Developmental Evaluation of Community Health Models in ASAL Counties in Kenya

WAVE I SUMMARY REPORT

inSupplyHealth
An affiliate of JSI Research & Training Institute, Inc.

HEALTHRIGHT INTERNATIONAL

Background

Kenya has a well-defined national health policy and a reform agenda focused on improving health care delivery services and systems and to contribute to the achievement of the Universal Health Coverage. The Kenya Essential Package for Health (KEPH) identifies that communities are the foundation of affordable, equitable and effective health care.

COMMUNITY HEALTH STRATEGY (CHS)

The Community Health Strategy (CHS) outlines the framework for development and implementation of comprehensive community health services. The CHS includes:

- **Community Health Unit (CHU)** serving a local population of about 5,000 people;
- **Community Health Volunteers (CHVs)** each providing services to between 20 and 100 households depending on the population density;
- **Community Health Assistants (CHA)** providing supervision and technical support to CHVs.
- **Community Health Committees (CHC)** supporting recruitment, management and governance functions

Through this strategy, households and communities are empowered with skills to take an active role in health and health-related development initiatives thus effectively contribute to the country's socio-economic development.

ARID/SEMI-ARID LANDS (ASAL) REGION

The counties in the arid/semi-arid lands (ASAL) of Kenya, including Samburu, Turkana, Wajir and Mandera, host marginalized populations that are remote, hard to reach, and sometimes migratory. These counties generally have low access to health services due to infrastructural challenges, poverty, low levels of literacy and education, social, and cultural factors, dynamic population movements and geographic barriers. Additionally, communities (particularly in Turkana and Samburu) experience frequent armed conflicts over land, water and pastures, and in Wajir and Mandera, safety issues related to terrorism are a real concern.

Altogether these social and cultural realities are coupled with vast geographies with low population density, creating an extremely complex and challenging environment for provision of community health services.

Developmental Evaluation

Developmental Evaluation (DE) collects and analyses **real-time data** to support innovative design and implementation, by providing relevant evidence for ongoing informed decision-making. 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.

This developmental evaluation focused on activities and outcomes of three community programs in order to generate evidence and learnings about sustainable and scalable models that can increase utilization of community health services (including family planning) in arid and semi-arid lands:

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.

Afya Timiza

Implemented by Amref Health Africa, aims to increase the use of quality county-led 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.

Nomadic Health Program

Implemented by Save the Children, seeks to increase the use of quality family planning 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.

The DE will be conducted in four waves of data collection, spread six months apart, over a two-year period. This report present findings of Wave 1.

WAVE 1 LEARNING QUESTIONS

1. What are the current CHV recruitment, mentoring and supervision strategies and processes and what assumptions are made in designing these strategies?

2. What is the role of CHVs according to guidelines and how does this compare to what is actually happening in the ASAL communities? How, if at all, does this differ for FP?

3. What are the conditions required for community based distribution of health commodities in the hard to reach populations? What is the suitable profile of a CHV and how, if at all, does this differ for FP commodities?

4. What potential modifications might be needed to the Community Health Strategy to ensure that the community health needs in the nomadic and semi-nomadic populations are addressed?

Methodology

Wave 1 targeted inquiry was a cross-sectional qualitative study conducted in nine sub-counties within Samburu, Turkana, and Wajir. Data sources included a total of Key Informant Interviews (KIIs) and 25 Focus Group Discussions (FGDs) [see below].

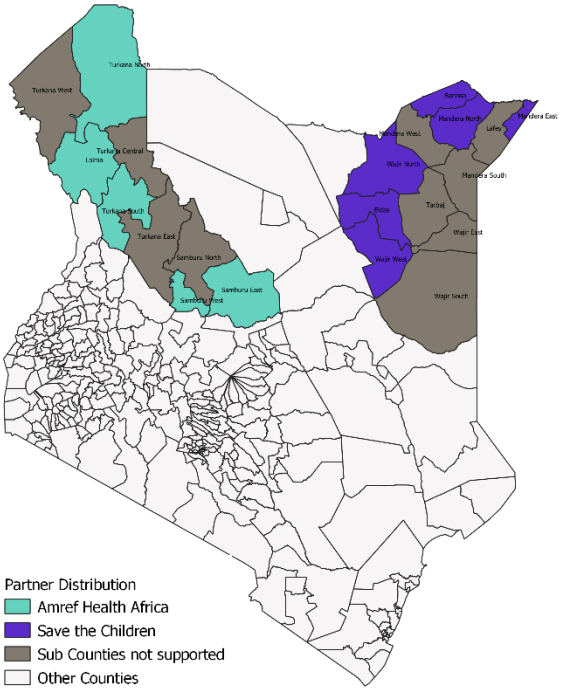
A 2-day training for Research Assistants (RAs) was conducted in Nairobi. We recruited a total of 16 RA (6 for Turkana, 6 for Wajir and 4 for Samburu).

KEY INFORMANT INTERVIEWS

KIIs were conducted with a purposive sample of County and Sub County health health personnel at the facility and community level, and community members.

Table 1. Key Informant Interviews

Position	Targeted	Number Interviewed
County officials • Reproductive Health Coordinator • County Pharmacist • Director of Health • Community Health Strategy Focal Point	12 total: 4 per county	8
Sub-county officials • Reproductive Health Coordinator • Sub County Pharmacist • Community Health Strategy Focal Point	27 total: 3 per Sub County	25
Facility & Community Health Personnel • Community Health Assistant • Facility In-Charge (FIC)	24 total: 4 CHAs & 4 FIC per County	26
Community Members • Community opinion leaders (cultural, religious)	6 total: 2 per County	6
Total	69	65



FOCUS GROUP DISCUSSIONS

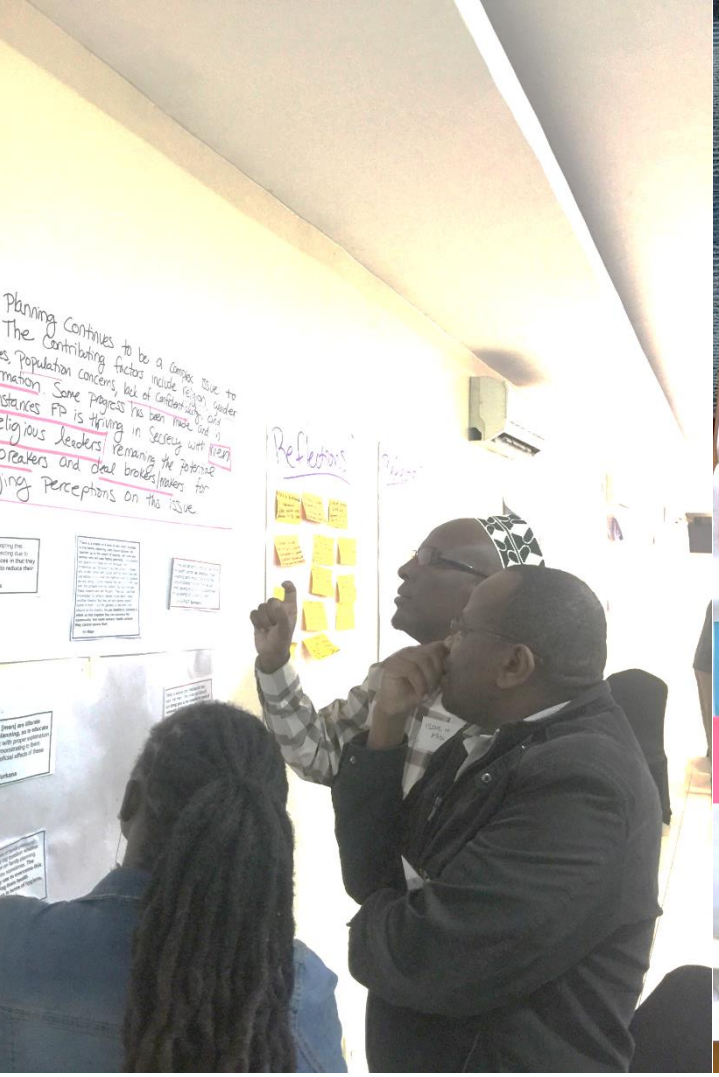
FGDs were conducted with three stakeholder groups: Community Health Volunteers, women of reproductive age, and men.

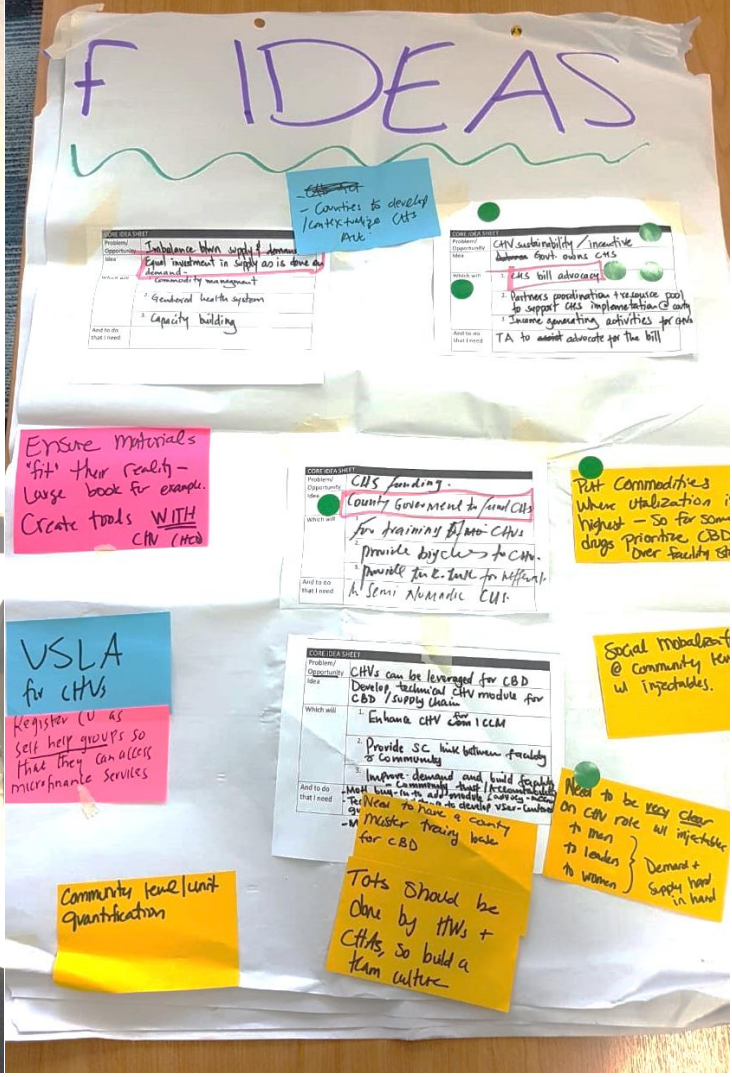
Each FGD session had between 8 -12 participants identified purposively with the help of the County and Sub County officers to ensure that selected participants represented a diverse range of experiences on the substantive issues of interest.

Table 2. Focus Group Discussions

County	Sub County	CHV	Men	Women	Total
Samburu	Central	2	1	1	4
	East	1	1	1	3
Turkana	Kibish	1	1	1	3
	Loima	1	1	1	3
	Turkana South	1	1	1	3
Wajir	Tarbaj	1	1	1	3
	Wajir West	1	1	1	3
Total		9	8	8	25

This study's research protocol was approved by the Institutional Ethics Boards of JSI and AMREF Health Africa. For further information on methodology and quality assurance, see the study protocol.





Analysis

RAPID ANALYSIS AND SENSEMAKING

As DE is meant to generate data that can be immediately understood and utilized by the projects, five weeks following data collection, and before the data were fully analyzed, national and county representatives from the three projects held a sensemaking meeting to discuss the emerging insights and suggest adaptations to respond to challenges.

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 of matters 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.

IN DEPTH ANALYSIS

Discussions from KIIs and FGDs were recorded, both in the form of handwritten notes and using audio recorders. To provide preliminary results, field notes were manually analyzed by organizing the information into emerging themes and reviewing common trends and discords across interviews. Further, transcription was done, and a thematic analysis was conducted with the aid of Nvivo.

This report includes both the data collected in the field as well as key insights from the sensemaking process.

COMMUNITY HEALTH NEEDS IN CONTEXT

There is limited access to, and use of, sanitary infrastructure which compromises the effectiveness of other health interventions.

Basic water and sanitation infrastructure is still a challenge in the ASAL communities of Wajir, Turkana and Samburu. Large parts of the counties are arid and the available water sources are often many kilometers away. Communities are therefore burdened with preventable diseases, straining an already under resourced health care system.

Many facilities that serve these communities **also lack reliable access to clean water**, resulting in unhygienic facilities and toilets, and potentially compromising the safety of essential services like skilled delivery.

"In this community, people need proper feeding, clean and treated water to avoid diarrhea and other sanitation related diseases."
- Men FGD **Turkana**

"Lack of water to the patients who are admitted in wards is a challenge. Our facility has no enough water for use by patients when they come for health services and we really need help on this."
- Women FGD **Turkana**

ASAL communities, though generally knowledgeable on health, has inadequate access to comprehensive quality facility-based health care, leading to poor service experiences by communities.

There are several factors contributing to this. Vast geographies with low population density means that communities must **travel long distances to reach the few static facilities available.**

Due to a **severe shortage of healthcare workers**, many lower level facilities are not staffed to provide the range of quality of services that would be expected, including essential services. Part of this is contributed to high turnover due to difficult working conditions within some rural areas.

This is compounded by the fact that health care workers from other counties or, in some cases other clans within the counties, who are considered **"non-locals" are not well accepted in the communities.** There is a tension between wanting to keep job opportunities available to those within the community and who understand their language and culture and the need for more specialized medical skills.

Lastly, the **lack of essential medicines** in health facilities means that even when community members travel to facilities, they risk not being treated.

"In addition, the medicine is not received as wanted because the important medicine is not brought to the facility. Medicine that are not so important are brought instead…. Not all services can be found at the facility. And if the person is not getting what they want at the facility then they don't come back again. That is why we have defaulters."
- CHV FGD **Wajir**

"Employing CHAs who come from different areas who are not staying in the facility to provide services to the people. We don't want those kinds of things. We want our people to be employed"
- CHV FGD **Wajir**

Community Outreach is a common strategy to overcome challenges with facility-based services in ASAL counties but requires significant logistical and financial support from implementing partners.

Outreaches include immunization, nutrition services, antenatal care, polio campaigns, treatment of minor ailments and health education to communities. However, partners provided most of the resources for vehicles, fuel, communication and health worker allowances. As such, many County and Sub County officers found **outreaches to be expensive, partner driven and ultimately not sustainable**.

"Some places are quite far from the facility. Outreaches are sometimes there and sometimes they are not. There are sites selected but you find the budget is not enough so we do major sites until we get another partner to cover the other sites. Some communities are reached more than others."

- KII **Turkana**

Despite some improvements in acceptability and uptake, family planning, a focal area for all three projects, remains a challenge due to cultural and religious norms and gender dynamics.

While certainly not a new challenges, stakeholders need to continue to think of innovative ways to address the persistent challenges.

"We sit with the family - the husband and wife- on one-to-one basis to discuss the family planning products to make them understand and remove any misconceptions they may have. Being Muslim community most people do not permit the family planning methods from the hospital."

- CHV FGD **Wajir**

"*Women are okay with family planning, but the problem is the men….When she gets FP it is the men who touch women at arms and if they feel the medication, they take them to hospital to have it removed. If there is a way to educate the men it would be good because they are the problem."*

- CHV FGD **Samburu**

RECOMMENDATIONS

- Communities do not think of health in a silo, and basic sanitation and hygiene continue to be a high priority. All health programming should be integrated to include this essential component of preventative health.

- While the community health strategy can fill gaps, there is also a need to address significant human resource and commodity shortages at the facility level. Not doing so threatens to undermine the community referral approach.

- Alternate models of Community Outreach should be considered, evaluated and/or scaled including, maternity shelters that provide accommodation to pregnant women nearing their expected date of delivery, and integrating health outreach activities to include other services of priority to the communities such as livestock vaccination, veterinary services and agricultural demonstrations, among others.

- Ultimately, Community Outreachs will need to be included in County and Sub County budgets if this is to be a sustainable model of service delivery.

- Programs focused of family planning must continue to involve men, cultural and religious leaders as a long-term solution to the barriers of uptake of family planning. Programs need to find ways of engaging this population that resonate with the context and lifestyles of the ASAL communities.

CHV ROLES, RECRUITMENT, MENTORING AND SUPERVISION

Community members and county health leadership overwhelmingly agreed that CHVs are the backbone of the CHS but CHVs are often doing more than what is stipulated in the guidelines, which has both positive and negative implications.

According to the CHS, a CHV's main role is to promote good health, listing 14 key functions, mainly consisting of health promotion activities such as home visits and dialogue days. **All respondents agreed that CHVs in the three Counties have done an excellent job of promoting good health**, citing increased knowledge of community members and positive health seeking behavior.

"For sure the strategy has enhanced some of the activities here…Our skilled deliveries have for sure improved because of this. Our defaulter tracing has been vibrant because we have contact persons in the villages. Immunization services, and you know, last year we won some trophy in Samburu county because of enhanced services in the county. Things to do with FP for sure we were as at now we are at sixty something percent from way back in thirties or something, this is because of the CHS. So CHS has really made so many things work in this sub county."
- KII **Samburu**

However, some respondents noted that CHVs have taken **on additional health facility roles**. For example, some CHVs reported dispensing medication at health facilities or dispensaries. One CHV reported acting as the facility in change when the usual person was away. Still others talked of administering drugs during community campaigns.

While this may offer additional responsibility, skill development and at times monetary support to CHVs, some CHVs are choosing to live closer to a health facility rather than in the heart of the community to take on this additional role. This could potentially have negative effects on implanting the community health strategy.

"When we have in a campaign like the trachoma campaign, we only expect them (CHVs) to tell us the households that are there...but because we have human resource constraints Sub County… a healthcare worker does the writing, but they (CHVs) administer drugs in the presence of a health care worker."
- KII **Samburu**

The guidelines also state that CHVs should treat common ailments and minor injuries, such as first aid. In many areas, CHVs are not able to take on this role due to lack of training and lack of commodities.

CHV Recruitment in the three Counties has generally followed the process prescribed in the CHS, with an essential modification for non-literate CHVs.

CHV recruitment includes a number of criteria to ensure the CHV is respected and committed to community health. The guidelines also state that he/she should be able to read and write. In Samburu, Turkana and Wajir, literacy levels are quite low, particularly among the older population, who are perceived as stable members of the community and more likely to be nominated for CHV, to mitigate the risk of attrition by younger people. To address this, otherwise capable individuals are selected and literate family members agree to help them carry out their duties.

"In hard to reach areas ...not all know how to read and write. The more you get into the interior the more you will get a village where nobody has gone to school and we had no option…to pick some of these people so long as they are ready to volunteer and work.
- KII **Turkana**

While the policy does not favor any gender in recruitment of CHVs, there are calls to be gender sensitive in recruiting CHVs especially when the services to be offered target sexual and reproductive health of women.

Part of reason CHVs may not have been trained to undertake all aspects of the CHS, is that training topics seem to be largely partner driven, irregular, and the topics are inconsistent.

The CHV training course is comprised of two sections:

1. The Basic Modules: Covering the basic competencies for CHVs including leadership skills, communication and counselling skills, basic health promotion practices and basic lifesaving skills. This is required.
2. The Technical Modules: Covering a verity of technical areas. Completion of the training is supposed to be based on local needs.

This evaluation found that most CHVs in these counties have undergone the basic training while few have completed the technical modules. For those that have, it was often because a subject was of particular importance to a partner, leaving CHVs lacking a comprehensive set of skills to offer communities.

"All the 1,080 CHVs have gone through the basic module through training but if we go to technical modules, the 7 technical modules, most of them have not done those modules. However, through the help of some partners some of them have done some of those modules like WASH, family planning and maternal and child health."
- KII **Samburu**

"It's done through training by different partners who train them in different programs like…nutrition. So it is narrowed down the partner or the partners in the sub counties."
- KII **Turkana**

Key mentoring and supervision structures to support CHVs are either non-functional or non-existent, due to both human and financial resources.

According to the CHS, the Community Health Committee is responsible for providing the governing structure at the community level, while CHAs directly supervisor the work of CHVs. In practice, the CHA has most of the responsibility, while the CHCs are less hands on, or in Turkana, non-existent.

While the mandate of CHAs is to build the capacity of CHVs, some CHAs lacked the necessary skill to provide this support. The sensemaking revealed that in some Sub Counties, there was interference with the recruitment process of CHAs by those in leadership at the county, resulting in some unqualified CHAs and not maintaining a presence at a health facility.

"CHAs recruited by the County, most of them have not even been inducted they are just posted and we do on job training assisted by the former CHAs who have been recruited by CHS seconded to the county."
- KII **Wajir**

"Sometimes you take a person [the CHA] to the village and you find that the person doesn't know anything and it's usually me who tells them how screening is done. I have educated them a bit."
- KII **Turkana**

Lastly, given the vast geographical distances and the nomadic lifestyle of populations in the counties, CHAs require time and funds to travel from one village to another. While some CHAs work closely with local leaders effectively carry out their duties, they are often not provided with means for transportation or communication.

"The villages are many and very far from each other and so to move up to there to mentor these CHVs becomes very hard for me… Sometimes maybe you want to make a call then you don't airtime to make that call because also your salary has been delayed."
- KII **Turkana**

As CHV roles expand, the MOH and partners need to find sustainable ways of rewarding volunteers congruent with duties assigned.

Per MOH guidelines, CHVs work on a voluntary basis. They are expected to dedicate a limited number of hours a day on their community health volunteer tasks, while engaging in other livelihood activities for income. However, the work of CHVs has evolved greatly, and CHVs and stakeholders noted that the roles and responsibilities put on CHVs often require more time than what is detailed in the CHS.

There are also a number of reporting activities, which can easily take more than their allotted time. Partners often have separate, project specific reporting requirements or tasks for CHVs which may or may not be coordinated with routine tasks. Amidst the difficult economic environment in these counties, this has created gaps in motivation.

"CHVs have a lot of work that include writing reports, referring mothers to hospital, mobilizing for the children to attend clinics, but are not paid promptly. CHVs have a lot of work to do in the facility. They go around the village collecting information and hand over to the nurse in charge but at home they are hungry. The nurse compiles and gets her/his salary using the CHVs' information, this goes around and a round…They too need to be supported because they are the one who do many health issues on a voluntary basis."
- CHV FGD **Turkana**

While many CHVs requested that stipends be paid and paid on time per County policy, other non-financial incentives such as bicycles, motorcycles, t-shirts, umbrellas, and perhaps most interestingly, learning opportunities were cited as potential motivators.

"We don't get paid but in training there is motivation so more training the more you are motivated."
- CHVs FGD **Samburu**

All challenges with the CHS are compounded by nomadic customs and vast landscape that characterizes the ASAL region.

In other areas of Kenya, one CHV for 20-100 households might be perfectly reasonable. However, in the ASAL counties, CHVs have to walk long distances to reach community members, and CHVs often have trouble locating community members. This creates work that is not only difficult but can be demotivating. For CHVs that do not move with the community, it may also mean that community-based health services are only available during certain times of the year, when communities are close to where CHVs live.

One of the CHVs' main roles is to refer community members to facilities for further care. However, with little transportation options, and long distances, CHVs' efforts to create demand often leaves them vulnerable, as those referring are burdening with paying the transportation bill.

Additionally, the referral system assumes communities have a linked health facility. However, for nomadic and semi-nomadic communities, the linked facility will change along the migratory routes. The current CHS structure is not designed for this. There is a lack of coordination for referrals, few effective feedback mechanism and weak monitoring and evaluation.

"The big issue is people travel from place to place with their animals, hence very tricky to get in touch with them. Following them will risk life with many things involved. Since the people in this area are involved in pastoralists activities therefore they move from one place to another hence making delivery of this services inaccessible to people."

- CHV FGD **Turkana**

"….but the big problem in the community referral system, they don't have ambulances, they don't have what do we call the tuk tuks…they go to a lot of other expenses just to refer those mothers and children….it's burdening the community more because they don't have the referral system in place. In semi nomadic what is needed is the strong referral system that is may be tuk tuks, they can be told maintenance and fuel is on their side that is cost sharing."

- KII **Wajir**

"So you know when a person is sick we do take or make an effort of calling the ambulance to take the sick person to the hospital or when will lack the ambulance will you call two motorbikes to take the person to the hospital but on the other side were not financially stable in paying the ambulance and sometimes the person may refuse to go to the hospital."

- CHVs FGD **Samburu**

RECOMMENDATIONS

- Successful capacity building programs for CHVs must consider literacy levels of volunteers, incorporating pictures, practical exercises and role play.
- MOH should develop a structured, predictable and regular capacity building program. The program should also ensure that CHVs are trained on all the 13 modules in a progressive manner as opposed to the partner driven modules.
- Explore cost effective training models that include initial training and refresher trainings as well as an ongoing mentorship program from the CHAs.
- Maintain a database of CHVs highlighting the trainings that they have undergone at the link facility, with a summary available at the County and Sub County level. The database can be used to prioritize training as well as help in resource mobilization.
- Address the shortage of healthcare workers with specific focus on the CHAs, especially in the remote and hard to reach communities.
- Rather than sticking to typical guidelines, rationalize the geographical sizes of community health unit given logistical support accorded to CHAs. This rationalization should also consider the time it takes to travel to all communities within the unit, available transport methods available, and travel cost.
- Building on the current CHS modifications, further explore and evaluate CHVs taking on expanded roles to carry out selected health facility services to reduce the workload of the healthcare worker. This has a two-way effect since the community members gain more confidence with the CHVs while also addressing some human resource gaps.
- Explore and test learning opportunities as a motivator for CHVs.
- Test incentive models for CHVs such as Village Savings and Loans Association or other Income Generating Activities .
- Consistently provide other non-monetary motivation strategies, including typical human resources incentivizing methodologies.
- Review the National Policy with an aim of introducing a scheme of service for the CHVs as they play an expanded role towards UHC.

Mobile Community Units

One model that is being implemented in Wajir to address the specific needs of the nomadic and semi-nomadic populations is the establishment of mobile community health units, or mobile CU. In contrast to the static CUs (i.e., the typical CU specified in the CHS), in a mobile CU CHVs will move along with the communities as they seek for pasture and water for their animals.

To be a CHV in a mobile CU one must belong to the migratory group and meet all the other qualifications considered in the selection of CHVs as per current CHS guidelines. These CHVs report to a CHA like the current CHUs and work closely with CHCs.

Key elements of a mobile CU:

1. Systemically tracking CHVs location to be able to provide services as needed
2. Solar power phone chargers made available to CHVs
3. Monthly outreaches via health workers and a vehicle, meeting communities where they are at any given time
4. Facilitating movement and capacity of CHVs
5. Using tuk tuks for a referral system
6. Modified training materials and data collection tools to resonate with pastoral CHVs

There is much to be learned from this innovative adaptation to community-based health care and will be a topic for Wave 2 of data collection.

COMMUNITY BASED DISTRIBUTION

Community based distribution (CBD) is meant to ensure basic health commodities reach beneficiaries at the last mile. Rather than needing to travel to a static facility, CHVs manage and distribute basic commodities such as select family planning products and oral rehydration solutions, among others. This is a particularly promising activity with nomadic and hard to reach communities, but also comes with additional challenges. This wave of data collection set out to establish the conditions required for CBD and a profile of CHVs who could manage products.

We found that an overwhelming majority of respondents agreed that CBD is a feasible approach in the ASAL areas and that all CHVs could manage commodities with the proper training.

Currently, there is very little CBD happening in the three counties, outside of two pilot activities. Some CHVs in Samubru are offering family planning and in Turkana, some CHVs are offering essential medicines for integrated community case management. These pilots service as early models to follow and use for learning purposes.

"In Samburu, we have about some CBDs who are giving really everything on family planning to the mothers. These CBDs are from those CUs and each of them are attached to a health facility so that health facility is specifically to give commodities to CHVs and always they have registers which they check on the numbers they have used and again they are directly attached to the CHEW, so they are the once making orders also they balance those commodities for CHVs. I really wish that all my CUs to be trained on commodity distribution."

- KII **Samburu**

"We are relaying on ICCM which has just started recently and which is being piloted in Loima but in other sub counties they are doing the same but it is more in Loima where by the CHVS are treating the diarrheal cases and malaria. They are not yet allowed to treat complex cases, for instance we are not able to give them drugs like Quinine. But we give the AL that is Antimalarials. We also give them ORS and zinc. Basically those are the drugs we are giving CHVS to manage minor diseases."

- KII **Turkana**

CHVs and community members are eager for CBD. However, in addition to training, the biggest barrier to CBD is the lack of commodities at the facility level.

There is support and momentum for CBD and should be a priority for County community health, particularly considering staff shortages.

"Immunization is becoming an overwork for one health worker... We need additional health workers or CHVs to be trained so that they can take over... We need the CHVs to be trained even on injections so that they can perform it in the villages."
- Women FGD **Turkana**

Per the CHS, the linked health facility should supply CHVs with the necessary stock. However, there is chronic shortage and erratic of essential medical supplies at the facility level. Even with proper training, it will be challenging to provide the commodities to the CHVs as facilities will be reluctant give up stock.

"How can CBD succeed when the facility has no drugs, even Panadol; they beg for drugs from big facilities. The only drugs available are AL...Community members have no cash to buy drugs. When provided with AL they use that only which does not help without Panadol."
- CHV FGD **Turkana**

While the CHS stipulates that the Kenyan Medical Supplies Authority (KEMSA) should provide CHVs with a "CHV Kit" that can be replenished at the county level, some are skeptical.

"The ministry has not yet provided the kits because they fear they can misuse them. There are no drugs given to our health facility… Initially even KEMSA is supposed to say these drugs is for CHVs, that is basic medicine like panadols, painkillers and ORS, zinc."
- KII **Wajir**

"Services which can be done at home by CHV which are minor cases but unfortunately we have to refer them to hospital since we don't have the kits. We do have manuals that we educate mothers with but in a case a child gets burnt we don't have the kit to administer treatment."
- CHV FGD **Samburu**

Despite limited roles in family planning, there is potential for CHVs to provide family planning services, including injections.

Family planning is one of the services that has improved because of the health education efforts of the CHVs. Except in selected communities in Samburu, the role of CHVs in family planning are currently limited to health education and referrals despite the fact the Kenya Family Planning guidelines allow CHVs to provide selected family planning methods, namely male condoms, female condoms, combined oral contraceptives, progesterone only pills, and injectable contraceptives.

Notwithstanding the challenges noted earlier around family planning, findings indicate that there is a potential for the CHVs to deliver family planning including injections at the community level.

"Some are afraid to come and get FP in the health center as rumors will start spreading and most of the time the husband doesn't know. They would prefer talking to a CHV in a dispensary and agreeing on a place to meet."
- CHVs FGD **Samburu**

CBD

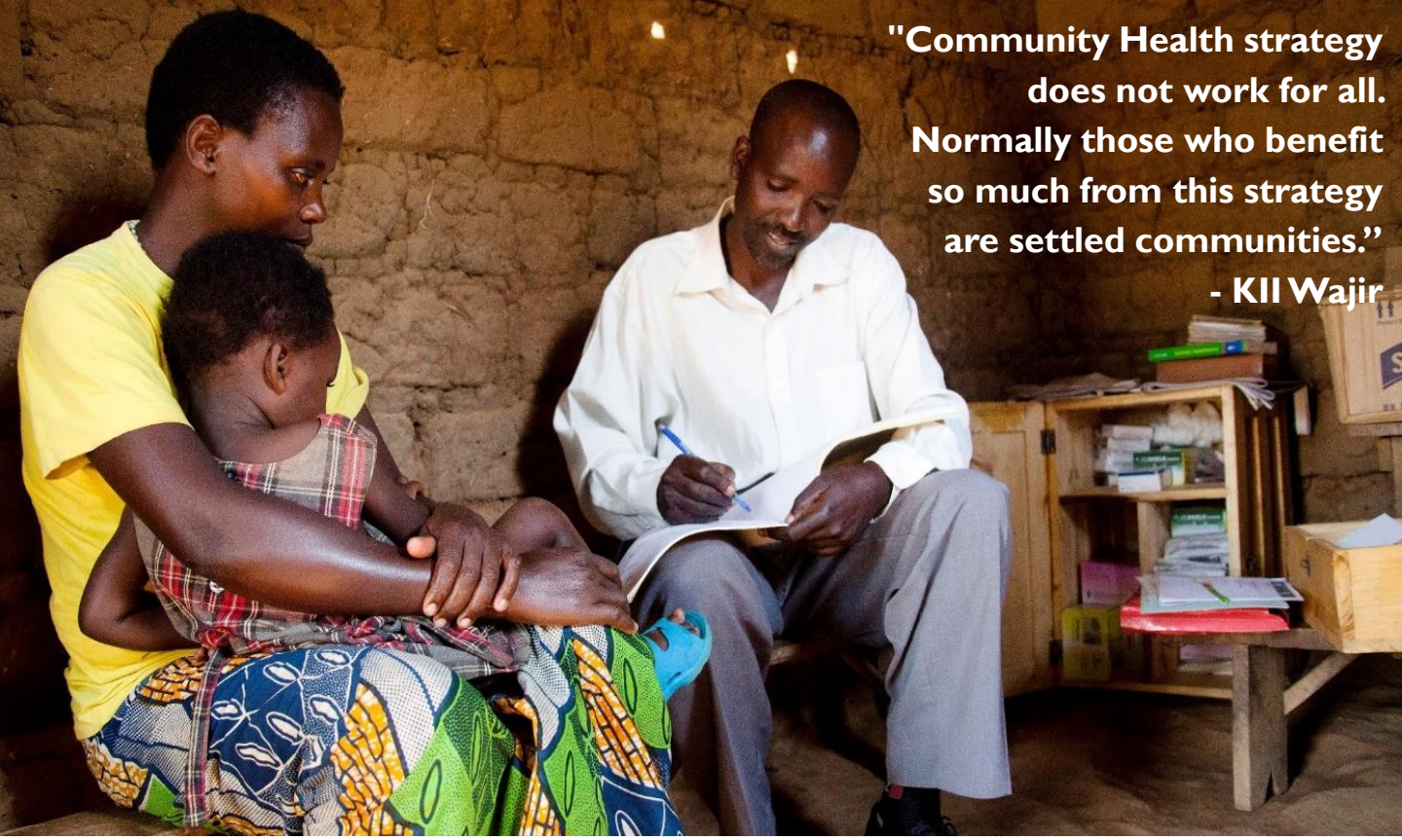
CBD will be introduced more widely in the three counties in the coming months, as inSupply Health will roll out cStock, a community stock management system that has been adapted to meet the needs of CHVs in ASAL counties.

CBD and cStock will be a topic for Wave 2.

RECOMMENDATIONS

- With significant human resource gaps, CBD can ease the workload at facilities. However, stock issues at linked facilities must be addressed for CBD to be successful.

- Once CHVs are trained, Counties should consider widening the scope of commodities made available at the community level and prioritize products to be stocked with CHVs to limit competition for resources.



Conclusions & Next Steps

The MOH, together with implementing partners have made significant progress in operationalizing and increasing uptake of community health services. However, gaps remain, particularly with respect to the CHS in the context of the ASAL counties.

As partners in the DE process, the projects remain committed to generating evidence and learnings of community health models in the ASAL communities. At the Sensemaking meeting, where preliminary Wave I findings were presented and discussed, participants developed an Ideas Wall to capture potential solutions based on the study findings. Each project then prioritized a set of adaptations to test in their respective project areas. All ideas are presented in Annex 1.

The findings of this report and three additional waves of data collection will continue to inform program implementations in the different regions. Prioritized questions for each wave will focus on the areas with urgent questions to be answered. Future waves will also include Mandera County.

Wave 2 Learning Questions

1. What strategies and processes are required to implement Community Based Distribution in static, semi-nomadic and nomadic population?
2. What are sustainable models to increase and maintain CHV motivation?
3. To what extent has COVID-19 affected the implementation and receipt of the community health activities?

Annex 1: Sensemaking Ideation

Table 1. Project Priority areas for testing

CHV skill development and support	
AT	• Explore a CHV mentorship program through CHAs
NHP	• Develop remote training and supervision support, using technology to overcome unique challenges e.g. distance, literacy, language barrier, etc. • Develop a CHS audio curriculum including audio visual aids in training materials
CHV Motivation	
AT	• Performance based incentives- IGA??? For CHV groups?
NHP	• Conduct a CHV workload analysis compared to CHS strategy • Institute a CHV financial savings program such as Village Savings and Loan
Community Based Distribution	
AT	• Linking CHVs with commodity security TWG
NHP	• Advocacy for community commodity procurement with Counties
SCALE	• Develop non-financial performance based incentives for data review meetings, such as providing capacity building activities if supply chain targets are met • Test virtual solutions to CBD training of TOTs
FP Sensitization	
AT	• Implement community dialogues such as “Tree of Men” s to clarify and validate “gate keepers” understanding of CHV roles in FP service provision
NHP	• Engagement religious leaders during CHV trainings and have them be part of CHV mentorship

Table 2. All ideas generated

CHV skill development and support
Contextualize CHV training curriculum, job aids and reporting tools to local conditions like religion, culture, literacy levels, community needs, and CHV needs and capacity to learn and retain knowledge
Establish a central mechanism for coordinating capacity building of CHVs at county level that maintains a training data base for CHVs
Implementation of knowledge and skills retention strategies post training for the CHVs that includes mentorship and continuous refresher training
A structured capacity building strategy for the CHAs and support for them to cascade the knowledge to CHVs
CHV Motivation
Institute long term incentives like VSLA where, through the county governments, CHVs are registered as self-help groups so that they can access microfinance services
CBD
Customize commodities given to CHVs to managed for different contexts
Ensure availability of the commodities for CHVs by including CBD needs in County forecasting quantifications
FP Sensitization
Continuous in service training and mentorship of healthcare workers on FP methods
Establish couple counselling on family planning and select male FP champions to support community efforts