POSITION PAPER No 1

What drives the Community Health services in Kenya

Results of a recent mapping exercise of Community Health Units in three regions of Turkana North, Greater Machakos, and Kibera

This position paper highlights the outcome of a recent mapping exercise in Turkana, Machakos and Kibera. Insights from this study indicate that communities have embraced the Community Health Strategy and its contribution to improved health status. CHWs have developed innovative ways to conduct referrals by using locally available means of transport, mobile phones and formation of referral networks. Although majority of CHWs receive support supervision, this support is not regular and does not reach all CHWs. CHWs in Turkana face additional challenges due to poor infrastructure, the harsh climatic conditions, insecurity, and cultural inhibitions. In some cases, transfers of DHMT members involved in the implementation of the community strategy resulted in lack of continuity.

CSOs should advocate for concerted effort to address these challenges through additional resources to support CHWs work, systematic and coordinated training of the CHWs, CHEWs, and CHCs across the country. A revision of the population norms for CHWs should be prioritized and solutions developed to address the diversity of challenges unique to each region.

The Community Health Strategy

The Kenya Essential Package for Health (KEPH) introduced six life-cycle cohorts1 and six service delivery levels. One of its key innovations is the recognition and introduction of level 1 service, which aimed at empowering Kenyan households and communities to take charge of improving primary health care their own health. This commitment is contained in a documented entitled "***Taking the Essential Package for Health to the Community, a strategy for the delivery of level one services"***. Popularly referred to as the Community Health Strategy or Community Strategy, the document laid out a comprehensive mechanism for initiation and implementation of life-cycle focused health action at level 1. This is based on four strategic objectives;

i. Provide level 1 services for all cohorts and socioeconomic groups, including the "differently-abled", taking into account their needs and priorities.
ii. Build the capacity of the CHEWs and CHWs to provide services at level
iii. Strengthen health facility–community linkages through effective decentralization and partnership for the implementation of level 1 Services
iv. Strengthen the community to progressively realize their rights for accessible and quality care and to seek accountability from facility-based health services.

The Community Strategy set an ambitious target of reaching 16 million Kenyans (3.2 million households) by 2009 which is yet to be achieved. The Strategy introduced the community-based approach as the mechanism through which households and communities take an active role in health and health-related development issues. The primary approach was to establish Community Health Units (CUs) to serve a local population of 5,000 people, enlisting Community Health Workers (CHWs) who each are directly responsible for delivery of services to the communities, Community Health Extension Workers (CHEWs) were also recruited to coordinate the work of CHWs and link them to health facilities. CHWs would be recruited and managed by the Community Health Committee (CHC).

The approach intends to build the capacity of communities to assess, analyze, plan, implement and manage health and health related development issues, so as to enable them to contribute effectively to the country's socio-economic development. The second major intended impact of the approach is that the communities will thereby be empowered

to demand their rights and seek accountability from the formal system for the efficiency and effectiveness of health and other services.

This Position Paper summarizes the outcome of a recent study initiative to map community units in Turkana North, Greater Machakos, and Kibera. Specifically, the Study sought to: develop an inventory of community units in the three regions and provide a description of their current status; prepare an overview of performance of the community units based on rapid feedback and observations; document successes, best practices, challenges, and recommendations to address the same.

The Mapping Approach

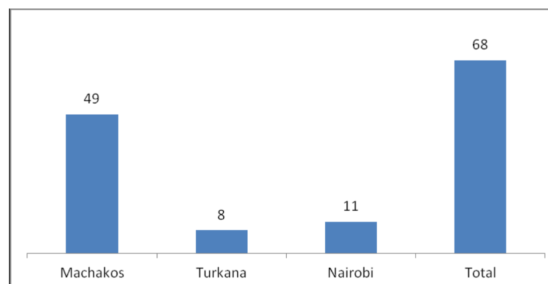
The study adopted a cross-sectional design. Stratified sampling was used in the selection of 67 community units. Probability proportionate to size sampling procedure was applied to determine the respondents based on number of CUs in each of the selected districts. A desk review of various program specific and related documents was conducted. Quantitative data was collected using a community unit inventory checklist, while qualitative data was generated from Focus Group Discussions and Key Informant Interviews.

Findings

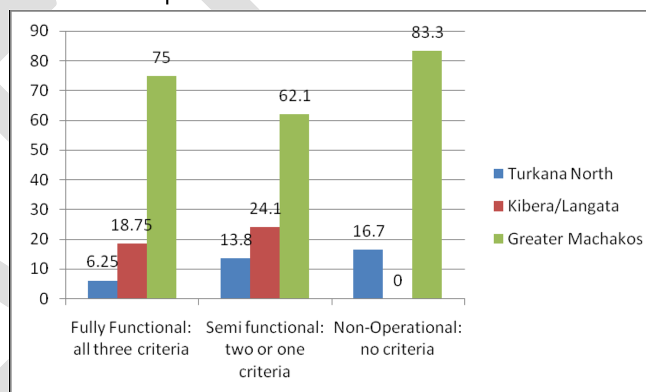
A total of 68 community units were assessed from the inventory of 68 units and the study revealed a number of findings.

***Individual characteristics*;** Majority of community health workers and CHEWs are males compared to females. Similarly, majority of CHWs have fair education levels having attained at least secondary level of education. Socio-demographic characteristics such as age, gender and education level were found to affect the work of CHWs. For instance, older CHWs are more likely to remain in their jobs compared to the younger ones would leave when they get more promising careers. In addition, the higher the level of education of the CHWs the more likely they are to perform better, with women being more dedicated as a result of gender roles in the communities.

***Coverage and distribution of CUs*;** Turkana had the lowest number of 8 units (11.8%), followed by Kibera with 11 units (16.2%) compared to Machakos with 49 units (72%).



***Functionality of community units*;** Overall, only 28% of established community units were functional.. Majority of the CUs are either semi functional or non-functional, meaning that they only perform limited tasks that a CU should perform or do not perform any at all. This situation is worse in Turkana and Kibera where less than 20% of the CUs are fully functional compared to Machakos with 75%.



Registration of households varied across the units with 30.6% of units having registered 1000 households. The rest had registered within varying ranges of 50-999 and 1007-1056.

Training and development; The average number of Community Health Workers trained per unit was 50 with 65.5% of the units having 50 fully trained CHWs. The range was however too wide, between 12 – 100. Fourteen percent of the units did not have any CHC trained. This was more in Turkana and Machakos where 40% and 13% of units do not have trained CHC respectively.

Table 2: Fully Trained CHWs

Number of CHW's fully trained/unit	Kibera n=9	Machakos n=43	Turkana n=5	Total n=57
≤20	0	2.3	60	7
21 - 49	44.4	7	40	15.8
50	0	86	0	64.9
51- 99	22.2	4.7	0	7
≥100	33.3	0	0	5.3
Total	**100**	**100**	**100**	**100**

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About half of established CUs (51.9%) have only one trained CHEW as opposed to the recommended number of two. The situation is worse in Turkana where 20% of units do not have a trained CHEW at all.

Selection and Roles of Community Health Workers ; The Study revealed that Community health workers (CHWs) I n these regions are mostly selected by the community, voted by the community or interested members of the community volunteer to be CHWs during a public *baraza.* The Selection is done in a way that ensures every village or plot is represented by a CHW. The selected CHW should be a role model in the community, young, capable of doing the work of a CHW and available to do the work of a CHW. However, in addition to the foregoing in areas such as Turkana, a person with wide experience and one who is familiar with national issues is strongly preferred and recommended.

The study therefore sought to establish the roles of the community health workers in the 3 areas. This was compared with the roles as stated in the CHS guidelines. From the FGDs, key roles for CHWs included;

- Maintaining personal and environmental cleanliness and hygiene by using latrines and leaky tins, clearing bushes, opening up clogged trenches
- Educating the community members on reproductive health and safe motherhood for example the importance of pregnant women making four ANC visits and hospital delivery
- Educating and sensitizing people on diseases such as HIV and TB
- Promoting good health seeking behavior for example encouraging the sick to go to the hospital
- Promoting health rights in the community by making sure that the disabled children are not hidden in the home but instead given requisite support and care. Disease prevention practices such as drinking treated water, sleeping under ITNs, immunization of under-fives, cancer screening, HTC, good nutrition
- Emphasizing on behavioral change for the youth through behavior change communication
- Provision of home based care to the chronically ill members of the community and educating family members on how to take care of them.
- Referrals for malnourished under-fives, pregnant women and the severely to health facilities for care
- Defaulter tracing for immunization, TB and ART

Community Health Workers face a number of challenges related to their work conditions and facilitation such as; lack of kits, data tools, incentives, identification such as badges. Almost all the CHWs (98.5%) do not receive monthly stipends.

Lessons Learnt

- Participation of community members in strengthening health systems elicits grass root acceptance, support and a sense of ownership. This resulted in increased demand for health services at level 1 thereby improving health of the target population.
- Active supervision and linkages forged between DHMT, CHEWs, CHWs, and CHC is key to the programme's sustainability.
- Creating community demand for health services must be matched with the availability of improved services within health facilities. A comprehensive, integrated approach to a multidimensional health program helps ensure that communities ultimately access the services they need.
- Volunteerism and lack of a clear career progression

Policy and Program Recommendations

1. Advocate for the review of the CHW:population norms to reflect the diverse community contexts across Kenya
2. Adapt and formally roll out standards for measuring CU functionality to facilitate tracking of their performance/functionality
3. Develop model community units to act as centers of excellence and learning across the country
4. Strengthen Community Based Health Management Information System and link it to the national HMIS to improve information flow and evidence based decision making
5. Build on innovations such as m-health to improve referrals and information management at level one
6. Develop and implement sustainability initiatives and motivation schemes for CHWs

Conclusions

Findings from the mapping point to glaring gaps in the implementation of the community strategy with noticeable disparities across the three regions. In spite of this, communities appreciate the community strategy and its contribution to improved health status. Insights from this study reveal a number of lessons learnt and best practices

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that can be used to improve implementation of the community strategy in different settings. These findings should be used to strengthen HRH systems at the community level in the proposed county governments.

Reviewers

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About the HRH Advocacy Project

The Human Resources for Health (HRH) Advocacy project was funded by the European Union through World Vision Austria, and implemented by World Vision Kenya (WVK), the Kenya Health NGOs Network (HENNET) and African Medical and Research Foundation (AMREF) in Kenya. The Project seeks to enhance access to primary healthcare countrywide through advocacy for increased human resources for health (HRH) and effective community level demand side accountability from primary health delivery institutions.

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