Strategies to strengthen community health provision through CHVs in the ASAL

Developmental Evaluation WAVE Ⅱ

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Executive Summary

The Development Evaluation (DE) approach focuses on gathering and understanding information during the implementation process, and iterating programming approaches in real-time.

Wave II of the DE exercise focused on the activities and outcomes of three community health projects in arid and semi-arid lands (ASAL) which serve nomadic, semi-nomadic and static communities: 1) Supply Chain Alternatives for the Last Mile (SCALE) implemented by inSupply Health which aims to improve supply chains to reach underserved communities in Samburu, Turkana Wajir and Mandera, 2) Afya Timiza Implemented by Amref Health Africa, aims to improve family planning, reproductive, maternal, newborn, child and adolescent health (FP/RMNCAH), nutrition and water, sanitation and hygiene (WASH) services in five sub-counties located in Samburu and Turkana, and 3) Nomadic Health Program (NHP) Implemented by Save the Children, which seeks to increase the use of quality FP services among nomadic and semi-nomadic populations in six sub-counties Wajir and Mandera.

The evaluation focused on three learning questions which explored the barriers to Community Health Volunteer (CHV) motivation, strategies and processes to implement Community Based Distribution (CBD) and the extent to which COVID-19 has affected program implementation and community health activities.

A mixed-methods approach was used, whereby a quantitative survey, Focus Group Discussions and Key Informant Interviews were conducted with various stakeholders in Samburu, Turkana, Mandera and Wajir including CHVs (current and former), Community Health Assistants (CHAs) and Facility In-Charges (FICs), county government staff, and implementing partners. Sensemaking events were held at the county and national level to validate findings.

Executive Summary

CHV motivation

Key findings around CHV motivation were that the majority of CHVs are deeply motivated by intrinsic factors and that service to the community and a commitment to community health are the main reasons CHVs become volunteers. CHVs are universally seen as a key pillar of the health strategy, and their roles are especially essential in the ASAL regions, where the communities are remote, hard-to-reach, and include nomadic and semi-nomadic populations. However, this cadre is often burdened with a high workload, weak training and supervision structures, and a lack of alignment between roles and incentives. The right combination of financial and non-financial motivators is needed to sustain CHV engagement.

Secondly, CHVs lack clarity in the voluntary nature of their roles and this results in unmet expectations. While CHVs identify themselves as volunteers, they clearly expressed unmet expectations of regular “salaries” and financial compensation.

In addition, most CHVs who do receive stipends indicated that they were inadequate and were not paid regularly. The expectations placed on CHVs are often more akin to that of a formal job, at the expense of a fulfilling volunteerism experience.

Training and supervision, highly motivating activities for CHV, are core elements of the Community Health Strategy (CHS) and are the responsibility of the county government. In practice, however, financial and technical support for training and supervision are often partner driven and inconsistent. In order to be an effective motivator, training needs to be consistently offered to all CHVs, not only a few, and must take into consideration literacy and language barriers. In addition, supportive supervision is considered critical and motivational, however it is challenging to execute well due to budgetary and human resource constraints.

Executive Summary

CBD

CBD is happening in each of the counties, both formally through the support of Implementing Partners (IPs) and informally with individual CHVs, however lack of commodities at linked facilities and lack of a County strategy for supplying CHVs threatens CBD success. Questions around the operationalization of CBD in both static and nomadic communities have yet to be fully answered, as COVID-19 delayed the rollout of some of the initiatives such as cStock. However, we do know that even untrained CHVs are managing some commodities informally, so there is a lot of potential for CBD. The lack of consistent supervision and low CHV motivation present additional challenges to the roll-out of CBD.

COVID-19

While the pandemic highlighted the importance of community based healthcare, stakeholders at all levels expressed feeling unprepared and unsupported during the pandemic, and saw a decline, at least initially, in facility and community based health services. The pandemic disrupted a significant proportion of routine community health activities across each county, most importantly community meetings, household visits, outreach activities, CHV training, health worker meetings, and some aspects of commodity distribution. However, CHVs were well placed to respond to key activities such as surveillance work, contact tracing, and community sensitization, despite challenges with motivation and inadequate resources to facilitate their job (e.g. personal protective equipment [PPE] and masks).

Executive Summary

Conclusion

Community health volunteers in Kenya continue to play a significant role in promoting health, despite the lack of proper engagement structures with government and non-governmental entities. To ensure they are a highly motivated workforce for continuity in community service delivery, CHVs should be facilitated and empowered to meet their basic needs, trained and skilled to offer quality services, supported through supervision and mentorship, and recognized and appreciated for their work.

Additionally, community members as well as health system actors should be reintroduced to the roles and responsibilities of a CHV, so that CHV work can be aligned with the voluntary nature of the role and reduce the pressure or unrealistic expectations. Resource mobilization structures are needed as are deliberate efforts for building CHV competence in delivery of specific services within the large spectrum of health services.

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01 INTRODUCTION

The evaluation focused on the activities and outcomes of three community health projects in ASAL

Supply Chain Alternatives for the Last Mile (SCALE) implemented by inSupply Health, aims to address inequities in access to health commodities through developing sustainable, scalable, and community-based distribution models that reach underserved, remote communities by improving supply chains in Samburu, Turkana, Wajir, and Mandera. SCALE works with both static and nomadic community health units (CU).

Afya Timiza Implemented by Amref Health Africa, aims to increase the use of quality county-led FP/RMNCAH, nutrition, and WASH services in five sub-counties located in Samburu and Turkana. Afya Tamiza focuses mainly on static CUs.

Nomadic Health Program (NHP) Implemented by Save the Children, seeks to increase the use of quality FP services among nomadic and semi-nomadic populations in Kenya by developing and testing the effectiveness and scalability of their service delivery model in six sub-counties located Wajir and Mandera. NHP focuses mainly on nomadic CUs.

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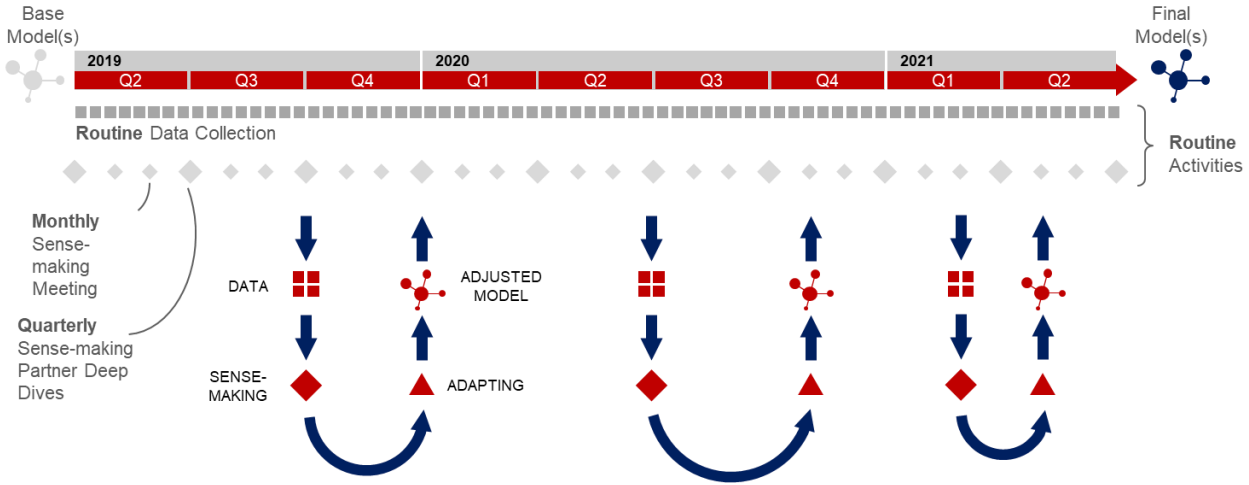
02 METHODS

DE results serve as a springboard to take action



The DE approach aims to **iterate** on implementation approaches in real-time by fostering a **deeper understanding** of the vast amount of information emerging.

Evaluators work closely with program implementation teams for quick documentation of program activities to uncover systems dynamics, interpret observations and trends, and most importantly, collaboratively learn to achieve better outcomes. The insights gained in the process inform programmatic adjustments that are needed throughout the project lifecycle.

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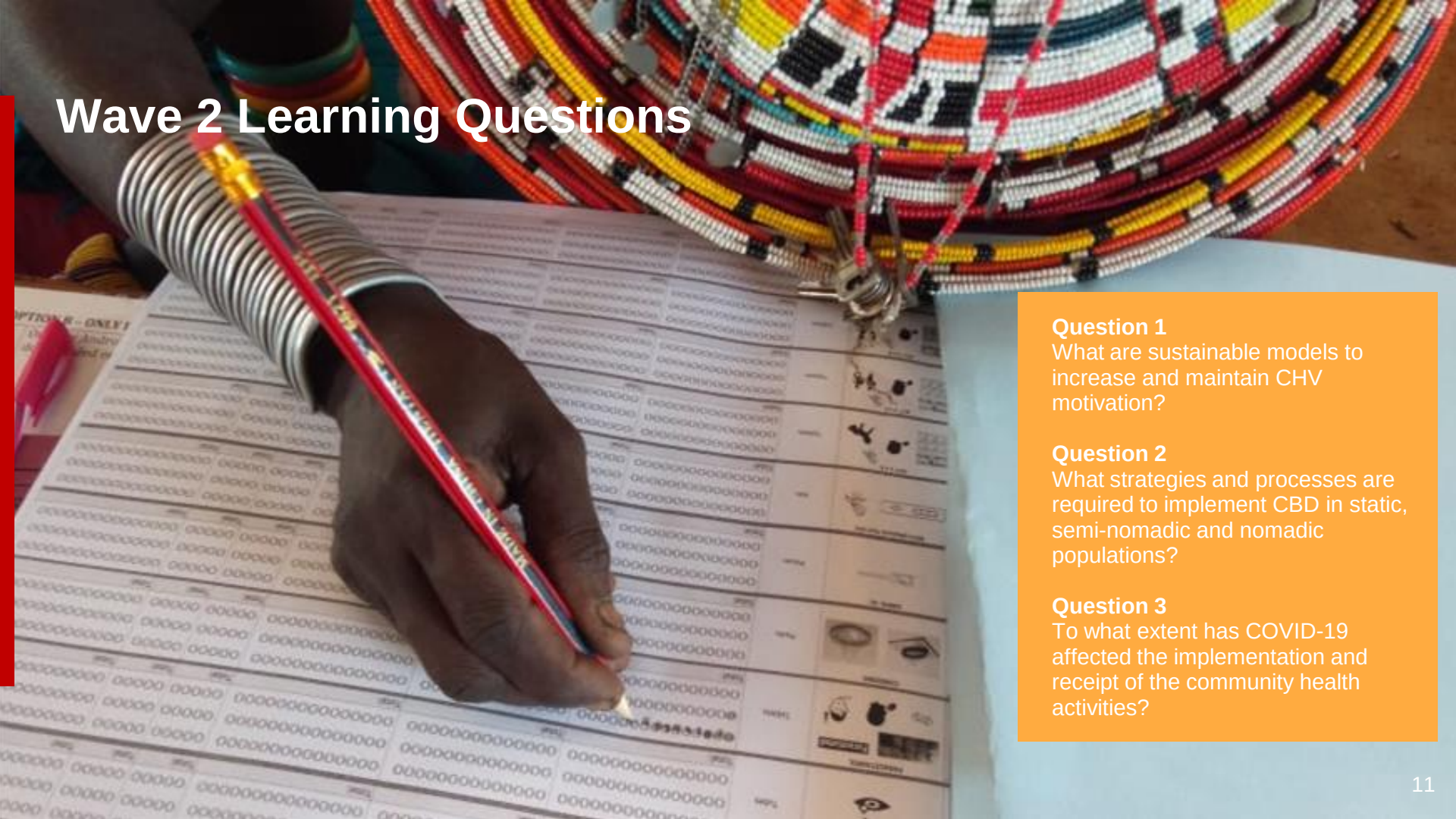
Wave 2 Learning Questions



Question 1
What are sustainable models to increase and maintain CHV motivation?

Question 2
What strategies and processes are required to implement CBD in static, semi-nomadic and nomadic populations?

Question 3
To what extent has COVID-19 affected the implementation and receipt of the community health activities?

Who we spoke to

375

QUANTITATIVE SURVEY RESPONDENTS

103

KEY INFORMANT INTERVIEWS

32

FOCUS GROUP DISCUSSIONS

Respondents included

Respondent type	Type of interview	Samburu	Turkana	Mandera	Wajir	Total
Current CHVs	Quantitative survey	64	86	39	35	224
	KII	6	17	8	8	29
	FGD	6	8	9	8	31
Former CHVs	Quantitative survey	8	3	11	42	64
	KII	2	3	1	0	6
CHAs and FICs	Quantitative survey	8	13	10	15	46
	KII	6	13	8	14	41
County/ Sub-County officials	Quantitative survey	5	9	13	14	44
	KII	10	18	28	29	85
IPs	KII	2	2	1	2	7

CHA = Community Health Assistant FIC = Facility in Charge IP= Implementing Partner KII = Key informant interview FGD = Focus group discussions

Research Activities

Data collection in 4 counties

County Sensemaking

National Sensemaking

The sensemaking process allowed stakeholders to connect their knowledge, skills and experiences with the raw data collected from respondents. Using experiential interactions, stakeholders were able to reframe their own understanding from the standpoints of beneficiaries at different levels of the health system and experiment with new ideas to solve challenges rooted in a human centered perspective.

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03 KEY FINDINGS, EMERGING INSIGHTS & ADAPTATIONS

Emerging research themes for CHV Motivation

01 The right combination of financial and non-financial motivators are needed to sustain engagement

02 CHVs lack clarity in the voluntary nature of their roles and this results in unmet expectations

03 Training and supervision, highly motivating activities for CHV, are core elements of the CHS strategy and should be the responsibility of the County government. In practice, however, training and supervision are often partner driven and inconsistent

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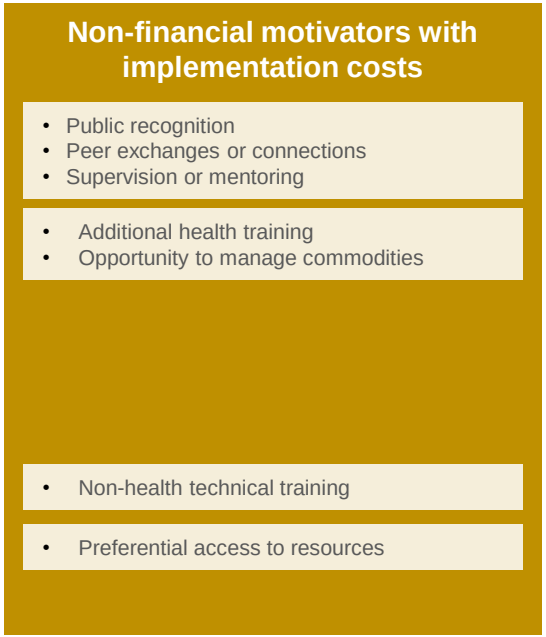
The majority of CHVs are deeply motivated by intrinsic factors

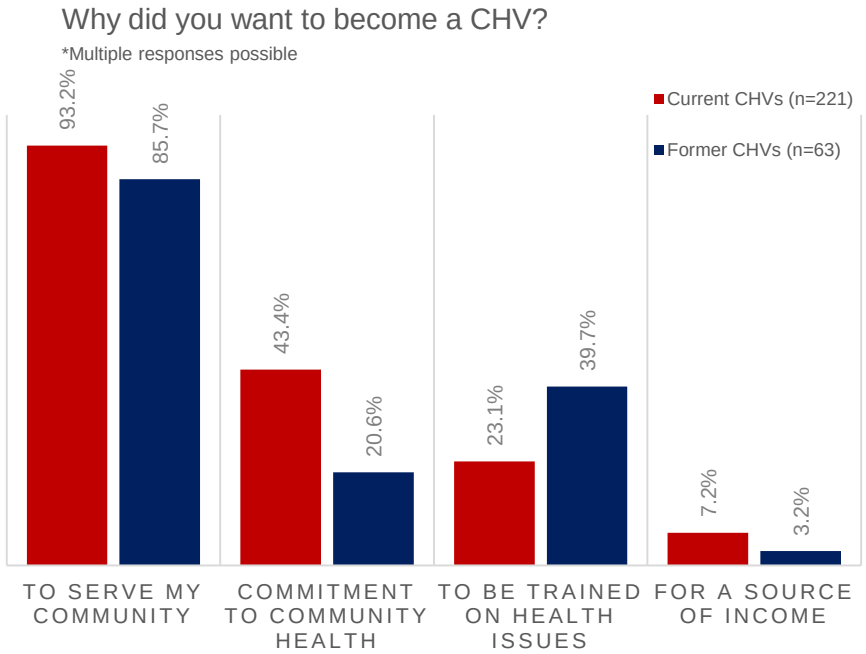
Current CHVs (n=222) were asked the following, using a 1-5 rating scale:

Regardless of whether or not you have had direct experience with this strategy, to what extent would this method motivate you if it were provided to you.

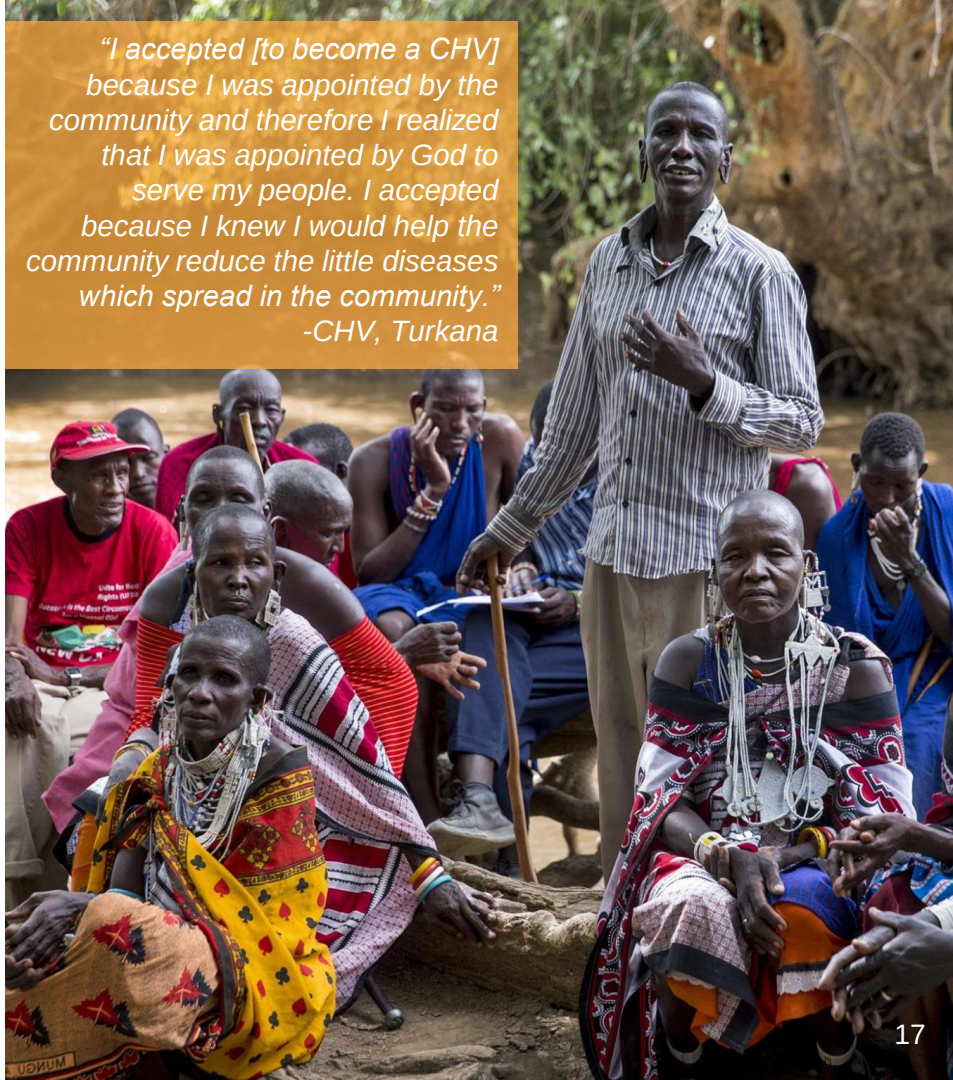


The following graphic shows the ranking of those motivators.

Serving the community and commitment to community health are the biggest reasons CHVs become volunteers



"I accepted [to become a CHV] because I was appointed by the community and therefore I realized that I was appointed by God to serve my people. I accepted because I knew I would help the community reduce the little diseases which spread in the community."
-CHV, Turkana



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CHVs view themselves as representatives of their communities who have been specifically nominated and entrusted to provide primary health care and even life-saving health services.

In fact, CHVs self-identify and are regarded as “village doctors” by the community and feel obligated to serve, particularly because their communities have limited access to healthcare. CHVs have a deep sense of commitment to their community and are often willing to serve them, even at personal cost.

For example, CHVs cited sacrificing their own time and resources helping clients travel to distant facilities or paying out of pocket for their clients’ treatment.

“I decided to do it with my whole heart... I accepted to take responsibility for the whole village because nobody can go to the households if he/she hates others. So I wake up in the morning, I leave my property like goats and cows... I leave them with my children so I can go to work in the village with my whole heart. There is no bicycle or even a motorbike. I just walk.”
- CHV, Samburu

“We are doing referrals from very far places and end up using our own money for transport of patients to health facilities.”
-CHV, Wajir

Contributing to successful referrals and seeing improvements in health give CHVs a sense of purpose and pride in their work.

CHVs are proud to contribute to more positive health outcomes in their community and towards raising the standard of health by providing basic health knowledge, treating minor illnesses and referring clients for advanced care. CHVs cited the following areas where they have had the greatest impact:

- Improved sanitation and hygiene
- Improved health seeking behavior
- Increased hospital births
- Higher uptake of child immunizations
- Improved nutrition and reduced morbidities

Although they are not financially incentivized to do so, CHVs consider their role in referring clients to seek medical attention at facilities a key part of their job, and an indicator of their success for which they desire monetary rewards.

The relationships with other community and health stakeholders enhances trust and acceptance of CHVs within the community and serves as a key motivator.

CHVs perceive public recognition to be an important personal motivator and sign of respect for their work. Access to identification materials such as t-shirts, bags, jackets and badges, are highly valued by CHVs as they enhance their credibility and professional esteem.

All stakeholders interviewed confirmed that CHVs' ability to coordinate and deliver community based healthcare, is improved when they are supported by health, religious and cultural leaders such as:

- CHAs
- FICs
- Traditional Birth Attendants
- Village administrators and elders
- Village committees
- Religious leaders
- Hospital committees
- Community health committees

“There was a woman who used to deliver at home. I went to that household and I taught her about the health benefits of delivering at the hospital. Giving birth at home affected her adversely as she would bleed and also lose weight. We started giving birth at the hospital and her health improved. She even started educating other women. That made me happy.”
-CHV, Samburu

“What has made me happy to be a CHV is that I have learnt a lot. Because women used to give birth at home. They used to be helped to give birth by traditional midwives. Sometimes they would bleed and die. But since we became CHVs we have witnessed many changes. Now, when a woman goes into labor they rush to where I am. Other times, they phone to let me know they are going into labor, and I write a referral for them to go and give birth in the hospital.”
-CHV, Samburu

“I feel so happy [when the community respects me], and I just find myself working with them with love and peace, without any fear.”
CHV, Turkana

Despite competing priorities and CHV activities interfering with family responsibilities, CHVs feel that they receive the necessary support from their families.

One of the challenges that CHVs face is balancing their personal responsibilities against their CHV tasks, which often requires them to carefully plan their days and create contingency plans in case there are conflicts between their personal and professional obligations. Most CHVs rely on their family members to share in the core day-to-day responsibilities (e.g. cooking, fetching water and firewood, cleaning, child care, herding livestock) so that they can attend to their CHV tasks. In some cases, CHVs cited family members stepping in as ‘‘assistant CHVs” in the absence of the CHV by dispensing medicines, taking the sick to hospital, or accompanying CHVs to conduct household visits within the village

While CHVs make their best efforts to manage their various responsibilities, they acknowledge that they have to make trade-offs when conflicts arise, often times delegating their family roles so that they can prioritize attending to CHV tasks, especially during health emergencies.

Female CHVs have the additional task of managing unpaid work in the home as well as domestic chores in line with traditional gender roles, while male CHVs largely attend to livestock and farming responsibilities.

“I am a wife in a family and I have a man who is the head of the family. That man is giving me a chance to serve the community in that he has never stopped me from working...he is giving me that chance.”
-CHV, Turkana

“[Our families] lead by example, by improving the health situation in the family i.e. observing and practicing good hygiene, seeking antenatal care and postnatal care services, and dispensing drugs when we are absent, but under our guidance.”
-CHVs, Wajir

“When I was chosen, I told my wife to understand that I am now a CHV. I have to go house to house. When I am working or when sick people in the community come to me, she understands...Even when I go the whole day, she wakes up early to make tea for me. She understands when I bring something home or when I come back empty handed. She also looks for work in order to support us sometimes.”
-CHVs, Samburu

Emerging research themes for CHV Motivation

01 The right combination of financial and non-financial motivators are needed to sustain engagement

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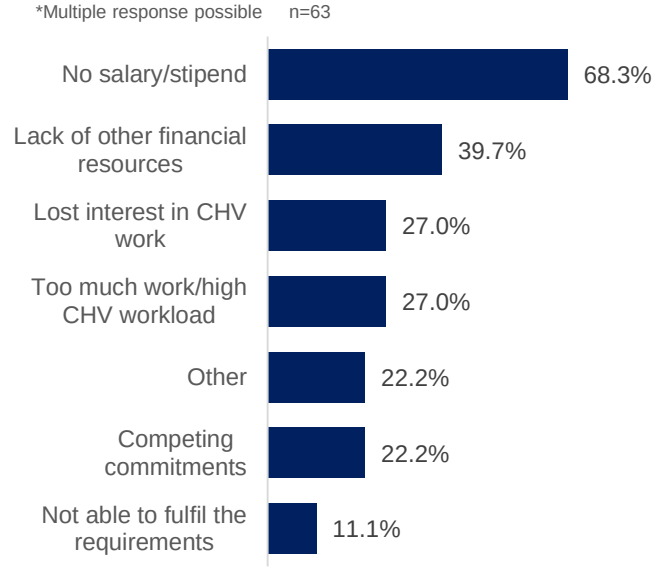
Financial incentives is not the primary reason to becoming a volunteer, but is key to retaining CHVs

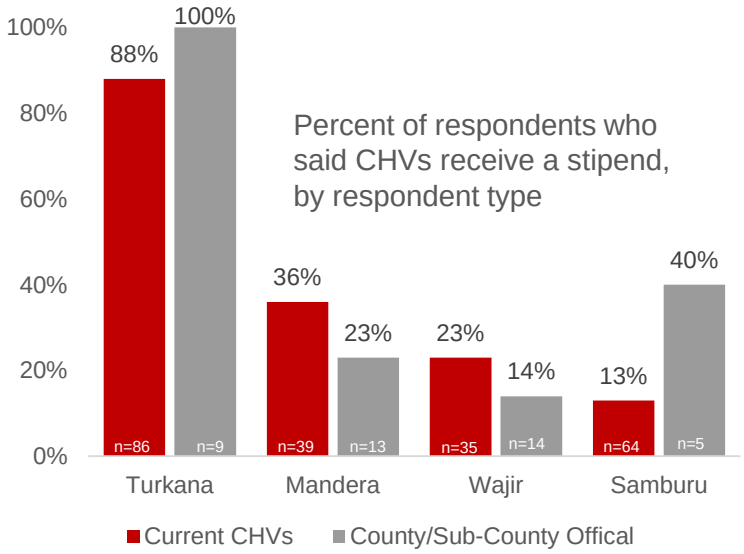
Why did former CHVs stop being a CHV?

*Multiple response possible n=63



"Lack of stipends [is discouraging] as we have family to care for; hence lack of money may force some [CHVs] to drop the work and concentrate on their animals."
-CHV, Wajir

However the percent of CHVs that receive a stipend for their work varies dramatically by County.



Percent of respondents who said CHVs receive a stipend, by respondent type

Misaligned perceptions are most dramatic in Mandara and Samburu, while there is more consensus in Turkana where an official policy outlines CHV stipends.

Previous Save the Children projects provided stipends to CHVs, however NHP does not provide stipends directly to CHVs. Rather, they are implementing livelihood projects, where the CHVs were put in groups and provided with seed capital to start an income generating project, perhaps contributing to this misalignment in Mandera. In Samburu East, CHVs are being provided with stipends through Feed the Children. Uzazi Salama, an Amref project used to provide stipend to CHVs in Samburu but stipends ended with the project. Respondents indicated that it can be demotivating when IPs provide a stipend that is not picked up by government budgets when IP support ends.

	REALITY For CHVs receiving a stipend, average reported to receive monthly (in KSh)	PERCEPTION For County/Sub-County officials who report CHVs receive a stipend, the average believe CHVs receive monthly (in KSh)	% of CHVs saying the amount is fair
Turkana	2,960 (n=76)	2,889 (n=9)	11% (n=77)
Mandera	1,857 (n=7)	500 (n=1)	42% (n=14)
Wajir	2,333 (n=6)	1,500 (n=2)	17% (n=8)
Samburu	1,375 (n=8)	2,000 (n=2)	0% (n=8)

10

AVERAGE NUMBER OF HOURS PER WEEK CHVs ARE EXPECTED TO WORK

17 ½

AVERAGE NUMBER OF HOURS PER WEEK CHVs REPORT SPENDING ON CHV TASKS

With Mandera reporting an average of nearly 24 hours

While CHVs identify themselves as volunteers, they clearly expressed unmet expectations of regular “salaries” and financial compensation, with the general sentiment being that there are no stipends and the few that are given the stipends are too small and irregularly paid.

CHVs feel strongly that their engagement is worthy of consistent financial motivation, commensurate with the workload and time commitment, which is currently larger than what is expected per the CHS. CHVs frequently cited a desire to be included in the county government payroll and be entitled to benefits, such as medical insurance and access to affordable credit. This was heightened by the fact that CHVs’ families depend on their ability to provide for them, and the acute poverty in the ASAL region. Most CHVs rely on funds received from CHV work as a primary source of income, even though it may not be the only source. CHVs also feel that the lack of remuneration undermines their credibility in the community, as the community perceives them to be paid health workers, while this is not actually the case.

> *“If we were given something small at least once a month. Because we have been told we are CHVs, Community Health Volunteers. We have volunteered for almost four years. But if we were given something at the end of the month, we would work even more. Because I have a family and kids. So when I go for household registration, or to test for TB...I at least have something small to bring back home for my children. So if we are given something small at the end of the month we would work even more than how we are working now.”*
>
> *-CHV, Samburu*

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Many County and Sub-County officials recognized the value of CHV work, and some even agree that, in principle, CHVs work is worthy of financial compensation. However, there remains a significant tension between voluntarism and employment, where Counties feel they are meeting their obligations.

County governments argue that the current policies do not require CHVs to be paid and therefore are not supported in the county budgeting processes. County respondents noted that CHV stipends are not currently feasible for the county governments to provide. Through the Universal Health Care (UHC), the counties committed to passing legislations to provide a framework to provide stipends to the CHVs. Only Turkana County has passed a bill to provide stipends to the CHVs, the rest of the counties are in the process of developing the bill to support provision of stipends.

Government stakeholders often reiterated during the interviews and the sensemaking process that these are volunteer positions. This contributes to not only a lack of stipends, but limited financing for CHV activities.

Key input from sensemaking CHVs are doing more than what the role was designed for. The intent of this role was to volunteer roughly 2 hours a day, during non-work, free time. Participants noted that CHAs should play a key role in planning an appropriate 10 hour work week for each CHV.

"One of the biggest barriers is the policy. The policy states that a CHV is a volunteer and so this is a big challenge because this blocks sources of funds to support."
-CHMT, Samburu

"We were to develop the [bill] for the county. It's still not realized but we're still pursuing it. The major setback is, you know, the issue of volunteerism is not sustainable. The county has done investment in Community Health Assistants in terms of the recruitment. I think we need to focus more on the recruitment of the Community Health Assistants. Because nobody will want to work for you for free. For example in Mandera we're supposed to be having 120 CUs. That is 1200 CHVs. If a bill is developed, it's a huge amount of money."
-CHMT, Mandera

For those that do receive stipends, they are often delayed. This is considered demoralizing and a major threat to CHV motivation, especially because CHVs feel that their role requires them to sacrifice their own time and resources.

In Wajir, static CHVs do not receive stipends, while those in nomadic and semi-nomadic settings do; an issue which is attributed to limited funds within the county government. This affects motivation for CHVs who do not benefit from stipends. In Turkana where the adopted CHS Act requires stipends, the county struggles to comply.

In other Counties there is a lack of continuity from partner funded stipends to County funded stipends, demotivating CHVs who feel that the County "cut" a source of income when partner project end. Other CHVs feel they have been given false promises that financial compensation is coming.

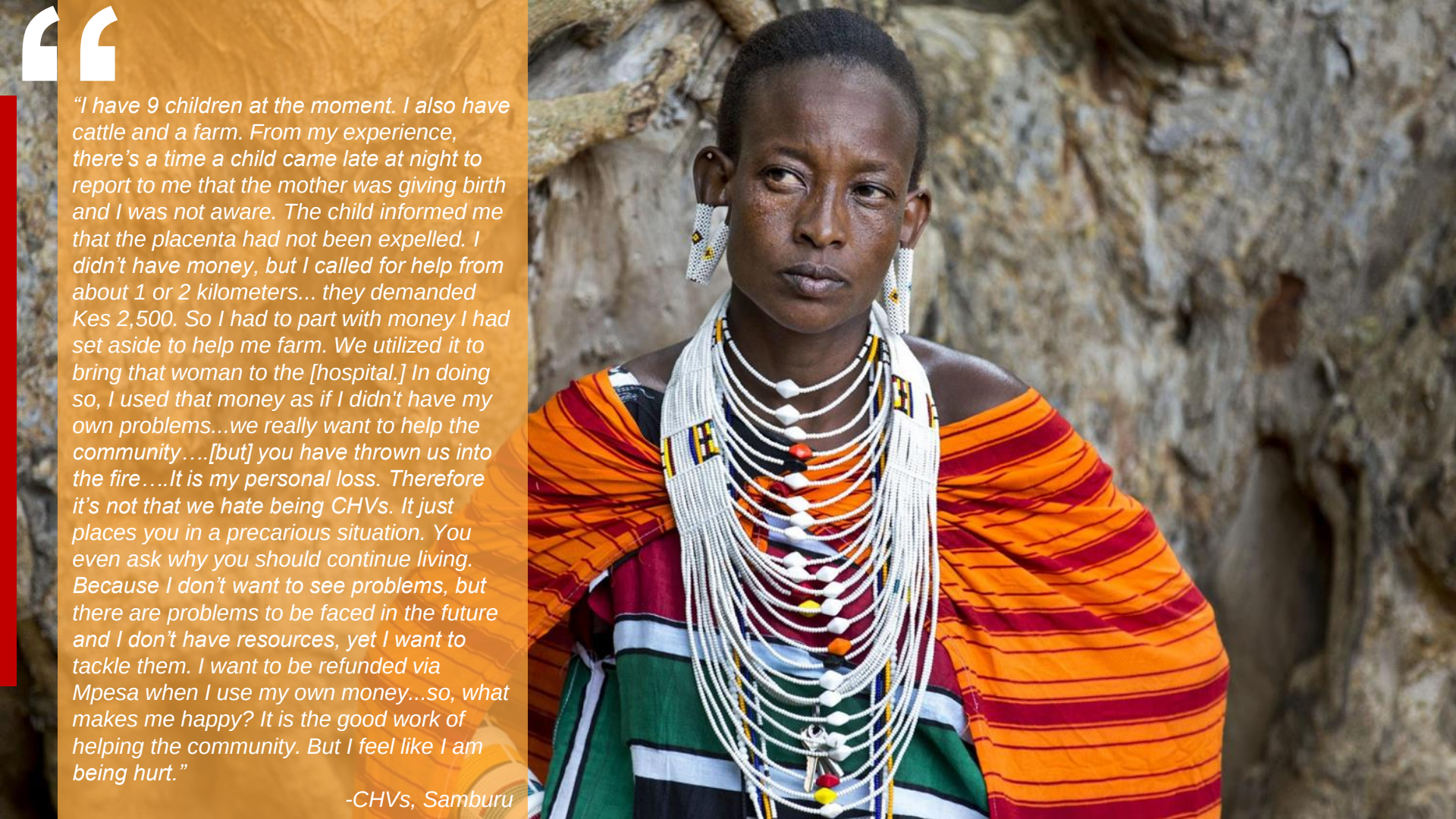
Key input from sensemaking Some CHVs feel a sense of inferiority and/or disrespect when their work is not validated, recognized and compensated. One example is that CHV feel competition rather than collaboration from traditional birth attendants, who sometimes position themselves as more knowledgeable and trustworthy to communities.

"Some [CHVs] have dropped out because they are not ready to volunteer because this work is voluntary so they are not ready to volunteer. When you tell them to collect their reports they don't do so. When you tell them to refer clients they don't do. When you tell them to attend meetings they don't attend. So that leads them to default…Some of them have started personal business so they say we don't have time for doing CHV work because we have our own businesses which we need to attend to."
-FIC, Turkana

"The perception from members of the community is that we earn salaries and we work for our interest. They mock our roles while we work voluntarily."
-CHV, Wajir

"The stipend is little because it doesn't meet the needs of a CHV's family. We need an increment to at least Kes 5,000. Some CHVs are illiterate and they usually hire other people to write their reports and they pay them. If the stipend doesn't come on time, the person may refuse to help in report writing."
-CHV, Turkana

"False promises. We have been promised by the county government to be given stipends."
-CHVs, Samburu



“I have 9 children at the moment. I also have cattle and a farm. From my experience, there’s a time a child came late at night to report to me that the mother was giving birth and I was not aware. The child informed me that the placenta had not been expelled. I didn’t have money, but I called for help from about 1 or 2 kilometers... they demanded Kes 2,500. So I had to part with money I had set aside to help me farm. We utilized it to bring that woman to the [hospital.] In doing so, I used that money as if I didn't have my own problems...we really want to help the community….[but] you have thrown us into the fire….It is my personal loss. Therefore it’s not that we hate being CHVs. It just places you in a precarious situation. You even ask why you should continue living. Because I don’t want to see problems, but there are problems to be faced in the future and I don’t have resources, yet I want to tackle them. I want to be refunded via Mpesa when I use my own money...so, what makes me happy? It is the good work of helping the community. But I feel like I am being hurt.”

-CHVs, Samburu

“I have cows, goats and a farm. And my children all go to school there is no one I can leave my cattle with, because sometimes my wife goes to fetch water or firewood or she has to take my child to the hospital. So I have to take care of the cattle and I am still needed in the community. I might receive a call about an emergency. Whom will I leave the cattle with? That’s my challenge.”

-CHVs, Samburu

Key input from sensemaking At the national level, members of the Community Health Division have acknowledged that CHVs are taking on responsibilities that were not envisioned as part of their role. One example is where CHVs report paying for transport for community members to reach the referral health facility. However, CHVs feel internal pressure (a sense of obligation) and extremal pressure (community expectations) to fill these gaps. This is compounded by the fact that when there is a shortage of paid government health workers CHVs are often asked to step in. In some instances, CHVs are considered "facility CHVs," working at the service delivery point rather than being based in the community. This may be a contributing factor leading to confusing expectations.

This point raised questions in both County and national sensemaking meetings about the role of CHA. Ideally, CHAs should provide hands on, community based support to CHVs. They are the facilitators of CHV work, providing support, managing their workload and managing community expectations should they be misaligned with the role of a CHV.

However, a number of factors inhibit this relationship including

- Shortages of CHAs in some areas
- Lack of trust among CHVs and CHAs, particularly when CHAs are from outside the community
- Language and cultural barriers, particularly when CHAs are from outside the community
- The role that politics play in appointing CHAs
- Underqualified CHAs serving in these paid roles

> *"We have CHVs in the facility supporting health workers. Remember before devolution, in Mandera County, almost 50% of the services in the health care facility were being run by CHVs. There were no health care workers….we still have gaps because most of our facilities are still run by one person."*
>
> *-CHMT, Mandera*

Income Generating Activities are a strategy currently being implemented, but require further investigation.

NHP as well as Feed the Children are actively implementing income generating activities (IGAs) for CHVs in Wajir and Mandera. Activities include training CHV groups in the Village Savings and Loan approach, registering groups with the Ministry of Social Services, and providing seed funding or grants for business activities.

However, when CHVs have been given similar opportunities to generate income, these strategies have not always worked, and groups often dissolve following IP support. Key reasons include:

- Lack of consistent non-health training to maintain their businesses
- Lack of group cohesion
- Challenge holding groups as a whole and group members accountable
- Competing interests and priorities for IGA members
- Delayed disbursement of grants/funds from IPs and lack of continuity

Key input from sensemaking Income generating activities need to include technical support in the form of group engagement and management, bookkeeping or numeracy in order to be successful.

"We were only trained on kitchen gardens but we were not supported further."
- CHVs, Turkana

"The CHV group [received funding from] Afya Timiza and Save the Children but the CHVs who were there by then left, hence division occurred among us."
- CHVs, Turkana

"Yes, they were given some money by Save the Children, about Kes150,000, but it is like they did not use it properly."
- FIC, Wajir

"Even right now there is an ongoing process to form groups of 10-15. Some [CHVs] already have goats, others, they have shops. They formed the groups of 20-10 so they were told to start small businesses which after a certain amount, Save the Children would top up for them. But nobody has reached the target. They are struggling to meet the target so that they can be topped up."
- CHMT, Mandera

Sensemaking Solution Generation

01 Create a CHV engagement policy and CHV guidelines that detail CHV roles and scope of work, purpose of household visits, hours to be spent per week as a volunteer, other expectations for CHVs as well as limitations to CHV work. Sensitize CHVs and community on these guidelines.

02 Reimagine and reinvigorate the role of CHAs. Ensure CHA recruitment is based on the needed skill set and empower this role to be advocates for CHVs. This includes managing community expectations on CHVs, creating a workplan in line with the voluntary role, and creating opportunities for non-financial recognition to tap into intrinsic motivation.

03 CUs create a CHV recognition plan that leverages religious and community leaders to publicly recognize CHV work.

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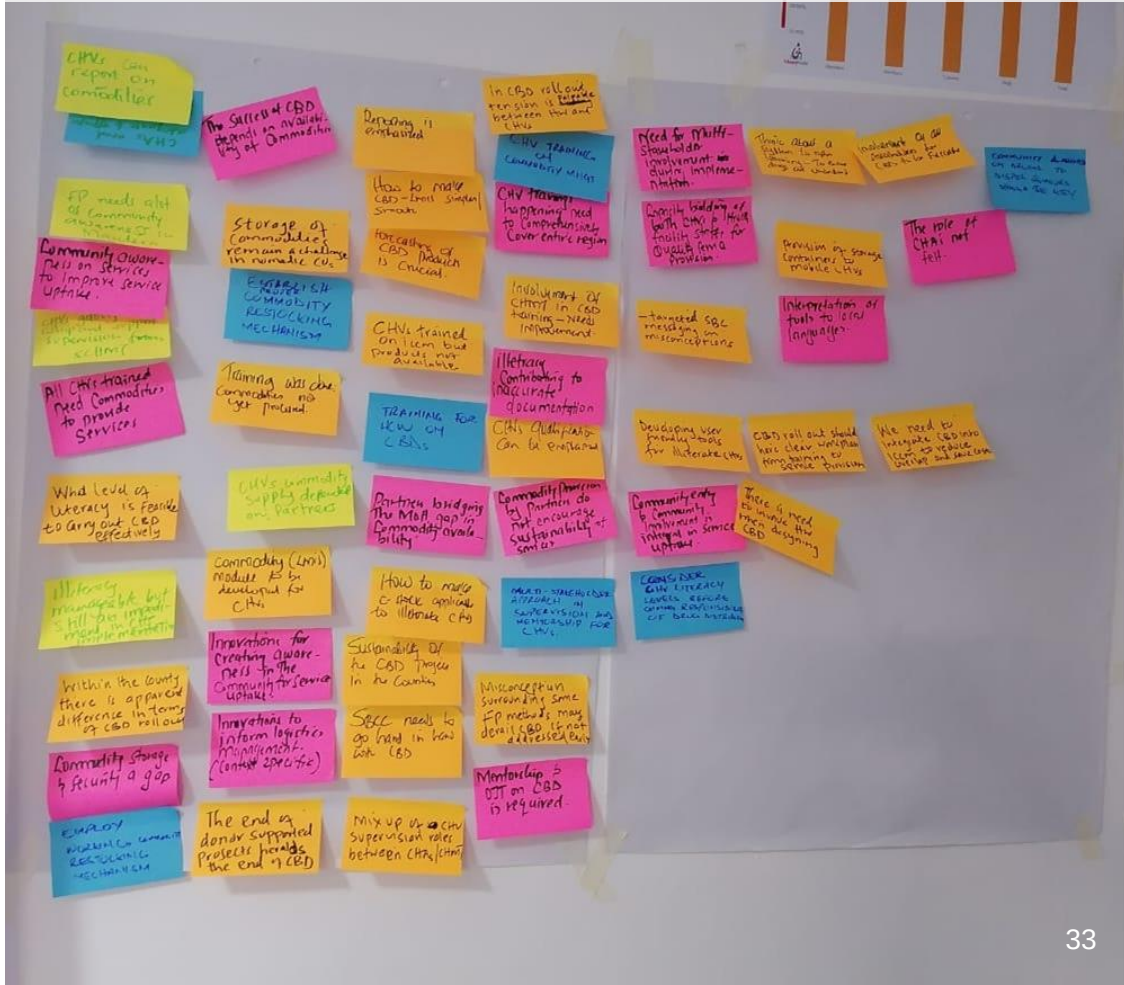
Sensemaking Solution Generation

04 Provide government benefits that have financial implications for CHVs, other than direct payments. Suggestions include educational support (free uniforms, books, fees, etc.) and free medical care and pharmaceuticals to CHVs and families at levels 4 and 5 facilities.

05 Revisit results based financing for CHVs. This could be based on successful referrals, community health outcomes, or other benchmarks of success.



Emerging research themes for CHV Motivation

01 The right combination of financial and non-financial motivators are needed to sustain engagement

02 CHVs lack clarity in the voluntary nature of their roles and this results in unmet expectations

03 Training and supervision, highly motivating activities for CHV, are core elements of the CHS strategy and is the responsibility of the County government. In practice, however, financial and technical support for training and supervision are often partner driven and inconsistent

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85%

OF CHVs REPORT RECEIVING ADDITIONAL HEALTH TRAINING, BEYOND BASIC CHV TRAINING

Continuous health training is a key source of motivation for CHVs, particularly when they receive certificates to validate their attendance and competencies.

CHVs value health education and consider it integral to their ability to serve the community and pass on important health messages, particular around iCCM and commodity management. CHVs expressed interest in acquiring more skills, including treating adults and not just children, and handling more advanced commodities.

While training is a core comment of the CHV experience, there is an opportunity to further motivate CHVs with training certificates, which will increase CHVs' professional confidence, serve as proof of transferable skills and potentially enhance their employability in other settings or Counties. Currently, CHVs have limited opportunities for this type of professional development courses, and rarely receive formal documentation to authenticate their skills.

While most CHVs have not benefited from any exchange visits designed to build their capacity, such opportunities were perceived to be valuable among those who participated.

Key input from sensemaking Training was often cited during the sensemaking meetings as being motivational because it provides an additional source of income for CHVs as they are facilitated with money to meet their logistic needs, and are often able to save some funds for their families.

In order to be an effective motivator, training needs to be consistently offered to all CHVs, not only a few, and must take into consideration literacy and language barriers.

In Wajir, static CUs and CHVs reported that they did not receive training on CBD, but semi-nomadic and nomadic CHVs and CUs did. Conversely in Mandera, nomadic CHVs receive little training, while static CHVs receive more opportunities for capacity building. This inconsistency was cited as a demotivator for some CHVs.

Governments and IPs have utilized innovative tools to adapt for the literacy and language barriers in the ASAL region. This has included using both manual and digital tools, using more graphic and less text heavy formats and encouraging CHAs to spend more time supporting nomadic and low literacy CHVs, as they require more time to interpret materials.

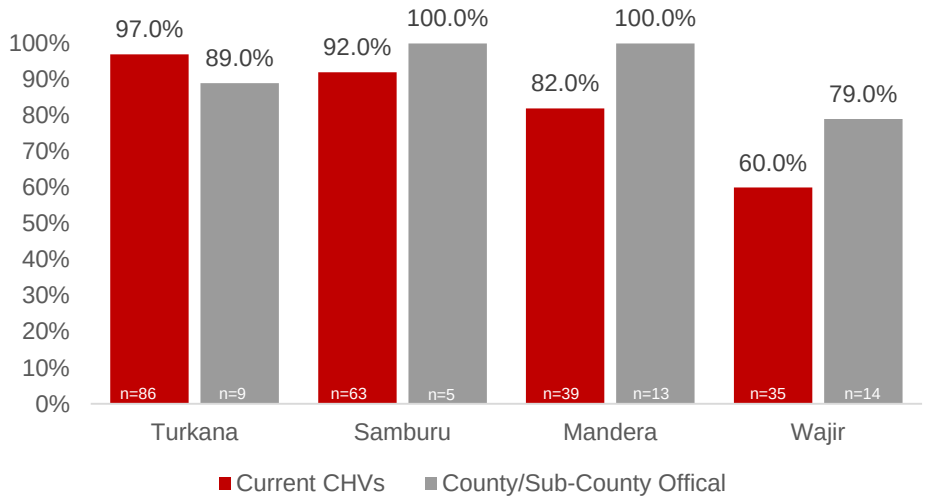
"Certificates are very important so that when one day you quit this work, at least you've got something to show and also maybe you go to another county and you want to continue your work."
-CHV, Samburu

"You are given several trainings without being given a recognition certificate...that is the biggest CHV demotivator. If you are given 10 years' training without certification, it will not help you. You heard in the morning when one of the CHVs was saying we have been trained several times but no recognition."
-CHV, Wajir

"We need to be given certificates to show that we have attended a certain meeting or training. It increases our morale."
-CHV, Turkana

Supervision is a significant source of motivation, as it enables CHVs to improve their skills, receive personal recognition for their efforts and strengthens the relationship between the CHAs and the CHVs

Percent of respondents who said CHVs receive supervision, by respondent type.



"[Supervision] changes [CHVs'] attitude and it also makes them feel that they are also working for the community and they are not being forced. It also makes them attached to their supervisor...if you are not in touch with them for long it makes them feel lonely, but if you are there once in a while, they will feel free maybe to ask for what they are lacking."

-CHMT, Wajir

"[Supervision] shows me that I am working together and closely with this person. I get highly motivated especially when the people there in the villages get to know the community health worker by the name and it also builds up the trust between the people and us."

-CHV, Turkana

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All respondents, from CHVs to County officials to IPs agree that supervision is essential, yet very inconsistent.

Challenges cited include:

- **Human resources:** There is low coverage of CHAs in most counties, the cadre responsible for providing CHVs supervision, contributing to irregular and at times, low quality supervision.
- **CHA capacity:** Although a large of number of CHAs have recently been recruited, some do not have sufficient capacity to manage supervision.
- **Budget prioritization:** At the county level supervision is not adequately resourced. CHAs often lack transportations and access to printed supervision tools.
- **Migration:** In Mandera and Wajir, supervision and mentorship are mainly conducted for the Nomadic and Semi-Nomadic CUs with support from NHP, while there are weak supervision structures for the static communities. However, supervision and mentorship in nomadic CUs is challenging due to unpredictable migration patterns, with some migration routes even crossing borders.

- **Targeted support:** Personalized support and supervision was cited as key to maintaining CHV motivation, although supervision in the ASAL Counties is often done in groups, both at the facility and in the field practical reasons. The results is that CHVs have limited opportunities to receive one-to-one mentorship, affecting the quality of support that CHVs receive for their actual day-to-day activities at the household level.
- **Insecurity:** Some areas are insecure and thus CHA travel is more restricted.

Effects of COVID-19 on Supervision In the early stages of the pandemic, face-to-face supervision was disrupted in each county due to restricted movement, however supervision has largely resumed with COVID-19 guidelines in place. Where supportive supervision is taking place, it is difficult as many CHVs and CHAs do not have masks or PPE.

"These are nomadic CHVs. Sometimes even the vehicle to access their areas is difficult. So the CHAs are supported using motorbikes for at least two or three days depending on the workload….Some of the CHVs might move out of the border, cross to other Counties such as Marsabit and [the CHAs] have to wait for them to return so that they can be mentored."
-IP, Wajir

"The [CHAs] don't have the capacity. They are only trained on community health concepts, but now the CHVs you have to take them through the entire community health module."
-CHMT, Mandera

"Organizing supervision requires some funds, because when you are going to supervise the CHVs and some of them are very far you will require some means of transport and some lunch, so I think that is something hindering supervision."
-CHA, Turkana

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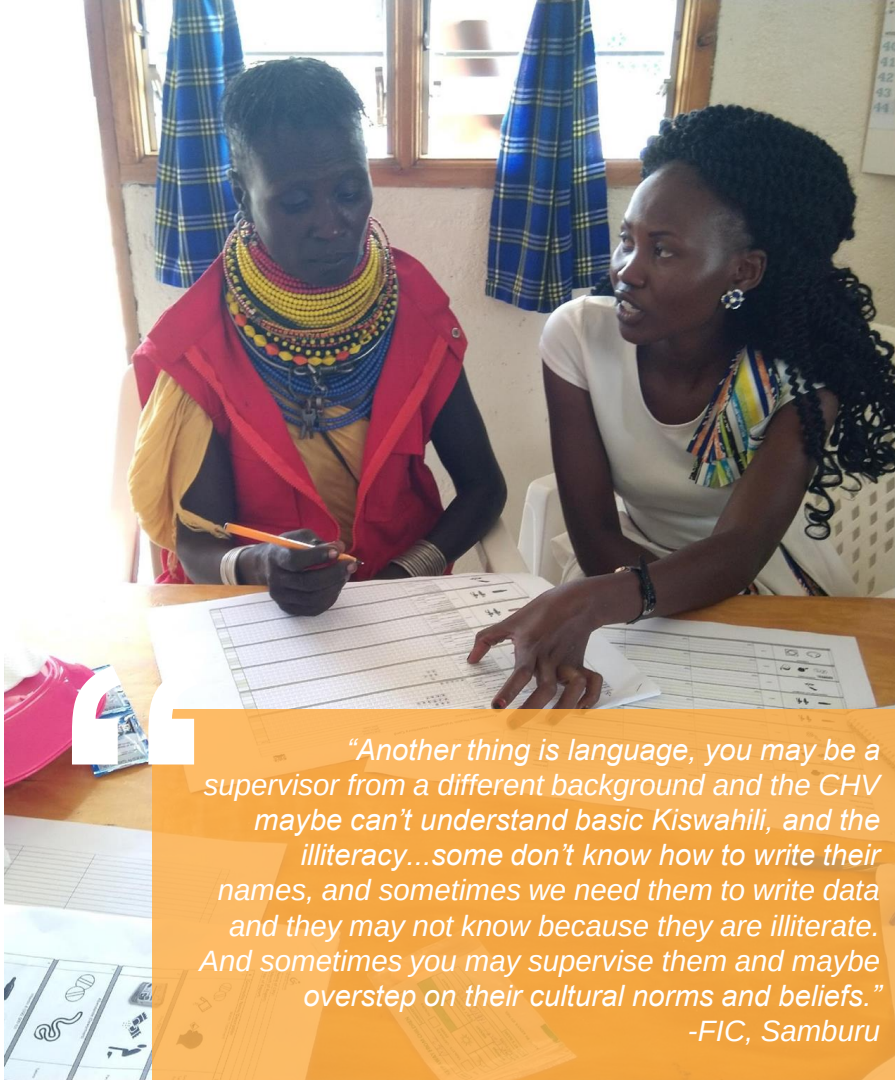
- **Literacy and language barriers:** Literacy affect the quality and method of supervision. Hands-on supportive supervision and mentorship is best suited for the low literate CHVs that are the majority. In Wajir, approximately 80% of the county population is considered low literacy, this is reflected among the CHVs. In some cases, CHA do not speak the same language as CHVs, certainly affecting the quality of support they are able to provide to them.

Key input from sensemaking Communication in a holistic sense is a challenge during supervision.

- Language barriers
- Lack of respect
- Poor network coverage
- Lack of electricity to charge phones



"Another thing is language, you may be a supervisor from a different background and the CHV maybe can't understand basic Kiswahili, and the illiteracy...some don't know how to write their names, and sometimes we need them to write data and they may not know because they are illiterate. And sometimes you may supervise them and maybe overstep on their cultural norms and beliefs."
-FIC, Samburu

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Other threats to motivation and the successful implementation of community based health care included inadequate infrastructure, including transportation options and limited supplies.

- **Transport:** Facilitated travel is considered essential for CHV motivation, particularly due to the challenges associated with the ASAL context where households are far apart, road infrastructure is weak and subject to seasonal damage, and public transport is more difficult to access. The lack of transport also affects the health outcomes of the communities. There are few, if any, ambulances for transporting patients in critical condition who require emergency care and lack of transport affect CHVs' abilities to trace defaulters, effectively distribute commodities, or reach out to nomadic populations.

  While it is clear that transport is a major challenges for CHVs, a number of strategies which included purchasing motorcycles for CHVs have been piloted in the past with little success, mainly due to sustainability issues.

There are also concerns around the appropriate mode of transport for CHVs. Bicycles are not ideal for moving around parts of the ASAL terrain, however motorcycles are more costly to purchase and to maintain.

- **Inadequate access to critical supplies:** Lack of job aids and supplies (e.g. gumboots, gloves, identification materials), and limited health commodities such as first aid kits, mosquito nets and essential drugs are a key source of CHV demotivation. Inadequate access to proper identification materials also reduces CHV confidence and motivation, and diminishes their credibility and trust within the wider community.
- **Lack of access to quality health facilities:** This remains a major challenge for many communities, as link facilities can be extremely difficult to access. Many facilities are not sufficiently sanitary, affecting community's ability to adopt and maintain improved hygiene practices.
- **Culture:** There are also instances of poor uptake of medical services, where community members may be resistant to follow-through with referrals for cultural reasons that are biased against modern medicine.
- **Shortage of medical staff:** Limited HR and poor doctor to patient ratio more generally also affects the work of CHVs, as patients may not be able to benefit from more advanced care even if they visit a health facility. This is particularly problematic in the marginalized ASAL region. In Mandera, the shortage of health workers is particularly severe, and CHVs are typically used to fill the health worker gap in the facilities, even heading the management of facilities.

"We should move away from the issue of voluntarism and move to having more community health assistants who are nurses and [doctors] in the community. You cannot call a community unit where there's no facility to refer patients to."
-CHMT, Mandera

"We need to have a maternity or labour ward because our women deliver on their way to the hospital and that is unhygienic for the newborn."
-CHVs, Turkana

"Some clients believe in traditional cultures and believes so when they are approached to go the hospital they tell them ,'No, we have our cultural beliefs which we believe in and we are not going to go to the hospital'... for example, you understand that for Turkanas, there are certain types of conditions they will not come to the hospital for because they believe if they get an injection, maybe they are going to pass away. So I think that is a demotivating issue."
-FIC, Turkana

Sensemaking Solution Generation

01 Create a standard certified CHV training curriculum, including initial training, regular refresher trainings, and specialized trainings.

02 Develop and utilize a CHVs database which tracks individual CHV's capacity, strengths and weaknesses and migration patterns to facilitate supervision.

03 Conduct a mix of targeted supervision, where a mentor customizes the areas of focus to the needs of specific CHVs, and organizes group sessions when there is a common area of weaknesses.

04 Target training and mentorship of CHVs using digital approaches - video, audio, tools and SOPs in local dialects.

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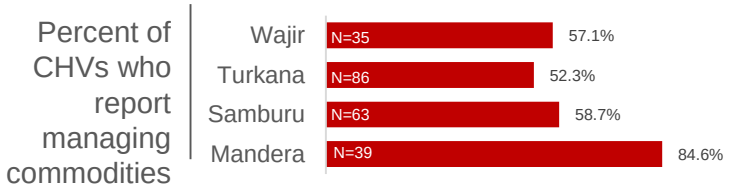
Emerging research themes for Community Based Distribution

01 CBD is happening in each of the counties, both formally through support of IP and informally with individual CHVs, however lack of commodities at linked facilities and lack of a County strategy for supplying CHVs threatens CBD success

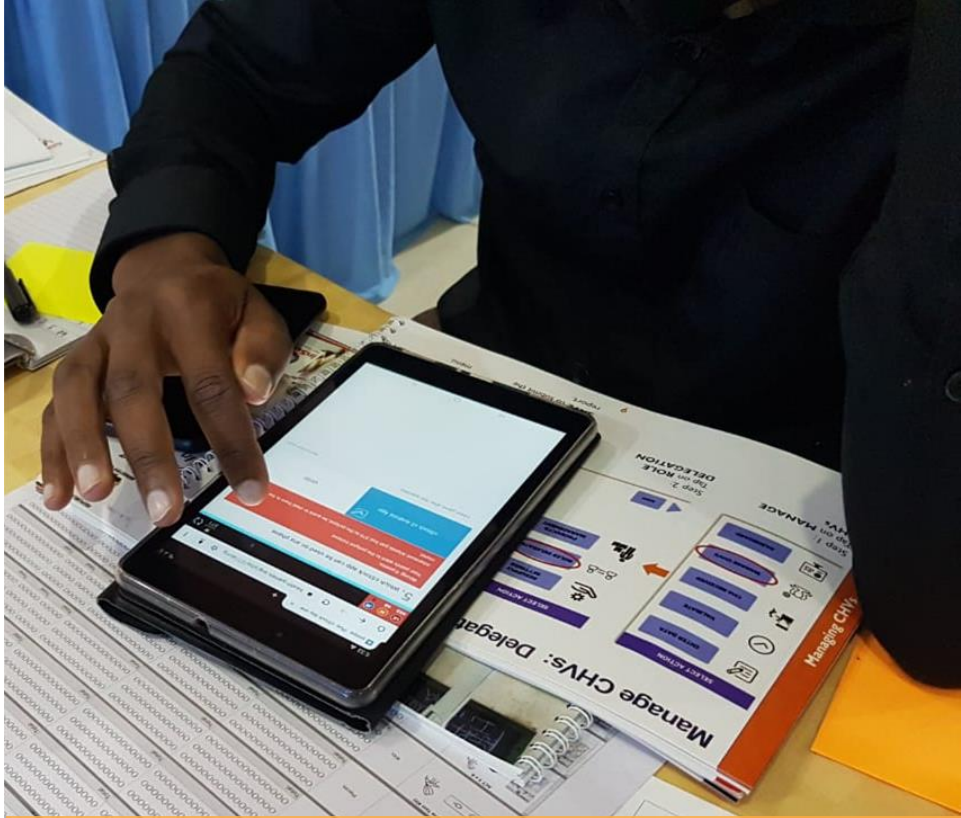
02 The lack of consistent supervision and low CHV motivation are additional challenges

Partners have initiated CBD roll-out, with some CHVs receiving training on iCCM, FP and commodity management (digital and manual tools), however this is a fairly new process.



Many CHVs have experience successfully treating minor illnesses using basic commodities, however not all CHVs in each of the counties are actively managing commodities.

Currently, most CHVs with access to commodities report managing essential drugs and nutritional supplements such as ORS, Zinc, paracetamol, antimalarials, condoms, vitamins and therapeutic foods. No CHVs at the time of the interviews had experience with DMPA-SC (Sayana Press), as training on the management and administration on injectable family planning is still underway.



At the time of the survey, SCALE was still training CHVs on the cStock, a community commodity management system, and therefore cStock was not widely discussed among CHVs. However there was particular optimism among partners and CHMT stakeholders about the potential of the approach to improve and streamline the commodity management process.

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Currently, commodities allocated for CBD are managed by partners who are purchasing, storing and distributing to CHVs directly, as systematic challenges prevent the use of the national distribution route.

In many of the ASAL Counties, products that could be used for CBD are chronically understocked at the facility level. When facilities do not have sufficient commodities, it is unlikely they will supply CHVs with stock. Therefore, the commodities allocated to CHVs are primarily sourced from partners and, in many cases, product selection or availability is program driven (e.g. FP, nutrition products, WASH).

Systematic limitations includes:

- Reactive and unpredictable ordering, where Counties begin the ordering process by looking at their limited commodity budget rather than quantifying need
- Delays in distribution through the national system
- Lack of commitment and prioritization of CBD from County leadership

Many CHVs in ASAL counties are engaged in informal CBD.

Even in geographies with no clear County level policy of engaging CHVs to distribute commodities in the four counties, many facility in charges, particularly in the remote areas, are providing CHVs with stock to distribute. This is an indication that CBD is viable.

Key input from sense making During cStock rollout, the SCALE project ran into challenges where some facilities were not willing to allocate stock to CHVs, particularly for commodities where facility stock might be low. The facility resistance to do so was mainly due to reporting channels or shortages of health facility level commodities. The project successfully advocated for the county pharmacists to send an official communication to subcoutny pharmacists and then facility in charges to release stock for CBD. For some counties like Samburu, the pharmacist wrote a letter to the subcounty pharmacists that detailed CHV involvement in helping to improve the accessibility of specific commodities through the cStock application to the communities under the supervision of the County Commodity Security Technical Working Group and InSupply Health.

Emerging research themes for Community Based Distribution

01

CBD is happening in each of the counties, both formally through support of IP and informally with individual CHVs, however lack of commodities at linked facilities and lack of a County strategy for supplying CHVs threatens CBD success

02

The lack of consistent supervision and low CHV motivation are additional challenges

CBD relies heavily on a strong CHV workforce that is sufficiently motivated to manage and report on commodities. In theory, resupply is done during supervision or routine check ins with facility staff. However, as previously discussed, CHV motivation is often low and supervision is inconsistent.

Supervision and mentorship are of particular importance during the roll-out and initial implementation of the CBD approach.

CHVs typically source commodities through their CHA or at the link facility. This should be done on a monthly basis, or as their stock runs out, however resupply is most challenging for nomadic CHVs. Partners have begun re-supplying nomadic communities at watering points and road access points, and is often combined with supportive supervision visits and outreach, but this is very heavily partner managed. In other cases, commodities are delivered directly to the community by implementing partners, particularly in case of emergencies.

"The last time I offered medication was last month... I collected them from this facility. The drugs are inadequate because the few ones I collect from the facility are never enough for the whole community, I just wish I was given enough medications."
-CHV, Turkana

"The frequent stock outs at health facility level demotivates the community health volunteers...now that we provided the initial kits for the CHVs, the challenge is that once the kits are exhausted, because even like for now, some of the items are almost being exhausted although we plan to replenish for maybe until the end of this year. So that means if the link facility is having a stock out, then even at community, at the CHV level they are stocked out."
-IP, Wajir

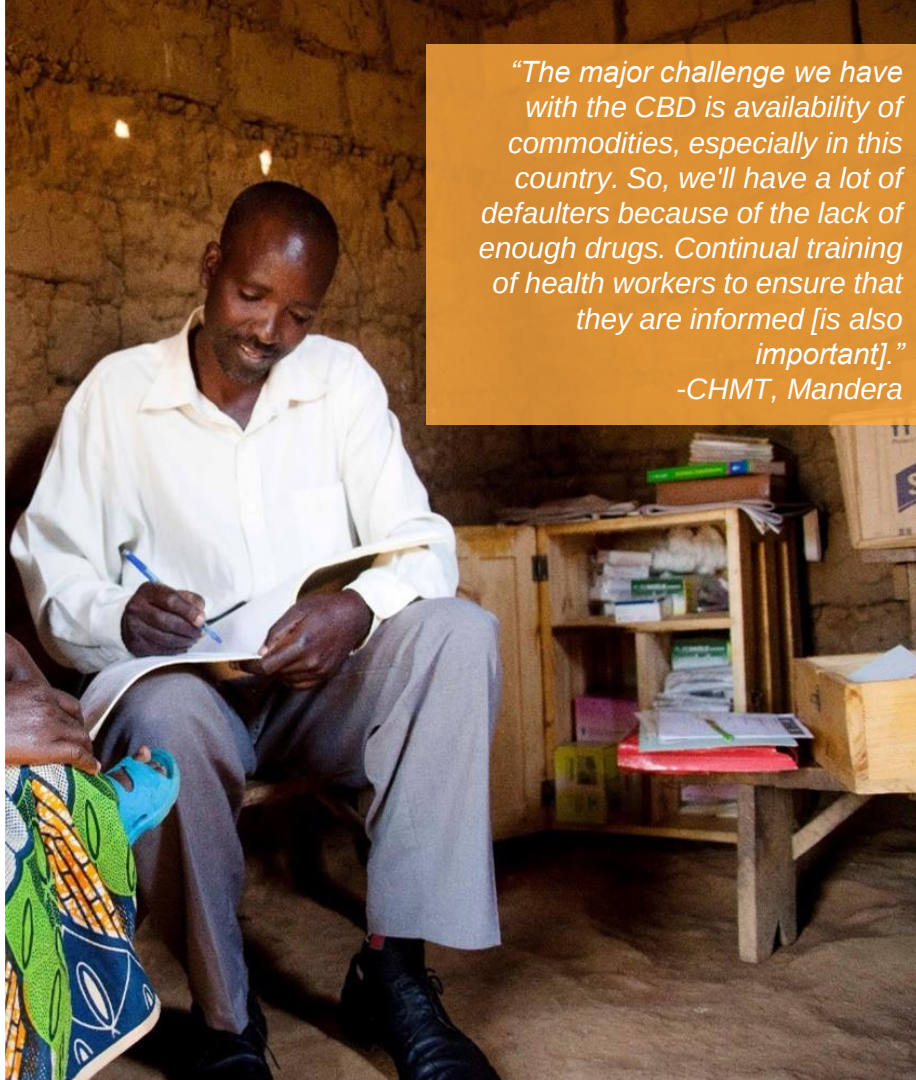
Key input from sense making Stock-outs at the facility level threaten to water down the investments made in training CHVs on commodity management. Thus one should not be addressed without the other.

While CHVs are technically entrusted to provide primary health care within their communities, they often feel ill-equipped because they lack basic commodities and proper training to manage and dispense them. This weakens the trust that communities have in CHVs to meet their basic health needs.

Availability of commodities is a key concern as CHVs report frequent stock-outs and delays in stock delivery. Often, when facilities are running low on a particular commodity, they are not willing to dispense their limited stock to CHVs. Many respondents also cited capacity and literacy as major issues, however as CBD continues to roll out, we hope these key challenges are addressed in the new curriculum.

The following challenges were frequently cited:

- **Storage of commodities:** CHVs mentioned that they do not have bags to store or keep their commodities as they travel for distribution.
- **Disposal of waste products:** There are concerns that CHVs, particularly in nomadic CUs, improperly dispose of waste.
- **Low literacy and numeracy:** This could affect basic reporting and management, such as forecasting or anticipating need.



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Sensemaking Solution Generation

01 Create a clear plan for how commodities are managed and allocated both in times of over and under stock at the facility level. For example, what stocks should be prioritized for CBD when facilities are understocked?

02 Ensure commodity security through making some adjustments during forecasting and quantification that take into consideration the consumption at the community in addition to the service consumption data. In the absence of community consumption data, the population statistics could help.

03 Take bold steps to address the myth and misconception on the use of DMPA-IM that it can cause infertility. Without addressing this attitude in the community, CBDs are likely to face animosity as they promote CBD. Dialogue days present opportunities for this to be realized. Other forums through which community sensitization on the concept of CBD can take place need to be explored.

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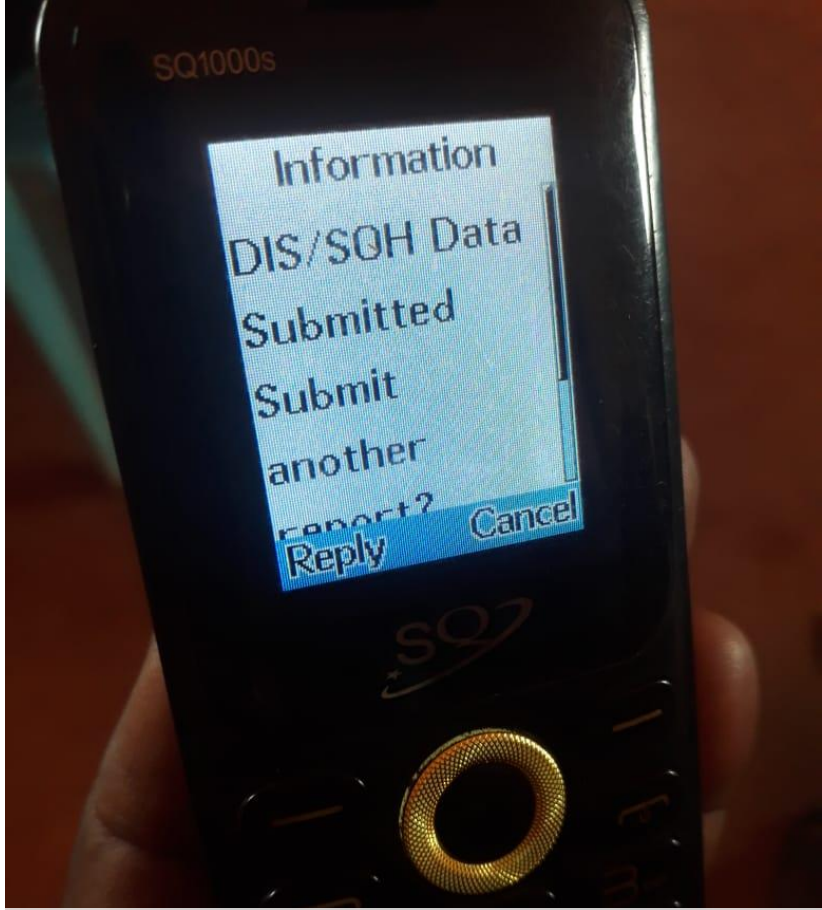
04

Continuous training and retraining to build CHV competence for all aspects of CBD, including frequent training and refresher training as well as targeted mentorship at community level. The training content should be customized to low-literate CHVs and there is a need to develop and utilize innovation approaches in training these CHVs like including visual aids to suit the literacy level. The training should include some sessions to help build CHVs' capacity to maintain confidentiality for their clients.



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Sensemaking Solution Generation

Emerging research themes for COVID

01

While the pandemic highlighted to importance of community based healthcare, stakeholders at all levels expressed feeling unprepared and unsupported during the pandemic, and saw a decline, at least initially, in facility and community based health services

The pandemic disrupted a significant proportion of routine community health activities across each county, most importantly community meetings, household visits, outreach activities, CHV trainings, health worker meetings, and some aspects of commodity distribution.

There were also indications that financial resources for regular community health activities were diverted to COVID-19 response activities, particularly surveillance and contact tracing. For example, in Samburu, contact tracing was prioritized over other activities, including supervision; some CHAs did not feel prepared to make the necessary changes or adaptations to their regular activities, particularly because the CHV and CHA working guidelines were not adapted in response to COVID-19.

In terms of community health, stakeholders reported fewer facility births, fewer immunizations, and fewer referrals and visits to the facilities in general; nutrition activities and tracing of defaulters was also disrupted during this period.

In some areas, however, CHVs were used for key activities such as surveillance, contact tracing and community sensitization, highlighting their unique role in pandemic response.

"It has really affected my [work] because getting into the community you get scared. It has also affected my work like for example ANC... the topic of social distancing becomes difficult, for example if you have 10 mothers ...because crowding in the hospital is also not required...some become defaulters, when you do a follow up, you get they have continued to be defaulters so you find it difficult to help her. Because they say when you go to hospital they don't want a lot of people at the facility."
-CHV, Turkana

"COVID has really affected us so much. There are some activities that we would wish to provide at the households and homesteads...There are a lot of children who have not been immunized but it becomes a challenge to provide the service because of COVID."
-CHV, Samburu

"Action days were interrupted. There's no frequent supervision. Household visits have also been affected."
-CHMT, Samburu

In most areas, CHV motivation has decreased during the pandemic due to:

- Inadequate PPE leaving CHVs feeling exposed to the virus and reluctant to provide services
- Inability to gather with communities for outreaches
- Reduced face-to-face supervision
- Deprioritization of CHV activities as focus shifted to facility based response to COVID-19
- Lack of healthcare support should a CHV test positive for COVID-19
- Increased workload for COVID-19 preparedness activities and contact tracing
- Delayed stipends due to reprioritization of funds during the pandemic
- Denial of annual leaves during the pandemic and having to be on duty 24h a day

"Of course, [CHV] motivation might have gone down if they are not provided with PPEs... without masks they may be reluctant to work. They may not have gloves. They are not as enthusiastic as they used to be. And again sustainability is a challenge...By the time they do the requisition [for masks], it may take a few weeks. So, during that time no one will move."
-CHMT, Samburu

"No, I am not motivated because I fear I might contract the disease and on top of that there is no payment I am getting, But I sacrifice to help my village. I am asking that we be supported during this COVID period because we hear there is financial aid but we have never received it."
-CHV, Turkana

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04 DISCUSSION

Discussion

CHVs are universally seen as a key pillar of the health strategy, and their roles are especially essential in the ASAL regions, where the communities are remote, hard-to-reach, and include nomadic and semi-nomadic populations. However, this cadre is often burdened with a high workload, weak training and supervision structures, and a lack of alignment between roles and incentives. The expectations placed on CHVs are often more akin to that of a formal job, while the enjoyment of volunteerism seems to fall victim to necessity of these functions critical to the health of communities. Additionally, CHVs, being a respected member of the community akin to a doctor or nurse, struggle with the ability to fulfill the communities expectations within the current incentive and support systems.

So how do we reorganize the work of CHVs to align with the spirit of volunteerism, while still filling a critical gap in health?

What are those services that can only or best done by CHVs and what government resources are thus best managed by CHVs on behalf of the community?

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A few key areas to consider:

Setting clear and consistent expectations for CHV work and the role that CHAs play: The government should take the lead on rectifying the tension between volunteerism and paid work by setting clear expectations with communities and CHVs and facilities. CHAs should continue being advocates for CHVs, ensuring their workload is commensurate with expectations and that they are not being financially or emotionally burdened in their role.

Tapping into intrinsic motivators: CHVs scope of work should prioritize those activities that highlight intrinsic motivation. Utilizing religious, community and health leaders to publicly recognize the work of CHVs should be part of the standard CHS.

Utilizing training as a motivator: Training opportunities provide multiple motivation mechanisms. They can serve as a way for CHVs to earn a small stipend for their family, as CHVs often save some transportation or food allowances for personal use; they transfer knowledge and skills that CHVs can then demonstrate to the community; and when provided certificates, can help CHVs formalize their skill set that can be used for future employment opportunities.

Providing consistent supportive supervision: Supervision is a high motivator and, as documented in the literature, key to ensuring quality health services. On the other hand, when supervision is not supportive, regular or equitable, it can serve as a demotivator. The role of the CHA should be clearly defined, and then contextualized and facilitated for context of the ASAL regions. Transport to reach to the CHVs remains a critical gap, making the supervision and mentorship to be nearly impossible unless facilitated by a partner.

Questions around the operationalization of CBD in both static and nomadic communities have yet to be fully answered, as COVID-19 delayed the rollout of some of the initiatives such as cStock. However, we do know that even untrained CHVs are managing some commodities informally, so there is a lot of potential for CBD.

In order to be successful, the national government and the County governments need to create a robust plan for sustained resupply, including ensuring that CBD is included in county quantifications and forecasting. Key to CBD is also ensuring that CHV motivation remains high, and that CHVs are properly

supported through in person, community based supervision, coupled with a county based policy on CBD that focuses on the iCCM commodities and family planning. The policy should outline the prerequisite requirements for a CHV to distribute commodities as well as manage drugs at the community level.

Community health volunteers in Kenya continue to play a significant role in promoting health, despite the lack of proper engagement structures with government and non-governmental entities. To ensure they are a highly motivated workforce for continuity in community service delivery, CHVs should be facilitated and empowered to meet their basic needs, trained and skilled to offer quality services, supported through supervision and mentorship, and recognized and appreciated for their work. Resource mobilization structures are needed and are deliberate efforts for building CHV competence in delivery of specific services within the large spectrum of health services.

Wave 3 will focus on sustaining and maintaining motivation and support for CHVs to fully operationalize Community Based Distribution, including the continued rollout of cStock.

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