



KENYA HARMONIZED HEALTH FACILITY ASSESSMENT (KHFA)

COMMUNITY HEALTH SYSTEMS REPORT 2018/2019

MINISTRY OF HEALTH
Division of Health Sector Monitoring and Evaluation



PREFACE

Kenya has drawn the Roadmap for accelerating implementation of UHC, which is one of the priority agendas for the National Government. Determining the level of availability and readiness of health facilities to offer services, as well as the quality of care across the sector is paramount in planning for UHC implementation. This then demands an objective and comprehensive assessment of the functionality of the health system at community and facility level. This initiative will therefore serve to provide baseline information needed for costing health investments in Kenya, including the UHC Roadmap and the Kenya Health sector strategic and investment plan

The Harmonized Health Facility Assessment (HHFA) was designed as a system to provide standardized assessments consisting of harmonized modules that cover all key blocks of service provision in a health facility, that include service availability, service readiness, quality and safety of care, and systems that support management as well as functionality of community structures. The HHFA approach departs from previous health facility assessments methods implemented in the past that have been implemented fragmentary, focusing on one area at a time.


Kenya has become the first country to adopt the approach of harmonizing the facility surveys into one comprehensive assessment. Lessons learnt during this process will be valuable for other countries in implementing similar surveys.

The HHFA has come at a critical time when plans to scale up UHC in Kenya are being developed. This then means that we now have the essential information needed to facilitate critical investments into health facilities, to facilitate them to deliver the essential health package for UHC.

We are certain that these results will significantly support us at national government, as well as our counties in planning and consequent management of available resources to maximize on outputs.

Finally, the HHFA findings will provide the foundation for which more regular service availability and readiness monitoring mechanisms will be established as part of routine reporting for sustainability.

It is our hope that all stakeholders and implementers will embrace these findings and utilize them, as this is a key element that will help us to significantly contribute towards our vision of a healthy, productive and globally competitive nation.



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Acknowledgements

The Kenya Harmonized Health Facility Assessment (KHFA) 2018 is a collective effort of multiple Health Data Collaborative partners at the global level that includes; The Global Fund, The World Bank, USAID, GAVI, PEPFAR/CDC, UNICEF, UNFPA, UN MDG, Health Envoy and WHO. The Kenya Harmonized Health Facility Assessment (KHFA) was implemented through a consultative approach involving a Health Facility Survey working group of technical experts from partners, countries, academia, and civil society as a key deliverable of the HDC Operational Work plan 2016-17, while taking cognizance of all new actors under a devolved system of governance.

The KHFA succeeds other past initiatives that were aimed to provide information on the degree of preparedness of health facilities to offer services through the SARAM in 2013, SDI 2012 & 2018 and SPA in 2010 among others. Such initiative will provide baseline information needed for costing the health investments in the Kenya UHC Roadmap and the Kenya Health Sector Strategic and Investment Plan 2018- 2023.

The preparation of the KHFA Survey would not have been possible without the support, hard work, and endless efforts of a large number of individuals and institutions. The team worked tirelessly to ensure the assessment was completed.

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Foreword

The Kenya health sector has re-aligned its policy and strategic direction in line with the Constitution of Kenya 2010. Health Service Delivery is one of the eight policy orientations specified in the Kenya Health Policy (KHP, 2014-2030). The Constitution of Kenya 2010 guarantees the highest attainable standard of health as a right while devolving governance to ensure improved service delivery, greater accountability, improved citizen participation and equity in the distribution of resources. Kenya's Vision 2030 aims at transforming Kenya into a globally competitive and prosperous country with a high quality of life by 2030. The Kenya Health Policy 2014-2030 outlines the direction that the sector is taking to ensure significant improvements are made in the overall status of health in Kenya in line with the Constitution of Kenya 2010, the country's long-term development agenda, Vision 2030 and global commitments such as the Sustainable Development Goals (SDGs).

The Government of Kenya has committed to providing Universal Health Coverage (UHC) under the "Big Four" agenda as part of socio-economic transformation by providing equitable, affordable and quality health care of the highest standard to all Kenyans. UHC will ensure that Kenyans receive quality, promotive, preventive, and curative and rehabilitation health services without suffering financial hardship. Kenya has drawn the Roadmap towards accelerating implementation of UHC agenda, determining the level of service availability, readiness, and quality of care across the sector.

Baseline information on service availability, readiness of health facilities to deliver services, quality of care offered, availability of human resources, leadership, governance, and quality of data is therefore required to inform strategic and operational planning and implementation processes for UHC in Kenya. As the country draws the Roadmap towards accelerating implementation of the UHC agenda, determining the level of service availability and readiness across the sector is paramount to progressive realization of 100% UHC by 2022.

The Kenya Harmonized Health Facility Assessment (KHFA) 2018 modules that were assessed include; Availability: Information relating to the physical presence of facilities, resources, and services, Readiness: Capacity of facility to provide specific services, Management & finance: Practices to support continuous service availability and quality, Quality & safety of healthcare: Includes indicators of the receipt of appropriate, effective and timely care by patients under safe conditions, and Community Unit: A qualitative assessment of the community structures via key informant interviews with Community Health workers and focus group discussions with clients in all 47 counties.

We look forward to working collaboratively across the national and county governments, partners, and all other stakeholders to ensure successful implementation of the findings.



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Abbreviations

CHC	community health committee
CHEW	community health extension worker
CHS	community health services
CHU	community health unit
CHV	community health volunteer
CHW	community health worker
FGD	focus group discussion
HHFA	harmonised health facility assessment
KII	key informant interview
MoH	Ministry of Health
NHIF	National Health Insurance Fund
NHSSP	National Health Sector Strategic Plan
SCCHC	sub-county community health coordinator
UHC	universal health coverage



1. Executive Summary

1.1. Background and Methods

As Kenya embarks on the roadmap towards accelerating implementation of the universal health coverage (UHC) agenda, the harmonised health facility assessment (HHFA) was implemented in 2018 by the Ministry of Health (MoH) with support from several partners including the USAID, WHO, UNFPA and UNICEF among others, to provide a comprehensive examination of the functioning of the health system and its impact on health. The aim of the HHFA was to determine the level of service availability, readiness, and quality of care across the sector. The HHFA included five main modules that focused on availability, service readiness, quality of care, management and finance, and community health services (CHS).


The inclusion of the community health module as part of the HHFA was meant to assess the quality and functioning of the CHS, and to identify areas of the community health system that need strengthening to inform the UHC agenda. The specific objectives were to (1) assess the availability of services that are delivered under the CHS, (2) assess the readiness of the structures tasked with the delivery of CHS, (3) assess the financial and management requirements for enhanced delivery of CHS, and (4) assess client and health worker views on the quality of services provided. CHS in Kenya comprise the preventive, promotive, and basic curative services that are delivered through the community health workforce. The workforce includes the community health volunteers (CHVs) and the community health extension workers (CHEWs). Services provided at the community level include family planning, maternal and child health services, education on hygiene and sanitation, deworming, nutrition education, guidance and counselling for adolescents, birth and death notification, polio campaigns, and referral services.

This report is based on an analysis of interviews with community health workers (CHWs) comprising the CHVs, CHEWs, and members of the community health committees (CHCs). Other interviews were conducted with mothers of children under two years of age and members of staff drawn from the community health unit (CHU) at the sub-county level. A total of 349 interviews were conducted: 67 focus group discussions with mothers of children under two years of age; key informant interviews with 71 CHVs; and in-depth interviews with 65 CHEWs, 44 members of the CHCs, and 47 sub-county community health coordinators drawn from 47 counties. A purposive sampling strategy was used to identify the community units from a list of health facilities that were part of the facility assessment sample. The community unit focal person provided names and locations of CHWs affiliated with the selected facilities, allowing the interviewers to randomly select four to six CHWs in each location to be interviewed.

1.2. Key Findings

A wide range of preventive, promotive, and basic curative services are being provided through the CHS. Key among them are the following: child health services; family planning; maternal health services; screening of non-communicable diseases, sexually transmitted infections, HIV/AIDS, tuberculosis, and malaria; treatment of malaria and communicable diseases, such as asthma and diabetes; and treatment of diarrhoea among children. The bulk of the services, however, fall under the broader remit of reproductive, maternal, newborn, child, and adolescent health.

Other commonly reported services are those that link the community to health facilities. In some counties, the linkage from the community to the health facilities is reported to be working well. In these counties, the relevant referral tools are available, there is good coordination between the CHVs and the health facility committees, and a functioning CHU is available.



A combination of structural, financial, sociocultural, and organisational barriers impedes the use of CHS. At the community level, structural barriers include the limited number of community units to cover the entire population and the limited number of CHVs to provide services to households under their jurisdiction. Financial barriers, including the lack of resources to support efficient delivery of services and payment of stipends, were frequently mentioned. Structural barriers at the facility level include shortages in essential drugs and commodities, limited number of health workers, long distances to the nearest health facility, and an inability to respond to emergencies occurring outside the official operating hours, especially at the dispensaries and health centres. Last, the organisational barriers include poor health worker attitudes, limited resources to facilitate referrals, and weak community representation on the facility health committees.

In counties such as Machakos, Nyeri, Kisumu, and Isiolo, there was some degree of optimism that the implementation of UHC was likely to address barriers related to affordability of services. Despite the optimism, however, there were no clear differences in terms of views regarding the success and challenges affecting delivery of CHS.

Assessment of the readiness of the structures to provide CHS examined the availability and functionality of CHUs, number and adequacy of the community health workforce, training and competencies of the community health workforce, and the functionality of management structures, such as the CHCs.


The assessment shows that critical structures, such as the CHUs and the CHCs that are tasked with implementing the CHS, are facing challenges that affect their functionality. These include poor staff motivation, shortages of community health workforce owing to high rate of attrition, inadequate training, and inadequate supply of essential commodities to be used by the CHVs.

A weak CHC undermines capacity for resource mobilisation and management, representation and performance appraisal of CHVs, and information management. In terms of numbers, there is a palpable shortage of the community health workforce and CHVs. The community health strategy envisages at least 10–15 CHVs per CHU, serving a population of 5,000 (1,000 households). Although there are counties like Siaya that report 100 percent¹ coverage in terms of the number of CHUs, data from this assessment point to a critical shortage of the community health workforce, characterised by fewer numbers of CHVs, low membership in CHCs, and outright unavailability in most cases.

Based on the revised structure for the CHS, 5 CHEWs are expected to provide services in the community, with help from approximately 10–15 CHVs. The internal logic of the CHS in Kenya is premised on a cadre of CHWs to discharge a variety of preventive, basic curative, and health promotive services. Any shortage of this critical workforce has far-reaching implications in terms of the ability to deliver CHS. These shortages mainly emanate from dropouts and lack of financial support.

The readiness of the CHS further requires a critical mass of the community health workforce with the requisite skills and competencies to implement these services. Ideally, the CHVs, CHC members, and CHEWs are expected to undergo focused training to prepare them for service. The CHVs, for instance, are expected to undertake both the basic and technical community health modules to equip them with the skills to deliver CHS. Interviews with both the CHVs and the sub-county community health focal persons show that several CHVs are not adequately trained. In other cases, the CHVs have not undergone the

¹ Every sublocation has a functioning community unit.



recommended training that comprises the basic and technical modules. Owing to the high attrition rate that characterises the community health workforce, frequent training and orientation of the workforce is critical.

The financing of the CHS remains a key challenge in several counties. Only a handful of county governments were reported to have taken positive steps to finance CHS from the county budgets. In most cases, the establishment and running of community units and other operational structures are largely left to partners, which make service delivery erratic. This challenge is particularly vexing in places where the CHCs are not able to mobilise resources to support the operations of the CHUs.

On the other hand, views relating to the uptake of health insurance show that communities understand the important role that it plays in promoting access to health services and in protecting families and individuals from catastrophic health expenditures. Several privately and publicly funded insurance schemes are available to the community. Some of the commonly mentioned schemes include the national health insurance scheme, Linda Mama, Afya Bora and Afya Plus, and M-Tiba. There was good general knowledge of health insurance across all counties, but there is low uptake, mainly attributed to fears relating to affordability of monthly premiums and a lack of access to registration facilities and centres at the local level.

1.3. Recommendations


Based on the findings, the following recommendations are made regarding steps to improve the availability of services and promote the readiness of the CHS to deliver services:

- Recruit appropriate numbers of CHVs, CHEWs, and CHC members in compliance with the Kenya quality model.
- Strengthen CHCs and equip them with the knowledge, skills, and resources to undertake their mandate.
- Allocate budgetary support for CHS as a critical and necessary component towards achieving the UHC.
- Consider incorporation of the CHVs into the formal healthcare workforce.
- Create awareness at the community level to make of use the CHVs as the first point of contact before visiting the health facilities.

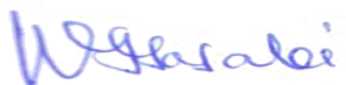
1.4. Conclusion

The services that are expected to be delivered through the CHS are available, albeit in a suboptimal manner. Several barriers limit the accessibility of health services at the community and health facility levels. These include costs associated with travel to the health facilities and negative attitudes of some health workers at the facility level.

The readiness to provide services is undermined by several structural and organisational barriers that should be addressed to promote the functionality of the CHS and prepare the path for UHC. There are policy and regulatory steps that should be taken to ameliorate the readiness to deliver services. Policy steps involve engaging with resource allocation to support the CHS, including the need to integrate the CHVs into the formal workforce, and regulatory steps involve seeking to implement the requirements of the Kenya quality model.



Overall, there are significant gaps in the implementation of the CHS, with noticeable disparities across the counties in relation to the number of functional CHUs, CHVs, CHCs, and CHEWs. Together, these gaps compromise the readiness to deliver CHS and ultimately, the access and use of services provided at levels 1 and 2 of the healthcare systems.



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2. Introduction

This report is based on the analysis of the qualitative data collected as part of the 2018–2019 harmonised health facility assessment (HHFA). The data were collected through key informant interviews (KIIs), in-depth interviews, and focus group discussions (FGDs). The population of interest for the interviews included community health volunteers (CHVs) and community health extension workers (CHEWs) drawn from 2 community units in each of the 47 counties.

Those who participated in the interviews were identified purposively, in consultation with respective community health focal persons at the county level.


The interviews mainly explored issues relating to the capacity and knowledge of community health workers (CHWs), the services they provide, the support they receive from the healthcare facilities, the challenges faced, and suggestions to improve the working situation of CHWs. FGDs were conducted with mothers of children under two years of age living in the catchment area of the health facilities that were sampled as part of the HHFA. The discussions with mothers focused on exploring health services locally available, their own use of health services for themselves and their children, and their use of family planning. The FGDs also explored their views regarding the quality of services provided to them at the hospital and their experiences with the use of reproductive and child health services. In some cases, the discussions also included exploration of why some women do not come for antenatal care and why some women prefer to give birth at home rather than in a healthcare facility.

2.1. Background

The role of community strategy in improving Health for All first came into the limelight in 1977 when World Health Organization member states adopted the Health for All concept. During the Alma Ata Declaration in 1978, countries worldwide recognised primary health as the foundation for achieving Health for All by the year 2000. This declaration was ratified by the World Health Organization, and since then several other initiatives have been formulated to reinforce this agenda. Among other things, the Alma Ata Declaration recognised the fact that people have a right to individually and collectively participate in the planning and implementation of their own healthcare and that primary healthcare forms an important part of the healthcare system.

Kenya has ratified international health initiatives, such as the primary healthcare recognition agenda that was articulated in the Alma Ata Declaration on Health for All by 2000, the 1987 Bamako initiative, the structural adjustment program on health by the International Monetary Fund and the World Bank in the mid-1980s, the Millennium Development Goals that were established at the Millennium summit by United Nations member countries in 2000, and the Abuja Declaration of 2000, among others. The implementation of some of these initiatives by the Kenya government has had mixed results on the health of all Kenyans.

Several policy changes have been implemented locally since the 1990s to revitalize the government's efforts to improve health. The establishment of the Kenya Health Policy Framework (MoH 2004) ensured a comprehensive health approach that encompassed the primary healthcare approach and addressed issues of equity, social justice, and democracy. To implement the Kenya Health Policy Framework 1994-2010, Kenya's Ministry of Health (MoH) for the first time came up with a national health sector strategic plan (NHSSP I) covering the period 1999–2004 (GoK 199-2004). This strategic plan aimed to address some of the pitfalls witnessed in Kenya's health system management and service



delivery, including improving resource allocation to health, decentralising health services and management, shifting resources from curative to preventive services, and strengthening governance.

As a result of the deteriorating health trends, the government formulated NHSSP II to cover the period 2005–2010 (MoH 2005–2010). This strategy embraced the primary healthcare approach. The key principles driving this strategy included the following: advocating an increase in equitable access to health services; improving the quality, efficiency, and effectiveness of service delivery; enhancing the regulatory capacity of the MoH; fostering partnerships in health; and improving financing of the health sector. As a deviation from NHSSP I, which failed to improve health outcomes, the Government of Kenya strengthened the implementation strategy's framework through the formulation of a Joint Programme of Work and funding to guide the investment decisions in the provision of health services up to the community level (GoK 1994). By 2010, there were clear reversals in the once worsening health indicators. For example, infant mortality decreased, from 78 deaths per 1,000 live births in 2003 to 52 deaths per 1,000 live births in 2008/2009, and child mortality also decreased, from 115 deaths per 1,000 live births in 2003 to 74 deaths per 1,000 live births in 2008/2009.² Some of the improvement in the health indicators occurred in an era when the Government of Kenya launched a community health strategy to provide level 1 health services alongside the other levels of the healthcare system as articulated in the Kenya Essential Package for Health framework.

According to the community strategy implementation guidelines, the goal of community health services (CHS) was to improve the health status of Kenyan communities through the initiation and implementation of life cycle-focused health actions at level 1 through the following:

- Providing services at level 1 for all population cohorts and socioeconomic groups, including “differently abled,” taking into consideration their priority needs
- Building the capacity of CHEWs and CHVs to provide services at level 1, and strengthening health facility community linkages through effective decentralisation and partnerships for the implementation of level 1 services
- Strengthening the community to progressively realise their rights to accessible and quality care to seek accountability from facility-based health services

The CHS are implemented through structures that are composed of the community health units (CHUs), which serve a local population of 5,000 people, enlisting CHVs, who are tasked with the delivery of services to the communities, the CHEWs, who coordinate the work of CHVs and link them to health facilities, and the community health committee (CHC), which is responsible for the governance of the CHUs and their linkages with the health facilities (GoK 2014-2019).

² Kenya National Bureau of Statistics (KNBS), Kenya Medical Research Institute (KEMRI), & Macro International Inc. (2004). *Kenya demographic and health survey 2003*. Calverton, MD: KNBS, KEMRI, & Macro International Inc.



Box 1. Roles and responsibilities of CHCs

- Provide leadership and governance oversight in the implementation of health and related matters in CHS at levels 1 and 2
- Prepare and present the community Annual Operational Plan on health-related issues at level 1 to the Link Health Facility Committee (and others as needed)
- Network with other sectors and developmental stakeholders towards improving the health status of people in the community unit (e.g., Ministries of Water, Agriculture, Education)
- Facilitate resource mobilisation for implementing the community work plan and ensure accountability and transparency
- Carry out basic human resources and financial management in the community
- Plan, coordinate, and mobilise the community to participate, along with themselves, in community dialogue and health action days through social mobilisation skills
- Work closely with the Link Health Facility Committee to improve access to health services for the community unit
- Facilitate negotiations and conflict resolution among stakeholders at level 1
- Lead in advocacy, communication, and social mobilisation
- Monitor and evaluate the community work plan, including the work of the CHWs, through monthly review meetings
- Prepare quarterly reports on events in the community unit
- Hold quarterly consultative meetings with the Link Health Facility Committee

Source: Community Health Strategy 2014

Linkages between the Community and the Health Facilities

The CHU is the operational unit for the CHS. In most cases, the CHU is the administrative unit known as the sublocation. Each sublocation consists of several villages, and each village is served by a CHW. Operationally, the community unit directly links to the rest of the health system through the first referral facility, referred to as the link health facility for the community. The CHEWs are attached to these link health facilities for the communities in which they supervise CHVs and thus establish direct links for CHWs with the first referral level. For most community units, the link health facility is a dispensary or a health centre. Each community unit provides services to approximately 5,000 people (GoK 2015).

Table 1. Core competencies of CHC members

• Effective leadership and management skills
• Communication skills
• Mobilisation and management of resources
• Networking
• Report writing
• Record keeping and bookkeeping
• Basic analysis and use of data
• Basic planning, monitoring, and evaluation skills
• Performance appraisal skills
• Conflict resolution skills

Source: Community Health Strategy, 2014



Harmonised Health Facility Assessment

The inclusion of the community health module in the HHFA was aimed at assessing the quality and functioning of the CHS and identifying areas of the community health system that need strengthening to inform the universal health coverage (UHC) agenda. The specific objectives were as follows: (1) to assess service availability; (2) to assess finance and management practices in relation to financing of the CHS; (3) to assess the readiness to provide CHS; and (4) to assess the quality of care provided at community and health facility levels, including the referral services.



3. Methods

3.1. Data Collection Methods and Tools Development

The CHS unit undertook the development of data collection methods and tools and all fieldwork logistics. Data were collected through KIIs and FGDs. The interview guides focused on five main areas: the recruitment, roles, capacities, and motivation of the community health workforce; range and quality of health services provided to special groups; linkages and referrals at the community level; experiences implementing CHS; and challenges of and recommendations for implementing CHS. The interview guides contained interview tools for these groups: sub-county health management team, CHCs, CHEWs, and CHWs. They also included an FGD guide for discussions with mothers of children under two years of age.

The guide used for the FGDs with the mothers had five main domains that explored the range of health services received, experiences with CHVs, health insurance and perceived benefits, perceived changes as a result of CHS implementation, and the challenges of and recommendations for improving CHS. The guide asked women questions related to health services locally available, their own use of health services for themselves and their children, and their use of family planning. It also explored women's experiences in terms of services that they felt performed well, those that performed poorly, and their experiences with the use of child health services and services for pregnant women.


All tools were developed in English with the acknowledgement that given the diversity of the 47 counties, research teams were prepared during training for direct translations of the FGD guide designed for mothers. Most FGDs were conducted in English and others in Kiswahili. FGDs conducted in Kiswahili were transcribed and transcripts were translated into English by multiple study team members to the extent allowed by the timelines and budget.

3.2. Site Selection and Sampling

Site selection started with the universal inclusion of all 47 counties in Kenya. This is because counties are varied in population size and density and contain numerous climatic, cultural, economic, ethnic, geographical, historical, linguistic, livelihoods, and social factors. In each county, two CHUs were sampled using the following criteria:

- CHUs sampled were those linked to the health facilities where the facility assessment was being conducted.
- Population density and distance to health facilities to ensure balanced representation as guided by the master facility list.

In each county, the MoH community module study team collaborated with selected sub-counties and community units. The selection process took place before the data collection teams travelled to the counties, and the MoH team ensured that all necessary permissions for data collection were sought from the county directors of health in liaison with the community focal persons in each sub-county where relevant community units were sampled. The data collection teams explained the purpose of the study and the approach before being granted permission to enter the community units and to engage with mothers from selected community units.



Participant Sampling

The CHWs were the population of interest for the community module, comprising the CHVs, CHEWs, and members of the CHCs. Others were mothers of children under two years of age and members and staff drawn from the CHU at the sub-county level. A purposive sampling strategy was used to identify the community units from a list of health facilities that were part of the facility assessment sample. The community unit focal person provided names and locations of CHWs affiliated with the selected facilities, allowing the interviewers to randomly select four to six CHWs in each location to be interviewed. Mothers of children under two years of age were purposefully selected with the help of the CHVs.

A total of 349 interviews were conducted; of these, 67 were FGDs with mothers of children under two years of age. In-depth interviews were conducted across all 47 counties with a total of 105 CHVs, 75 CHEWs, 55 CHCs, and 47 sub-county community health coordinators (SCCHCs). In each county, in-depth interviews were conducted with a total of four CHVs, four CHEWs, one to two CHC members, and one to two sub-county health management team members.

3.3. Training and Data Collection

Research assistants who participated in the data collection exercise were trained by a consultant with expertise in qualitative research methodologies, with support from MoH staff drawn from the CHU. The training focused on the design, objectives, and purpose of the assessment, the ethics of the assessment (obtaining community entry permissions and getting informed consent), understanding the interview guide questions, and interviewing techniques. The team was also guided through the standard operating procedures of transcription and how to deal with the intricacies of direct and back translation from local languages to English and vice versa. Data collection tools were piloted, and revisions were incorporated into the final versions of the tools prior to the start of data collection.

Data collection was undertaken between October and December 2018. All participants were reminded of the voluntary nature of the study, after which they provided informed consent for the interviews and discussions and for audio recording. All interviews were conducted in the language most appropriate to the participants and at venues that were mutually convenient to both the participant and the interviewer. On average, interviews took 15–30 minutes, and FGDs lasted 30–60 minutes. In some instances, photographs of the interview process were taken and archived with the audio recordings. These files used protected passwords to which only the study team had access. Consent was sought to take and use photographs for the sole purpose of the assessment.

3.4. Transcription and Data Coding

Qualitative data from KIIs and FGDs were audio recorded and transcribed using Microsoft Word. The research team lead, supervisor, and research assistants held daily debriefing meetings to provide an overview of issues raised. Both the transcripts and the notes made during the interviews were managed using NVivo 10 software (QSR International). Preliminary analysis entailed open coding and progressive categorisation of issues based on inductive approaches (in which analytical categories are derived gradually from the data) and deductive approaches (in which ideas from the interview guide shape the coding scheme). These categories and themes were further refined as findings emerged from the data. Themes derived from the data were analysed through the development of analysis charts.

3.5. Coding and Data Analysis


The assessment used a participatory approach to data analysis and coding. The first data analysis workshop was held in Mombasa from 28th January to 2nd February, 2019. During the workshop, the community module study team, including the data collectors and the MoH CHS expert, worked collaboratively with two qualitative data analysis consultants to develop a codebook to guide the data analysis. The workshop started with an introduction to qualitative data analysis and a review of the objectives of the facility assessment and the community module. The team then reviewed the different interview guides used in the field to develop a framework against which the codebook was eventually developed. Thus, the joint coding process was a journey that started with individual immersion in the data and individual coding based on the study tools questions, which generated 102 codes. These codes were further reorganised into nine themes following consultation with the community health team drawn from the MoH and partners.

Preliminary coding using the nine-category codebook was undertaken, with the aim of testing its robustness. The results were organised into nine emerging thematic areas and emerging theory, which were then mapped into the four modules on which the HHFA was based, as represented in Table 2.

Table 2. Emerging themes from the initial coding

Category	Themes	Subthemes
Service availability	Services provided	Services for All groups
		Services for Special groups
	Benefits of CHS	Suggestions for improvement
	Challenges facing CHS implementation	
Financing community strategy	Financing Community Health Structures	Perceived value of health insurance
		Challenges encountered in National Health Insurance Fund (NHIF) registration
		Suggestions to improve uptake
	Financing of CHS	Challenges to uptake of health insurance
Readiness to provide CHS	Availability of Community Health Structures	Adequacy of community health workforce
	Functionality of community Health structures	Coverage and numbers
		Roles and responsibilities
	Community health workforce	Training received
		Challenges affecting service readiness
Perceived quality of care	Linkages and referrals	Perceived effectiveness
		Types of referrals
		Challenges encountered
		Suggested strategies to improve care and linkages

During a subsequent report writing workshop held on 18–23 March 2019, the team worked collaboratively to organize themes and content for the report. The results are thus presented under the



four modular areas, encompassing all six emerging themes as subsections. These results were presented to and discussed with the broader HHFA team and relevant stakeholders during a final writing workshop held on 29 April–3 May, 2019 resulting in this synthesised report.

3.6. Limitations

The study had the advantage of collecting data from all 47 counties to allow for a comprehensive understanding of the environment in which the CHS are being implemented. The assessment also collected data from participants with real-world experience of providing or using services provided through the primary healthcare. Despite these advantages, there are several limitations. First, the quality of the data collected through various data collection methods was not good. In most cases, the way in which questions were posed invited a yes or no answer, which is not appropriate for qualitative data analysis. In addition, there was minimal probing of the answers or opinions of the respondents, which deprived the interview of an opportunity to provide context and background to the perspectives given by the respondents. Nonetheless, the data provide useful insights into the functionality of the CHS and identified critical areas that should be addressed to facilitate the provision of good quality primary healthcare services.



4. Findings

This section presents the findings following the six themes that emerged from the coding framework (see Annex 1 for the coding framework).

4.1. Service Availability

Interviews with the CHWs revealed that a wide range of health promotive and preventive services are provided through primary care. The interview quotes in Box 2 capture the range of services provided.

Box 2. Services provided through the CHS

First when we go to the household we assess the problem of that family so if needs family planning we talk about family planning ... if it is a disease we assess what kind of disease like malaria ... we refer but if it is slight malaria then we give AL to the patient. **FGD, CHVs, Kisumu**

We also advocate for best health practices like personal hygiene, sanitation, how to dispose waste and may be in terms of nutrition how to get balanced diet ... we also have services like referring pregnant women who is in remote areas, you can access the facility. **FGD, CHVs, Bomet**

Immunisation services and also the CHVs come and teach us on how to breastfeed our children. **FGD, Mothers, Elgeyo Marakwet**

The health services I get are family planning, taking my child for immunisation and sometimes we are given nets to sleep in. **FGD, Mothers, Homa Bay**

At our households we receive water treatment tabs which the CHVs give us, they also give us zinc and ORS for our children ... polio vaccines ... we were taught about mother to mother support group and father to father support group by the CHVs. **FGD, Mothers, Isiolo**

We provide the community with net that help them, and we also give them RDTs for testing malaria on the ground, so we test and if positive we give the drugs. **FGD, CHVs, Siaya**

The range of services that were mentioned by both mothers and CHVs include deworming, personal and environment hygiene and sanitation, civil registration services for deaths and births, referral and linkages to health facilities, and participation in health awareness campaigns, such as polio campaigns and mass vaccination. Services provided at the health facility level include malaria prevention, testing, and prophylaxis; immunisation; family planning; and HIV testing and counselling. There were no differences in the range of services that mothers reported compared to those reported by CHVs. Table 3 provides a summary of the commonly mentioned services.

Table 3. Services provided at the community level

Range of health services available
Deworming
Personal and environmental hygiene and sanitation
Immunisation
Malaria prevention and testing
Family planning
Death notification
Birth registration
Referrals to health facilities
HIV testing and counselling
Polio campaigns
Water treatment education
Breastfeeding education
Household education
Antenatal care education and sensitisation on facility delivery
Nutrition education
Guidance and counselling for adolescents on reproductive health

4.2. Perceived Benefits from implementing CHS

Interview excerpts in Box 3 illustrate the benefits associated with the implementation of CHS as reported by CHWs, mothers of children under two years of age, CHC members, and SCCHCs.



Box 3. Benefits from Implementing CHS

We have a lot of CUs reporting zero home deliveries ... deliveries in our sub-county is around 65 percent because most of our mothers deliver in the nearest sub county ... so it is not a magic it is an effort by community health workers ... I can say for sure community health system is working. **KII, SCCHC, Kisumu**

There are a lot of changes, there is reduction of disease burden, when called for baraza a number of them shows they are in good health. **KII, CHC, Baringo**

There has been a decrease in maternal deaths in the community this has been done since the community is aware of the importance of delivering in hospitals. **KII, CHC, Bungoma**

The immunisation coverage in Suba was 48 percent it is about 80 percent ... in terms of latrine coverage ... We have improved from 37 to 82 percent. **KII, SCCHC, Homa Bay**

Personally, I was delivering at home before but now my last child I delivered here (healthcare facility) and here is good place. **FGD, Mothers, Garissa**

There are many changes ... pregnant women previously they feared going to the hospital and even delivering at the facility but after a lot of sensitisation nowadays even this facility has a very big number of mothers who deliver here. The community knows the importance of delivering at the facility and they do it. **KII, CHC, Kilifi**

Immunisation coverage is very high because of community strategy ... even there are no diarrheal cases ... and even mothers are coming to deliver in the health facilities because of community strategy. **KII, SCCHC, Kiambu**

Prevention of mother to child transmission has reduced/prevented since mothers have been educated and healthcare has improved. **FGD, Mothers, Kakamega**

The respondents often talked about the benefits arising from the implementation of CHS, in terms of the perceived changes in some of the health indicators. These include improved use of health facilities for deliveries, reduction of maternal and perinatal deaths due to decrease in cases of home deliveries, improved immunisation coverage, improved linkages between the community and the health facilities, and reduction in the number of cases of communicable diseases.



4.3. Barriers to Accessing CHS

Despite the benefits arising from the implementation of CHS, several barriers to the use of health services were reported. Interview excerpts in Box 4 illustrate some of the barriers to the use of health services at the health facility level.

Box 4. Barriers to use of health services at the facility level

There are so many requirements for you to be admitted to maternity—gloves, basin, cotton wool, surgical blade. We even buy these things in advance and keep them with us to stay prepared. These items are not available at the facility. Without which you cannot be attended to. **FGD, Mothers, Nyeri**

There are days we come to the health facility; we are given a prescription but go away without drugs which we must purchase ... sometimes you have no money. **FGD, Mothers, Embu**

The challenges we have is mostly transport. Some of us we come from far to come to health facility. We are charged a lot of money by matatu people. We pay sometimes one thousand, three thousand up to five thousand. That is a big challenge. **FGD, Mothers, Mandera**

We get a lot of problems especially for the pregnant mothers, during the weekends, there are no health services. Thus, you must use transport to go to Kwale and there is a problem with the vehicles currently. **FGD, Mothers, Kwale**

The barriers reported here mainly relate to the services offered at the health facility level. These included shortages of health workers in the facilities, commodity shortages, and lack of essential amenities, such as laboratories. Inability to pay for health services remains a key deterrent to access and use of services. Participants particularly cited the burden of having to purchase drugs that were not readily available in the health facilities. In other cases, the long distance to facilities was a major deterrent to accessing health services, especially in rural areas with inaccessible roads and the lack of a reliable public transport system.

The commonly reported barriers at the community level are illustrated by interview excerpts in Box 5.

Box 5. Barriers to access and use of health services at the community level

In most cases, the CHVs are not effective ... they don't have a first aid kit, in case something happens in the community they can't assist without a kit. They also need a means of transport to visit the households. **KII, CHEW, Isiolo**


We need uniform, boots, and raincoats. We also need equipment and tools. The gadgets are very few—we only have one blood pressure machine per sublocation. Sometimes they are not working because we don't have batteries. There are shortages of blood sugar kit. **KII, CHEW, Nyeri**

We are not able to reach all the people, because most of the time you walk on foot, even if there is a case that needs attention ... CHVs feel they are not motivated. It becomes hard for you to work because most of the times the CHVs are complaining saying we are not telling the government or the county government at least to consider them. **KII, CHEW, Meru**

We have problems where some religious beliefs ... some churches do not allow their members to seek medical help or use family planning services, they believe in praying. **FGD, Mothers, Kakamega**

We have a lot of challenges ... first, we have community mobility, we don't have motorbikes, fuel ... we are forced to use our own motorbikes ... motorbikes for this activity, vastness of the area. **KII, CHEW, Laikipia**

Barriers to use of CHS were often reported in terms of the failure of the CHVs to discharge their mandate. The barriers included lack of equipment, such as the CHV toolkits, lack of essential supplies, lack of transport to facilitate mobility of the CHVs in the community, poor motivation, and sociocultural practices that affect care-seeking behaviour.



4.4. Use of Services Among the Special Groups

Across all counties, the use of healthcare services by special groups, such as the elderly and those with physical challenges, is affected by a myriad of factors, as shown by the interview excerpts in Box 6.

Box 6. Barriers to use of services by special groups

In most cases, their mobility is a big problem ... we don't have wheelchairs ... or other equipment for helping the disabled. **FGD, CHVs, Turkana**

The challenges that they are going through now is that they lack those special aides ... to use like hearing to facilitate better communication with ... they lack the walking aid like bicycle ... and there are those who are poor and they don't have those special bicycles to bring them to the hospital even though they are sick. **FGD, CHVs, Busia**

We are not prepared for this ... there is a time we requested the Ministry of Health to train us on sign languages, but they did not; I have four clients who are disabled ... communication is a problem. **FGD, CHVs, Kisumu**

Sometimes the elderly do not have money, maybe she doesn't have someone who can help him or her with support of money and when he or she goes there, at the pharmacy they need money, the lab and at X-ray they also need money so they get stuck and fail to be treated and just go back home ... generally the vulnerable people need special attention from us, from the doctors, from nurses so I think that attention should be recommended. **FGD, CHVs, Siaya**

Suggestions to Improve Healthcare Services

Respondents provided a range of suggestions on how to improve the CHS provided at the community and health facility levels.

Three main suggestions were commonly reported: (1) increase the resources earmarked for supporting the primary healthcare services, including recruitment and support of CHVs; (2) increase community sensitisation so community members take an active role in managing their health; and (3) standardise the implementation of CHS by all stakeholders to avoid confusion. The quotes in Box 7 illustrate these suggestions.

Box 7. Suggestions to improve services at the community level

Set aside adequate resources to support CHVs to do their work ... equip them and provide stipends to motivate the health workers at the community. **KII, CHEW, Turkana**


Maybe if they can employ more CHAs because you find that since we were employed, some CHAs have left, so we need to employ more CHAs. **KII, CHEW, Migori**

I would suggest the people at the ground level, that is, the CHVs, be motivated a lot to improve the health indicators ... the common indicators which are bring problems to our country they depend on the community. **KII, CHEW, Machakos**

I don't like when an NGO comes today, the other one comes tomorrow, the third day there is a new NGO, all these people with different things ... let it be harmonised, because like the other time we were taking reports; you have 3 or 4 reports 6 for different ... it means the work is not going to be efficient. **FGD, CHVs, Siaya**

There is need for advocacy in terms of enrolment for NHIF so that they can go to hospital because they do not have income. **FGD, CHVs, Elgeyo Marakwet**

The quotes in Box 8 present suggestions to improve services at the health facility level.



Box 8. Suggestions to improve services at the health facility level

I would like to see our facilities better equipped for better service delivery to the community to avoid them going to the private sector for services. **KII, CHEW, Kajiado**

Our facility is poorly equipped ... when you go to the hospital in the maternity room, we have only three beds surely! ... at times you find several mothers have delivered and they have to share that bed ... something should change. **FGD, Mothers, Busia**

At night there are no doctors, we call them, and he delays before he comes ... also when you come to the hospital any minute from four pm, you find the hospital locked, no services ... and even over the weekend. **FGD, Mothers, Lamu**

Overall, increasing resource allocations to critical infrastructural support, such as equipping facilities with laboratories and commodities, was given as an important factor in helping facilities to be responsive to the needs of clients.

Addressing the negative attitude towards clients by healthcare workers was mentioned as an important step towards providing respectful care to clients. Disrespectful care was seen by many as a key deterrent to use of health services, especially by pregnant women and adolescents.

Other respondents underscored the importance of exploring ways to address mobility challenges among the elderly and pregnant women. Provision of ambulance services and stipends to facilitate transport to healthcare facilities during emergencies were reported by some as viable options. These suggestions were given by CHWs who decried the challenges encountered, especially when they referred elderly patients and pregnant women to health facilities.

Last, respondents noted that access to services in some health facilities was a challenge, especially during the weekend and after hours.

Suggestions to Improve Healthcare Services for Special Groups

Interview excerpts in Box 9 provide suggestions to improve the availability of services for special groups.

Box 9. Suggestions to improve service availability for special groups

People like the disabled and elderly should be provided with means of transport ... which they use to and from health facility (e.g., wheelchairs) ... they can also be given some cash every month to support themselves like the elderly. **FGD, CHVs, Mandera**

We need to know the cohorts in every community, maybe we come up with the data of number of people with special needs so as to clearly know the cohorts in that community level and plan. **KII, CHEW, Laikipia**

People with special needs such as the elderly can be given NHIF cards to help them access care at facility level and even develop mobile clinics to treat such people in the community. **FGD, CHVs, Nyamira**

The suggested solutions to improve service availability for people with special needs included providing special aids for those with mobility, speech, or visual impairments, improving their mobility or designating special facilities that address their needs, developing mobile clinics to facilitate outreach and take services to those unable to access health facilities, and providing subsidies to households unable to pay for monthly national health insurance premiums.

Other services that were commonly reported were those related to linking the community to health facilities. In some counties, linkage and referral to health facilities was reported to be working well, as illustrated by interview excerpts in Box 10.

Box 10. Factors facilitating effective referral at the community level

It is effective because, we have the MOH 100 that's the referral tool then we have a CHV desk which goes on daily. So when someone is referred to a health facility, he/she will find a CHV at the CHV desk and the CHV who is at the desk, will receive the referral and will write it in the black book. **KII, CHEW, Migori**

Referrals are taking place ... they normally refer even if we are missing referral forms ... we advise them to write even on a piece of paper and take to hospital for filling. **KII, CHEW, Trans-Nzoia**

Initially we were given a number to call for the ambulance, and it worked well **FGD, CHVs, Kakamega**

It is very effective because all the CHVs are given MOH referral books ... we feel the referral is formal and can be documented when we refer cases to the facility. **FGD, CHVs, Garissa**

Yeah the referral is good because the CHV they have referral tool, they have a tool called MOH 100 which they normally use to refer from community to the facility. **KII, SCCHC, Siaya**

For us I would say that the facility health management committee is very helpful ... all issues from the community are addressed ... this promote referrals and patients are happy. **KII, SCCHC, Makueni**

The availability of referral tools played an important role in facilitating timely initiation of referrals and follow-up to ensure completion. In addition, CHVs felt confident that the referral system was formal because the details are captured in the relevant referral register, MOH 100. In these counties, the relevant referral tools were available, there was good coordination between the CHCs, the link health facility existed, and a functioning CHU was available.

Interviews with CHEWs revealed that the existence of a CHC was necessary to address any conflicts or issues. CHVs go through the CHC for resolution, which helped maintain the standards of the services delivered. CHC representation was deemed as adequate because there was good representation of CHEWs, public health officers (PHO), women, youth, disabled, and religious leaders in the committees, so everyone's views and needs were represented.

In other cases, however, the ability of the CHS to spearhead referral services was compromised by several barriers that included lack of referral tools, and inadequate resources for patient transport and communication, especially when patients are referred to the link facilities. Also, poor relations between the CHUs and their link facilities undermined the quality of the referral services. In some cases, CHVs complained of a lack of recognition and respect by the staff at the link facility, who often refused to attend to the referred patients and failed to sign referral forms handed in by patients. Interview excerpts in Box 11 illustrate these barriers.



Box 11. Barriers to effective referral and linkage

We don't have referral books, we had them, but they are finished and were advised to use papers, but when you write a referral the patient ignores it and throws it. So, we request for the referral books. **FGD, CHVs, Lamu**

Our referrals are not taken seriously by the doctors, they throw them away. **FGD, CHVs, Kwale**

It is not effective because the staff who are at the facility level are not conversant with the community strategy ... some of them have a negative attitude towards the CHVs. **KII, CHEW, Machakos**

Community members complain that they lack transport to health facilities ... and even when they visit the facility where they were referred there are delays in getting services. **FGD, CHVs, Narok**

Suggestions to Improve Referral Services

According to the participants, linkages and referrals can be improved by ensuring that information on proper referral of the community to the facility is shared with all facility departments, instituting a referral office or referral desk in health facilities to reduce delays, and supporting monthly review meetings to review referral completion and facilitate defaulter tracing. Other suggestions to improve the quality of referral services include increasing the number of CHEWs to strengthen their capacity to supervise the CHVs. By doing so, the quality of the referrals undertaken by the CHVs will improve, owing to better supervision and coverage. The interview quotes in Box 12 present suggestions given by respondents to address bottlenecks to effective referral and linkage.

Box 12. Suggestions to improve referrals and linkages to care

Yeah the nurses and the doctors should be sensitised and they should know actually that when a CHV takes time her time to refer then it means that there is some seriousness to attend to the patient because... **FGD, CHVs, Siaya**

We need joint planning between the facility committee and the community health committee ... the CHC chair should be a member of the facility committee. **KII, SCCHC, Lamu**


It would be nice to have a referral desk where all referrals are collected and taken to the doctor to be served so that the patients don't have to queue with a referral. **FGD, CHVs, Kilifi**

4.5. Readiness to Provide CHS

The assessment of the readiness of structures to provide CHS examined the availability and functionality of CHUs, number and adequacy of the community health workforce, training and competencies of the community health workforce, and the functionality of management structures, such as the CHCs.

Availability of Community Health Structures

Interviews with the community health workforce show that structures that are tasked with the implementation of the CHS are available but face several challenges that affect their functionality. These include high turnover, lack of finances, staff shortages and lack of knowledge among the volunteers. The quotes in Box 13 illustrate the challenges.



Box 13. Availability of structures to implement CHS

To say the truth, we don't have any CHCs. It was not formed. **KII, SCCHC, Kiambu**

Two of the CHUs do not have a CHC and those that have not, have less than 9 members and some of the CHCs have opted to become CHVs due to the nature of activity they are being engaged in. **KII, SCCHC, Mombasa**

The CHVs' turnover is so high due to lack of support and recognition for instance at some point we wanted to merge two CHUs due to the number of CHVs remaining. **KII, SCCHC, Mombasa**

Right now out of about 18 CHUs required we only have 4, which are already established and functional. **KII, SCCHC, Baringo**

CHCs died because they don't have finances and we don't involve them in any activities. **KII, SCCHC, Nyeri**

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These interview quotes suggest that critical structures needed to implement the community health strategy, including the CHUs and the CHCs, are facing various challenges that impede their functionality.

Even where these structures are available, they face staff shortages, as illustrated by the interview excerpts in Box 14.

Box 14. Shortages in community health workforce

We have very few CHEWs because you can get a CHEW who is in charge of 5 units because we are very few. For instance, we have only 10 CHEWs in the sub-county and we have 22 units. So there is a gap. **KII, SCCHC, Kiambu**

CHCs are supposed to be the bakers of the bread ... to look for the finances to support the unit. However, as I earlier said when selection was done, they expected to be supported not them supporting the unit. **KII, SCCHC, Kisumu**

We've never had a CHC meeting since 2015 ... the reason behind it is motivation, you know this is a group of people who have responsibilities and most of them are working, so they don't come for the meeting. **KII, CHEW, Machakos**


we were about 50 when we started ... now we are about 20 ... when we were told it was about volunteering some left. **FGD, CHVs, Machakos**

CHVs lack motivation, transport is not provided, and they feel misused. Some CHVs drop out on the way. **KII, CHEW2, Nyeri**

This assessment points to a critical shortage of the community health workforce characterised by decreasing numbers of CHVs and CHEWs.

Understanding of Roles and Responsibilities

Box 15 shows views regarding the roles and responsibilities of different cadre of the CHW workforce.



Box 15. Views on CHW roles and responsibilities

CHVs

We teach on cleanliness in the households ... also refer those who need further attention to the facility; and take the pregnant mothers to the facility in case of need. **FGD, CHVs, Mombasa**

CHEWs

I am the overseer of the community health related activities, resource mobiliser, organizer of community action days that is dialogue, feedback the action itself. I am one of the people in the planning committee concerning outreaches and any problem that concerns the community. I also train the CHVs on health-related issues and have oversight on their activities. I also assist them in the reporting systems till to the DHIS. **KII, CHEW, Machakos**

I guide the CHVs, I do supervisions, I have a plan of supervising 5CHVs in a week, but due to competing tasks it doesn't happen ... the CHEW oversee the work of the CHVs, but there has been infightings as the CHVs feel superior. **KII, CHEW, Mombasa**

CHCs

We are supposed to plan for example when we have clean-up of the environment ... then we can have education forums like when we have them we educate them and plan to visit schools to empower them ... we meet as a committee because of the sake of the baraza so that we can go and educate our people. **KII, CHC, Kiambu**

They are supposed to do resource mobilisation and issues of advocacy of community health units. We had only one who would write proposals and look for donors; however, the ones who are there are not that active. **KII, SCCHC, Mombasa**


The main role of community health committee is to provide governance and leadership. They also do monitoring and evaluation of the work of CHVs ... resource mobilisation and of course they provide a linkage between the health facility committee and CHC. **KII, SCCHC, Baringo**

CHVs and CHEWs have clearly designated roles. The core mandate of the CHVs is to spearhead preventive and health promotion activities through community education and mobilisation, facilitating civil registration for births and deaths and mobilising the community for health action through forums such as dialogue and action days. Owing to the staff shortages described during the interviews, it is apparent that these important services are not provided as adequately as expected.

CHEWs reported that their role is to provide technical leadership and guidance to CHVs through supervision and training and by spearheading the selection and recruitment of CHVs. In addition, CHEWs are tasked with the responsibility of tracing and addressing defaulters who have falling out of a given treatment regimen and encouraging them to seek care and treatment. Other responsibilities include monthly reporting and analysis of reports submitted by the CHVs. The overall responsibilities of CHCs are the governance and leadership of the CHS through resource mobilisation to support the activities of the CHUs, organisation of the community outreaches and other forums to foster community action, promotion of individual involvement in managing their own health, community advocacy, and oversight of the operations of CHVs.

Training of the Community Health Workforce

The competencies and skills of the workforce tasked with the delivery of CHS is an important determinant of the preparedness to deliver health services at the community level. Interview excerpts in Box 16 show that in several instances the CHW had received some form of training on different aspects of implementing CHS. A combination of scenarios was reported. In some cases, the CHVs had been exposed to some form of training, but in other cases, they were yet to be trained. The same situation was reported among the CHEWs.



Box 16. Views on training of the CHWs

A challenge to the CHVs, if they could go for updates, the ones called refresher courses so that they can be reminded what they are supposed to do that will help a lot. **KII, CHEW, Machakos**

All the CHEWS are not trained on the community health strategy curriculum but only have an on-job training. **KII, SCCHC, Mombasa**

In Kikuyu sub-county most of the community health units are not trained. **KII, SCCHC, Kiambu**

We were trained in several things. The roles and responsibilities, communicable diseases ... also on FP and child health matters ... another one on HIV and gender-based violence. This was done by the Ministry of Health in collaboration with AMREF. **FGD, CHVs, Nyeri**

We have been trained twice ... by Red Cross, the Save the Children, UNICEF, and also World Vision. The training covered how to complete household register, use RDTs. **FGD, CHVs, Turkana**

4.6. Financing CHS

The finance and management component for the community module examined views related to the financing of both CHS and payment of health services by community members. The two were deemed important to tease out views regarding resource allocation practices for supporting CHS and to explore the uptake of health insurance to protect communities against catastrophic health expenditure.

The findings show that the financing of CHS remains a key challenge in several counties, where limited budgets, if any, are set aside for supporting CHS. Only a handful of county governments have reportedly taken positive steps to finance CHS. In some cases, the establishment and running of community units and other operational structures are largely left to partners, resulting in uneven service delivery. Interview excerpts in Box 17 illustrate views related to the financing of CHS.

Box 17. Financing of community strategy

In fact, if we were getting something we could have trained the rest of the CUs but what we have now, those who have been trained, we got funds from National Government when we were in the National Government. **KII, SCCHC, Kiambu**

We do our annual work plan and factor in the activities we want supported by the county, but we have never received any support from the county or national Government apart from payment of salaries of the 5 CHEWS ... financing has been coming from selected donor partners. **KII, SCCHC, Mombasa**

The county government is providing technical support through personnel that is there for every CU there are community health extension workers and of course for the sub-county myself is the community strategy focal person. **KII, SCCHC, Baringo**

Basically in terms of financing in the county, majorly we get our support from the partners the county government has been planning, we've got support but not as much as we are getting in from the partners, I think in terms of percentage I would give the partners around 70% and the county around 30%. **KII, SCCH1, Kisumu**

Views related to uptake of health insurance show that communities understand the important role it plays in promoting access to health services and protecting families and individuals from catastrophic health expenditure. The quotes in Box 18 illustrate this understanding.



Box 18. Perceived value of health insurance

For those of us who don't have insurance, we must pay for health services through harambees, help from relatives or out of pocket. **FGD, Mothers, Kakamega**

Yes, I have heard of it and my husband have the NHIF card if anyone in my family gets sick we go to the hospital with the card and we will not pay anything for the services. **FGD, Mothers, Mandera**

For NHIF, I have used it for six years and sometimes when my child is sick and I don't have money, I take the child to Nangina Holy Family and the card will cover. **FGD, Mothers, Busia**

Linda Mama helped me a lot because when I was having this baby I was carried for free, I just called them and they carried me for free and took me to the hospital and after giving birth also, that is my gain. **FGD, Mothers, Busia**

Several privately and publicly funded insurance schemes are available to the community. Some of the commonly mentioned schemes included the NHIF, Linda Mama, Afya Bora and Afya Plus, and M-Tiba.

Despite the general knowledge regarding the importance of health insurance, low uptake was attributed to fears relating to affordability of monthly premiums and lack of access to registration facilities or centres at the local level, as illustrated by the interview quotes in Box 19.

Box 19. Reasons for low uptake of health insurance

Inadequate finances are one of the reasons most mothers don't have insurance since most of them are unemployed. **FGD, Mothers, Kakamega**

The elderly ask us why pay five hundred shillings the first month and be unable to pay the following month. Money problems, some people are not able to afford registration for NHIF. **FGD, CHVs, Laikipia**



5. Discussion


The objective of the community module in the HHFA was fourfold: (1) to assess the availability of services that are delivered under the CHS, including the physical presence of facilities and other resources; (2) to assess the readiness of the CHS structures tasked with the delivery of CHS; (3) to assess the financial and management requirements for enhanced delivery of CHS; and (4) to assess client and health worker views on the quality of services provided.

A wide range of preventive, promotive, and basic curative services are being provided through the CHS. Key among them are as follows: child health services; family planning; maternal health services; and screening of non-communicable diseases, sexually transmitted infections, HIV/AIDS, tuberculosis, and malaria. The bulk of the services fall under the broader remit of reproductive, maternal, new-born, child, and adolescent health. It is important to note that maternal and child health are the main areas of coverage for the UHC, as there is evidence suggesting that most households, especially the poor, spend more income on maternal and child health complications as a result of a lack of medical coverage (Gandham NV Ramana 2013). Although several services were mentioned as being available, a combination of structural, financial, sociocultural, and organisational barriers impeded the use of CHS. At the community level, structural barriers included the limited number of community units to cover the entire population and the limited number of CHVs to provide services to households under their jurisdiction. Financial barriers included the lack of resources to support efficient delivery of services and payment of stipends. Structural barriers at the facility level included shortages in essential drugs and commodities, limited number of health workers, long distances to the nearest health facility, and an inability to respond to emergencies occurring outside the official operating hours, especially at the dispensaries and health centres. The organisational barriers included poor health worker attitudes, limited resources to facilitate referrals, and weak community representation on the facility health committees.

With regard to financial barriers, interviews in some counties, such as Machakos, Nyeri, Kisumu, and Isiolo, reported a degree of optimism that the implementation of the UHC was likely to address barriers related to affordability of services. Despite the optimism, there were no clear differences in terms of views regarding the success and challenges affecting delivery of CHS. Part of the approach to foster UHC is through the removal of user fees at all public facilities, including levels 4 and 5 facilities, and ensuring commodity security through the Kenya Medical Supplies Agency. In addition, it is expected that counties implementing the UHC will be provided with conditional grants to strengthen the health system and primary healthcare interventions. With these additional resources, counties will be able to strengthen their primary healthcare networks, with a focus on community health systems.

The implementation of the CHS is premised on the availability of functioning structures, such as the CHUs, the CHCs, and the forums, including the dialogue and action days. Community units are the engines that drive the CHS. Although the findings suggest the existence of these units country wide, their functionality was undermined by several limitations, including poor motivation, limited numbers, inadequate training, and limited financial resources to support the operations of these structures. The lack of an adequate number of CHUs suggests that there are people in the community who are not able to access the promotive and preventive health services that are offered by the CHWs. Challenges relating to the absence of health services at level 1 of care are well known (UNICEF, 2010).

The CHC is a critical body that should be strengthened for the CHS to function optimally. The CHC is expected to provide the necessary linkage between the CHW and the link health facility through representation, conflict resolution, development, and implementation of plans to deliver health services



that address the needs of the community. In addition, the committees are tasked with networking and resource mobilisation to support the functioning of the community units and the CHVs. This assessment has shown that the CHC is one of the poorly functioning structures in the CHS. It is noteworthy that most of the challenges that were highlighted by this assessment reflect the weaknesses of this important governance organ that is tasked with resource mobilisation and management, advocacy, performance appraisal of CHVs, and information management. Together, these weaknesses compromise the selection, training, work ethic, and motivation of the community health workforce, as well as the capacity to delivery services. Kenya can benefit from lessons learnt from other African countries in terms of strengthening the functionality of these governance structures. In Zambia for instance, the CHCs are incorporated into the healthcare delivery system, with a formal regulatory body and standardized remuneration (Zulu JM 2013). In addition, evidence from Ethiopia, has shown that the support of health facilities to community health committees play a critical role in influencing its functionality (Creanga AA 2007).

Another element related to the assessment of readiness to provide CHS is the skills and competencies of the community health workforce. Ideally, the CHVs, members of the CHC, and CHEWs are expected to undergo focused training to prepare them for service. The CHVs are expected to undertake both the basic and comprehensive training to properly equip them with skills to deliver CHS. The findings from this assessment suggest that clear gaps exist in terms of training across the community health workforce. For example, interviews with CHVs revealed that most of them have not been exposed to the comprehensive module. In addition, several CHEWs had yet to undertake any training. Owing to the high attrition rate that characterises the community health workforce, frequent training and orientation of the workforce is critical. The Kenya quality model dictates that there should be a continuing professional development programme for all CHEWs and CHVs that should be coordinated by the sub-county health management team. Owing to these challenges, the community health workforce is ill-prepared to deliver services. First, community health workers are demotivated by the enormous burden they encounter. The CHVs, for instance, lacked the means of transport for mobility within their catchment area and lacked airtime for communication purposes. Second, the CHVs faced a heavy workload occasioned by attrition and non-replacement. Third, there was a lack of essential toolkits and working aids, some as basic as an identification badge or a bag to carry the forms and tools, lack of incentives, non-payment of monthly stipends, and lack of medical coverage for CHVs. These challenges point to a case of neglect for an important cadre in the healthcare system.



6. Conclusion

The services that are expected to be delivered through the CHS are available and are reported to have made a positive impact in improving the health status of the population. Despite these benefits, the implementation of the CHS remains suboptimal. The availability of services is compromised by limited resources to support the operations of the structures tasked with the delivery of CHS, a lack of essential commodities, and negative attitudes of some health workers at the facility level.

In addition, the readiness to provide services is undermined by several structural and organisational barriers that should be addressed to promote the functionality of the CHS and prepare the path for UHC. There are policy and regulatory steps that should be taken to improve service delivery readiness. Policy steps should engage with decisions and practices related to resource allocation to support the CHS, including the need to integrate the CHVs into the formal workforce, and regulatory steps should seek to implement the requirements of the Kenya quality model.

Overall, there are significant gaps in the implementation of the CHS, with noticeable disparities across counties in relation to the number of functional CHUs, CHVs, CHCs, and CHEWs. These gaps compromise the readiness to deliver services and, ultimately, the access to and use of services that are supposed to be implemented through the CHS.



7. Recommendations


A robust primary healthcare system is dependent on existence of well-functioning CHS. To achieve this, the assessment offers the following recommendations:

- Provide budgetary allocation to support the establishment, training, and operations of CHS structures.
- Recruit the appropriate number of CHVs, CHEWs, and CHC members in compliance with the Kenya quality model.
- Strengthen CHCs and equip them with the knowledge, skills, and resources to undertake their mandate.
- Consider incorporating the CHVs into the formal healthcare workforce.
- Create awareness at the community level to use CHVs as the first point of contact before visiting the health facilities.
- Sensitize staff at health facilities on importance of referrals initiated by the CHVs



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Appendix 1. Coding Framework

Identified Codes
CAPACITY
CHVs
<ul style="list-style-type: none"> Recruitment process
<ul style="list-style-type: none"> Training
<ul style="list-style-type: none"> Roles and functions of CHVs
<ul style="list-style-type: none"> Skills required
CHEWs
<ul style="list-style-type: none"> Recruitment process
<ul style="list-style-type: none"> Roles and Responsibilities
<ul style="list-style-type: none"> Training
CHC
<ul style="list-style-type: none"> Role
<ul style="list-style-type: none"> CHS implementation
<ul style="list-style-type: none"> Community health activities
CHALLENGES FACED BY CHS Workforce
<ul style="list-style-type: none"> Stipends
<ul style="list-style-type: none"> Motivation
<ul style="list-style-type: none"> Training
<ul style="list-style-type: none"> Tools
COMMUNITY HEALTH STRATEGY
Sustainability and continuity
Implementation
<ul style="list-style-type: none"> Challenges
<ul style="list-style-type: none"> How addressed
<ul style="list-style-type: none"> Process
<ul style="list-style-type: none"> Role of partners
Adequacy of community health workforce
<ul style="list-style-type: none"> CHEW to CU ratio
<ul style="list-style-type: none"> Coverage of CU
Effectiveness
<ul style="list-style-type: none"> Benefits or achievements
<ul style="list-style-type: none"> Role of CHS in creating change
Financing
COMMUNITY REFERRAL SYSTEM
<ul style="list-style-type: none"> Formal systems
<ul style="list-style-type: none"> Maternal referrals



Identified Codes
<ul style="list-style-type: none"> Challenges experienced
<ul style="list-style-type: none"> Initiatives facilitating referrals
<ul style="list-style-type: none"> Recommendations to improve referrals
FINANCING COMMUNITY HEALTH SERVICES
<ul style="list-style-type: none"> NHIF registration
<ul style="list-style-type: none"> Benefits of NHIF
HEALTH SERVICES PROVIDED
Challenges utilizing the services
<ul style="list-style-type: none"> Financial
<ul style="list-style-type: none"> Socio-cultural
Services provided by CHVs
LINKAGES TO HEALTH FACILITIES
<ul style="list-style-type: none"> Views on effectiveness of referral system
<ul style="list-style-type: none"> Role of CHC in planning
<ul style="list-style-type: none"> Mechanisms to strengthen linkage
RECOMMENDATIONS
<ul style="list-style-type: none"> Financing
<ul style="list-style-type: none"> Governance
SPECIAL NEEDS SERVICES
Challenges accessing care
<ul style="list-style-type: none"> Disabled
<ul style="list-style-type: none"> Elderly
<ul style="list-style-type: none"> People living with HIV/AIDS



Appendix 2 Tools

8.1. I. Key Informant Interview Guide: Sub-County Community Health Coordinator

Introduction

My name is -----and with me is----- from ----- . We are here to assess community health services as part of the Harmonised Health Facility Assessment being conducted in all 47 counties in Kenya. This will be an open discussion and we will be happy to hear your views which are important for planning of health services. It is therefore important that you participate freely in this exercise. The information you provide will be confidential and used only for research purposes. The discussion will take about an hour. As part of the exercise we request that we record the discussion so as to capture correctly all the ideas. The recordings will not be used for any other purpose other than assist us to write out the notes.

Would you like to participate in the discussion? Yes No (TICK)

1. How is the community strategy implemented? Probe on - the governance structure, support for implementation
2. How effective is the community health strategy? Probe on - What indicators at the health facility are attributed to Community health services? Which of these have improved?
3. How is the implementation of the community strategy financed?

Probe – Through a structured work plan and budget of the County, Through Partners Support, Through National MOH technical support, through County Health Act)

4. What is the coverage of Community Health Unit in the sub-county? What is the ratio of CHEW to CHU and ratio of Sub county population to CHU.
5. What mechanisms are in place to ensure strengthening of community-health facility linkage? Probe: Representation – CHC in the Health Facility Committee, referral system. What can be done differently?
6. What is the role of the Community Health Committee? Who are the members?
7. What role do partners play in implementing the community strategy?
8. What challenges do you face in implementing the community strategy? Any recommendations?



8.2. II. Key Informant Interview Guide: Community Health Extension Worker

Introduction

My name is -----and with me is----- from ----- . We are here to assess community health services as part of the Harmonised Health Facility Assessment being conducted in all 47 counties in Kenya. This will be an open discussion and we will be happy to hear your views which are important for planning of health services. It is therefore important that you participate freely in this exercise. The information you provide will be confidential and used only for research purposes. The discussion will take about an hour. As part of the exercise we request that we record the discussion so as to capture correctly all the ideas. The recordings will not be used for any other purpose other than assist us to write out the notes.

Would you like to participate in the discussion? Yes No (TICK)

1. Recruitment

How were you employed as a CHEW in this County? (Probe – County Service Board, CHMT, National MOH, Deployment)

2. The capacity of CHEW

What is the background of your professional training and in which field? (Probe – Certificate, Diploma, Degree level in Public Health Nursing, Laboratory, Community Health, Social Sciences)

a. Tell us about your training background

b. What is your role as a CHEW in this community unit?

Probe for:

- Training of CHVs –

o What topics are covered in the training?

- Supervision of CHVs and Mentorship

o How often are CHVs supervised?

o How many CHVs do you supervise per Community Unit (CU)?

- Review minutes of Community meetings


- Collating and reporting of community data

- Community participation/engagement through community dialogue, community action days, community meetings

c. Have you had any training in Community Health Strategy?

d. Have you been trained as a CHEW through KMTTC?

3. How are the CHVs motivated to work? 3



4. Community-facility linkages

- a. Is the community represented in the Health Facility Committee? If yes, how?
 - b. How effective is the community referral system? Probe for Referral tool (MOH 100) for the CHVs, the Referral file in the health facility
 - c. What tools do you use in reporting CHV activities? How are these tools used?
5. What is the role of the Community Health Committee? Are you a member? If so, what is your role?

Challenges and recommendation

- 6. What challenges do you face in implementing the Community Health Strategy? Any recommendations?
- 7. What changes would you want to see to improve the delivery of services at level 1 (community)? 4



8.3. III. Key Informant Interview Guide: Community Health Committee Chairperson

Introduction

My name is -----and with me is----- from ----- . We are here to assess community health services as part of the Harmonised Health Facility Assessment being conducted in all 47 counties in Kenya. This will be an open discussion and we will be happy to hear your views which are important for planning of health services. It is therefore important that you participate freely in this exercise. The information you provide will be confidential and used only for research purposes. The discussion will take about an hour. As part of the exercise we request that we record the discussion so as to capture correctly all the ideas. The recordings will not be used for any other purpose other than assist us to write out the notes.

Would you like to participate in the discussion? Yes No (TICK)

1. In brief share your roles as a Community Health Committee (CHC) in the implementation of Community Health Services?
2. What would you say about the linkage of CHCs with the Facility Health Committee? Probe: Representation, Planning for the Community Health Units (CHUs) and linkage with the Health Facility
3. Share with us any Community Health activities in your CHUs? Probe for their involvement in Community Dialogue Days, Community Health Action Days, Outreaches, etc.
4. Has there been any change to the community on the implementation of community health activities? Probe for benefits, achievements. What has been the role of CHCs in achieving that change?
5. What challenges have you faced as a CHC in the implementation of the community health activities in this community health unit?
6. How have these challenges been addressed?
7. What can be done to ensure continuity of community health activities?



8.4. IV. Focus Group Discussion Guide: Community Health Volunteer

Introduction

My name is -----and with me is----- from ----- . We are here to assess community health services as part of the Harmonised Health Facility Assessment being conducted in all 47 counties in Kenya. This will be an open discussion and we will be happy to hear your views which are important for planning of health services. It is therefore important that you participate freely in this exercise. The information you provide will be confidential and used only for research purposes. The discussion will take about an hour. As part of the exercise we request that we record the discussion so as to capture correctly all the ideas. The recordings will not be used for any other purpose other than assist us to write out the notes.

Would you like to participate in the discussion? Yes No (TICK)

1. The capacity of CHVs

- a. Please tell us about how you were selected to be a CHV. Why do you think you were selected as CHV?
- b. Please tell us about the training you were given. Who did the training, what was the duration of the training and what kinds of skills did you learn? How useful are the skills?

2. Role and Function of CHVs

- a. What kinds of services do you provide at the community? To whom? In what kinds of situations?

Probe for: services provided at community level

- Health promotion of specific key health services (ANC, FP, MCH, immunisation, PMTCT)
- disease prevention and control (HIV, TB, Malaria),
- are seeking and compliance with treatment advice for the health conditions,
- hygiene and environmental sanitation,
- youth and adolescent's services,
- building capacity of communities to claim for their rights to health,
- Support for birth registration
- Support for NHIF registration

- b. When maternal death occurs in the community how is it reported? (These are deaths of mothers that occur due to pregnancy or pregnancy related complications from time when a woman is pregnant, childbirth and up to 42 days after delivery)

- What about when a perinatal death occurs in the community? (death of a foetus from 28 weeks of pregnancy up to first 7 days after birth)
- How are other deaths in the community reported?

- c. What kinds of rewards or payments in cash or in kind have you been receiving? From who e.g. partner, County

- d. How would you like to be motivated?



2. Health Services to people with special needs

a. What are some of the challenges/problems people with special needs in this community face in accessing healthcare in health facility?

- Persons living with HIV/AIDS (probe for ART, ARVs, RH & FP, stigma, accessing Prevention with positive (PWP) services)
- The Elderly
- People with disabilities (probe for sick children, ANC, delivery in health facilities, PNC, Community based Counselling and Testing, PMTCT, ART, Youth and RH services)

b. In your opinion, are there actions that can be taken to improve the quality of healthcare services offered to people living with HIV/AIDS, the elderly and people with disability in this community?

3. Community referral system

a. What do you do when complications occur for instance during pregnancy and childbirth, child illness etc.? How do you assist? (Probe for referral)

b. Are there any formal systems for making referral? (Probe for referral booklets/slips)

c. What problems / challenges do you experience? (Probe for distance, transport availability and payment, facility staff attitude and support)

d. What initiatives exist in this community that facilitates referral to the nearest health facility government transport or ambulance, Community Ambulance, Individual efforts?

e. What else can be done and by whom to improve referral?

4. Linkage to the healthcare facility

a. What kinds of contacts do you have with the healthcare facility?

Probe for:

- Meetings with healthcare staff?
- Guidelines for how to provide services.
- Supervision?
- Submission of reports to the facility? (MOH 515)
- Assistance provided to you by the staff.
- Referrals made? (MOH 100)
- Community Health Committees representation in the Facility Health Committee

5. Challenges and recommendation

a. What challenges do you face in your work as a CHVs? Probe: Recognition as health providers, Unreliable or lack of stipend payment, Lack of other motivation, Unreliable availability of reporting tools, lack of refresher trainings)

b. What kinds of changes in your work would improve the services you offer?



8.5. V. Focus Group Discussion Guide: Mothers

Introduction

My name is -----and with me is----- from ----- . We are here to assess community health services as part of the Harmonised Health Facility Assessment being conducted in all 47 counties in Kenya. This will be an open discussion and we will be happy to hear your views which are important for planning of health services. It is therefore important that you participate freely in this exercise. The information you provide will be confidential and used only for research purposes. The discussion will take about an hour. As part of the exercise we request that we record the discussion so as to capture correctly all the ideas. The recordings will not be used for any other purpose other than assist us to write out the notes

Would you like to participate in the discussion? Yes No (TICK)

1. Tell us about the health services you receive in your household?

Probe for:

- Health promotion: Birth Planning, Exclusive breast feeding, Hand washing practice, feeding practices, ANC, FP, MCH, immunisation, PMTCT)
- Referrals

2. Are you aware of Community Health Volunteers (CHVs) in your community? What do they do?

Probe for: Services provided by CHVs: Household visits, Health promotion on

Family Planning, Hygiene, Deworming, Nutrition, HIV, TB, Malaria; Referrals, condom distribution; defaulter tracing

3. How many of you have health insurance cover?

a. If not, why?

b. If so, tell us about the insurance cover you have.

Probe for: NHIF or any insurance cover you have? / NHIF Registration, Free Treatment, Free maternity Delivery

4. How do you benefit from your Health insurance (NHIF or any other?)

5. In the last 5 years has there been any change you have realised in your family's health in general through the services offered to you in your household/health facility?

6. How is your experience from the services you get from your nearest health facility?

Probe for: Whether referred by CHVs, self-referrals or care giver

7. What have been the challenges you have faced while using the services offered to you in your household/health facility? Probe for financial, cultural/community beliefs

8. What do you think can be done differently for you to access quality health services you require in your household/health facility?



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