Package for Health at Level 1 (2013)
2) Integrated Community Case Management for Sick Children Under 5 years. (MOH September, 2013 Edition)
3) http://www.who.int/pmnch/knowledge/publications/policy_compendium.pdf

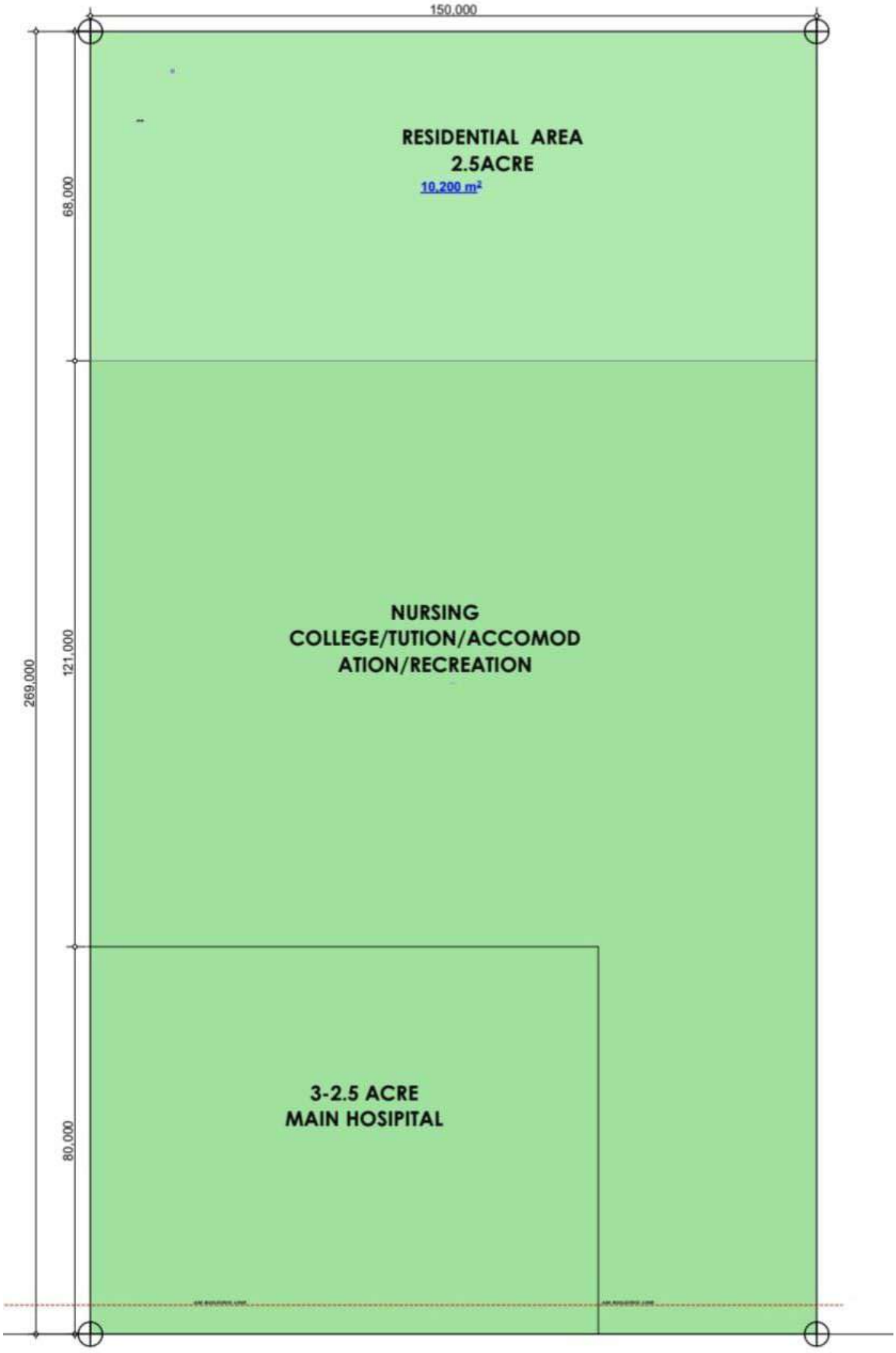


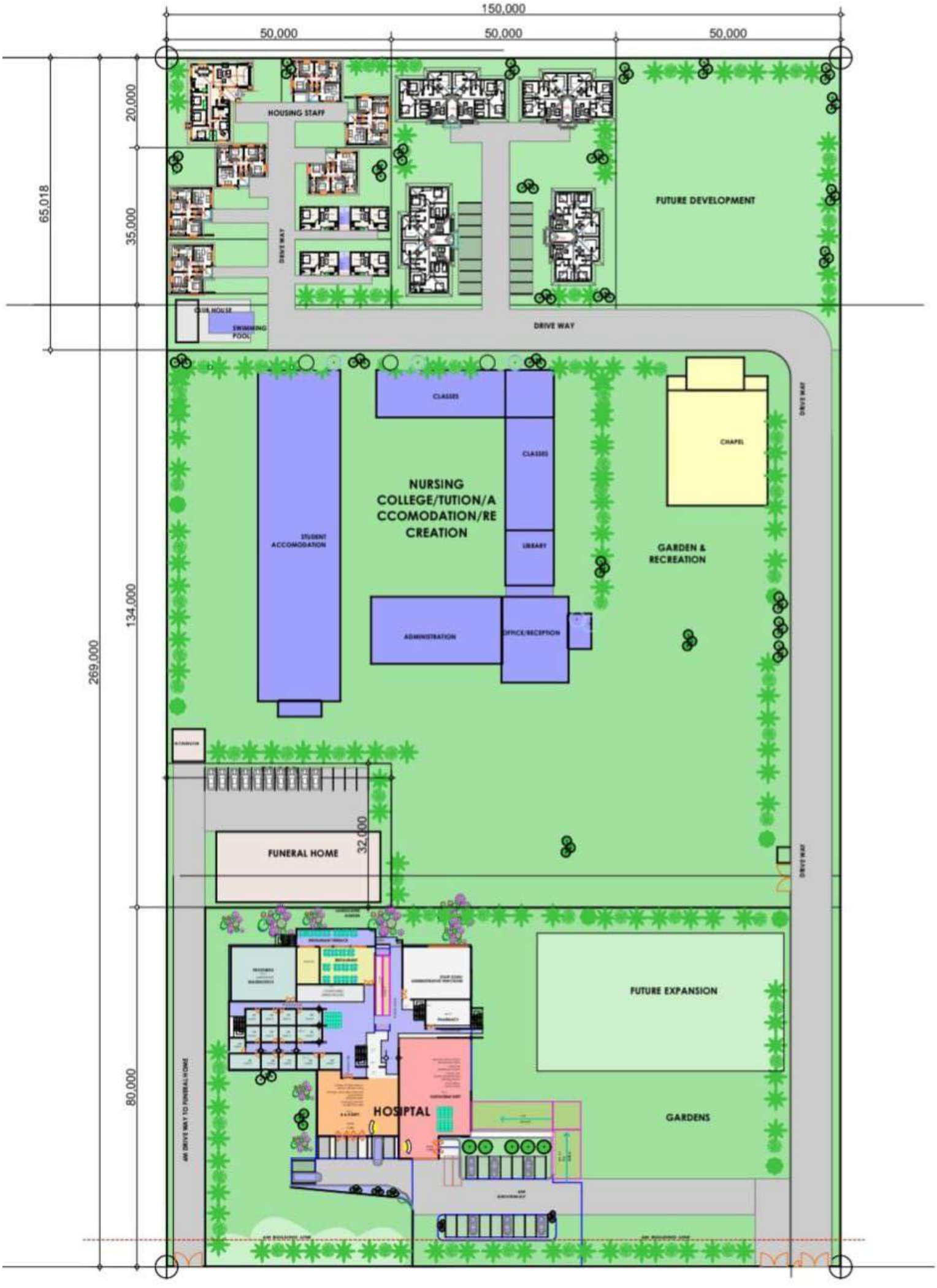
The Proposed WRoH Health System Mode

PROPOSED HOSPITAL COMPLEX IN BISIL

Outline Proposal **Date:** 28th April 2023

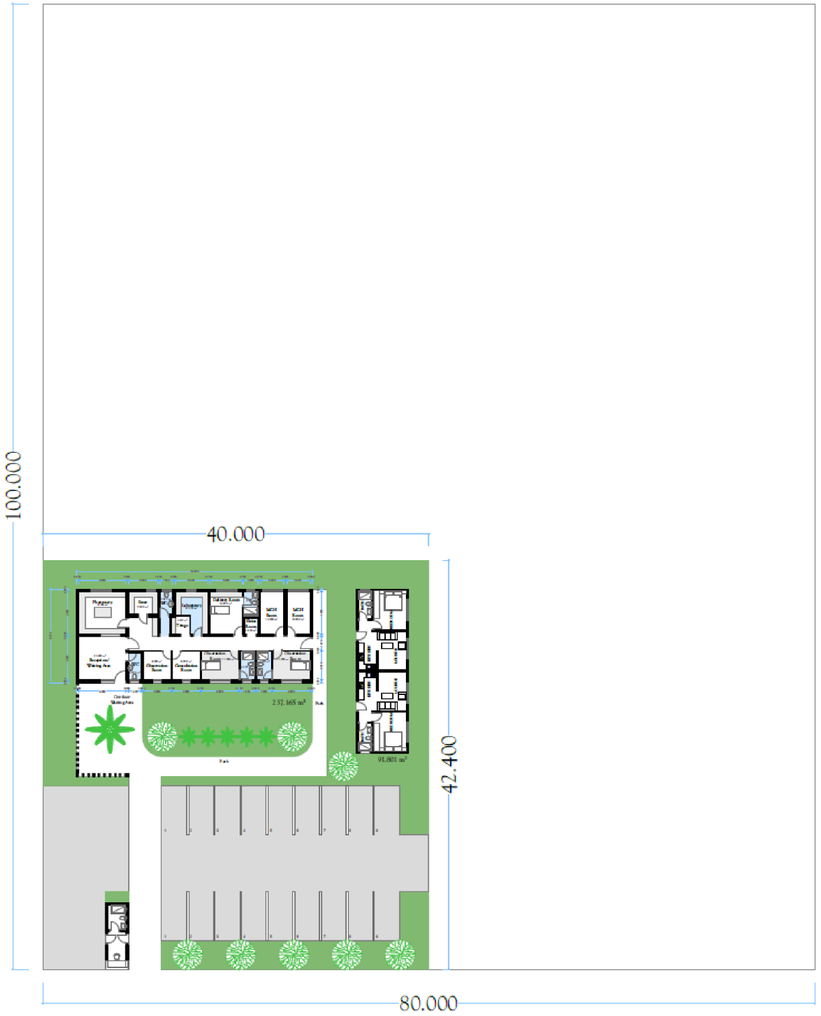
Design
ARCHITECTS, PLANNERS INTERIOR DESIGNERS & PROJECT MANAGERS

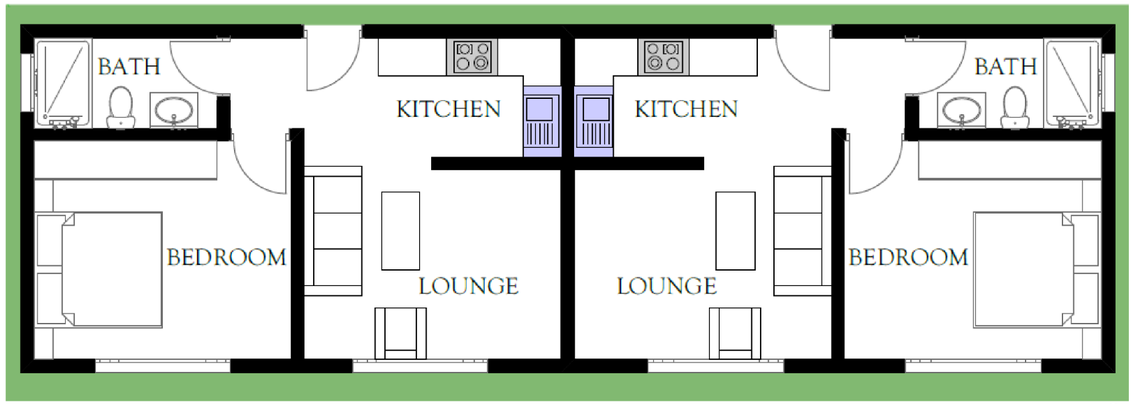

150.000
RESIDENTIAL AREA
2.5ACRE
10,200 m²
68.000
NURSING
COLLEGE/TUTION/ACCOMOD
ATION/RECREATION
121.000
269.000
3-2.5 ACRE
MAIN HOSPITAL
80.000
KITENGELA -NAMANGA ROAD


150,000
50,000
50,000
50,000
65,018
20,000
35,000
134,000
269,000
80,000
32,000
HOUSING STAFF
DRIVE WAY
FUTURE DEVELOPMENT
CLUB HOUSE
SWIMMING POOL
DRIVE WAY
CLASSES
CLASSES
CHAPEL
NURSING COLLEGE/TUTION/ACCOMODATION/RECREATION
STUDENT ACCOMODATION
LIBRARY
GARDEN & RECREATION
ADMINISTRATION
OFFICE/RECEPTION
FUNERAL HOME
FUTURE EXPANSION
HOSPITAL
GARDENS
KITENGELA -NAMANGA ROAD

PROPOSED KAJIADO RURAL CLINIC DESIGN

The Site Plan



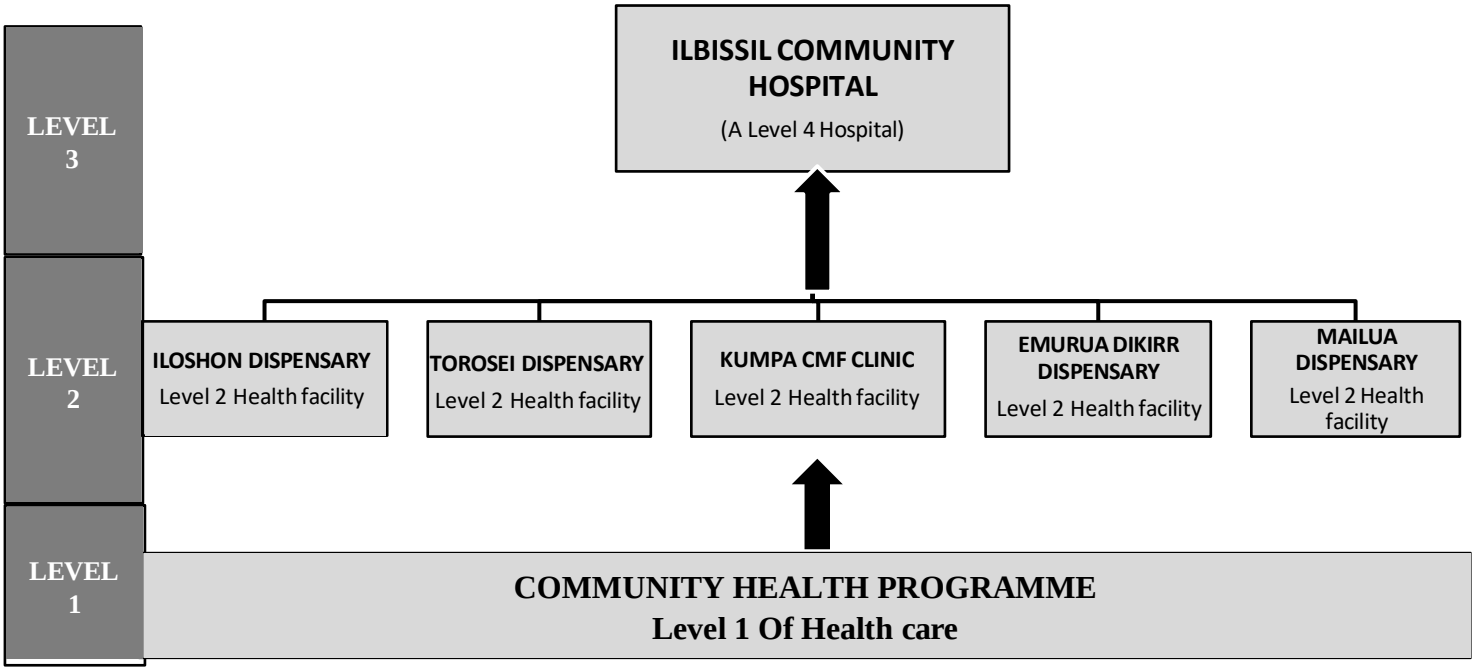


Staff Housing 91 m 2

CLINIC FLOOR PLAN

WOODS' ROOTS OF HEALTH

THE PROPOSED KAJIADO HEALTH SYSTEM MODEL.



ILBISSIL COMMUNITY HOSPITAL START UP COST

START - UP BUDGET (CAPITAL EXPENDITURE) - PHASE 1

Item description	Unit	No. of units	Unit cost (USD)	Frequency	Total Est. Cost (USD)
Facility Land	Acre	10	15,000	1	150,000
Landscaping, fencing (Chainlink fence) & planning	Perimeter fence	1	35,000	1	35,000
Phase 1 construction (Hospital)	Phase 1 - Architect's BoQ	1	715,000	1	715,000
Phase 1 construction (Guest houses)	Phase 1 - Architect's BoQ	1	420,000	1	420,000
Phase 1 construction (General, Staff Houses)	Phase 1 - Architect's BoQ	1	420,000	1	420,000
Fully installed HMIS (EMR & Accounting)	System	1	17,000	1	17,000
Computers, servers, printers, TVs & accessories	Equipment	1	16,500	1	16,500
Intercom (Phones & infrastructure)	Intercom system	1	2,100	1	2,100
Storage hardware (Bins, office cabinets & drawers)	Equipment	1	6,000	1	6,000
Ultrasound machine	Machine	1	15,000	1	15,000
X-RAY Machine	Machine	1	55,000	1	55,000
Medical equipment (theater)	Equipment	1	125,000	1	125,000
Endoscopy/Laparascopy set	Equipment	1	250,000	1	250,000
Medical equipment (Laboratory)	Equipment	1	65,000	1	65,000
Medical Machines (Dental unit)	Equipment	1	20,500	1	20,500
Medical equipment (Clinics)	Equipment	1	11,000	1	11,000
Furniture (Clinics and offices)	Furniture	1	16,700	1	16,700
Stadby Generator (50kva) HL Power	Equipment	1	15,000	1	15,000
Water systems (Borehole and/or rainwater harvesting)	Water system	1	120,000	1	120,000
Website development		1	3,500	1	3,500
4WD Landcruiser		1	95,000	1	95,000
Ambulance Vehicle		1	90,000	1	90,000
Sub-Total (USD)			**2,528,300**		**2,663,300**
Miscellaneous and contingency provisions @ 15%					399,495.00
Grand Total (USD)					**3,062,795**
Grand Total (Ksh.)					**367,535,400.00**

ILOSHON DISPENSARY START UP COST

START - UP BUDGET (CAPITAL EXPENDITURE)

Item description	Unit	No. of units	Unit cost (in USD)	Frequency	Total Est. Cost (USD)
Facility Land	Acre	2	7,500	1	15,000
Landscaping, fencing (Chainlink fence) & planning	Perimeter fence	1	8,000	1	8,000
Construction (Dispensary)	Architect's BoQ	1	50,000	1	50,000
Staff house	Architect's BoQ	1	34,000	1	34,000
Water systems (including borehole, rainwater harvesting)	Water system	1	45,000	1	45,000
Fully installed HMIS (EMR & Accountiung)	System	0	-	-	-
Computers, servers, printers, TVs & accessories	Equipment	1	1,500	1	1,500
Intercom (Phones & infrastructure)	Intercom system	1	200	1	200
Storage hardware (Bins, office cabinets & drawers)	Equipment	1	1,500	1	1,500
Medical equipment (Laboratory)	Equipment	1	4,500	1	4,500
Medical equipment (Clinic)	Equipment	1	3,500	1	3,500
Furniture	Furniture	1	600	1	600
Solar System (Power backup)	Equipment	1	4,000	1	4,000
Sub-Total			**15,800**		**167,800**
Miscellaneous and provisions @ 15%					25,170
Grand Total (USD)					**192,970**
Grand Total (Ksh)					**23,156,400.00**

MAILUA DISPENSARY START UP COST

START - UP BUDGET (CAPITAL EXPENDITURE)

Item description	Unit	No. of units	Unit cost (in USD)	Frequency	Total Est. Cost (Ksh)
Facility Land	Acre	2	9,500	1	19,000
Landscaping, fencing (Chainlink fence) & planning	Perimeter fence	1	8,000	1	8,000
Construction (Dispensary)	Architect's BoQ	1	50,000	1	50,000
Staff house	Architect's BoQ	1	34,000	1	34,000
Water systems (including borehole, rainwater harvesting)	Water system	1	45,000	1	45,000
Fully installed HMIS (EMR & Accountiung)	System	0	-	-	-
Computers, servers, printers, TVs & accessories	Equipment	1	1,500	1	1,500
Intercom (Phones & infrastructure)	Intercom system	1	200	1	200
Storage hardware (Bins, office cabinets & drawers)	Equipment	1	1,500	1	1,500
Medical equipment (Laboratory)	Equipment	1	4,500	1	4,500
Medical equipment (Clinic)	Equipment	1	3,500	1	3,500
Furniture	Furniture	1	600	1	600
Solar System (Power backup)	Equipment	1	4,000	1	4,000
Sub-Total					**171,800**
Miscellaneous and provisions @ 15%					25,770
Grand Total (USD)					**197,570**
Grand Total (Ksh)					**23,708,400.00**

TOROSEI DISPENSARY START UP COST

START - UP BUDGET (CAPITAL EXPENDITURE)

Item description	Unit	No. of units	Unit cost (in USD)	Frequency	Total Est. Cost (USD)
Facility Land	Acre	2	7,500	1	15,000
Landscaping, fencing (Chainlink fence) & planning	Perimeter fence	1	8,000	1	8,000
Construction (Dispensary)	Architect's BoQ	1	50,000	1	50,000
Staff house	Architect's BoQ	1	35,000	1	35,000
Water systems (including borehole, rainwater harvesting)	Water system	1	45,000	1	45,000
Fully installed HMIS (EMR & Accountiung)	System	0	-	-	-
Computers, servers, printers, TVs & accessories	Equipment	1	1,500	1	1,500
Intercom (Phones & infrastructure)	Intercom system	1	200	1	200
Storage hardware (Bins, office cabinets & drawers)	Equipment	1	1,500	1	1,500
Medical equipment (Laboratory)	Equipment	1	4,500	1	4,500
Medical equipment (Clinic)	Equipment	1	3,500	1	3,500
Furniture	Furniture	1	600	1	600
Solar System (Power backup)	Equipment	1	4,000	1	4,000
Sub-Total					**168,800**
Miscellaneous and provisions @ 15%					25,320
Grand Total (USD)					**194,120**
Grand Total (Ksh)					**23,294,400.00**

KUMPA CMF CLINIC

START - UP BUDGET (CAPITAL EXPENDITURE)

Item description	Unit	No. of units	Unit cost (in USD)	Frequency	Total Est. Cost
Facility Land	Acre	0	-	1	-
Land fencing (Chainlink fence)	Perimeter fence	1	3,500	1	3,500
Renovation + latrine construction (Dispensary)	Architect's BoQ	1	6,000	1	6,000
Staff house	Architect's BoQ	1	29,200	1	29,200
Water systems (including borehole, rainwater harvesting)	Water system	1	-	1	-
Fully installed HMIS (EMR & Accountiung)	System	0	-	-	-
Computers, servers, printers, TVs & accessories	Equipment	1	1,000	1	1,000
Intercom (Phones & infrastructure)	Intercom system	1	150	1	150
Storage hardware (Bins, office cabinets & drawers)	Equipment	1	600	1	600
Medical equipment (Laboratory)	Equipment	1	1,200	1	1,200
Medical equipment (Clinic)	Equipment	1	700	1	700
Furniture	Furniture	1	-	1	-
Solar System (Power backup)	Equipment	1	-	1	-
Sub-Total			**-**		**42,350**
Miscellaneous and provisions @ 15%					6,353
Grand Total (USD)					**48,703**
Grand Total (Ksh)					**5,844,300.00**

EMURUA DIKIRR DISPENSARY

START - UP BUDGET (CAPITAL EXPENDITURE)

Item description	Unit	No. of units	Unit cost (in USD)	Frequency	Total Est. Cost (USD)
Facility Land	Acre	0	-	1	-
Land fencing (Chainlink fence)	Perimeter fence	1	3,500	1	3,500
Construction (Dispensary)	Architect's BoQ	1	-	1	-
Staff house	Architect's BoQ	1	25,000	1	25,000
Water systems (including borehole, rainwater harvesting)	Water system	1	35,000	1	35,000
Fully installed HMIS (EMR & Accountiung)	System	0	-	-	-
Computers, servers, printers, TVs & accessories	Equipment	1	1,000	1	1,000
Intercom (Phones & infrastructure)	Intercom system	1	150	1	150
Storage hardware (Bins, office cabinets & drawers)	Equipment	1	600	1	600
Medical equipment (Laboratory)	Equipment	1	1,200	1	1,200
Medical equipment (Clinic)	Equipment	1	700	1	700
Furniture	Furniture	1	600	1	600
Solar System (Power backup)	Equipment	1	2,000	1	2,000
Sub-Total					**69,750**
Miscellaneous and provisions @ 15%					10,463
Grand Total (USD)					**80,213**
Grand Total (Ksh)					**9,625,500.00**

WOODS' ROOTS OF HEALTH

KAJIADO HEALTH SYSTEM PROPOSAL

5 YEAR BUDGET SUMMARY (In USD)

		COMMUNITY OUTREACH PROGRAMME	KUMPA CMF CLINIC	ILOSHON DISPENSARY	TOROSEI DISPENSARY	MAILUA DISPENSARY	EMURUA DIKIRR DISPENSARY	ILBISSIL COMMUNITY HOSPITAL	TOTAL	BALANCE BROUGHT FORWARD	ANNUAL FUNDING NEEDED
	START- UP COST	**266,310**	**48,128**	**192,970**	**194,120**	**197,570**	**80,213**	**3,062,795**	**4,042,105**	**-**	**$ 4,042,105**
YEAR 1	OPERATIONAL COST	-	5,264.88	31,881.49	32,067.44	32,067.44	4,381.64	962,374.57	**1,068,037.46**	-	
	REVENUE		8,590.90	57,497.65	54,441.74	62,774.91	5,154.54	1,105,771.18	**1,294,230.92**		**$ 1,068,037**
	PROFIT	-	3,326.02	25,616.16	22,374.30	30,707.47	772.90	143,396.62	**226,193.46**	-	
YEAR 2	OPERATIONAL COST	199,148.90	5,726.86	34,746.99	34,949.66	34,949.66	4,389.31	1,048,872.56	**1,362,783.93**	**1,294,230.92**	
	REVENUE		9,231.76	61,786.82	58,502.95	67,457.75	5,539.05	1,214,635.21	**1,417,153.55**		**$ 68,553**
	PROFIT	- 199,148.90	3,504.90	27,039.83	23,553.29	32,508.10	1,149.74	165,762.66	**54,369.61**		
YEAR 3	OPERATIONAL COST	212,872.75	6,229.38	37,870.04	38,090.92	38,090.92	4,395.08	1,143,144.96	**1,480,694.05**	**1,417,153.55**	
	REVENUE		10,242.55	68,551.96	64,908.53	74,843.81	6,145.53	1,347,627.55	**1,572,319.93**		**$ 63,541**
	PROFIT	- 212,872.75	4,013.17	30,681.92	26,817.61	36,752.89	1,750.46	204,482.58	**91,625.88**		
YEAR 4	OPERATIONAL COST	227,542.34	6,776.00	41,273.79	41,514.53	41,514.53	4,403.05	1,245,890.55	**1,608,914.78**	**1,572,319.93**	
	REVENUE		11,814.84	79,075.03	74,872.32	86,332.71	7,088.90	1,554,495.19	**1,813,679.00**		**$ 36,595**
	PROFIT	- 227,542.34	5,038.84	37,801.24	33,357.79	44,818.19	2,685.85	308,604.64	**204,764.22**		
YEAR 5	OPERATIONAL COST	243,222.85	7,370.58	44,983.46	45,245.84	45,245.84	4,413.24	1,357,870.89	**1,748,352.70**	**1,813,679.00**	
	REVENUE		14,163.79	94,796.23	89,757.97	103,496.85	8,498.27	1,863,550.30	**2,174,263.42**		
	PROFIT	- 243,222.85	6,793.22	49,812.77	44,512.13	58,251.01	4,085.03	505,679.41	**425,910.72**		
TOTAL	**OPERATIONAL COST**	**882,786.84**	**31,367.69**	**190,755.76**	**191,868.40**	**191,868.40**	**21,982.32**	**5,758,153.53**	**7,268,782.93**		
	REVENUE		**54,043.84**	**361,707.68**	**342,483.52**	**394,906.04**	**32,426.30**	**7,086,079.44**	**8,271,646.81**	**2,239,589.71**	**$ 5,278,831**
	PROFIT	**- 882,786.84**	**22,676.15**	**170,951.92**	**150,615.12**	**203,037.64**	**10,443.98**	**1,327,925.91**	**1,002,863.89**		

May, 2021 (Revised, February 2024)