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HRH Dimensions of Community Health Services

Constraints and Promising Practices

A significant proportion of the Kenya's population continues to carry high burden of preventable illnesses putting pressure on service provision at all levels of the health system. In line with the Kenya Vision 2030 and the National Health Sector Strategic Plan III 2008-2012, the government developed the Kenya Essential Package for Health and thereafter prepared a document titled ***"Taking the Kenya Essential Package for Health to the Community: A strategy for the delivery of level one services***". Popularly referred to as the Community Health Strategy (CHS) (2006), this Strategy, seeks to empower the Kenyan communities to take charge of their own health. Elaborate structures for mobilizing community health workers, guidelines, and budgetary allocations have been made to ensure the full roll out of this Strategy but with mixed results across the country.

This study has corroborated findings of previous evaluations by UNICEF (2010) and AMREF(2012) that decry the huge underinvestment in HRH Planning, development and management for community health services. Hence these studies emphasize the need for greater investment in community level health workforce issues. Particular focus should be directed to strengthen workforce planning, rationalization of work load, motivation and incentive structures, career paths, routine supervision and management and investments in CHW training. This position paper emphasizes the leadership role that government must take at national and county level to allocate resources, coordinate partners and ensure collaboration between CHWs and formal cadres in the health system.

The HRH Problem at the Community

With the launch of community health strategy in 2006, the government established itself on a path to reverse the declining health indicators by providing an essential package of health services primarily at community level. By 2011 a total of 1649 CHUs had been established; formative documents were developed to facilitate implementation of CHS including guidelines, curricula and reference/trainers manuals; the Division of Community Health Services (DCHS) has also intensified its coordination role to ensure that the same curriculum and materials are used by all key implementers leading to better coordinated training at level one. Development partners, CSOs, the government and the community embraced the strategy and have made varied investments to facilitate its roll out. A vibrant coordination mechanism is in place through the inter-agency coordinating committee (CHS ICC) which brings together both state and non-state actors working on community health issues.

The outcome of this Strategy however deviates from expectation and recent evaluations have sought to establish the underlying constraints to its full implementation. A mid-term evaluation of the Strategy by UNICEF Kenya in 2010 identified a wide range of issues most of which could be related to the planning recruitment, development and routine management of the community level health workforce. It in particular it pointed out challenges related to insufficient allocation of resources to address HRH constraints at community level leading to inadequate staffing; lack of incentives and a career ladder for CHWs making their recruitment and retention difficult.

Against this backdrop, this study sought to generate information on HRH dimensions of community level service provision and to identify the best practices for replication/ scale up as well as identify gaps in community level HRH. Specifically the assessment sought to identify the critical HRH constraints facing delivery of community health strategy, determine the roles of FBOs and CSOs in community level HRH, determine and document HRH cadres at community level, assess the barriers and constraints that affect HRH at community level, identify best practices/supportive community level HRH practices

and approaches and provide recommendations for stakeholder engagement in community level HRH strengthening.

Methodology

The assessment team used a combination of purposive and convenience sampling to draw the sample of community units to visit. A purposive sample of 5 CSOs was selected based on classification of community health units by the division of community health services i.e. Urban, Agrarian, Settled rural and Nomadic community. The classification was based in population density.

The Study grouped the information sources into 4 categories

i. *Policy sources mainly at the National level*
Key informant interviews were held with key officers at the Divisions of community Health Services (DCHS), Division of Reproductive Health (DRH), NASCOP, Division of Child Health (DCH) and TB control. These are officers in the government key to the implementation of the community health strategy.

ii. *Sources at the community level (From District level to community level)*
The team managed to visit and interview 5 Community Units. In the visits to the health units, the team managed to meet and talk to 5 CHEWs, 56 CHWs, 3 District Community Health Strategy Coordinators(DCHSC), 2 District Public Health Officers (DPHO), AMREF project officer at Kibwezi and over 21 clients (community members served by the CHWs). Majority of the 56 CHWs who were interviewed were female (60.7&) and about one fifth of them were over 50 years old. Of these CHWs, 71.4% were married and only 23.2% were single. Another 5.4% were in other types of relationships i.e. either living together but unmarried, divorced, separated or widowed. More than one half of the CHWs had at least completed secondary education while only 10.7% had college or university education.

iii. *CSO/NGO/Partners*
The assessment team visited NGOs that were involved in the implementation of the community health strategy, mainly drawn from the list of HENNET member NGOs. Key informants with indepth knowledge of the CHS were also interviewed.

iv. Document and reports review. A desk review of documents and reports on the implementation of the community strategy in Kenya and similar projects implemented elsewhere outside Kenya. This enables wider understanding, comparison to derive lessons that could be applied to improve the Kenyan Strategy.

Findings and Observations

1. Current HRH Practices under the Community Health Strategy

HRH Policy and planning; The department of Primary Health Care through the Division of Community Health Services of the Ministry of Public Health and Sanitation is the coordinating body of the community health strategy. The policy on HRH stipulates that each trained CHEW is expected to supervise 25 CHWs. However, on the ground practice is different as their deployment is influenced by factors such as availability of staff and population density among others. The policy stipulates that each CHU should have two CHEWs; a facility CHEW and a community CHEW Due to country wide shortage of nurses and PHTs, deploying the few who are available to the CHUs is proving difficult for some DHMTs and is made even worse by the frequent transfers of MOH staff. This leads to lack of continuity of services offered by CHEWs at the community level. There was evidence across respondent CUs that community had been adequately involved in the selection of CHWs.

CHW Training and Development; Training of CHWs has been supported mainly by implementing partners including World Vision, GAVI through MOH and other donors with community health programs. They provide financial support that covers items like training, training materials, accommodation and transport. Partners work closely with DHMTs and technical programmes in implementing training.

HRH Support and Performance Management ; At the district level, supportive supervision is spearheaded by the District Coordinator and assisted by members of the DHMT particularly the Public Health Nurse and the Public Health Officer. At the community level supervision is undertaken by CHEWs (67%) and CHCs (31%) and health facility (2%). The CHWs are supervised weekly and monthly. The CHWs prepare plans and share them with clients.

One of the ways through which the performance of CHWs is assessed in by carrying out joint supervisory visits by DHMTs and implementing partners. The MOPHS reviews and monitors CHW performance through monthly support supervision by CHEWs and the monthly data submission which captures indicators such as number of home visits, dialogue days attended and action days attended.

Role of non-state actors in community level HRH; **The** activities of FBOs and CSOs (implementing partners) are made possible through the support of development partners. At national level, both development and implementing partners have played a major role in supporting the development of guidelines, training manuals and curricula. At district level the implementing partners have trained health workers in preparation and implementation of Annual Operational Plans (AOPs). The DHMTs have been supported to build capacity of District Community Strategy Coordinators (DCSCs) and CHEWs to implement activities at level one. The DHMTs coordinate the training through the DCSCs.

Establishment of community units; The MOPHS and implementing partners have been involved in establishing CHUs throughout the country. According to the CHS Resource Mapping Result (DCHS/MOPHS,2012), 5 partners had facilitated establishment of 728 CHUs country wide.

CHW Capacity building; The implementing partners provide financial support either to government or FBOs and CBOs that is used to carry out a wide range of activities including training, provision of materials, accommodation and payment for transport to and from training venues. Partners work very closely with the DHMTs and technical programmes to undertake the training.

Payment of allowances and provision of kits for CHWs; Under the "CHW performance based incentive" some partners pay monthly allowances to CHWS who submit reports as required. In addition some organizations provide kits comprised of ORS, de-wormers, salter scale, thermometer, iodine, spirit, cotton wool, dettol soap, gloves. However this is not widespread and CHWs lack basic kits to address minor health problems. Further there is no formal mechanism of engagement as these incentives are provided as and when resources are available.

HRH Cadres at community level; The main HRH cadres at community level are CHEWs and CHWs and their work is to deliver health services to the community. The CHEWs are government employees and they come from mainstream cadres such as Public Health Officers/Technicians, Medical Records Officers and Pharmaceutical Technologists, Nutritionists, Community Development Officers among other mid –level health professionals. The CS document refers to the CHEWs as 'coaches' of the CHWs. Must be trained for 4 months over a standard period of time within which they should cover a set core learning modules.

CHWS on the other hand are community level volunteers and are sometimes referred to as the 'gate keepers' of health in the community. They are trained to provide information on family planning, distribute some pills and other barrier methods, well baby care issues, perform basic client screening and referrals to health facilities, provide information on HIV/AIDS, STD,TB,Malaria, Hygiene, environmental sanitization and community based IEC/BCCC. Communities have also incorporated the informal health system into the community health network.

2. Barriers and constraints affecting HRH cadres at community level

Insufficient recognition of CHW role and contribution; Some professionals do not recognize the CHWs as health care providers hence do not accord them the necessary support.

Absence of career progression opportunities**;** Absence of formal career ladder for community health workers means the CHW will leave any moment there is an opening outside.

Inadequate funding for CHS; Owing to minimal funding from government there is too much donor dependency making sustainability of activities impossible.

Disproportionate workload; 80% of CHWs cover more than the recommended 20 households per CHW while all the CHUs visited had only 1 CHEW who supervised more than 100 CHWs in the CHU.

Inadequate working tools; Reporting tools were inadequate, unavailable or not user friendly.

Inadequate incentives/lack of motivation; There is high attrition due to volunteerism and lack of allowance.

Large and unmet training needs; There is lack of adherence to existing guidelines when it comes to implementing CHS activities.

3. Promising best practices and approaches for HRH at community level

Many CHUS have embraced CHS and have significantly contributed to improvement in service uptake. This has worked very well particularly where one of the CHEWs provides health care services at the link health facility. Other emerging best practices included;

Transforming CHCs to CBOs; Many CHCs have been registered as CBOs and have initiated movement towards sustainability by engaging in income generating activities and exploring other ways of sourcing for funding.

Strong Health information systems and sharing health reports; Evidence based dialogue model to clarify myths and issues on services use and problem solving from the chalkboard has

facilitated service up take. In this regard, the processes are community led

Setting up community based Health insurance; Community based health insurance is based on the principles of voluntary participation, built in solidarity mechanisms and reciprocity. Some of the CHCs have been empowered through IGA and contribute to a community resource fund either monthly or during harvesting.

Recommendations

Planning and budgeting for CHWs; Apart from broad statements in the CHS, MoH at national and county level need to identify clear HRH priorities and include them in annual budget estimates to reduce reliance on donors for this component of our health strategy. Better coordination will be needed to direct limited resources to areas with direst need.

Recognition of CHWs; Sensitize health care providers about the potential of CHWs and their contributions to the health care system so that they can be effectively utilized and the credibility of CHWs is not eroded.

Harmonize approaches but allow flexibility and innovation; Standard prescriptions and norms provided for HRH within the CHS Common approach. The government should ensure that all players follow its guidelines in the implementation of CHS wherever they are working.

Supplies and logistics; The government and partners should facilitate the CHWS movements in expansive and hard to reach areas by providing appropriate means of transport, ensure adequate supply of CHW kits and provide budgets and uniforms for easy identification to the clients.

Training and Development; The government and partners should train more CHEWS and CHWs in order to attain a workable ratio, develop CHW training "log book" and provide clear job descriptions. The government should ensure that CHS functions are included during basic/pre service training of health workers opting to become CHEWS after their training and that they should be deployed only for this work. The government should develop a set of core competencies and guidelines for CHWS and offer them ongoing training and supervision to ensure they meet the community's evolving health care needs

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About the HRH Advocacy Project

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

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