Context analysis for the performance and sustainability of the community health strategy in Kenya: home based counselling and testing

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BACKGROUND

Kenya has a national policy known as the Community Health Strategy (MOH 2006) is based on use of volunteers referred to as community health workers (CHWs) linked to primary health facilities through Community Health Extension Workers (CHEWs). The program has been implemented with varying degrees of success in implementation of primary health services by government as well as vertical programs run by non-governmental organizations (NGOs). 'REACHOUT: Reaching out and linking in health systems and close-to-community services' is a five year multi country EU funded project whose aim is to maximize the equity, effectiveness, and efficiency of close-to-community services in rural areas and urban slums in six countries: Mozambique, Indonesia, Kenya, Malawi, Bangladesh, and Ethiopia. This study represents the first phase of REACHOUT aimed at identifying contextual factors that influence the performance of CTC (close-to-community) providers and CTC services in Kenya.

STUDY AIM AND OBJECTIVES

This study represents the first phase of REACHOUT in which LVCT will be collecting key data that will be used to develop a framework for improvement of CTC services across the 6 countries that can be adapted for use in Kenya with regards to home-based testing and counselling (HBTC). The specific objectives are to:

1. To identify evidence for interventions which have an impact on the contribution of CTC providers to the delivery of effective, efficient and equitable care
2. To map the types of CTC providers
3. To assess structures and policies of the health system for strengths and weaknesses regarding organization of CTC services and management of CTC providers
4. To identify and assess contextual factors and conditions that form barriers or facilitators to the performance of CTC providers and services

To synthesize evidence on key barriers and facilitators to be built on in future CTC interventions and identify knowledge gaps to be filled regarding CTC services

STUDY DESIGN, METHODS AND SAMPLE

The study was conducted through a desk review, stakeholders mapping and a qualitative study. Stakeholder mapping was done through consultations while the desk review included journal articles, policy documents, grey literature, and programme reports. We purposefully selected 179 participants and conducted 10 Focus Group Discussions and 40 In-Depth Interviews for the qualitative study. The Qualitative study took a descriptive exploratory design. Digitally recorded data was transcribed and translated where applicable. Data was coded and analyzed using Nvivo10.

FINDINGS

The Kenya Community Health Strategy - policy vs. practice: The Community Health Strategy policy was being used during implementation but with variations in the number of providers, training offered, data collection tools and supervision mechanisms. The facility managers and DHMT members who were not directly involved with the CTC providers did not have adequate knowledge on the guidelines and were not aware of the ongoing review.

Community Engagement and expectations: The community was involved in recruitment and selection of the volunteer CHWs, but not CHEWs. The dialogue and action days where community's feedback was expected were not always carried out. The community was not adequately aware of their role and that of others in the CHS which hampered their ongoing support. Community members expected curative services and supplies from CHWs which were not available resulting in community and CTC provider frustrations.

Supervision: We found that the supervisors at community level did not have clear guidelines with inconsistency in the methods and frequency of supervision. The challenges in supervision included inadequate transport provision, high supervisor workload, and inadequate training on supervision.

Integration of HIV in CHS: There was support for a training CTC provider to provide Home Based Testing and Counselling (HBTC) services to the community. Challenges identified included CHEWs lack of training in HBTC, inadequate test kits and possible community rejection due to stigma and fear of confidentiality breech by CTC providers.

Incentives: Though there was a policy on CHW stipend, the volunteer CHWs received minimal monetary incentives or none at all and were sometimes forced to use their own resources. Non-monetary incentives included community recognition and positive change in the health of community.

Workload: CHEWs played a double role and often the facility based responsibilities were prioritised over community work. The CHWs workload was not clearly defined and practice differed from one unit to another.

Referral: CTC programs resulted in higher utilization of some facility based services. The community expected transport to the link facility and preferential treatment on arrival. The referral process was hampered by long distances to health facilities, lack of transport and inadequate supplies or services at the link facility.

LESSONS LEARNT

Our study identified three key areas as gaps in CTC service provision for which we aim to pilot interventions through two quality improvement cycles within the scope of REACHOUT. These key areas include: Promotion of community engagement component; Strengthening supervision and quality assurance; and Integration of HIV in the community strategy through inclusion of HBTC.

CONCLUSION

It is evident that CTC providers are well accepted and play an important role in health service provision. CTC providers' capacity should be built and supplies offered to provide additional preventive, basic curative services and simple rapid diagnostic tests such as malaria and HIV. Referral systems should be strengthened by addressing challenges such as availability of services, supplies and transport. CHWs and CHEWs were willing to be trained on delivery of HBTC thereby ensuring universal access of HIV services through the strategy. Training and

quality assurance of providers and community education on confidentiality, can help to address HIV/AIDS stigma.

Standardized training of supervisors accompanied by harmonized guidelines and standard operating procedures should be provided as part of a broader quality assurance package for community strategy. CHEWs workload should be eased by avoiding working in both health facility and community. Non-material incentives should be identified and strengthened to motivate CTC providers and reduce attrition. Income generating activities should be encouraged for CHWs.