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# THE STATUS QUO OF COMMUNITY BASED HEALTH CARE PROGRAMMES IN KENYA:

## A Report of A Study Review

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## INTRODUCTION:

This report delineates the results of a study review of existing Community Based Health Care programmes in the Republic of Kenya. The review was carried out between July and September of 1980, and was facilitated by the generous support and cooperation of Dr. Roy Shaffer of the African Medical Research Foundation's (AMREF) Community Health Worker Support Unit.[1] Within the allotted time period, I reviewed as many CBHC programmes as conditions permitted. Although I managed to construct project profiles on (i) the Ministry of Health / UNICEF supported Community Based Health programme in Kakamega, (ii) the Marakwet Community Health Project at Kapsowar, and (iii) AMREF's Kibwezi Rural Health Scheme,[2] since I did not visit these programmes for the purpose of interviewing their Community Health Workers, they are not reported on in this paper. Other less formalized "community based" programmes, which does not imply that they are ineffective, are not reported on either. A sampling of these programmes might include: (i) Rhamu Service Centre, (ii) AMREF's Mobile II Team at Ngoryika, Masailand, (iii) Life Ministry at Letain Mission Hospital (near Kericho), (iv) Kenya Catholic Secretariat in Membu, (v) the training of traditional birth attendants in appropriate care at the Chulaimbo Rural Health Training Centre, (vi) the CODEL programme in Kitui,[3] and (vii) the Busia District Training Project at Sio Port (Pathfinders). Finally, the proposed CBHC programmes in Kitui[4] and Turkana[5] and the current pilot research programme in Kiambu District are not reviewed here since they have not as yet been implemented.

## METHODOLOGY:

For the remaining programmes -- all of them NGO's and in most cases church related -- the review procedure consisted of:

(1) interviews and discussions with programme administrators and funding agencies,

(2) site visits to the CBHC programme to study the programme in action and to talk to the Community Health Workers, the trainers of the CHWs,

and the supervisors of the CHWs,

(3) writing up the results of the review of each CBHC programme in a project profile, and then having the profile itself cross checked by the supervisors in the field for accuracy of reporting (Cf. Appendix 1), and

(4) condensing the detailed information into the format presented here.

The Community Based Health Care programmes reviewed in this way are:

(1) Nangina Community Health Programme,

(2) Kisii Public Health Aides Programme,

(3) Machakos Village Health Workers Programme,

(4) Maua Health Development Project,

(5) Saradidi Rural Health Development Project,

(6) Chogoria "Health for the Family" Programme.

From the original format of the questionnaire (Cf. Appendix 1) the information was reduced to the outline that follows (Cf. Appendix 2). The above 6 programs are presented in this way.

PROFILES OF COMMUNITY BASED HEALTH CARE PROGRAMMES:

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|---|---|
| Name: Title: | NANGINA COMMUNITY HEALTH PROGRAMME |
| Sponsor: | Kenya Catholic Secretariat |
| Funding Agency: | Misereor |
| District: | Busia |
| Date Started: | 1976 |

OBJECTIVES AND GOALS:

The goals of the Community Health Worker programme are defined as follows:

"(1) To improve the health and nutrition status of the community, particularly of children, pregnant and lactating mothers; and to lower morbidity and mortality rates.

(2) To make available minimal health and nutrition education to the maximum number of people; and services relevant to the community in terms of effectiveness.

(3) To attain better environmental sanitation which is a necessary measure for the prevention, control, and eradication of communicable diseases.

(4) To create a better understanding and to promote good relationships between the hospital and patients from the community.

(5) To make every father and mother a health educator in their own homes."[6]

ORGANIZATION AND MANAGEMENT:

Administrators:

Sr. Dr. Leda Liboon, Mrs. Anne Rajwais (PHA), and Miss Beatrice Nekisa (KCN / FP).

Community Health Committees:

There is no Community Health Committee in the Nangina

CBHC programme, but there are "Christian Community Groups." Of the 47 Christian Community Groups, 44 have selected members for training as Community Health Workers. The CHWs themselves, however, select their own chairman, secretary, and treasurer.

Community Health Workers:

The volunteers themselves elected to be called "Community Health Workers"; the original term of Clan Health Worker seemed too restrictive.

CBHC STAGES OF DEVELOPMENT:

The development of Community Based Health Care in its present form, was prompted by the work being done by the Nutrition Aide Field Workers. This programme which was initiated in 1974 - 1975, trained workers to follow up mothers with malnourished children and to give health and nutrition education talks. Then with the organization of the Christian Community Groups, which were "modelled on the example of the early Christians who were responsible to each other," the members of these groups felt that a natural way of motivating and assisting each other to improve and change their way of life and to relieve the suffering of their neighbors, would be through health education. This suggestion from the hospital resulted in the CCGs selecting volunteers for training at Nangina.

RELATIONSHIPS:

CHW - Christian Community Group:

The Christian Community Group selects from its members persons to be trained as Community Health Workers. Once or twice a month the CCGs sponsor "group home visiting" after which they meet to hear and to record the report of the CHWs who have made the visits. At this bimonthly meeting, to which the local leaders are also invited (the assistant

chief, ligurus -- i.e. headmen and their assistants), they listen to the talks of the CHWs and discuss their problems and difficulties and then ways and means of improvement. The talks given by the CHWs cover topics such as: the dangers of using local medicines, the usefulness of digging latrines, the diseases of cholera, malaria, etc.

CHW - Service Delivery Points:

The CHWs work in close cooperation with the Public Health Aides who are in charge of the MCH clinics at the hospital and the mobile clinics. The CHWs help set up the mobile clinics at the site (for example, by providing chairs for the mobile clinic barazas), and assist with the weighing and recording of children.

CHW - Supervisors of Activities:

The CHWs are supervised by the Public Health Aides (PHAs). The CHW is trained by one of the 5 PHAs and is subsequently supervised in the field by the same person. For example, at the baraza held after the CHWs have carried out the bimonthly or monthly group home visiting, the PHA answers any questions that the CHW is unable to answer. The PHA also receives a copy of the report of the group home visiting.

COMMUNITY HEALTH WORKERS:

Selection:

Community Health Workers are selected by their corresponding Christian Community Group. They must be, and are in most cases, older men or women who are respected as community leaders. There are no specific qualifications specified, except that they must be well motivated to help and teach their community.

Training:

The CHWs are trained for two weeks at Nangina Hospital. In each training session, there are approximately 20

students; there is also a monthly meeting giving input in continuing education, and a refresher course once a year. The training is done using the psycho - social method as posited by Paulo Freire.

In very general terms, the content of the CHW course covers: Basic health and nutrition, hygiene and sanitation, and mother and child care.

Support for Services:

The Community Health Workers are volunteers. They are not paid for their services to community members, but in the traditional context, may be reimbursed with a chicken, eggs, soap, etc.

Job Description:

Activities:

The CHWs assist in the monthly mobile clinics. This activity involves: charting the children on the Road to Health chart, taking blood pressures, measuring the height, and giving brief health education talks.

The CHWs also do home visiting about 2 - 3 afternoons a week. Any home in the area is visited irrespective of religious affiliation. The nature of their work here is along the lines of preventive and promotive health education.

Supplies:

The first group of trainees received a first aid kit containing aspirin, tetracycline ointment, chloroquin, Benzyl Benzoate, Gentian Violet, a delivery kit, and health education charts. Anytime that these drugs are low, the CHWs present themselves to the Pharmacy at Nangina Hospital, on Wednesdays, and their kits are refilled.

Working Place:

The CHWs work out of their own homes. On mobile clinic days, however, they assist there.

Numbers Trained and Population Served:

There have been 77 CHWs trained to date, with 60 remaining as active volunteers. Of those who left, it was for reasons of lack of salary or change of residence.

Each CHW serves approximately 60 - 80 families. Another way of stating this is that for each liguru (headman) responsible for approximately 130 dalas (compounds), there are 2 - 3 CHWs.

There are 44,000 people in Samia Location (according to the latest census), of which approximately 50% are served by the Nangina Community Health Programme.

EVALUATION:

There have been two forms of evaluation: external and internal. The internal evaluation is by the CHWs themselves, and involves simple measurements of changes in the number of latrines built, the numbers of people at the clinics, etc.[7] External evaluations have been done by Sr. Dr. Leda Liboon, Sr. Dr. Janet Gottschalk, Daniel Makuto,[8] and Abdulwahab Makki.[9]

RESULTS:

The CHWs have discovered that more latrines have been built, that there is an improvement in environmental sanitation, and that there are better agricultural methods and more vegetables planted. The Hospital staff have recognized measureable improvements in the goals and objectives as stated.

2.

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|---|---|
| Name: Title: | KISII PUBLIC HEALTH AIDES PROGRAMME |
| Sponsor: | Kenya Catholic Secretariat |
| Funding Agency: | Cebemo, Canada Interchurch, and "home parish" in the UK |
| District: | Kisii, South Nyanza, and Kuria |
| Date Started: | November 1975 |

OBJECTIVES AND GOALS:

Because of the paucity of community health services available in the Diocese, the objective of the programme is to train public health aides (PHAs) to act as a link between the villages and the dispensaries; these PHAs would then reinforce the need for immunization and MCH care through health education and services. Furthermore, the PHAs would reinforce in practise the principle of working more closely with the community, and thereby influence nurses who work out of the dispensaries to be more "community" oriented.

ORGANIZATION AND MANAGEMENT:

Administrators:

Sr. Joan Devane (Project Director)
Sr. Gill E. Horsfield (Trainer and Supervisor)
Miss Benta Asambo (Trainer)

Community Health Committees:

There really are no Community Health Committees who support the activites of the PHAs. Nevertheless, within the Diocese, the various parish councils refer candidates to the Kisii Diocesan Medical Board; i.e., they are responsible for suggesting names of women whom they would like to have trained as Public Health Aides. Often the chief or sub chief assists in the selection / referral process.

Community Health Workers:

The title given this cadre of persons is Public Health Aide (PHA). They are supervised by the trainers (to a limited extent) but primarily by the dispensary nurse to which they are attached.

CBHC STAGES OF DEVELOPMENT:

Using the experience she had gained from working in the Nangina Programme, Sr. Gill E. Horsfield started to train PHAs to run child welfare clinics. From her perspective, this was the only realistic way of starting a community health programme that would provide MCH services to the community. This training programme started in 1975, and to date, there are 51 PHAs working in 21 different health units; 15 of these health units are in Kisii Diocese.

RELATIONSHIPS:

PHA - Parish Council:

There is no functional ongoing relationship between the parish council and the PHA; the parish council merely recommends the name of a candidate that they wish to have trained as a PHA. The final selection, however, is made by Sr. Gill herself.

PHA - Service Delivery Points:

The PHA is attached to a dispensary and responsible to the nurse in charge. In many cases, the PHAs themselves take on the responsibility of running the child welfare clinics out of the respective dispensary. Finally, it is from the dispensary as base that the PHA is required to do home visiting.

PHA - Supervisors of Activities:

The PHAs are supervised on a daily basis by the nurse in charge of the dispensary. Once a year, however, Sr. Gill

visits the PHAs in their own home area and reviews with them the problems and difficulties on the job. Often this involves the difficulties the PHA encounters in their relationship with the nurse in charge; in this case, Sr. Gill discusses and reinforces with the nurse what the PHA has been trained to do. Another forum for supervision is the once yearly seminar that is attended by all the PHAs; at this time they discuss their work, their accomplishments, and difficulties.

PUBLIC HEALTH AIDES:

Selection:

Ideally, the PHAs would be selected by their local community, but in actual fact, only 10% of the aides are chosen in this way. Most of them are either chosen by the nurse at the health unit, by the parish council, or by the chief. In all cases, the trainers make the final selection of candidates from the list of names presented.

Training:

There is a five month training period for the PHAs. Of the total five months, three months is spent in intensive training which includes home visiting and some clinical experience. This is followed by a three week period when the PHAs survey the health problems in their own area, and then by one months experience in which they teach in the schools and organize health seminars in their villages.

In general, the training involves three areas of study:
(1) To teach the PHAs to understand the diseases in their own areas and the ability to explain the causes to the people and to work for change. This includes everything from the building of latrines to the need and importance of immunizations.
(2) The PHAs are taught how to approach people with respect and understanding; in so doing, their advise and help will be made acceptable.

(3) They are also taught how to run and manage antenatal and child welfare clinics.

Support for Services:

The Public Health Aides are paid 305/= Ksh a month for full time work. For the moment, these salaries are paid for by Canada Interchurch Fund for International Development.

Job Description:

Activities:

The Public Health Aides are involved in preventive, promotive and a certain amount of curative care. Generally, the emphasis that any one PHA works on in her community will reflect the particular health needs of the area from which she has been selected. Some of the PHAs are training volunteers to help them.

Supplies:

The Public Health Aides are equipped with these items: 1 jiko, 2 soufouriers, 1 plate, 2 bowls, 1 large cup, 1 small cup, 30 small dishes, 30 plastic spoons, 2 spoons, 1 teaspoon, 1 cooking stick, 1 knife, 1 sieve, 1 dishtowel, 1 handtowel, 1 soapdish, 1 razor blade, 1 piece of material, 1 lifebuoy soap, 1 vaseline, 1 flannelgraph board, flannelgraph pictures, posters, and 2 wash bowls. These items assist the PHAs in the health education and nutrition demonstrations given at the child welfare clinics. During these clinics, there are numerous points of reinforcement of health education ideas: at the weighing and measuring of the child, during the discussions individually with each mother, during the health talks, and at the demonstration meal with vegetables and fruits available in the area.

The centres where the PHAs work from are also supplied with scales, etc., for the child welfare clinics. They are also supplied with teaching aids.

Working Place:

The PHA works out of the dispensary, health centre, or mobile clinic. For those living in flatter areas and where the distances are long, bicycles are given to the PHAs. In the hilly areas they use their own feet.

Numbers Trained and Population Served:

Fifty-five PHAs have been trained out of which 51 are still working in the programme. The remaining 51 PHAs are working in 21 different health units.

EVALUATION:

One of the purposes of the five-day refresher course held once a year (attended by the majority of PHAs trained) is for ongoing evaluation of the programme. A more individualized evaluation of the work of each PHA is carried out by the trainers in the field: the trainers observe the work of the PHAs in their home villages, check their visiting books, observe how they manage specific and ubiquitous problems to the area, and look at the attendance records at the child welfare clinics -- this form of evaluation is subjective.

3.

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|---|---|
| Name: Title: | THE MAUA HEALTH DEVELOPMENT PROJECT |
| Sponsor: | The Methodist Church of Kenya |
| Funding Agency: | World Neighbors and Private Donors |
| District: | Meru |
| Date Started: | July 1977 |

OBJECTIVES AND GOALS:

The objective of the Maua Health Development Project is to examine ways in which the communities who receive clinical services from the Hospital (i.e. through the mobile clinics) can continue to be provided with these services, but in ways that do not create dependency and in ways that are financially viable. This goal was predicated on the assessment made that the one day monthly clinics were not, in the long run, promoting the health of the people in the area.

Simply stated, the goal of the programme is to "help people to help themselves."

ORGANIZATION AND MANAGEMENT:

Administrators:

Miss Margaret Bailey and Miss Mattie Tolley (both with training in midwifery, community nursing, and registered nursing), with assistance from 4 ECNs: Mary Mbaabu, Janet Kaithime, Rose Mburunga, and Enid Muthoni.

Community Health Committees:

The Health Committees make the selection of volunteers who will be trained as Community Health Volunteers (CHVs) or Atethia. They are also made responsible for collecting the funds necessary to equip the mobile clinics.

Community Health Workers:

The Maua Methodist Hospital administration calls these persons Community Health Volunteers (CHVs), whereas the communities themselves call them Atethia, which in Kimeru means "helper."

CBHC STAGES OF DEVELOPMENT:

Community Based Health Care developed from the increasing demand for clinical services in the more remote rural areas within the hospital cachement area. To respond to these requests in economically realistic ways, it was determined that there be two methods of approach:

(1) In areas where there were no established clinical services, the hospital would (i) wait for a request from the community for some form of clinical service; (ii) meet with the community publically in a baraza at which time the hospital would indicate what it was prepared to do; (iii) the community would be advised to form a health committee; (iv) this health committee would select volunteers to be trained as CHVs; at the same time funds would be collected to buy an examination bed and scales, etc., for the mobile team; and finally, (v) the volunteers selected would be trained at the Hospital and the MCH clinic would begin on a regular basis.

(2) In areas where there are already existing services, barazas would be held with the various communities where there are mobile clinics once a month, to suggest that they form a health committee for the purpose of selecting volunteers.

RELATIONSHIPS:

CHV - Community Health Committees:

The CHV is at all time directly responsible to their community health committee. Any problem reported to the Health Committee by the atethia is first handled there before it is referred to the chief, the D.O., or the

hospital administration. For example, if the CHV sees that in a certain area people are without food, the CHV will first go to his/her own community health committee for discussions of ways and means of ameliorating the problem.

CHV - Service Delivery Points:

The CHV assists at the monthly mobile clinics for the whole day, first with setting up the equipment, and then afterwards with storing the supplies and equipment and cleaning up of the site. During the clinic itself, the CHV assists the ECN from the hospital with weighing the children, record keeping, and giving health education talks to the assembled mothers.

CHV - Supervisors of Activities:

The CHVs are trained and supervised by the same ECN. These ECNs are based at Maua Methodist Hospital and run all of the MCH clinics at the hospital, as well as the mobile clinics in the surrounding areas. It is during these monthly visits that the ECN records the problems raised by the CHV; the ECN may join the CHV on that same day in visiting a home that is of special concern.

COMMUNITY HEALTH VOLUNTEERS:

Selection:

The CHVs are selected by their respective Community Health Committee. There are few criteria used in this selection process, other than the fact that they must be respected. Both men and women are selected to be CHVs: in reality, there is approximately 1 man to 3 women.

Training:

The CHVs are trained for two days a week for a duration of five weeks at Maua Methodist Hospital. Subsequently, there is ongoing training at the MCH clinic every month. Fifteen CHVs are trained at a time, all from the same sub location.

The emphasis of the training programme is on Maternal Child Health.[10] The method of training is psycho social with an important component of the training in how to approach people.

Support for Services:

CHVs work on a part time basis and are not paid. Once a year there is a modest award given to the best CHV in the sublocation: the person is selected by the other CHVs.

Nevertheless, the CHVs have devised their own support mechanism — in the Athiru Gaithi sub location. The approximately 8 atethia there have established a voluntary association of CHVs / atethia: they call themselves the "Athiru Gaiti Atethia Group Project." Each atethia pays a registration fee of 5/= to belong to the "Athiru Gaiti Atethia Group Project" and amongst themselves they have elected a Treasurer and a Chairman. On Wednesdays, they meet on a rotation basis at each others homes, and work for the entire day in that persons shamba (or any other work that the member needs to have done). On that day, the atethia member puts 5/= into the project kitty kept by the treasurer. The members hope to use the money as an emergency fund (if one of the atethia is in need), and/or start a cooperative project (perhaps poultry raising).

Job Description:

Activities:

The CHV is expected to (i) do home visiting, (ii) assist at the monthly MCH clinics, (iii) give group health education talks, and (iv) improve his/her own lifestyle.

Supplies:

Each Health Committee raises money to purchase the equipment for the MCH clinics. The CHVs use this equipment on clinic days and are responsible for its safe keeping. They do not

administer drugs.

Working Place:

The CHV works out of the home except on clinic days.

Numbers Trained and Population Served:

Thirty-five CHVs have been trained out of which twenty-five are still active. There is approximately 1 CHV for every 60 families.

BUDGET:

World Neighbors is currently supporting the project with funds with a 20% reduction in funds every year over the next five years; the intention of this funding design is that the programme should ultimately be fully self reliant.

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| Name: Title: | MACHAKOS VILLAGE HEALTH WORKERS PROGRAMME |
| Sponsor: | Kenya Catholic Secretariat and Diocesan Development Office |
| Funding Agency: | Cebemo |
| District: | Machakos |
| Date Started: | September 1978 |

OBJECTIVES AND GOALS:

The stated objective of the Machakos Village Health Workers Programme was to organize MCH services in locations of Machakos District where they are non existent. The volunteers trained would support the existing service system with preventive and promotive health education.

ORGANIZATION AND MANAGEMENT:

Administrators:

Sr. Joan Devane (Project Director)
Geraldine Huising (SRN, SCM, and ADM. NT)
Mrs. Beata Ndunge Mulli (SCN)

Community Health Committees:

The initiation of Community Health Committees has not been very successful; the committees that were established were for the sole purpose of raising the funds to build an 'harambee' dispensary.

Community Health Workers:

The term for these workers varies from Village Health Worker (VHW) to Community Health Workers (CHWs).

CBHC STAGES OF DEVELOPMENT:

The CBHC programme was conceptualized in the Machakos Diocesan Development Office. The Coordinator of the Development team thought that a health programme along the lines of Kisii or Nangina would contribute to the amelioration of the blatant MCH needs in some parts of the District. The Diocesan team then approached the Kenya Catholic Secretariat to staff the programme.

Geraldine Huising was approached in 1977 in the Netherlands, and subsequently came to Kenya in 1978. She began with an investigatory review of the Nangina and Kisii programmes to find out how they were managed. Following this study, she reviewed the health service delivery structure in the whole of Machakos District and wrote up a report of what she thought was possible in the District. Her one stipulation was that "without a Kenyan counterpart," she would not embark on the project. After Mrs. Beata Ndunge Mulli joined her, the Machakos Village Health Workers Programme was launched in September, 1978 at Katangi. Since then, workers have been trained at Ekarakara and Masinga as well.

RELATIONSHIPS:

CHW - Community Health Committees:

Unfortunately, there is no viable ongoing relationship between CHWs and Community Health Committees. In some cases, the established Community Health Committees assisted in the selection process. As Geraldine and Beata said, "committees collapse constantly." Nevertheless, the unofficial support mechanism for the CHWs appear to be the elders in the community.

CHW - Service Delivery Points:

The CHWs are in the truest sense "community" workers. Any contact that the CHWs have with the personnel who work

at the dispensaries, is for the purpose of discussing defaulters at MCH clinics, children who are malnourished, etc. At Katangi, the staff discuss problems of this nature once a month with the CHWs.

CHW - Supervision of Activities:

The trainers of the CHWs / VHWs supervise their work in the field. Once a year, the trainers visit every CHW for one full day in their home area. There is also a week workshop once a year for the CHWs.

COMMUNITY HEALTH WORKERS:

Selection:

The CHWs are selected by a village group (for example, a women's group, a church group, a cooperative, etc.), and the sub - chief must sanction the selection made. Criteria for selection are: (i) married, (ii) minimum education of Standard 6, (iii) must belong to the area and a respected member, (iv) their husbands must agree to their becoming CHWs, and (v) they must be willing to work on a voluntary basis.

Training:

The CHWs are trained for a period of three months using the psycho social method as the format for their training. There is a limited amount of dispensary experience provided as well as two intervals during the training for field work. There is no curriculum for the programme: the trainers begin with the needs and problems of the women in the area, and then through dialogue and discussion of these problems, work together with the trainees in arriving at appropriate solutions.

Support for Services:

The CHWs work as volunteers on a part time basis -- approximately three afternoons per week. In one area, after one year of

voluntary service as a CHW, they receive 100/= pocket money. There are comments by many of the volunteers, however, to the effect that "if you do not pay us we will stop."

Job Description:

Activities:

The CHWs provide health teaching services in barazas, home visits, women's groups, church groups, and in primary schools.

Supplies:

After one year, the VHW receives a first aid box with malaria prophylaxis and aspirin in it.

Working Place:

The CHW / VHW works out of her own home.

Numbers Trained and Population Served:

In most cases, there is one VHW for 50 homes. To date, 46 VHWs have been trained; 2 of these volunteers have left to work in private clinics.

At Katangi, there are 8 VHWs for approximately 10,000 people; at Ekarakara, there are 16 VHWs for the same number of people; and at Masinga, there are 14 VHWs for approximately 16,000 people.

BUDGET:

For January to December, 1979, the total expenditures for the Machakos Village Health Workers Programme, excluding the salaries of the trainers, was 37,165.24 Ksh. This phenomenally low figure includes these items: pocket money for a few VHWs, the total cost of the yearly seminar, food and lodging during the course given at Ekarakara and

Masinga, office expenses, educational materials for the training of VHWs, petrol and repairs, and capital expenditures (namely, beds, blankets, and utensils)!

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|---|---|
| Name: Title: | SARADIDI RURAL HEALTH DEVELOPMENT PROJECT |
| Sponsor: | Saradidi Rural Health Project |
| Funding Agency: | Family Planning International Assistance |
| District: | Siaya |
| Date Started: | February 1979 |

OBJECTIVES AND GOALS:

(1) To improve the health of the Saradidi Community and hence their quality of life by providing a health service system that is acceptable to them and one in which they are involved.

(2) The service system focuses on the vulnerable groups which form 42% of the total population: women in child bearing age and children under five years of age.

(3) To provide information about responsible parenthood and to provide family planning methods to members of the Saradidi community.

(4) To make the community based programme comprehensive in design and implementation; i.e., concurrent to the initiation of MCH / FP and general health services, organizing a Women's Sewing Group as well as other income generating project -- egs. carpentry, poultry, latrine covers, gardens, marketing, etc.

ORGANIZATION AND MANAGEMENT:

Administrators: Dr. Dan C.O. Kaseje (Project Director)
Mr. Robert Adongo (Administrator)
Mrs. Rose Aruwa (CN at Saradidi "Harambee" Health Centre)

Community Health Committees:

There are 15 Village Health Committees with five people on

each committee.

Community Health Workers:

The name given to these workers are "Village Helpers Towards Health", which in Cholluo is Jakony.

CBHC STAGES OF DEVELOPMENT:

Before the formation of the Saradidi Rural Health Development Project, the Diocese of Maseno South ran mobile clinics (staffed by a nutritionist and a public health nurse) through the church -- Church of the Province of Kenya. A number of "health secretaries" at this time were appointed to dispense a limited number of drugs.

Emergent to this service, the Saradidi community recognized that the health service coverage for them was very low; in discussions with Dr. Dan C.O. Kaseje (a member of the community), community members identified a solution to their problem and decided to initiate Community Based Health Care through the structure of the local church congregation (CPK). Within the existing church committee there was a "rural development committee" which selected a task group called the "interim committee." The stated function of the "interim committee" was to mobilize the community through 'creating awareness' of the need for an organized CBHC programme. As a result of their efforts, in each village a "village health committee" was selected; representatives of each Village Health Committee (VHC) then formed and constituted the "project committee" of the Saradidi Rural Health Development Project. With the increasing work load and development of the project, a steering committee (or executive) has emerged to carry on with the administration and planning of the programme. As Project Director, Dr. Dan Kaseje "facilitated the articulation of needs and organized a response to meet those needs." CBHC seemed to be the appropriate method -- in

the eyes of the community members -- of ameliorating the needs of (i) water, (ii) unemployment for the youth, and (iii) health care. To date the Village Health Committees have selected "Village Helpers Towards Health", twenty-eight of which have been trained.

RELATIONSHIPS:

VHTH - Village Health Committees (VHCs):

The VHTH are selected by their respective VHCs and are immediately responsible to them. The part time salary paid to the Jakony is administered through the VHCs. Most members of the VHCs are themselves VHTH.

VHTH - Service Delivery Points:

The VHTH is a community and not a dispensary worker.

VHTH - Supervisors of Activities:

The VHTH is responsible to his/her VHC and to the CN at the Saradidi Health Clinic. The CN evaluates the content of the health education and information provided by the VHTH, as well as the records kept, while the VHC measures the accessibility / availability patterns of the VHTH amongst village members.

COMMUNITY HEALTH WORKERS:

Selection:

The VHTHs are selected by the VHCs. The criteria used in the selection are: that they are married to people in the area; that there is a sexual bias towards women; their age between 25 and 35 (in reality, the ages span from 20 - 49, with an average of about 30); having children; and are compassionate and respected. The educational background of the current VHTHs are: two have no education, four have primary school, four have secondary school, and the remainder have Standard seven.

Training:

The training of the VHTH was done by AMREF, personnel from the Rural Health Training Centre, extension workers, and Government of Kenya Family Health Field Educators; in future, the CN attached to the Saradidi Health Centre will carry out the training The training itself begins with 2½ weeks in the village, followed by 1 day every fortnight at the Health Centre, to reach after 2 years, a total of 6 working months in hours trained.
The format of the curriculum for the VHTH is one of "discovery" and "discussion," and falls into these broad categories: data collection and inventory, communications, family health, communicable disease control, environmental health, nutrition and immunization, and knowing when to refer a person to the health centre.

Support for Services:

The VHTH are paid through their VHCs. The maximum payment for the services of the VHTH is 250/= per month. The deployment patterns of payments through the VHCs to their VHTHs is monitored by the Project Director and the executive of the Saradidi Rural Health Development Project; they are encouraging the money to be used as 'seed money' for income generating projects. In principle, the VHC negotiates with the VHTH an acceptable payment to everyone concerned.

Job Description:

Activities:

The VHTH work on a part time basis and ideally 2 - 3 hours per day. If, as is expected, there are 2 VHTH for each village (1 village having approximately 60 households), and the requirement is that the VHTH must visit each household every two weeks, this would involve 3 households per day (a five day week), or 15 households per week.
The VHTH are expected to carry out (a) Health and Family Education: i.e. general health, child care, and responsible parenthood.
(b) Home visitation: care for under fives (weighing, nutrition);

observation of high risk pregnancies; and collection on morbidity data. (c) Encouragement of Family Planning methods and the referral of first acceptors; concomitantly, providing a continuous supply of methods to acceptors.

Supplies:

The VHTH is supplied with folders, pencils, Tabs. chloroquin, a bangle bracelet, and FP methods and supplies. In very few cases, the VHTH is supplied with a bicycle.

Working Place:

The VHTH works out of his or her own home.

Numbers Trained and Population Served:

At Ramba sub location, there are 6 VHTH for three villages (1260 people); at Memba, there are 10 VHTH for 5 villages (2100 people); at Omia Malo, there are 10 VHTH for 5 villages (2100 people); and at Siger, there are 2 VHTH for 1 village (420 people).

BUDGET:

For the members of Saradidi community itself -- excluding the costs to F.P.I.A. -- the Project costs approximately 100/= per village per year. However with the feeding of visitors (sodas, rice, chapatti, etc.) the incurred expenses are undoubtedly much higher.

EVALUATION:

There will be two forms of evaluation, one external and one internal. The external evaluation will be done every three months by an WHO team, and the internal one will be organized by the project executive committee mobilizing the data through the VHTHs. The two systems will be compared for accuracy of results.

Name: Title: CHOGORIA "HEALTH FOR THE FAMILY" PROGRAMME

Sponsor: Presbyterian Church of East Africa (P.C.E.A.), Chogoria

Funding Agency: Family Planning International Assistance

District: Meru

Date Started: May, 1980

OBJECTIVES AND GOALS:

As stated in the project profile, the objectives of this new Community Based Health Care programme are:

"(1) To continue and improve the MCH/FP rural Satellite Clinic activities ...

(2) To develop a set of tested and proven MCH/FP service and education strategies for application in rural areas of Kenya, and to develop a plan to incorporate the most practical and cost - effective of these strategies in Chogoria's overall MCH/FP program. The following will be tested:

- Community-based distribution of contraceptives
- Use of male Field Health Educators
- Reorganization of services for more efficient coverage of the target population
- Introduction of Family-Oriented Record-Keeping
- Strengthening community participation in Project activities
- Special services directed at special groups (eg. older women, employed women, etc.)

(3) To implement a Family Planning/Sex Education Program directed at secondary school students in the Chogoria area...

(4) To provide theoretical and practical training for seventy - five (75) enrolled Community Health Nursing Pupils ... in family planning.

(5) To ... disseminate the information gained by this Project on methods for improving rural MCH/FP services to other Non - Government Organizations (NGOs) and the Government ..." [1]

ORGANIZATION AND MANAGEMENT:

Administrators:

Dr. Andrew H.C. Boddam - Whetham (Project Director)
Mrs. Asenath Murunge (Project Assistant)

Community Health Committees:

The committees are called Area Health Committees; originally they were Dispensary Building Committees.

Community Health Workers:

The name given to these workers are Family Health Workers (FHWs).

CBHC STAGES OF DEVELOPMENT:

In 1968, the management of Chogoria Hospital heard of the success of the Mwana Mujimu Clinic in Kampala, Uganda, and started a similar Child Welfare Clinic and Health Education programme at Chogoria. OXFAM and Church of Scotland support continued for this programme until 1978. Work began with an MCH/FP clinic at Chogoria Hospital, and as a pilot project, mobile clinics out to three existing satellite dispensaries; all of these existing dispensaries had been built by the communities through harambees. Once a month, Chogoria Hospital provided the services of a medical doctor for these mobile clinics. Community organization for these services began with the formation of Dispensary Building Committees (at the Village / Sublocation level), which later on became in name and function Area Health Committees.

In 1974, Family Planning International Assitance (FPIA) began funding the Chogoria programme. A training programme for Health Educators was developed at this time, and between 1975 and 1976, thirty Family Health Field Educators (FHFEs) were trained along the lines of the Government FHFEs. Two FHFEs were stationed at each satellite dispensary and were

paid a salary of 400 Ksh per month. As of May, 1980, there salary is the same as Government FHFEs. Initially these Health Educators were called "Family Planning Field Educators" but then became "Family Health Field Educators" as in the Government programme -- the rationale for this change in labelling was to break away from the dominance of family planning in the programme. In all cases the educators were chosen by Chogoria Hospital from the 2 or 3 sent by their committees to the hospital for training. The initiative for these programmes came from the communities themselves: after a committee is established in the community, they then approach Chogoria Hospital for assistance. The Department of Community Health (Chogoria Hospital) then decides whether there is duplication of services in the area and sanctions the location and building of an harambee satellite dispensary.

At the end of 1978, the Chogoria programme was evaluated by an independent university team.[12] This team presented strategies for improving the activities at the community level and suggested that Community-based Health Care be developed to manage the distribution of contraceptives more adequately. It was proposed that this be accomplished through (i) education at the community level -- for example, following up of defaulters in the programme, and (ii) community-based distribution of contraceptives through "Family Health Workers" (FHWs). This strategy would focus on MCH and FP activities.

As of September, 1980, Family Health Workers have been trained to support the work of FHFEs in the community.

RELATIONSHIPS:

FHW - Area Health Committees:

The Area Health Committees select the FHWs, assist in their supervision -- i.e. evaluate their popularity in the community and effectiveness in doing their job, and decide on remuneration for their FHWs.

FHW - Service Delivery Points:

Only for the purpose of record keeping and renewing supplies of condoms and pills, will the FHW use the dispensary as a base. Nevertheless, their will be a natural link between what the FHFEs provide in services at the dispensary, and what the FHWs provide in the community.

FHW - Supervisors of Activities:

The FHW's activities are monitored by his or her own Area Health Committee — i.e. how they are being accepted in the community. Concomitantly, the FHWs are supervised and immediately responsible to the personnel at their dispensary (the EN or ECN, the EN - midwife, and the FHFEs).

FAMILY HEALTH WORKERS (FHWs):

Selection:

The respective Area Health Committee of the FHWs make the selection. The only criteria for this selection is that the FHW is respected, literate, and able to keep accurate records. There is a recognized bias towards women as FHWs, nevertheless, there is a need to recruit men as well because of their generalized opposition to family planning methods.

Training:

The FHWs are trained for one week at the Department of Community Health, Chogoria Hospital, and subsequently in the ~~field.~~ Generally, the requirement for FHWs is that they completely understand the objectives of MCH/FP (information, education, and service delivery). They are also taught how to motivate members of the community towards "health for the family" using psycho - social skills. With these general requirements in mind, the curriculum for the FHWs will be constructed during the course itself in response to the needs of the FHWs.

Support for Services:

The Family Health Workers are not paid, nevertheless, the

Area Health Committees which have selected them, may decide to remunerate the services of the FHWs in some way (in kind, an annual gift, etc.).

Job Description:

Activities:

The Family Health Workers (i) educate, (ii) motivate, and (iii) follow up defaulters of MCH/FP; eventually, they will (iv) work at the community-based distribution (CBD) of pills and condoms.

Supplies:

The Family Health Workers are supplied with pills, condoms, teaching aids, and representative food items (eg. maize, beans, finger millet, etc.) for nutritional instruction. The supplies are renewable at the dispensary. The FHWs may be required to dispense Tabs. Chloroquin as well.

Working Place:

The FHW works from his or her own home.

Numbers Trained and Population Served:

The training has begun in an initial 5 sublocations; from these areas, they will spread out until each of the remaining sublocations has for a start, 3 FHWs. Since in principle 1 FHW will serve their own village, the number of workers in each sublocation will be increased according to the number of villages in each sublocation -- i.e., 1 FHW will serve the area (village) in which they live. There are 42 sublocations in the Chogoria Hospital cachement area, and it is proposed that each one has FHWs serving there.

In general, 1 village involves approximately 20 - 50 homes (i.e., traditional Meru homes) under 1 headman helper (munjuri). One FHW might serve then, 20 - 50 homes.

BUDGET:

There is no cost to the supporting service other than in its initiation. The supporting service employs the FHFEs (who provide the link between the hospital and the FHWs), but in general, there is a very low cost planned for the CBHC programme.

EVALUATION:

The evaluation team with Professor Henry Mosley of the Institute of Population Studies (University of Nairobi), have devised a new record keeping system. It is too early to determine whether it will be effective.

1 I acknowledge the support and advice of Dr. S. Kanani, S.D.D.M.S. and Dr. J. Maneno, A.D.M.S. Various members of the Rural Health Project have also facilitated the study review, in particular Mr. F. Bennike and Mr. S. Obiero. Without the support of persons in the field who administer, manage, supervise, or even work as "Community Health Workers" in CBHC programmes, this report could not have been written. I thank all of them -- there are too many to mention -- for their hospitality and generosity to me.

2 The failure to report on these two programmes are entirely my own responsibility.
For information on the Kibwezi CBHC programme, confer:
(i) "Kibwezi Rural Health Scheme: Position Paper No. 1"; The Training of Community Health Workers, Health Behaviour and Education Department, AMREF, 1979.
(ii) "Kibwezi Rural Health Scheme: Position Paper No. 2"; Village Development / Village Health Committees, Kibwezi Team, AMREF, 1979.

3 Cf. the "Kitui Feasibility Study Report," USAID, Nairobi.

4 Cf. the "Turkana District Health Development Programme: 1979 - 1983", A Health Delegation Report, prepared for the Norwegian Agency for International Development (NORAD), 2 volumes, January, 1980.

5 A sampling of these particular proposed CBHC programmes might include: Rhamu Service Centre; AMREF's Mobile II Team at Ngoryika, Masailand; Life Ministry at Lerain Mission Hospital; the Kenya Catholic Secretariat at Membu; the training of traditional birth attendants out of Chulaimbo Rural Health Training Centre; the Diocese of Maseno South Health Care Project; and the Busia District Training Project at Sio Port.

6 Confer the Nangina Hospital and Public Health Report, Funyula, Kenya (1978).

7 Dr. Roy Shaffer of the Community Health Worker Support Unit (AMREF) is currently involved in the construction of self evaluation techniques for Community Health Workers. It is hoped that this system will facilitate the measurement of changes in health status in the community where they serve, thereby motivating the workers themselves and the community to continue with preventive and promotive health education.

8 Cf. Daniel G. Makuto's dissertation presented to the Tropical Child Health Unit, Institute of Child Health, University of London: Evaluation of the Nangina Hospital Community Health Worker Programme and its Effect in Promoting Maternal and Child Health (1979).

9 Cf. Abdulwahab M. Makki's dissertation submitted to the Tropical Child Health Unit, University of London: Study of the Organization, Acceptability and Coverage of Mother and Child Health Services of the Nangina Hospital Project Kenya (1979).

10 Cf. their syllabus in the report of the Second Seminar on CHWs held at Limuru Conference Centre. 17 - 21 March, 1980: AMREF, Nairobi.

11 Cf. Family Planning International Assistance (FPIA) "Project Description and Budget" (Kenya - 03 Modification 10).

12 Cf. the "Chogoria MCH/FP Programme: Evaluation Report", Institute of Population Studies, University of Nairobi.

## APPENDIX I

# QUESTIONNAIRE ON COMMUNITY BASED HEALTH CARE (CBHC) ACTIVITIES IN KENYA

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A. 1. District _____

2. Location _____

3. Date Questionnaire Completed _____

4. Supporting Service (eg. Diocese of Maseno South, Kenya Catholic Secretariat, etc.)

_____

5. Funding Agency (if other than the above)

_____

6. Title of Community Based Health Care Programme

_____

_____

7. Date Programme Started _____

8. Brief Programme History (stating the need for the programme, how the programme was initiated, and who was responsible, etc.)

9. If there is more than one area served by this CBHC programme, where are they located, when did they begin, what is the population served, and how many workers are there in each area.

| Date Started | Location | Population Served | No. of Workers |
|---|---|---|---|
| (a) | | | |
| (b) | | | |
| (c) | | | |
| (d) | | | |
| (e) | | | |
| (f) | | | |
| (g) | | | |
| (h) | | | |

B. PERSONNEL IN THE CBHC PROGRAMME (with attention given to their job description, function, and training):

1. Programme Administrators (persons and/or committee, etc.):

Name(s) _____

_____

Function _____

_____

2. Community Health Committees:

Name _____

_____

Function _____

_____

3. CBHC Workers:

Name of Workers Given _____

_____

Function _____

3. continued ...

(a) How were the CBHC workers selected, who made the selection, and what criteria were used?

(b) What types of workers are there (i.e., are there different functions given to workers in the community that are health related: preventive, promotive, etc.)? Why were these categories of persons chosen?

(c) Are the workers paid or remunerated in any way?

(d) Do they work full time or part time?

(e) By whom and how often are they paid?

(f) What are the characteristics of the workers (age, sex, education, occupation)? This may be different than the initial criteria used in the selection of the workers.

(g) Who did the training of these workers?

(h) What training did the trainers have (eg. special training, experience in CBHC programmes, clinical experience, experience in teaching motivational skills, etc.)?

(i) What was the length and sequence of the training (eg., 4 weeks formal discussions, 6 weeks field work, 1 week at the health centre or dispensary, etc.)?

(j) What were the educational objectives and what curriculum was used in the training of the CBHC workers? (Append a copy)

(k) What was the most effective part of the course, as experienced by:

the CBHC workers:

the trainers of the CBHC workers:

(l) How often are refresher courses given for the CBHC worker? Who gives these courses and where are they given? Is there a per diem and transport needed for these courses? Who pays these expenses?

(m) How many CBHC workers have been trained?

How long did each one take?

Of those who left, why did they leave?

(n) What supplies does the CBHC worker have? (drugs, scales, etc.)

How are these obtained and how often?

(o) What transport does the CBHC worker have?

How is it maintained?

(p) Is there a building or base for the CBHC worker? From where does he or she carry on their work?

4) Support Staff:

(a) What is the role of medical doctors in the CBHC programme?

of Community Nurses (differentiate types of nurses and function)?

of Health Inspectors?

of Teachers?

of the Community Health Committee (or its alternative)?

of Community Development Officers (or their equivalent)?

of Home Economists?

of Agricultural Assistants?

of Others? List and specify.

C. MATERNAL CHILD HEALTH AND FAMILY PLANNING: (MCH/FP)

1) What are the priority health problems in the area and what success has been achieved in ameliorating these problems through the CBHC programme?

2) Are there special MCH (Maternal Child Health) problems?

3) Are there special FP (Family Planning) problems?

4) Give details of specific work done in the CBHC programme that addresses problems of MCH/FP:

Water:

Food and Nutrition:

Education:

Day Care:

Home Economics:

Housing:

Other:

(L) SOCIAL -CULTURAL ORGANIZATION OF CBHC SERVICES:

1) How are the "communities" defined and isolated in this programme (e.g. religions, organization , kinship groups, geographical area, social function, etc.).

2) What led to the community wanting CBHC?

3) How was the participation of community members obtained, stimulated, and initiated?

4) What were the social action stages of community participation (Qualify)?

Was a dispensary built (harambee effort)?

Were committees established?

Were barazas held?

5) What measures were taken, if any, to cope with priority health - related problems, before the initiation of CBHC?

6) To what extent is community satisfaction measured? How is this measured? How is this communicated to evaluators?

7) What are the major achievements so far in the CBHC programme, as articulated by the

Community:

CBHC workers:

Health service personnel (Government, Non - government)

8) How was this measured?

9) What are the major problems so far in the CBHC programme, as articulated by the

9 continued...

Community:

CBHC workers:

Health service personnel (Government, Non - governmen

10) What methods of evaluation are used for the CBHC programme?

11) Who decides on how the evaluation will be carried out?

12) Who collects the data?

13) Give examples of how the data is recorded and tabulated (e.g. are there tabulations of an increase in the percentage of BCG scars given, pit latrines built; are records kept of persons who refuse to participate in programme; etc.).

(E) POLITICAL, ADMINISTRATIVE, AND PLANNING PROCEDURES:

1) What policy statements have been made for CBHC programmes in this area?

When?

By whom?

10 continued...

How was and is this disseminated?

2) What relationship does this programme have with Government action and policies in the area? To what extent are these programmes integrated?

in the field:

at the central or district level:

3) Was this programme planned at the national level or at the community level?

4) What plans are being made for this CBHC programme now at the national and at the community level?

5) Is there any support for this programme in the media? Nationally? Internationally?

(F) BUDGET:

1) What is the cost of the CBHC programme to the Supporting Service, and how is financing the programme arranged?

11 continued..

2) How successful have the supporting services been in refinancing the programmes? What are the expectations of the funding agencies?