Close-to-community health care service providers in Kenya

"Community health workers are accepted and appreciated by both health workers and the community."

INTRODUCTION

Kenya's Ministry of Health has a national policy known as the Community Health Strategy, which aims to reform primary health care at the community level. The strategy is based on using volunteers - known as Community Health Workers (CHWs) - linked to primary health facilities through Community Health Extension Workers (CHEWs). The programme has been implemented with varying degrees of success in government-run primary health services and non-governmental organization (NGO)-run vertical programmes. The government is currently reviewing this strategy, and wants to increase the number of CHEWs and decrease the number of CHWs, and revise their roles and responsibilities. This will address some of the identified shortcomings of the current strategy and align it with successful models in other countries.

This research brief presents information from the first phase of REACHOUT (see page 2), which identifies contextual factors that influence the performance of CHWs and CHEWs in Kenya. The results will inform the implementation of two improvement cycles to test interventions.

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KEY MESSAGES

- Evidence shows that CTC providers are well accepted and play an important role in health service provision at community level.
- Community engagement can help to close the gap that currently exists between policy and practice. Community users and beneficiaries should be involved in the development and dissemination of the new Community Health Strategy.
- Supervision and quality assurance is generally lacking and should be developed through training packages, supervision guidelines and tools.
- Referral systems should be strengthened by addressing health systems challenges such as the quality and availability of services, supplies in the facilities and transport through ambulances or other locally available options.
- CHWs and CHEWs are willing and should be trained to deliver Home-Based Testing and Counselling, thereby ensuring the integration of HIV services in the new strategy.

ABOUT COMMUNITY HEALTH WORKERS

In the 1970s, countries invested in Community Health Workers (CHWs) who received basic training and were often volunteers. Programmes involving CHWs went into decline due in part to political instability, economic policies and difficulties in financing. However, there is renewed interest in strengthening community-level services, using a variety of close-to-community (CTC) providers.

ABOUT REACHOUT

REACHOUT (Reaching out and linking in: health systems and close-to-community services) is a five-year multi-country project consortium. It aims to maximize the equity, effectiveness and efficiency of CTC services in rural areas and urban slums in six countries - Bangladesh, Ethiopia, Indonesia, Kenya, Malawi and Mozambique - with support from its European partners in the Netherlands and UK.

A CTC provider is a health worker who carries out health promotion, prevention and curative services and who is the first point of contact for the community. A CTC provider can be based in the community or in a primary facility with a minimum level of para-professional training (two to three years). The performance of CTC providers can be influenced by broad factors such as community and political contexts, health systems (financial model, logistics and supplies) and the design of interventions, such as incentives and supervision. The main focus of REACHOUT concerns formal community health workers, but their interaction with other less formal CTC providers such as expert patient volunteers, informal private practitioners, lay counselors and health promoters is also important.

REACHOUT consists of three phases: conducting a context analysis through desk review and qualitative studies to identify contextual factors that influence the performance of CTC providers and CTC services; implementing two improvement cycles to test interventions for improving CTC performance and their contribution to CTC services; and further interventions to improve performance.

As part of REACHOUT, a context study was conducted in two Kenyan sites in Nairobi and Kitui from August to September 2013.

SYNTHESIS OF LEARNING

METHODS

The methods for the context analysis were a desk review, stakeholder mapping and qualitative study. The desk review looked at secondary data on programmes that involve CTC providers in Kenya. Researchers reviewed journal articles, policy documents, grey literature, programme reports and stakeholder consultations with partners and the Division of Community Health Services (DCHS). The stakeholder mapping identified stakeholders in community health programmes through consultation with LVCT Health, a Kenyan NGO and other local partners and NGOs. The country advisory group members and the DCHS also contributed.

The qualitative study adopted a descriptive exploratory design. The sites in Nairobi and Kitui were selected because of the presence of functional community units and LVCT Health's history of working with them on the provision of home-based HIV testing and counselling. Qualitative study participants were involved in or linked with the Community Health Strategy at various levels including service users and service providers - CHWs, CHEWs, and home-based testing and counselling services (HBTC) – and health managers and policymakers at the national level. Researchers collected data using focus group discussions, semi-structured interviews and semi-structured questionnaires.

MAIN FINDINGS

CHWs were accepted and appreciated by the health workers and communities. Community members reported that providers linked them to health services and that communities had adopted healthy practices. However, there was some variation from the policy in the areas of training, supervision and incentives.

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Policy versus practice

- The Community Health Strategy was the national policy, but during implementation there were variations in the number of CHWs used, training offered, the way that data was collected, and supervision mechanisms.
- CTC services were mainly in the area of maternal and child health, water and sanitation and vertical programmes focused on HIV and tuberculosis.
- The facility managers and District Health Management Team (DHMT) members who were not directly involved with CTC providers did not have adequate knowledge about the guidelines and were not aware of the ongoing review.

Community engagement and expectations

- The study found that the community was involved in the recruitment and selection of volunteer CHWs, but not CHEWs.
- The 'dialogue and action' days for the community to give feedback were not always carried out and were dependent on partner NGO support.
- The community was not adequately aware of its role or that of others in the Community Health Strategy, which hampered its ongoing support and participation.
- Community members expected curative services and supplies such as bed nets from CHWs, which were not available. This resulted in frustrations among communities and CTC providers.

Supervision

- Supervisors at community level did not have clear guidelines, and there was inconsistency in the methods and frequency of supervision. They faced challenges of inadequate transport provision, a heavy workload and inadequate training.

Integration of HIV in the Community Health Strategy

- Support existed at all levels for a trained CTC provider supporting HBTC services to the community. But there was a lack of training for CHEWs in HBTC, inadequate test kits and possibly community rejection due to stigma and a fear about lack of confidentiality by CTC providers.

Incentives

- The volunteer CHWs received minimal monetary incentives, despite the existence of a policy on stipends. Sometimes they were forced to use their own resources to subsidize services.
- Non-monetary incentives included community recognition and positive changes in the health of the community.
- The lack of financial rewards was a major disincentive for volunteer CTC providers and was perceived as having led to a gradual reduction in the workforce (attrition).

Workload

- CHEWs played a double role and often prioritized facility-based responsibilities over community work.
- The CHWs' workload was not clearly defined and practice differed from one unit to another. The small number of CTC providers, attrition, and multiple workloads from vertical programmes contributed to a heavy workload for the CHWs.

Referral

- CTC programmes resulted in higher use of some facility-based programmes, as CTC providers were involved in client referral.
- The referral process was hampered by long distances to the health facility, a lack of transport and inadequate supplies or services at the link facility.
- The community expected transport to the link facility and preferential treatment on arrival.

ANALYSIS OF THE FINDINGS

Evidence shows that CTC providers are well accepted and play an important role in health service provision at community level. The findings demonstrate that involvement of users and beneficiaries in the development and dissemination of policy helps to close the gap between policy and practice that will be vital in review of the Community Health Strategy. Consideration of Community engagement and increased community participation during programme design and implementation and its inclusion in CHW and CHEW training may result in improved recruitment, improved ways to mobilize material and non-material resources in the community to assist implementation and increased community support beyond recruitment.

Building CTC providers' capacity and providing required supplies can enable provision of preventive, basic curative services and simple rapid diagnostic tests such as malaria and HIV alongside current services. Referral systems can be strengthened by addressing health systems challenges such as the quality and availability of services, supplies in the facilities and transport through ambulances or other locally available options. CHWs and CHEWs were willing and can be trained to deliver HBTC,

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thereby ensuring the integration of HIV services in the strategy. Training and quality assurance of providers and community education on confidentiality have been shown to help to address HIV/AIDS stigma in HIV programmes.

To ensure quality, the community health strategy requires a quality assurance package consisting of standardized training of supervisors and community health committee members, harmonized guidelines and standard operating procedures and tools for supervision. This can also help to reduce multiple reporting lines that create confusion during the strategy implementation. Lessons can be drawn from the HIV testing and counselling programme, which has a national quality assurance component.

The double role played by CHEWs' may reduce efficiency. The community strategy policy needs to define the role and placement of CHEWs to minimize this. A possible suggestion would be to systematically calculate the workload considering the package of care to be offered and the population and geographical area to be covered. On the other hand, it emerged from the study that the personal family responsibilities of voluntary CHWs are an important consideration when determining the CHW workload.

The results demonstrated that non-material incentives motivate CTC providers and reduce attrition. The policy and implementation needs to encourage identification and scaling up of both non-financial and financial incentives that are realistic and based on what the government or communities can afford

to sustain. The financial incentives to be scaled up include income-generating activities that allow CHWs to earn a stipend. Policy guidance on incentives should avoid being prescriptive, to allow communities to develop practical suggestions.

RECOMMENDATIONS FOR IMPROVING INTERVENTIONS

The study identified main three areas where improvements to CTC service provision can be made. Two REACHOUT quality improvement interventions will focus on these areas, and pilot interventions. These areas include:

- **Strengthening supervision and quality assurance through the development of training packages, supervision guidelines and tools**
- **Promoting community engagement; this is especially critical for gaining community support for the upcoming revised Community Health Strategy**
- **Integrating HIV in the new strategy through the inclusion of HMTC training within the CHEW training and the implementation of quality assurance mechanisms.**

FULL PAPER

Mireku M., Kiruki M., McCollum R., Taegtmeyer M., de Koning K. and Lilian Otiso (2014) Context analysis: Close-to-community health service providers in Kenya, REACHOUT Consortium http://reachoutconsortium.org/media/1837/kenyacontextanalysisjul-2014compressed.pdf

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