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**INFORMATION, EDUCATION, AND  
COMMUNICATION ASSESSMENT,  
BUNGOMA DISTRICT**

**Ministry of Health of the Republic of Kenya  
Bungoma District Initiative**

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## ACRONYMS

AIDS	acquired immune deficiency syndrome
AMREF	African Medical and Research Foundation
ANC	antenatal care
BDEDP	Bungoma Urban Family Development Project
BDI	Bungoma District Initiative
CBD	community-based distributor of contraceptives
CBHC	community-based health care
CBO	community-based organization
CHW	community health worker
CNT	community nutrition technician
CO	clinical officer
CPK	Church of the Province of Kenya (Anglican Church)
CSM	communication and social mobilization
DHEO	district health education officer
DHMT	district health management team
FHFE	family health field educator
GMA	growth monitoring agents
GTZ	German funding agency
HIV	human immunodeficiency virus
IEC	information, education, and communication
KAYO	Kenya Anglican Youth Association
KBC	Kenya Broadcasting Corporation
MO	medical officer
MOH	Ministry of Health
MSW	medical social worker
MYWO	Maendeleo ya Wanawake Organization
NFW	nutrition field worker
NGO	nongovernmental organization
PHC	primary health care
PHO	public health officer
PHT	public health technician
SDA	Seventh Day Adventist Church
STD	sexually transmitted diseases
TB	tuberculosis
TBA	traditional birth attendant
TOT	training of trainers (commonly used to refer to trainers)
TT	tetanus toxoid
TV	television
VHC	Village Health Committee

## **SUMMARY AND RECOMMENDATIONS**

### ***Summary***

The Bungoma district information, education, and communication (IEC) assessment was carried out in all nine administrative divisions that make up the district. The purpose was to describe the available IEC infrastructure, assess its weaknesses and strengths, and make recommendations on how it could be strengthened and used during implementation of the Bungoma District Initiative (BDI) Project. Field work was carried out between March 16 and April 24, 1998, by a BASICS consultant, the Bungoma district health education officer, and a Bungoma Ministry of Health (MOH) medical social worker.

Data for the assessment was collected qualitatively through a review of records and interviews guided by a discussion guide (see Appendix). In all, 161 health workers and members of the public were interviewed. Respondents included members of the district health management team (DHMT), members of the various health facility committees, managers of relevant projects operating in Bungoma district, members of the provincial administration, health workers, child caretakers, school children, teachers and village-based members of the general public.

The assessment found Bungoma to have a good infrastructure, with potential to effectively deliver messages from the district to the village level. The delivery system includes teams of facility-based paid motivators (family health field educators, public health technicians, community nurses, and nutrition field workers) and several cadres of volunteer community-based motivators (community health workers, community-based distributors of contraceptives, and growth monitoring agents). In addition, members of the provincial administration (chiefs, assistant chiefs, and village headmen) enthusiastically deliver health messages on the basis of what they heard other people saying, as they have not received any formal health training.

The churches, schools, NGOs, mission, and private health facilities are all available to participate in MOH-led initiatives to promote health.

Prevalence of radio sets is high in the district, and the Nairobi-based Kenya Broadcasting Corporation (KBC) is heard clearly in all parts of the district. Many people in the district regularly listen to the radio.

Although a good IEC infrastructure is in place, at the moment it is unable to perform to its full potential for the following reasons:

- Supportive supervision from health workers is inadequate
- Community visits by health workers who provide IEC are infrequent
- Most community-based volunteer motivators have stopped doing health work because they are not paid to do so
- IEC activities emphasize educating women while leaving out men
- Communication and relations between caretakers and health workers are poor
- There is a lack of appropriate educational materials to use in IEC activities

The underlying causes for these shortcomings include the following

- Poverty and the rising cost of living make it difficult for people to find time for volunteer work
- Donor agencies tend to pay for all services, including voluntary services, which has had a negative impact on voluntarism
- There is a tendency to give different rewards to different categories of volunteers doing similar work
- There is a widespread belief among health staff that it is unfair to ask people to work without pay
- Inadequate attention is paid to developing interpersonal communication skills of health workers
- No budget exists to enable MOH to develop Bungoma-specific IEC materials

Health (including malaria) messages, are communicated at barazas (public meetings), churches, schools, funerals, health facilities, mobile clinics, home visits, and women's and youth meetings. The range of messages disseminated in respect to malaria is clearly too wide, and includes messages of questionable value to the control and management of malaria. Channels of communication most preferred by respondents include health facilities, mukasa (the village headman), churches, radio, and schools through pupils.

### ***Recommendations***

For the present IEC infrastructure to provide maximum benefits, the BDI project needs to do the following

- 1 Determine a minimum package of effective, actionable malaria messages and interventions to promote
- 2 Emphasize communicating malaria control and management messages through the channels preferred by most people, namely health facilities, mukasas, churches, radio, and schools
- 3 Mobilize the selected communication channels and provide target-oriented IEC training to those expected to play a leading role in message dissemination
- 4 Discuss issues relating to voluntarism, community participation, and supportive supervision, and find workable solutions in view of the importance of these components to the success of IEC programs
- 5 Develop strategies for greater involvement of men in malaria control programs, as they are often the lead decisionmakers in the home

## **1 INTRODUCTION**

### **1.1 Background**

The Bungoma District Initiative (BDI) was launched on March 3, 1998, in Bungoma. Its objectives are to

- Improve management of fever and anemia, principally among children under 5 years of age, by health workers at health facilities
- Improve capability of mothers and other caretakers to manage fever and anemia at the household level
- Improve prevention and management of malaria in pregnancy
- Increase household use of insecticide-treated materials
- Collect and effectively use information for planning, monitoring, and evaluation

The project is currently in the process of implementing a series of studies designed to facilitate development of focused program strategies and activities. The present assessment was conducted as part of the program of data collection.

### **1.2 Communication in health services**

Health communication is a cross-cutting component in which all health workers need to be skilled in varying capacities. The clinical officer needs communication skills in the examination room to explain to the patient about his/her ailment, the nurse needs it to convince the patient about the seriousness of his/her condition and the need to change habits that may be contributing to the patient's ill health. Even MOH cleaners need good communication skills, together with key messages to communicate about MOH projects. They too have a responsibility to promote MOH projects, for they sometimes hurt the projects whenever they speak negatively about them.

For this reason, the assessment includes in the IEC delivery structure more categories of MOH staff than would normally be included.

### **1.3 Assessment objectives**

- i) Describe the infrastructure available for health promotion in Bungoma district, along with methods and processes used to carry out IEC activities
- ii) Identify key targets for health interventions, especially targets for malaria control and management programs
- iii) Identify channels for reaching target groups and assess the strengths and weaknesses of each
- iv) Assess the extent to which communities are involved in health promotion and ways to increase community participation
- v) Gather and document recommendations that can strengthen health promotion in Bungoma district, especially in regard to malaria control

## 14 Methodology

Data for this assessment was collected in Bungoma district between March 15 and April 24, 1998. Data was collected qualitatively through a records review and interviews using a discussion guide (see Appendix). In all, 161 people were interviewed. Respondents included members of the district health management team (DHMT), members of the various health facility committees, managers of relevant projects operating in Bungoma district, members of the provincial administration, health workers, child caretakers, school children, teachers, and village-based members of the general public (see activity table that follows). Interviews were carried out in all nine administrative divisions that make up Bungoma district. The assessment was led by a BASICS communication consultant assisted by the Bungoma district health education officer and a medical social worker.

### Assessment activity schedule

WEEK	DATA COLLECTION AND ASSOCIATED ACTIVITIES	PEOPLE CONTACTED
<b>One</b> March 15-20	Planning, Maendeleo ya wanawake organization, Bungoma family helper project, child welfare society of Kenya, Bungoma urban development project, Joo enterprises, Sirisia health center, Kimilili sub-hospital, Webuye health center	35
<b>Two</b> March 22-27	Mbakalo, Ndal, Naitiri, Korosandet	67
<b>Three</b> March 29- April 3	Debriefing with DHMT members	7
<b>Four</b> April 5-10	Reformed church, Seventh Day Adventist church, full gospel church, Webuye, sipala primary school, church of the province of Kenya, salvation army, nalondo secondary school, Baha'1 faith	44
<b>Five</b> April 12-17	Engaged elsewhere	0
<b>Six</b> April 19-25	Working with the formative research analysis team Carrying out the last interviews (Lugulu hospital, Misikhu Nekeki CBO, AMREF project) Bringing all assessment field notes together	8
<b>Seven</b> April 26-30	Report preparation	0
	Total number of people interviewed	161

During week three, the assessment team debriefed with the DHMT Together they identified additional lines of investigation, then followed up with the investigation the next week

## 2 MINISTRY OF HEALTH IEC DELIVERY SYSTEM

The table below summarizes the Ministry of Health’s IEC delivery structure Cadres with direct health IEC responsibilities appear in bold type, while other cadres that are well placed to carry out health motivation but not designated health motivators are in regular print

<b>INSTITUTIONS</b>	<b>IEC FUNCTIONARIES</b>	<b>COMMUNITY SUPPORT</b>
District Medical Officer of Health	DHMT members	Bungoma District Health Management Board
District health management team	<b>District health education officer</b>	Board above serves this level
Hospitals (Bungoma and Webuye)	<b>Family health field educators, PHTs</b> Others PHOs, MOs, nutritionists, (NFWs, CNTs), MSWs, pharmacists, nurses, clerical and subordinate staff	Bungoma Hospital Health Management Committee Webuye Hospital Health Management Committee
Sub-hospital and health centers	<b>Family health field educators, PHTs, CNTs</b> Others COs, nurses, clerical and subordinate staff	Sub-hospital/health center development committees
Dispensaries	<b>Family health field educators (only some dispensaries), PHTs, CNTs</b> Others nurses, clerical and subordinate staff	Dispensary development committees
Community/Villages	<b>CHWs, CBDs, board members, GM agents, TBAs</b> Others chief, asst chiefs, mukasa, teachers, pupils, priests, circumcisers, breastfeeding mothers support groups	VHCs, women’s groups

## 2.1 Overview

A five-tier government health delivery structure was identified in Bungoma district. The structure includes the following:

**District level** At the district level is the district health education officer (DHEO), a member of the DHMT, and head of health education in the district.

**Hospital level** Bungoma district has two government district hospitals (Bungoma and Webuye). At the hospitals are family health field educators (FHFE) who report to the district health education officer. Other personnel who carry out IEC duties at this level but do not report to the DHEO include public health officers, public health technicians, medical officers, nutritionists, community nutrition technicians, nutrition field workers, nurses, medical social workers, and clerical and subordinate staff.

**Sub-District hospital and health center level** The district has one government sub-district hospital and 13 health centers. This level incorporates family health field educators as well. Other cadres carrying out IEC activities include public health technicians, community nutrition technicians, clinical officers, nurses, clerical and subordinate staff.

**Dispensary level** Bungoma district has eight government dispensaries. Some of the dispensaries have family health field educators while others do not. Other categories of personnel carrying out IEC activities at dispensaries include nurses, clerical officers, and subordinate staff.

**Community and village level** Various volunteer cadres carry out IEC activities in the community. They include community health workers, community-based distributors of contraceptives, growth monitoring agents, and traditional birth attendants. Others are chiefs, assistant chiefs, mukasa, teachers, pupils, priests, women group leaders (in church and elsewhere), and circumcisers (who have a unique opportunity to convey health promotion messages as they initiate male children into adulthood).

Paid staff receive support from a network of community committees, starting with Bungoma district health management board at the apex and ending with dispensary development committees at the lowest level. Village health committees, women groups, church-based and other groups support volunteer motivators in the community.

## 2.2 Facility-based motivators

### District health education officer

Responsibility for implementing IEC programs lies with the district health education officer (DHEO), a member of the district health management team based at the district head office in Bungoma. The current DHEO in Bungoma district is a nurse with extensive training in IEC who has served in IEC positions for the past 11 years. He runs a one-person office, with 14 family health field educators in health facilities around the district reporting to him. The DHEO shares a small office with two medical social workers, one of whom provides him with some badly

needed assistance. He is also a co-opted member of the district health management board and doubles as the district primary health care and district STD/HIV coordinator.

### **Family health field educators**

Family health field educators were introduced in Kenya's health services in the 1970s to motivate and recruit clients for family planning, especially in the community. There are 14 FHFES in Bungoma district based at hospitals, health centers, and some dispensaries. They carry out motivation campaigns for various health activities, at health facilities as well as in the community. At health facilities, FHFES conduct health talks, immunize children, and counsel clients on family planning. In the community, they attend public meetings (barazas) to disseminate health messages, work with women and other interest groups, and follow up family planning and other medical cases (such as patients on TB treatment in the community).

The 14 FHFES report visiting 20 homes in a month. They report difficult cases, (e.g., sick people who do not want to go for treatment or people who do not want to construct latrines) to the mukasa for follow-up and enforcement as necessary.

For many years now, no new FHFES have been recruited or trained. This type of cadre are lessening as staff resign, retire, or die.

### **Public health technicians (PHTs)**

Public health technicians (commonly referred to as *bora afya*) have secondary school education with two years of health training that focuses on environmental sanitation. Their training covers general home cleanliness, including disease control through appropriate environmental management. In addition, PHTs are responsible for implementing the public health act, which empowers them to prosecute people who endanger public health. Of all the paid health cadres, PHTs are the most widely known in the community. They are best known for their role in inspecting and condemning business premises that do not adhere to the recommended standards of hygiene.

Each PHT covers one sub-location and attends barazas to provide health education on a wide range of health education topics. PHTs concentrate on water hygiene, market sanitation, insect and vector control, food quality control, and personal hygiene. Other duties of PHTs include home visits to follow up on medical cases, and reports on other issues to the provincial administration (especially mukasa) for follow-up.

In some areas of Kimilili division, PHTs visit their sub-locations of assignment regularly and have lists of all people living in these areas. In addition to disseminating information and prosecuting defaulters, PHTs record and report on a wide range of events that take place in the community (e.g., new homes being established, new business premises coming up, etc.). Because PHTs are well known in the community and are already working in environmental management, most health staff interviewed thought PHTs to be the right cadres to spearhead

malaria control education. PHTs report to the public health officer (PHO), who is their representative in the DHMT.

### **Medical officers of health (MOs)**

Medical officers of health are qualified, with a medical degree. In Bungoma, they are available only at hospitals, where their main responsibility is to diagnose illnesses and treat the sick. Their pronouncement on any medical subject carries a lot of weight with the people, and for this reason they should be appropriately incorporated in the malaria control and management communication. Their role in malaria control education could be in talking to parents of the sick children or patients about the causes and prevention of malaria as they examine and treat malaria cases.

### **Nutrition workers**

Three categories of nutrition workers are involved in disseminating health messages in the Bungoma district: nutrition field workers (NFWs), community nutrition technicians (CNTs), and nutritionists. There is only one nutritionist based at the District Medical Office. The other nutrition cadres work from hospitals and health centers.

CNTs are the new cadres of nutrition educators who are now replacing NFWs. Both disseminate nutrition education at health facilities (during health talks) and in the community where they promote balanced diets, maintenance of kitchen gardens, food hygiene, and related matters. They are supervised by the district nutritionist.

### **Medical social workers**

Bungoma district has two medical social workers (MSWs) who work from Bungoma district hospital and visit Webuye hospital a couple days a week.

Medical social workers were introduced in Kenya's medical services early in the 1980s to replace the nonmedical social workers, who were found to be inadequate to carry out health-related investigations and counseling. Recruitment and training of the cadre stopped in the mid-1980s, after graduating only a few classes. Since that time, officers leaving service have not been replaced.

Medical social workers work closely with clinical officers and doctors who refer to them cases that need social worker input. Once referred to them, the cases are investigated and the affected person counseled. When needed, MSWs liaise with families and relatives of the affected person to obtain additional help.

One of the two MSWs in the district also assists the district health education officer with communication work, in addition to his work as an MSW. The MSW is keen on IEC work and believes that he can integrate malaria prevention and control messages in his counseling activities.

## **Nurses**

Various cadres of nurses perform nursing and IEC duties in health facilities and in the community. These cadres include registered nurses, enrolled nurses, and community nurses. In addition to conducting health talks at health facilities, community nurses attend public meetings to conduct IEC, make home visits, and follow up on cases in the community. Some of the community nurses coordinate the activities of community-based volunteer motivators.

## **Clinical officers (COs)**

Health centers are headed by COs, who examine patients and prescribe drugs. Like medical officers, clinical officers have opportunities to talk to patients about malaria as they examine and treat malaria cases.

## **Clerical officers and subordinate staff**

These two cadres are generally left out of IEC discussions and usually have little information about health programs. Without access to correct technical information, they sometimes pick up rumors and half truths about programs which they pass around when asked questions by friends and associates outside the workplace. In the eyes of the public, however, they remain insiders and are expected to know what is happening in the organization that employs them. It may be cost effective to equip these two cadres with the needed information (even if only as members of the public who can use the information themselves and share it with friends).

## **Management boards and health development committees**

To decentralize and involve communities in the planning and implementing of their health services, health units throughout the country are expected to establish appropriate volunteer committees to do the following:

- Provide a link between health facilities and the community
- Support development and financing of health plans and programs
- Review and approve budgets
- Set fees to be paid for services rendered
- Oversee the management of health facilities
- Generally support the activities of health facilities

The Bungoma district works with a fully fledged health management board, and the hospital level is supported by a health management committee. The health centers and dispensaries have development committees that hire and supervise casual workers to keep the environment of health facilities clean. The committees are also responsible for raising funds for construction of additional facilities.

Committee members of lower tier health facilities are expected to facilitate health promotion activities in their communities and mobilize their communities for health action during disease outbreaks

## **2.3 Community-based motivators**

### **Community-based volunteer motivators**

Village-level health workers were introduced in Kenya's health services to replace higher caliber, paid motivators such as family health field educators (see above). The rationale was that because village-level workers were elected by the community and lived among the people they served, they would understand their communities better, would be more committed to serving them, would be better accepted and therefore more effective in their service. They would also be more sustainable since they were not paid.

The first cadre of community-based health promoters to emerge was the community health worker (CHW). Other cadres that have emerged since and operate in Bungoma district include community-based distributors of contraceptives (CBDs) and growth monitoring agents (GMAs).

These motivators have been recruited, been trained, and gone back to carry out health motivation on a wide range of topics in their communities. Community-based motivators are expected to disseminate health messages through public meetings, discussions at churches and other organized groups, home visits, and follow-up of clients (e.g., family planning clients and TB patients on treatment, to ensure that they take their contraceptives and drugs). The motivators also promote draining stagnant water, keeping homes clean to reduce mosquitoes, keeping kitchen gardens to improve nutrition, etc.

In addition to disseminating health messages, CBD agents are expected to distribute contraceptives (condoms and pills). Growth monitoring agents weigh children on their own or in collaboration with nurses who come in mobile vans to provide services to remote areas. Provision of tangible commodities and services gives the last two cadres more credence and visibility than those services offered by CHWs, who "give nothing, they only tell us to go to the clinic."

Unpaid and little appreciated, more CHWs have abandoned their motivation work than any other cadres. Some were recruited to become CBDs or GMAs.

The activities of village-based volunteer motivators are coordinated by facility-based community nurses. The motivators are expected to make monthly reports to the supervisors. The current assessment showed that although hundreds of village-based volunteer health promoters have been recruited over the past few years, very few of them have remained active. In most places, community members were not aware of the existence of such agents among them. Investigations showed that during the first year or so after training, community-based volunteer motivators carry out health motivation work enthusiastically. But soon after, they slacken and stop operations.

altogether. It was reported that having stopped motivational work, some motivators avoided meeting health workers. Most CHWs stop working because they are not paid, despite being informed at the time of recruitment that they would receive no payment. Respondents interviewed during this assessment explained that “at the recruitment meeting, health workers explain clearly that the positions are voluntary, and people recruited would serve the community without payment. But apparently many see this as a mere test to reduce the number of candidates. They keep hoping that at some point they would be paid. They see ‘volunteers’ funded by other agencies in the district receiving payment or gifts, such as bags, and hope that this will happen to them too. When it doesn’t happen, they quit.”

The point is well illustrated by CBD cadres recruited by the Ministry of Health through different donor agencies. The oldest of the CBDs were recruited under the Kenya-Finland PHC project, which has since come to an end. This category of CBDs received no incentives at all. CBDs recruited under the GTZ project received boxes for keeping contraceptives, calendars, pens, and stationery.

The government CBD categories work side by side with Maendeleo ya wanawake organization’s CBDs, who get Ksh 450 per month. The Lugulu friends mission’s CBDs were enabled by the mission to acquire two sunflower oil presses.

Other reasons for relative ineffectiveness of community-based volunteer motivators are

- Inadequate supportive supervision from health workers
- Fear that they do not have adequate knowledge to answer questions put to them by the people during education sessions
- Fear of approaching and motivating men (Most community-based volunteer motivators are women)
- Getting discouraged when the people they try to motivate do not respond positively
- Lack of commitment to serving without material benefits
- Tendency of community members to disregard motivators because “they have no medicine to give.”
- Inadequate acceptance of motivators by some community members who take the position “What can so and so tell me about health?”

Community-based volunteer motivators appear to remain active only when they receive payment or gifts (see reference above to MYWO and GTZ CBD agents), when they are involved in an income-generating activity as a group, or when they charge for services rendered and keep the money. Lugulu mission hospital CBDs have remained relatively active because the mission has helped them to acquire two sunflower oil presses. The business success of Bumula community pharmacy enabled CHWs to make a little money, which has motivated them to remain active. The MOH-recruited GMAs in Bumula charge Ksh 3 for every child served during clinics, and

this has helped them remain active as a small group. Lugulu mission hospital GMAs are similarly active because they keep the money they collect during child clinics.

### **Traditional birth attendants (TBAs)**

Traditional birth attendants are the best of village-based health motivators. They are traditional, they are well integrated in community life, and the community has since developed a way of compensating them for their services. Many TBAs have been trained in the district by MOH, NGOs, and mission hospitals, and have been equipped with kits to examine pregnant mothers and to assist mothers during delivery. The training also equips TBAs to advise pregnant mothers to visit the clinic for check ups, deliver first babies at a health facility, go to the hospital for delivery if they are pregnant with twins, take children for immunization and monthly weighing, and get TT immunizations during pregnancy. Other messages disseminated by TBAs at barazas and elsewhere include keeping kitchen gardens, making pits for rubbish disposal, constructing and using latrines for fecal disposal, and keeping homes clean.

While they disseminate health messages freely, TBAs are paid for delivering babies. The payment they receive is small (up to Ksh 200 per delivery), but they nevertheless feel compensated enough to continue to provide services for pregnancy, delivery, and free health education to those who come to them. In addition to payment for assistance given during delivery, in some places TBAs have financial “merry go round” arrangements that increase their income and promote their sense of belonging and motivation. In Kimilili, for example, TBAs are expected to visit the sub-district hospital once a month to deliver reports of activities they carry out. Up to 17 TBAs in the merry go round visit the health facility. Each of them gives Ksh 100, which goes to a member in rotation. If on that day there is a member with a pressing problem, an additional Ksh 50 is given to assist that member.

### **Traditional healers**

Although the MOH has not worked closely with traditional healers, most of the healers reportedly recognize the value of using modern health services and refer patients to modern health facilities for treatment of diseases “that need modern treatment,” such as malaria. Even when they feel that “ebikumba” (insertion of broken bottles, pots, and other items in a human body) are involved, after removing such fragments they advise the patient to go to the health facility.

### **Traditional circumcisers**

Through training, in 1988, 1990, and 1992, MOH sensitized traditional circumcisers to the need to improve techniques to protect young men from becoming infected with TT and HIV. Messages included sterilization of circumcision equipment and advising those circumcised to come to the hospital for TT injection. As a result of the training, more newly circumcised young men visited health facilities for TT injection, and circumcisers used better sterilized equipment.

### **Churches**

The church was mentioned as one of the most convenient locations to place health messages for widespread dissemination to the community. MOH has sometimes used churches to disseminate health messages, but not nearly enough. Interaction between MOH and the church has been limited to giving lectures, showing films to church groups, and asking churches to make announcements relating to preventive measures during disease outbreaks.

The enormous opportunities that exist for disseminating health messages through the church are discussed in section 4.

### **Community groups**

As in most parts of Kenya, women's groups are the most numerous in Bungoma district, followed by youth groups. These groups come together for various reasons relating to welfare or generation of income. They include cooperative societies and environment, health, and tree-planting groups, and others. However, the groups are yet to be tapped for health promotion. Even groups that start as a result of health activities shortly drop the health agenda (see Bungoma urban family development project in section 4). Integrating health messages in the activities of these groups could prove most beneficial.

### **Schools**

Teachers have in the past been trained (e.g., during outbreaks) to disseminate messages to pupils for their own use and to carry the message home. Sometimes interested teachers have obtained health information on their own and passed it on to pupils to take home.

In the past, MOH has implemented successful child-to-child immunization programs, leading to the immunization of more than 4,000 children. Program activities took pupils into the community to identify defaulting children and motivate their mothers to take them for immunization at the nearest health facility. In addition, in 1987 through 1989, MOH worked with schools to make demonstration latrine slabs and motivate schools and surrounding communities to construct VIP latrines. Many latrines were constructed as a result of this program. These successes indicate the potential that exists in integrating schools in action for health.

### **Village health committees**

Nearly all villages visited during this assessment had village health committees. Membership to the committees varied, with between 9 and 15 volunteers chosen from among the villagers. In most places, the village headman (mukasa) was a member, in others, he was the chairman of the committee. Terms of reference for VHC are to

- Discuss and take action on health issues in the village
- Welcome and host visitors coming in the name of health
- Disseminate health education in the village
- Carry out activities requested by health facility staff
- Organize meetings and invite experts to address people

Members of VHCs are said to disseminate health messages during barazas and during village meetings called for various reasons from time to time. VHC members are expected to receive IEC materials and to place posters in conspicuous places (such as shopping centers) where people can see them. Although health staff reported that VHC members had received training to equip them for duties expected of them, VHC members themselves believed that they had received no training and needed to be trained. In addition, they requested IEC materials to use in educating people. In most places visited, however, VHCs were said to be inactive and they seldom met. Most people interviewed said they did not know the members of their village health committee.

### **Individual health board and committee members**

According to health board and committee members interviewed, individual members of the boards and committees are expected to disseminate health messages in the villages they live in and help patients get to health facilities when they are sick. However, community members interviewed said they were not aware of committee members who disseminated health messages in the community. Some committee members admitted that they were ineffective in performing this role because people do not turn up when they call them because they do not have medicine to give them.

### **Provincial administration**

All people interviewed during this assessment felt unanimously that the most effective way of reaching people with messages, including health messages, was to place the responsibility of dissemination with the village headman (mukasa) and other members of the provincial administration.

Mukasa is a community-appointed volunteer charged with the responsibility of managing the affairs of a village. Once appointed by villagers, mukasa is integrated in the work of the provincial administration as the link between the administration and the smallest community units. He remains unpaid but benefits from fees and in-kind payments villagers make to have their work done and disputes settled.

MOH has not formally involved mukasa and his seniors (assistant chiefs, chiefs, district officers, district commissioner) in dissemination of health messages. However, many mukasa are already disseminating health messages in the meetings they call and find time to go house to house disseminating messages, especially during disease outbreaks. They use the knowledge they get from listening to health workers who make presentations during barazas.

Community members see mukasa as the most effective change agent because he

- Is enthusiastic about his work
- Is respected in the community and when he calls a meeting people turn up

- Can reach men, who are otherwise difficult to reach
- Does not rely only on meetings, but also disseminates messages door to door when necessary. When there is a shortage of manpower, mukasa has adequate clout to mobilize temporary volunteer workers
- Can use his authority to pressure people to comply when necessary (Most people interviewed believed that it is sometimes desirable to apply moderate pressure to achieve compliance in health programs )

Chiefs and assistant chiefs also disseminate health messages based on the information they gather during health professionals' presentations at barazas and various community meetings

Some members of the provincial administration are so committed that they are taking major initiatives to promote health. The sub-chief of Kimilili sub-location is establishing a health committee that will comprise elders and technical people. A key activity of the committee will be to promote dissemination of health messages at public meetings, through interest groups, and door to door. Areas of concentration will be protection of water sources, home cleanliness, latrine construction, construction of stands for drying plates, and malaria control through draining of stagnant water and keeping homes free of unnecessary foliage. Volunteers involved in health promotion will report monthly, and the committee (six women and eight men from each village in the sub-location) will meet to review activities monthly.

The following will be implemented to keep committee members motivated

- Health experts will be integrated into the committee
- Nonprofessional committee members will work alongside technically trained ones. Committee members will guide trained health workers when they come into the community from elsewhere
- Community-based motivators will be introduced to community members during public meetings

Watching mukasa, chiefs and sub-chiefs interact with their subjects reveals the good relations that exist between the people and their rulers in Bungoma district. The good relations place mukasa in a position to become a good educator. The mukasa has the attributes of a sustainable volunteer: he is already enthusiastic about health and is disseminating health messages even without training and formal recognition as a motivator. Like the TBA, he is well integrated in the life of the community and is paid in a socially sustainable way.

Yet in order for the mukasa to be integrated in the proposed IEC strategies, he will need training, both in health content and in effective teaching methods.

## **Social development assistants**

Social development assistants are officials of the Ministry of Culture and Social Services who facilitate formation of community groups and promote sporting and other cultural activities. The officers are active in convening group meetings, to which they invite various departments to disseminate the messages they may wish to communicate. If needed, the officers can help convene meetings or organize groups that can be involved in malaria control activities.

## **2.4 Coordination**

The MOH in Bungoma has been trying to reach out to other agencies and has facilitated formation of the district AIDS committee, which brings together the MOH, NGOs, and other agencies working in AIDS and related areas under the chairmanship of the district commissioner. The district commissioner is the representative of the office of the president in a district, with the mandate to coordinate all development activities and government departments. Formation of an intersectoral health committee under the chairman of the district commissioner has been proposed but not yet implemented.

## **3 STRENGTHS AND WEAKNESSES OF MOH IEC DELIVERY STRUCTURE**

### **3.1 Successes and failures**

Bungoma district has run some very successful health education programs in the past. These include the child-to-child immunization project, which led to the immunization of 4,000 children, the latrine construction program which led to a significant increase of VIP latrines in schools and in the community, and the circumciser education program, which led to a significant increase in the number of newly circumcised young men going to health facilities for TT immunization.

Currently, nearly all people living in the district have heard of the need for good health and the measures they can take to combat diseases and improve the health status of the individual, the family and the community. But according to respondents, many do not comply. Key reasons given for noncompliance are:

- Illiteracy
- Poverty
- Culture, with people arguing that “this is what we have always done”
- Scorn, as in “What can so and so tell me?”
- Religious and cultural beliefs that are against modern health services
- Shyness about teaching men. Most educators are women and are shy to teach men. Some men would not like to be taught by women.

### 3 2 Strengths of the structure

The MOH IEC structure is strong in the following ways

- It stretches from the district to the village level
- It uses both salaried staff and volunteers
- Both staff and volunteer categories seem to have received good initial training in IEC and to disseminate a wide range of messages
- On the whole, the formal health delivery system interacts reasonably well with volunteers and the community level. Mothers say their primary source of health messages is the health facility

### 3 3 Weaknesses

**Supervision** Supportive supervision from paid health workers to volunteer motivators is limited at all levels and inadequate to motivate and sustain the volunteer motivator infrastructure. Commonly used forms of supervision comprise (1) DHMT team supervision once a month (when there is petrol), and (2) program coordinators' supervision (whenever coordinators can free themselves from other duties at health facilities). Except for "visiting to look at the projects volunteer motivators are carrying out" (such as bean planting with seeds advanced by the health facility), there was little evidence of a systematic supervision process with a rationale for selecting where to go for supervision and/or areas of CSM skills to promote during supervision.

Most supervisors preferred to call volunteer motivators to the health facility once a month "to bring reports and discuss their problems," rather than meet them in the community. Few motivators attend the meetings at health facilities. They complain of lack of transport to bring them to the health facility, some (especially TBAs) are too old to walk the distances.

**Motivation in the community by paid staff** Paid staff do not go into the community as often as desirable. Reasons given are the volume of work at the health facility and lack of transport. Transport is particularly needed to enable staff to reach remote parts of the district. The transport problem is often compounded by the fact that some health workers (such as PHTs) live in urban areas far away from the sub-locations of their assignment.

Several years ago, two donor agencies working in Bungoma issued bicycles to facility-based health workers to ease the transport problem. The first bicycles were issued by the Kenya-Finland PHC Project in 1988 and the latest were issued by GTZ in 1995. The bicycles were apparently issued directly to the users without the involvement of the district health management team and were never recorded in MOH books. This resulted in some health workers receiving more than one bicycle.

Initially, the donors used to give spares for the bicycles, but this assistance stopped when it was abused by people requesting spares too often, or to repair non project bicycles. After the

assistance was withdrawn, it was expected that bicycle users would maintain the bicycles at their own cost and use them for both health and personal purposes. Attempts by the MOH to take stock of the bicycles have been unsuccessful.

**Record keeping and utilization** Management of health records at most health facilities is found to be inadequate. Most of the records also lacked the information that could facilitate follow-up of clients in the community. Motivators follow up only those cases they have located through their own contacts.

**Voluntarism and volunteer morale** MOH activities rely on volunteers to disseminate health messages in the community. However, sustaining voluntarism has proved difficult, and volunteers trained in the past have since stopped health promotion activities. Reasons for faltering voluntarism include poverty in the face of the rising cost of living, donor tendency to pay for all services (including voluntary), especially at the beginning of projects when there is much money, different benefits being given to similar cadres managed under different projects, and the widespread staff belief that people cannot be expected to work free of charge.

**Relations between mothers and health staff** Mothers who come to health facilities for services complain of scolding by nurses and use of rude language. They say they are afraid to ask nurses questions and only take the information the nurses offer. There is clearly a need to improve health workers' interpersonal communication skills, which should help them improve relations with their clients and disseminate key messages as they come in contact with clients.

**Competition between education and services at health facilities** Mothers come to health facilities expecting to be served in the shortest possible time so that they can return to their work. But when they get to the clinic, they find that they have to start by listening to a health talk before they can be given the services they came for. Many caretakers seem to resent this and feel that health talks are a waste of time.

Webuye health center reported that some time back clients hated health talks so much they waited at the gate and came into the health center compound only when they thought that health talks were over. The clinical officer in charge of the health center responded by abolishing health talks, and instead encouraged education during the course of treating and giving medicine.

Some clients resent long history-taking sessions with health workers. They complain that health workers spend too much time asking them questions instead of treating children quickly and releasing them to attend to other activities.

The complaints point to the need to improve IEC and other interactions that take place between health workers and clients.

**Program sustenance** Little attention is given to program sustenance during planning and implementation of IEC activities. Programs tend to be donor driven, do little to mobilize and

sustain community ownership, and are generally reduced in size and vitality as soon as donor funding stops

**Availability of resources and equipment** Scarcity of resources has hampered the ability of MOH to purchase inputs such as oil for spreading over large masses of water to stop mosquito breeding. Poverty makes it difficult to buy and use mosquito nets, and this could hamper development of comprehensive IEC packages that can lead to tangible malaria control results

Respondents lamented that while in the past *bora afya* (now PHTs) used to spray stagnant water with chemicals, they did not do that any more. They hoped the project would make the needed chemicals and mosquito nets available for use in the community

**Refresher courses** Because of funding constraints, MOH does not organize refresher courses to update village-based volunteer motivators and revitalize them frequently. Opportunities for refresher courses have arisen only when a donor or the district level has wanted them. The district level sets the dates and the agenda for such courses, with little involvement of the facility level

#### 4 OTHER DEVELOPMENT AGENCIES IN IEC

Bungoma has few NGOs, and even fewer that disseminate IEC beyond their own premises. The NGOs working in the district include the Bungoma family helper project, Bungoma urban family development program, the red cross society, Maendeleo ya wanawake organization, churches, mission hospitals, and private hospitals. Partnership for productivity has since ceased operating in the district. Details of the activities about the organization are as follows

##### *Maendeleo ya wanawake organization*

Maendeleo ya wanawake organization (MYWO) started activities in Bungoma in 1968 with three projects: women and energy, leadership training, and MCH/FP

As a result of donor support, MYWO eventually recruited 173 village-based CBD agents, two supervisors, three nurses, a manager, and support staff. The main donor has, however, given notice of intention to pull out at the end of June 1998, and unless another donor is found, MCH/FP activities of the organization may come to a halt. CBD agents are supported by staff of the department of social services and MYWO sub-locational subcommittees

MYWO is a volunteer organization with an elaborate network of committees from the national to the sub-location level. Members serve the organization in a voluntary capacity. The chairperson of the organization in Bungoma, Mrs. Dina Khayota, explained that voluntarism worked very well when the organization started in 1952. But "inflation and donor funding have killed the volunteer spirit, and now people want to be paid for everything they do." The organization's volunteer CBD agents get Ksh 450 per month

In the past, the organization had organized competitions to encourage people to keep their homes clean and observe hygiene and other good health practices Mrs Khayota believes that the competitions have a place and could greatly stimulate adoption and sustenance of good health practices She requested assistance to enable MYWO to open a drug store to stock malaria drugs and mosquito nets to sell at prices people can afford (Bumula community pharmacy is carrying out similar activities)

Difficulties experienced include

- Long distances covered by CBD agents because of lack of transport
- Lack of funds for refresher training to keep CBD agents up to date
- Shortage of funds for programs
- Loss of interest by MYWO committee members Committee members thought they would receive payment for their services When payment was not forthcoming, they stopped turning up for meetings As a result, most committees in the district are inactive

### **Bungoma Family Helper Project**

The Bungoma family helper project started operating in Bungoma district in 1994 under the sponsorship of Christian children's fund Its activities include primary health care, small enterprise development, and an education program Through the PHC program, orphaned children and children from poor families are checked and treated for any diseases they may have Malaria and worms are the most common diseases they are treated for The families of selected children receive education on nutrition and are assisted with farm inputs (including dairy cows) and advice to improve their agricultural production

The organization employs 21 field educators in Kandui and Bumula locations who help identify the families that should be assisted and disseminate messages on environmental sanitation, keeping the compound clean, safe drinking water, agro forestry, dairy farming, poultry keeping, tree planting, family planning, and avoiding diseases such as malaria

Methods used to disseminate information include seminars, public meetings (barazas), and home visits

The current principal donor (Christian children's fund) plans to pull out in August 1998, an event that could bring the project to a halt if no other donor comes up There are, however, chances that GTZ may pick up the costs, although no specific understanding has not yet been reached

### **Bungoma urban family development project (BUFDP)**

The BUFDP started activities in Bungoma in 1990 The organization aims to transform the poor and needy, both economically and spiritually

The project has two social workers who go into the community, identify poor and needy families, and write reports about them to send to the headquarters. Based on the reports, eligible families are selected for the following benefits:

- Sponsorship and payment of school fees and other school dues for eligible children
- Farm inputs

Schools in which sponsored children are enrolled in often receive support from Bungoma urban family development project as well. Support given could be in form of building materials, text books or other school supplies. Other services offered by the organization include:

- Church leaders' leadership and stewardship seminars
- Youth camps on family life
- Family planning seminars
- Provision of building materials to poor families
- Cows and instruction to families on how to care for the animals
- A feeding program for orphaned and destitute children at Kandui children's home
- A feeding program for malnourished children from poor families at Tuuti
- Carpentry and garment-making courses at the organization's center in Bungoma
- Monthly immunization, weighing, and growth promotion outreach and education sessions at Ekilate and Siyoa (Visits to the third outreach point were discontinued because of poor attendance)

On average, more than 200 clients are served on every mobile visit.

During outreach days, social workers conduct educational sessions, often supported by the chief, sub-chief and TBAs. The names of all people attending clinics are registered, and the lists are used by BUFDP social workers to develop programs of home visits.

Visits are made to the homes of families selected to participate in the BUFDP assistance programs. The families to be visited are notified in advance and are encouraged to invite other people, especially those benefitting from outreach services, to come to their homes and receive more information and counseling.

Gathering in people's homes has stimulated formation of a number of women's groups, which are now engaged in income-generating activities. Once the groups are formed, however, they tend to concentrate on income generation and credit activities and do little in health and education.

There is a need to find ways and means of encouraging these groups to make health a prominent agenda in their activities

### **Other organized groups**

Bungoma is full of both women's and men's groups. These include cooperatives, welfare groups, neighborhood groups, and income-generating groups. However, the groups do not have health on their agenda. It would be helpful to find ways and means of integrating health in the activities of these groups on the basis of a theme, such as "Putting health first makes more income."

### **Child Welfare Society of Kenya, Bungoma Branch**

The Child Welfare Society of Kenya, Bungoma Branch, runs a home for destitute, abandoned, and neglected children in Kandui, within Bungoma municipality. Here the children are fed and cared for. The care includes sponsorship of children to schools, vocational training, and resettlement of children back in their homes or elsewhere so that they can start a more permanent life. Some children have been given land on which they have built houses and made a new life.

The home also puts children up for adoption. Before couples are allowed to adopt the children, however, they receive education in child rights, the adoption process and foster care. Similar education is given to volunteers who serve on the committees of the home, and all children in the home receive education on child rights and on a variety of health topics.

### **Churches and religious groups**

As in other parts of the country, the vast majority of people living in Bungoma district are associated with one church or another. They respect the church and attend church functions regularly. Messages disseminated from the church may stand a chance of reaching many people. In addition, the church is fairly well structured for message promotion, with groups and unique opportunities that can be used to disseminate messages. These include integrating messages in sermons and meetings of various interest groups, such as women's groups, youth groups, and, in some churches, men's groups (Adventists). Churches and religious groups active in the Bungoma area include the reformed church, Seventh Day Adventist (SDA) church, full gospel church, Church of the Province of Kenya (CPK, Anglican), Salvation Army, friends church, and Baha'i faith. There are also a few Muslim congregations.

Many of these groups are already disseminating health messages, and some have health programs that recruit volunteers to work in the community (reformed church, CPK, Salvation Army, and Baha'i faith). Structures and activities that present opportunities for integrating health messages in religious organizations include the church leadership and committee system (including chairmen, deacons/deaconesses, church elders), women's groups (mama dorcas in SDA, mothers union in CPK, women's fellowship groups in the full gospel church), youth groups (Kenya Anglican youth organization in CPK, pathfinders in SDA), home church leaders (cell leaders in the full gospel church). Many of these groups are uniformed, disciplined, and enthusiastic about providing humanitarian services that others can benefit from.

Programs in which health messages can be integrated include church seminars, vocational training institutions, and leadership training programs

### **Misikhu Catholic mission hospital**

Misikhu Catholic mission hospital provides two kinds of health services curative health care at the hospital and preventive health care through the community health care program

#### ***Curative health services***

Misikhu provides normal curative hospital services, including examination, drugs, and treatment of in-patients In addition, the hospital provides the whole range of primary care services

The hospital is concerned, however, that patients need to know more about their ailments, take drugs as required, and practice various disease-prevention measures To help people adhere to these requirements, the hospital gives health talks while patients wait for treatment and gives additional information during counseling at the time of treatment Information given to patients and caretakers includes details about the diseases the clients may be having, the importance of taking the drugs given until they are finished, and what to do to prevent further health problems

Problems the hospital faces include patients hopping from one form of treatment to another, selling or sharing drugs meant for one patient, taking half a dose, and discontinuing when the patient “feels cured ” These concerns force the hospital to keep patients in the hospital for longer periods, even for fairly simple ailments

To ensure that both nurses and doctors give patients the messages they need, the hospital takes the following measures

- At their daily meetings, the hospital medical team (three doctors and two clinical officers) review the content of the information the staff give to the patients
- During ward rounds, team members review patient case notes, pointing out information that should be given to the patient
- The need to give information is reinforced during staff meetings and refresher training

#### ***Community-based health care project***

The Misikhu mission hospital community-based health care project covers Naitiri, Mbakalo, Mt Elgon, and Misikhu locations and has recruited 16 trainers (TOTs) and about 350 community health workers, each covering 10 houses or a little more

Community health workers are a cadre of volunteers selected by their communities and trained by the project in three phases over a one-year period Once trained, they are expected to return to their communities to disseminate health information at barazas, through home visits, and at other venues CHWs are expected to meet at a sub-locational level with their TOT once a month, and

TOTs (also volunteers) are expected to meet with CBHC supervisors at Misikhu every two months. During both meetings, reports are given.

To facilitate the work, TOTs are given bicycles with a yearly allowance of Ksh 1,000 for bicycle maintenance.

As with government-recruited community-based volunteer motivators, CHWs request payment at nearly all the meetings. The requests have not been met by the hospital and as a result, half of the CHWs are inactive. The remaining half have been kept going because

- The CBHC team gives close supportive supervision, including frequent visits to the field and attendance at sub-locational CBHC meetings.
- TOT refresher courses are given two times a year. These help motivate TOTs and strengthen the team.
- Income-generating activities are promoted. The hospital is beginning to respond to the pressure relating to payment. It recently set aside a revolving fund of Ksh 10,000 to support income-generating activities.

### **Lugulu friends mission hospital**

The central catchment area for Lugulu mission hospital includes Misikhu and Lukusi locations. The hospital also works closely with the two major factories in the district: Pan Paper and Nzoia Sugar companies.

Like other health promotion organizations in the district, Lugulu friends mission hospital employs analogous cadres of health workers and uses similar opportunities to disseminate health messages. Yet they appear to have experienced a higher level of success in some areas than the other organizations have been able to achieve.

At the mission hospital, health messages are disseminated during health talks in different areas of the hospitals, such as in the children's ward and at the antenatal clinic. They also disseminate information in the community in schools, at churches, at barazas, and in women's and youth groups. Categories that are trained by the hospital and that disseminate information in the community include paid nurses and community volunteer TOTs, CHWs, CBD agents, GMAs, and TBAs.

### ***Community TOTs***

The hospital has selected and trained a wide variety of community TOTs from among staff of the provincial administration (chiefs, assistant chiefs, mukasa), the church (priests/pastors, lay leaders, members of interest groups, such as women and youth groups), women's groups, teachers, representatives of the different departments at Pan Paper and Nzoia Sugar Company, and extension workers of other agencies and government departments. After training, individuals selected return to their stations and disseminate health messages at barazas and during home

visits, care for the sick at home, and report to the hospital cases of sick people who need help or are unwilling to go to the hospital

In addition, community TOTs train others to carry out the activities they themselves are carrying out. The replica effect increases the labor force available to work, maximizes community sensitization, and promotes the feeling that health promotion is the responsibility of all members of the community, not a preserve of a few. As more and more people become involved in disseminating messages, it becomes increasingly difficult to justify paying any of them for their part in service to the community.

Out of the 40 CBDs recruited by the hospital, 34 remain active. During this assessment, the team was repeatedly told by respondents that field workers from Lugulu mission hospital were more active than those employed by other organizations.

In factories, trained individuals conduct health education sessions, carry out peer counseling, distribute condoms, and care for sick colleagues. Pan Paper goes a step further and organizes educational folk media activities. Church leaders disseminate messages in church congregations, funerals, women groups, seminars, church leaders' meetings, and marriage counseling sessions.

Nursing staff at the hospital follow up on cases reported in the community and provide assistance as needed.

### ***Motivation***

The following partially explains in part the relative success of Lugulu's community education activities.

- 1 The volunteer motivation system recognizes achievement and services rendered
  - After training, participants are awarded certificates
  - Lists of trained individuals are given to the provincial administration, who introduces them to the community at barazas and asks people to consult them on health issues
  - Trained individuals are given a prominent role during mobile outreach clinics, giving them an image of "village doctors"
- 2 There is constant supportive supervision from hospital staff. Visits made by hospital staff to the village and in the homes of motivators boost motivators' morale, and their standing in the community. During interactions with the village-based motivators, health staff shares important information designed to improve future strategies.
- 3 The TOT committee (comprising all TOTs in a given area) meets monthly to discuss and find solutions to their common problems and give mutual support to one another.
- 4 The hospital supports income-generating projects that provide additional motivation
  - Growth monitoring agents are allowed to share the Ksh 5, which they charge mothers per child served during outreach clinics in the community.

- CBDs have been supported by the hospital to acquire two sunflower oil presses (at Ksh 26,500 per press) from funds provided by the hospital and earn income from the profits Each unit supports nine CBDs
- CHWs have started fish farming activities with the support of the hospital

## **5 COMMUNICATION PLANNING AND IMPLEMENTATION**

MOH communication planning and implementation in Bungoma district may be divided into three categories routine program, disease outbreaks, and special projects

### **5.1 Routine program**

Planning and implementation of the routine IEC program can be divided into three parts preparation of the monthly program, implementation of activities, and reporting

At the beginning of every month, all salaried health staff who disseminate health messages prepare programs of the activities they will carry out in the coming month and forward it to their supervisors Programs may be prepared on any piece of paper, as there is no standard format Generally, monthly programs include date, place, and activities to be carried out

Family health field educators forward their programs to the district health education officer Activities carried out normally include talks at health facilities, home visits, barazas to attend, mobile clinics to attend, and IEC visits to schools, churches, and other groups Reports sent to the DHEO at the end of the month usually comprise purely quantitative statistics specifying the number of activities carried out and sometimes the number of people present at those activities They usually contain no qualitative narratives that describe issues and problems encountered Out of the statistics, the DHEO compiles a monthly report for the DHMT IEC activities of other cadres (see section 2) are not included in the DHEO's report and can be reviewed in their respective departments (public health department and nursing department)

### **5.2 Disease outbreaks**

When a disease outbreak is reported, it is discussed in a DHMT meeting and immediate plans are made to investigate the gravity of the situation During the recent cholera outbreak, curative, surveillance, and investigation teams were set up The surveillance team (headed by the DHEO) identified affected persons, sprayed affected homes as necessary, and provided the affected family with health education

Only verbal education was given, without the assistance of educational materials (see also the section on "IEC materials" elsewhere in this report) Messages were disseminated through all available media at barazas, in churches, in schools, in marketplaces, etc

### **5 3 Special projects**

Implementation of special projects, especially donor-funded ones, is preceded with a project proposal that includes normal project details, such as situation analysis, problem statement, target groups, goals and objectives, strategies and activities. Objectives are stated in general terms. Target groups are also identified in general, not in specific, terms (see below)

## **6 IEC TARGET GROUPS**

From the focus group discussions and personal interviews, we found that most IEC activities target women

- Most PHC services target women and children
- Health messages are discussed most often at health facilities, places that are more frequented by women
- Women are better organized in groups and, therefore, easier to reach with health messages
- When message disseminators visit homes, they are more likely to find women
- Most motivators (salaried and volunteers) are women, and often when they find men at home, the latter excuse themselves to allow women to talk. Many of the women motivators are shy to disseminate messages to men

Men get messages mostly from barazas, which they attend in greater numbers than women. They are more likely to get messages from radio than women are (see 9 2)

### **6 1 Audience definition**

Both at the MOH and in other agencies, audiences for health messages are defined by general categories. When categorizing audiences, message disseminators talk about “ANC mothers,” “TB patients,” or “people of village X.” IEC programs do not undertake finer definitions that segment audiences on the basis of information needs, parity, age, or educational levels

### **6 2 Role of men in malaria control and management**

Malaria control and management programs may include elements such as provision and use of mosquito nets and insecticide for re-treatment, and ensuring that children are treated promptly when they have malaria. Men have a strong voice in how their children get treated when sick (especially when the disease gets serious and treatment is expensive) and may be called upon to provide bus fare or bear other costs that can facilitate treatment. Besides, chores relating to the management of the environment, such as destroying broken pots, draining stagnant water, and keeping the compound clean are the responsibility of men. It will be necessary, therefore, to develop strategies that can adequately reach men and involve them in the proposed malaria control interventions

## 7 MALARIA CONTROL MESSAGES

It is clear from the assessment that there is no standardized, generally agreed upon package of malaria control messages that ought to be emphasized in message dissemination in the district, and different individuals (at health facilities and in the community) lay different emphases on different messages. Clearing bushes around homes and draining stagnant water seem to be the most emphasized of all messages, even though this activity is of little value in preventing malaria. Other messages are presented in the chart below in three categories: easy to act upon, difficult to act upon, and questionable messages. The first two categories are those of respondents. The third column was added by the assessment team to distinguish between messages generally regarded as relevant to malaria control and those that may not be relevant.

EASY TO ACT ON	DIFFICULT TO ACT ON	QUESTIONABLE
Take malaria patients to the health facility early	Plant bananas far from the homestead	Clean your compound, cut grass and bushes
Take all the malaria medicine given at the health facility	Prune bananas to remove leaves which can hold water after the rains	Boil water to avoid malaria
	Make sure your house has adequate light and air	Drain stagnant water
	Close up the space between the roof and the wall plate of your house	Get rid of tins and broken pots
	Put wire gauze on windows and doors	Feed on a good diet
	Use mosquito nets	Observe good home and personal hygiene
	Use mosquito coils	Spend more time with your family so you can find out early when they are sick and take appropriate action
	Spray your houses	Take medicine when you have malaria
	Take weekly prophylaxis	Keep drains open and flowing

**Note** It has been shown that cutting brush and grass around the compound does not reduce *Anopheles* biting or malaria transmission and thus should NOT be part of malaria prevention messages. Draining stagnant water on an individual household basis will also have little impact. *Anopheles gambiae* has a flight range of more than 2km. Getting rid of tins and broken pots is also questionable. *Aedes aegypti*, the mosquito vector of Yellow Fever and Dengue virus, breeds

in such containers, but *Anopheles* are more often found in ground water. Thus, clearing tins and broken pots is good against Yellow Fever, but not malaria. Likewise, *Anopheles gambiae* breeding in leaf plant axils is extremely rare. One should never suggest villagers prune their banana trees. The eave space between the roof and wall is a common entry point for mosquitoes, but it is also a major point of ventilation. It can and should be screened, but it is unreasonable to ask householders to close the eaves and block air flow. Mosquito nets by themselves provide only partial protection, whereas insecticide-treated nets are very effective. One may argue that the insecticides are not available, but they will be soon, and so we should always speak about "insecticide-treated nets," and not just bednets. Mosquito coils are minimally effective. *Anopheles gambiae* feeds predominantly after midnight, so lighting coils or burning leaves in the early evening may reduce *Culex* mosquito biting but not the malaria vector. Spraying houses with residual insecticide is effective if a high (over 80%) percentage of houses are sprayed. Using aerosols or flit guns is expensive and, like the coils, will not offer protection in the early morning hours when it is most needed. Weekly prophylaxis is also not recommended. Two courses of Fansidar during the second and third trimester, especially for primigravidae women, is recommended, but weekly prophylaxis for entire populations is not. Take malaria patients to health facility early, yes, but it is more realistic to tell the population that they need to take a full course of chloroquine or Fansidar (depending on the MOH recommendation), whether it is from a government or private facility. They should be told not to waste their money on inappropriate injections and infusions.

**Action Point** The program will need to determine a minimum effectiveness package of malaria control messages and interventions to promote

## 8 CHANNELS OF COMMUNICATION

In the table below are listed channels and opportunities used for health promotion in Bungoma district. Respondents consider health facilities, mukasa, churches, radio, and schools to be the most effective channels for disseminating health messages.

USED SETTINGS & CHANNELS	CONSIDERED MOST EFFECTIVE
Barazas (chiefs, asst chiefs, mukasa)	Health facilities (women)
- lectures	Mukasa
Funerals	Churches
- public announcement	Radio (KBC Kiswahili service)
Health facilities	Schools
- health talks	
- small departmental talks	
- individual counseling	

USED SETTINGS & CHANNELS	CONSIDERED MOST EFFECTIVE
<p>Pharmacies</p> <ul style="list-style-type: none"> <li>- counseling about drugs</li> </ul> <p>Mobile clinics</p> <ul style="list-style-type: none"> <li>- health talks</li> <li>- individual counseling</li> <li>- women's groups</li> </ul> <p>Mobile cinema vans (film/video shows)</p> <p>Women's groups</p> <ul style="list-style-type: none"> <li>- lectures</li> <li>- discussions</li> </ul> <p>Home visits (by trained village-level educators, salaried health staff, mukasa-selected village volunteers)</p> <ul style="list-style-type: none"> <li>- small group discussion</li> <li>- individual counseling</li> </ul> <p>Visits to TBAs by pregnant mothers</p> <ul style="list-style-type: none"> <li>- individual counseling</li> </ul> <p>Churches</p> <ul style="list-style-type: none"> <li>- pulpit announcements</li> <li>- women's group discussions</li> <li>- fellowship meetings</li> <li>- plays and music</li> </ul> <p>Schools</p> <ul style="list-style-type: none"> <li>- lectures</li> <li>- music and plays</li> <li>- teachers</li> <li>- pupils (carrying messages home, mainly to mothers)</li> <li>- film/video shows</li> </ul> <p>Radio (KBC national service)</p> <p>Mentioned to a lesser extent</p> <ul style="list-style-type: none"> <li>- Peers, traditional healers, neighbors and old women</li> </ul>	

## **9 IEC MATERIALS**

Because of financial constraints, Bungoma district does not produce any educational materials but uses materials sent from MOH headquarters or acquired from NGOs and other sources

### **9.1 IEC print materials**

Most of the time, the DHEO has some materials from MOH headquarters to distribute. They are always materials meant for national use and not necessarily those the district needs most. The materials are either in English or Kiswahili.

Most of the materials received are posters, and are stored in two crowded cupboards in the DHEO's office. They are issued to health workers who request them. The health workers who are issued materials, in turn make them available for use at the clinics where they work.

Posters were widely regarded by respondents as useful educational materials that should be posted in prominent places where many people can see them. However, respondents said posters are rarely seen in villages except "in health facilities and in health workers' houses." On the other hand, some community-based health workers and members of health management committees said they placed posters in prominent places such as at meeting places, marketplaces, and shopping centers for people to see and learn from.

Most people interviewed could recall some of the posters they had seen and the subjects they covered (such as family planning, kwashiorkor, polio, diarrhoea, etc). However, many respondents said posters did not give enough education and should be followed by teaching. Some of the posters were difficult to understand without an explanation, and it would be helpful to place them in places such as shops or kiosks and train the shop or kiosk owner to explain them. A member of a health center development committee said shopkeepers in his village had responded positively to requests to display health posters in their shops. In addition, they agreed to be trained to explain them to people who needed an explanation.

### **9.2 Newspapers**

The most commonly read newspapers in the district are the *Daily Nation*, *Taifa Leo*, and *The Standard*. *Taifa Leo* is a sister newspaper to the *Daily Nation* and is written in Kiswahili.

Newspapers are mainly read by men. Many newspaper readers find Ksh 25 too high a price to pay for a newspaper every day, so there is a lot of newspaper sharing. One person buys a newspaper and others borrow it to read.

### **9.3 Radio and TV**

Very few people in the district own television sets. However, most have access to the radio. Radio stations received in the district include Radio Uganda (English and Ugandan languages), the National (Kiswahili) Service of Kenya Broadcasting Corporation and the general (English)

service of KBC, both broadcasting from Nairobi, the Kisumu station of KBC (broadcasting in Luhya and other western Kenya languages), Radio Tanzania, Dar es Salaam (Kiswahili), and some of the newer FM radio stations (mainly music and entertainment) broadcasting from Nairobi

By far, the most popular radio station is the National Service of KBC (Kiswahili) The best listening time is between 7 P M and 9 P M News is the most popular program, followed by death announcements Other programs people prefer include various health and development programs such as daktari wa radio, kwa akina mama, maisha bora, mpango wa uzazi, daktari kimende, mtu ni afya Other favored programs include games and programs such as Je, huu ni unguana

A significant number of people listen to educational (mainly health) programs on Radio Uganda, and many young people prefer to listen to music programs on the English service of KBC and on the newer FM stations

Although both sexes listen to radio, men are more likely to listen to radio more regularly than women Factors that hinder women's listenership include the following

- Pressure from men (who usually control radio use) to switch off the radio to preserve batteries
- No time to listen to the radio because they are busy with kitchen chores
- Men not buying batteries for the home radio regularly and giving priority to the little radios they walk around with
- Inconvenient air time Some educational programs come on air when women are working outside the home

Respondents recommended that radio materials for Bungoma district be broadcast in Kiswahili from the KBC in Nairobi, because this is the station that most people listen to

Although the KBC station in Kisumu is only 120km away, and the station has a Luhya language slot, the station is hardly listened to in Bungoma district Reception in the district is very poor and most of the time the Luhya dialects used on it are not Bukusu and, therefore, many Bukusu speakers find it difficult to understand them The third reason is that Luhya is allocated only a short time every day, and many people do not know when these times are

#### **9 4 Music and drama**

Music and drama have been used in schools and at the Pan Paper company to disseminate health messages with promising success As a result, Pan Paper supports a standing drama group

## **9.5 Video and film shows**

The office of the DHEO has a number of health videos that it shows to schools, churches and the general public in marketplaces and other suitable public venues. Projectable materials held at the DHEO's office include films on HIV/AIDS, family life education, sexually transmitted diseases, counseling skills, insect-transmitted infections (including malaria), and others.

The videos and films are shown using a mobile film van made available through the Kenya-Finland PHC project. The van is stationed at the provincial headquarters in Kakamega and can be used by the district that has the money to pay. The van comes with a library of health films, which can be freely used by the district hiring the service.

## **9.6 Storage of IEC materials**

The office of the DHEO has limited space, and IEC materials and equipment have no proper storage space. They are crammed into two filing cabinets, which makes retrieving them difficult. The office needs additional storage space to make it easier for those managing the stores to find and issue materials as may be needed.

## **9.7 Resources for material production**

Quality material development facilities are not available in Bungoma district. However, Joo Enterprises Ltd, situated in Bungoma town, offers a number of innovative graphic design and typesetting packages, including MS Publisher 97, Power Point 97, calendars, and T-shirt design packages. Some of the packages generate computer illustrations and can modify artists' scanned-in illustrations.

## **9.8 Language**

Most people living in Bungoma district speak the Kibukusu dialect of the Luhya language and a minority speak Olutura and Tachioni dialects of Luhya. Also in the district live some Teso and Sebei speakers. The latter two tribes are linguistically unrelated to the Luhya language. In addition, an assortment of tribes have settled on farms formally owned by the white settlers, making Bungoma one of the most cosmopolitan districts in the country.

All the people interviewed during this assessment (the majority of them Babukusu) were of the opinion that IEC materials developed for the district should be in Kiswahili. They said written Kibukusu was difficult to read, even by native Babukusu. If written in Kibukusu, they added, a substantial proportion of non-Babukusu living in the district would miss out on the messages.

A minority said the materials could probably feature Kiswahili and English, while an even smaller minority suggested accommodating Kibukusu on the materials for the benefit of the few who may not be comfortable with Kiswahili.

## 10 COMMUNITY PARTICIPATION

Community support is recognized as an important asset to health programs. The assessment found that local communities supported health activities in Bungoma district to some extent. The community utilized health services, provided committees to support the management of health facilities at all levels, and provided volunteers to carry out motivational activities in the community. Village headmen actively promote health messages in the community, especially during village meetings, and go door to door disseminating messages, especially during disease outbreaks. Also, consumers of health services willingly pay for the services they receive from health facilities.

Item 3.3 lists some of the weaknesses of the MOH's IEC delivery structure. Other reasons for the relatively low level of community participation are as follows:

- Lack of specific strategies and activities designed to increase community involvement beyond sitting on committees and attending meetings at health facilities
- The limited contact health workers maintain with the community
- Poverty and the rising cost of living which forces people to spend long hours working for their livelihood, leaving little time for voluntary services
- Failure of health services to identify and work with cadres and individuals best placed to stimulate community participation

Section 4 gives the case of Lugulu Friends Mission Hospital, which has had reasonable success in tackling these problems. The hospital has used the following six strategies:

- Identifying and working with institutions and individuals best placed to disseminate messages widely and credibly in the community (such as village headmen, churches, schools, enlightened retired persons)
- Providing training and commissioning trained individuals to disseminate messages throughout the community, especially within their own groups
- Providing trained volunteers (CHWs, CBDs, GMAs) to spearhead message dissemination in the community and support churches, schools, and other community institutions and groupings to disseminate messages widely through the structures
- Providing community-based TOTs who can make frequent supportive supervision visits to community-based motivators
- Providing close supervision and interaction between motivators and the hospital. Hospital staff make frequent visits in the community to share experiences with motivators, boost their morale, and hold refresher courses to update their knowledge and revitalize team work
- Addressing the problem of poverty among volunteer village-based workers by supporting motivators to start group income-generating activities, such as sunflower oil pressing and fish farming

## **11 COMMUNICATION CAPACITY AND CAPACITY BUILDING**

The individuals involved in the dissemination of health messages (see section 2) in the Bungoma district IEC establishment seem to have received good general training in IEC, but they have had little or no experience with targeted behavior-change communication. The limited supervision done is similarly generalized and does not focus on developing any specific communication component (e.g., interpersonal communication or dissemination of key messages at service delivery points).

### **11.1 Current training opportunities**

Health staff carrying out IEC in the district (family health field educators, community nurses, public health technicians) received communication courses during their basic training, some many years ago. They have since had refresher IEC training from time to time, usually during orientation when a new program is being launched. During such orientation sessions, communication may take from an hour to a couple of sessions. The orientation workshops are usually attended by participants from different health departments.

Training of village-level cadres has followed a pattern similar to that of paid health workers. The cadres are initially recruited and trained to take part in a specific project. After recruitment, they receive comprehensive training, with practical sessions in between, lasting from 3 to 6 months. Thereafter, most opportunities for further training come in the context of introducing a new project. Occasionally, the initial sponsor, who recruited the motivators in the first place, funds refresher courses, which are managed from the district headquarters.

There will obviously be a need for orientation and skills training at the beginning of BDI communication and social mobilization activities to equip motivators and other relevant players for their roles. Motivators' ability to plan and deliver result-oriented IEC programs will need to be strengthened and concerns about sustainability built into overall and training strategies.

### **11.2 Other resources for IEC development**

One of the most important drawbacks to community participation (see above) is infrequent contacts between health workers and the community. The major reason for this is given as lack of transport to go into the community. The Kenya-Finland PHC project and GTZ have in the past given bicycles to facilitate motivators' communication, but owing to administrative problems, the scheme has not worked as well as it could have worked.

For IEC to achieve intended targets, BDI will need to discuss and find a workable, sustainable solution to the issue of motivator transportation in the community.

## 12 RESPONDENT RECOMMENDATIONS

During interviews, respondents freely offered recommendations they believed could improve IEC activities in the district. The recommendations are reproduced below as they were given. Communication planners are urged to review the recommendations and consider them together with others that will be generated during planning discussions.

- The three preferred channels of communication in Bungoma are the provincial administration (chiefs, assistant chiefs, and village elders), the church, and the radio. These should form the backbone of malaria communication strategies.
- Upgrade the teaching skills of relevant church people and the provincial administration and provide them with educational materials to use in disseminating health messages.
- Find ways and means of integrating and institutionalizing health discussions and action among existing women, youth, church, cooperative, and other kinds of groups.
- Train shopkeepers and give them posters to put them in their shops and explain to people who come to their shops. Give them other materials to distribute as well.
- Establish meeting and information centers in villages where notice boards can be erected so that IEC materials can be posted on them.
- Establish health clubs in schools and link them with child-to-parent educational activities.
- Employ more committed health staff and village motivators.
- Provide means of transport to health workers and motivators.
- Increase the number of paid health workers so that they can visit house to house.
- Educate health committees at all levels on health matters.
- PHTs should live in the sub-locations where they are assigned to work.
- Promptly replace staff who have been transferred.
- Health facility staff should go into the community and educate people more often.
- Support women's groups to acquire and sell mosquito nets at a small profit.
- Recruit more male educators.
- Introduce all educators at barazas and elsewhere so that they are widely known and people can identify and approach them when they need their services.
- Promote the "health comes first" message throughout the district, because when health fails, all else fails.
- Provide refresher courses to revitalize village-level educators.
- Strengthen collaboration with the administration.
- Emphasize mobile clinics.
- Establish village pharmacies to stock malaria drugs and mosquito nets (commercialize malaria control and management supplies for sustainability).

- Integrate health activities and education in the activities of women's groups and support the groups to establish income-generating activities that will help sustain the continuity of these groups Link the groups with other sources of finance for additional seed money
- Recruit and train volunteer youth and give them educational materials to distribute free of charge
- Engage young people to do health education on payment Alternatively, the community could collect money and give it to the health facility to use for giving incentives to young people
- Train mukasa to be able to deliver health messages more effectively
- Establish a rural newspaper to (1) promote sharing of approaches across the district and (2) publish information that will make people fear the effect of the diseases being controlled
- Inform communities about the program and allow them time to organize themselves for action in their own way and time
- Develop carry-away IEC materials similar to the posters we hung on the walls
- Develop cassette messages for clients to listen to as they wait for services
- Develop posters (most frequently mentioned recommendation)
- Distribute reading materials in villages

**APPENDIX**

**Appendix**  
**BUNGOMA DISTRICT INITIATIVE**  
**IEC ASSESSMENT QUESTION GUIDE**

- 1 Describe the MOH IEC structure in Bungoma district
- 2 What IEC activities is MOH involved in?
  - What is the rationale of the activities?
- 3 How are the activities carried out?
  - People/departments/agencies involved and the roles they play
  - Strengths
  - Limitations
  - Provision for sustenance
- 4 What are the main target groups that health IEC focuses on?
  - How are the targets segmented, and why?
- 5 What channels of communication are used to reach the target groups?
  - How are the following channels of communication used for health promotion?
    - Mass media, especially radio
    - Seminars, workshops and courses
    - Drama
    - Folk media
    - Interpersonal communication channels

- 6 What role do the following play in health communication
- Schools
  - Churches
  - Village health committees
  - Other community groups
  - Volunteer health promoters (such as CHWs)
  - Traditional health consultants (such as TBAs, traditional healers, traditional circumcisers)
- 7 What other IEC opportunities are available in view of the local culture and lifestyles?
- 8 How are mass media (especially radio) used for IEC in the district?
- Successes
  - Issues and limitations
  - Opportunities for improvement
- 9 What processes are used to carry out IEC activities?
- Planning
  - Material development
  - Monitoring
  - Evaluation
- 10 What other agencies are involved in IEC in Bungoma district?
- What are they involved in?
  - Whom do the agencies coordinate/work with?
  - Successes
  - Shortcomings

- What other agencies could be involved?
- 11 What IEC materials are used?
- How are they developed/acquired?
  - How adequate?
- 12 To what extent are communities involved in IEC activities?
- Planning
  - Implementation
  - Monitoring
  - Evaluation
  - What structures in the community facilitate community involvement?
  - What can be done to strengthen community involvement?
- 13 What steps are taken to ensure that IEC activities
- Are targeted and relevant
  - Bring about the desired behavior change
  - The new behavior is developed and sustained over time
- What else can be done to ensure that IEC activities meet these targets?
- 14 What resources IEC resources are available in the district?
- Human
  - Production
  - Other
- 15 What IEC capacity building activities are in place?
- What other cadres need capacity building

- What capacity building activities would be most effective?
- 16 How is IEC for health coordinated in the district
- How adequate is the coordination?
  - Strengths
  - Weaknesses
  - How can coordination be further enhanced?
- 17 How is IEC for malaria control carried out at the moment?
- Successes
  - Limitations
  - What can be done to improve
  - How should IEC be carried out in BDI?
- 18 Who should be the key IEC targets on the BDI Project?
- Why?
  - What channels would be effective to reach these targets?
- 19 Please give any additional suggestions that can improve the effectiveness of IEC for health in Bungoma