MIKINDURI CHILDREN OF HOPE COMMUNITY-BASED HEALTH CARE FINAL REPORT FOR SITUATIONAL ANALYSIS

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EXECUTIVE SUMMARY

There is a health care crisis in Africa. Sub-Saharan Africa has only 3% of the world's health workers and commands less than 1% of the world's health expenditure[1]. People, sick and in need of care, across the continent are dying en route to ill-equipped facilities in under-resourced countries. Over-worked health workers are being crushed under the staggering need for support which completely outpaces their ability to respond. Kenya is one of 57 countries globally gripped with a health worker crisis where fewer than 2 doctors, nurses and midwives serve every 10,000 persons- the minimum standard set by the WHO is 23 [2]. An absence of adequate government-led responses is creating a frightening system where already-scare doctors and nurses in public facilities do double duty in their own private clinics thereby causing further strain on the public system. There have even been disturbing reports of health professionals stealing provisions from government hospitals to stock private clinics, or encouraging services to be acquired within the private system.

There is an urgent need for dynamic and practical strategies to address the health needs of grassroots communities across Kenya. There is a movement growing around the world utilize models which provide care outside of formal health facilities in the communities in which people live. These models are often referred to as "community based health care" or "community home based care". The World Health Organization broadly defines Community Home Based Care as "*any form of care given to ill people in their homes. Such care includes physical, psychosocial, palliative and spiritual activities*. "[3]

It is against this backdrop that Canadian-based Mikinduri Children of Hope (MCOH) and their Kenyan sister organization Mikinduri Hope Community Development Organization (MHCDO) (herein referred to as MHCDO/MCOH) commissioned two professionals to undertake a six-week consultancy (two of which were spent in Kenya) to examine two key questions:

1. Is community-based health care an appropriate model to meet the identified needs of the Mikinduri community?
2. Is community-based health care a priority for MHCDO/MCOH?

In order to thoughtfully answer these questions, it was essential to understand, as deeply as possible within the time available, the nuances of the Mikinduri community. The principal focus of this analysis was to seek primary information from community members themselves. Four focus-group discussions were held in Kinwe, Mikinduri, Kagwuru, and Thangatha in order to create a space for people to share their aspirations, opinions, and priorities and therefore ground our recommendations in their lived experiences. It was also critical to understand these community insights in tandem with other key stakeholders such as government, civil society, and local leadership. This primary research was then considered within the context of current practice within the body of knowledge and practice focused on community-based health care.

This report presents why the answers to the key questions above are: yes, community-based health care is both an appropriate model for Mikinduri and a priority for MHCDO/MCOH. CBHC

[1] *Taking stock: Health worker shortages and the response to AIDS*, WHO, 2006

[2] *WHO Flyer on Strengthening Human Resources for Health*, WHO, 2010

[3] *Community Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002.

can play a vital role in health care delivery, particularly given Mikinduri's relatively limited health facilities and the rugged, rural terrain that make traveling distances a challenge. CBHC relies on communities driving the programme which gives the model a powerful ability to respond to the unique character and capacity of each community that implements it. It is this adaptability and transferability that makes CBHC a sustainable and effective model of service delivery.

Certainly CBHC is not a panacea. A Community Health Worker (CHW) augments the effectiveness and accessibility of formal medical care but is not a replacement for a doctor or nurse. CBHC must be included in a wider structure of health support. However, when these linkages are in place to create a fluid continuum of care, CBHC can provide culturally relevant, sensitive and holistic services often preferred by families at the community level. To ensure quality care, CBHC programmes need community leadership and government-supported health infrastructure and expertise.

It is here where the sense of momentum and political will regarding the relevance of community-based health care within Kenya must be acknowledged. The Ministry of Health has offered a clear plan of action with the *Community Strategy*, a policy framework which clarifies the role that CBHC will play within the health care continuum. The policy, while perhaps overly bureaucratic, complicated, and prescriptive, represents an important tool in moving towards a quality, state-led health care system that is truly accessible to all.

For MHCDO/MCOH, CBHC is not useful simply for health care activities, rather it creates a powerful mechanism for strengthening the impact of all project activities. Mobilizing and supporting teams of CHWs at the community level provides an enhanced ability to: provide holistic support to the most vulnerable; create a link between the community and organizational programme implementation; collect data and conduct monitoring and evaluation; effectively use resources (financial, staff time, material benefits, etc); engage in more informed and strategic advocacy that is linked directly to the grassroots level. In this sense, by holistically supporting CHWs in the project area, MHCDO/MCOH will not only be promoting the Ministry of Health's priorities, but their own organizational mandate as well.

Each community is unique; therefore there is no one "right" model of community-based health care. However, there is much to be learned by the growing body of knowledge around the model. The World Health Organization provides a useful document entitled C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action* which is cited often throughout this report (see Annex II for an overview of the essential elements of a community home based care programme taken from the WHO document). There is recognition of the expanding scope of care work and consensus that CBHC is an important model to address critical health skill shortages, particularly in sub-Saharan Africa. Good practice also abounds regarding addressing gender inequality, incentives for care work, transportation challenges, harmful cultural practices, supervision mechanisms, in-patient care, and referral networks. Overall one message is clear: communities must own, drive, and lead the process of establishing and maintaining community-based health care systems.

Recommendations to MHCDO/MCOH

Based on the momentum on the ground, and consolidating all of the groundwork that has been done to gather information about the community-based heath care project, the following actions are recommended:

- **Read and be intimately familiar with the Ministry of Health's Community Strategy and National Health Sector Strategic Plan (NHSSP) II.** It is essential that MHCDO/MCOH are well-versed in the strategic priorities of the Ministry of Health so that programmatic and advocacy platforms be focused on strengthening existing efforts as

opposed to creating new, parallel systems. The Community Strategy is particularly relevant for establishing a community-based health care programme.

- **Establish a sub-committee of the Advisory Committee/Board with some expertise in community-based health care that will focus on establishing a CBHC programme.** The role of this committee would be to develop a programmatic strategic plan for CBHC in consultation with key community representatives. This committee should be comprised of individuals residing in Mikinduri and Canada. There should be solid expertise regarding CBHC. Ideally this programmatic strategic plan would be linked with a 3-4 year internal strategic plan for the organization as a whole; however, the development of this strategic plan should not hold back the work of the CHBC sub-committee or the community level action. The needs of vulnerable households are urgent.

- **Present CBHC plan to the community.** It is essential for the community to validate whatever plan the sub-committee develops. It is very important that this consultation is conducted with the groups that took part in this situational analysis **and** the broader community (i.e. through a baraza or other mass community forum). For the groups that participated in this research, they must feel confident that sharing their needs and challenges with MHCDO/MCOH will lead to action in a timely way. This will encourage them to continue sharing their needs, knowing that it will contribute to tangible results. Additionally, it is acknowledged that the groups engaged for the focus group discussions are currently receiving some level of essential support through the Chalice/MCOH sponsorship programme. Thus, it stands to reason that there are many households in more urgent need. All people, with a special attention to the most vulnerable of the vulnerable, must be actively engaged in validating any programme that is developed.

- **Develop partnerships as driven by the priorities and needs outlined in the programme strategic plan.** Partnerships cannot drive the service offering of CBHC. Rather, partnerships must come as a direct result of the community needs. Once a CBHC plan has been developed and validated by the community, it then becomes very clear what partnerships/networks are needed. This will ensure that the network of partnerships serves to strengthen the CBHC programme to meet the priority needs of the community. Without this strategic partnership development, one risks being pulled off course or in multiple different directions by the objectives of other entities.

- **Hire a project coordinator, based on the skills set identified in the CBHC plan.** It is a substantial amount of work to coordinate the establishment of a CBHC programme. While existing staff are very enthusiastic about the programme, and would likely be capable to do the work, it would be very challenging for them to be able to take this on in addition to their current workloads. It is recommended that MHCDO/MCOH hire a dedicated project coordinator who has the necessary competencies, is passionate about CBHC, and committed to empowering the community.

- **Pilot a project in a defined area, evaluate the results, integrate lessons learned and expand as needed**. It is recommended that MHCDO/MCOH starts small with the resource available before rolling out to all project areas. This will afford the time needed to learn important lessons, refine the programme, develop systems, and build a track record of service provision. This will also strengthen future resource mobilization efforts as requests can be made based on evidence-based experience. It is recommended that communities participate in selecting the pilot location(s) so that they can feel invested in the outcome.

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Background

Mikinduri Children of Hope (MCOH) has been working in the Mikinduri area since 2003 implementing projects on medical services, clean water, economic development, child sponsorship, education, technology, nutrition, and agricultural development. In order to conduct this grassroots work, MCOH established Mikinduri Hope Community Development Organization (MHCDO), a community-based organization registered in Kenya[4]. One of the most significant interventions implemented by MHCDO/MCOH since 2007 has been annual health missions which mobilize teams of health providers (doctors, nurses, speech therapists, physiotherapists, etc) and other professionals (agricultural specialists, engineers, etc) from Canada and Kenya to provide essential medical, dental, and vision services and development support to the Mikinduri community. It was during these annual missions that the MHCDO/MCOH team identified an absence of stable, quality health services which people could access on a regular basis throughout the year. Community-based health care was identified as a possible model to provide holistic health services to the community on an ongoing basis.

With a desire to address the priority needs of vulnerable households in the Mikinduri area, MHCDO/MCOH embarked on a project to evaluate the relevance of CBHC to the community and the role, if any, the organization should play within such a programme. Two consultants were commissioned by the group to conduct a situational analysis to address these questions and offer recommendations on a concrete way to move forward.

The deliverables for the Situational Analysis were to prepare a comprehensive report that:

- Developed a profile of the priority health and development needs as articulated by the community members and key institutional stakeholders
- Conducted an environmental scan to assess the existing capacity, assets, challenges and needs in relation to the provision of health services, including the integration of existing MCOH programmes into a holistic community-based health care programme
- Assessed the readiness of local community actors to take on a community-based health care project
- Made evidence-based recommendations that strengthened the community's capacity to lead the implementation of a community-based healthcare programme
- Recommended key partners to move the project forward.

This report outlines the findings of the participatory process that was undertaken, and act as a framework to inform the process of establishing a community-based health care project. It aims to support MHCDO/MCOH make sound programmatic, evidence-based decisions and contribute to the organization's broader vision of empowering the Mikinduri community and reducing the grinding impact of poverty. The success of this project is dependent on listening to the needs of the local community and taking the concrete steps necessary to strengthen a community-driven, local network of health providers that strategically link and leverage competencies and resources to provide the best possible health care, while integrating this initiative with the services currently provided by organization in a holistic way.

[4] Given the close partnership between the Canadian and Kenyan organizations, this report will refer to both organizations as "MHCDO/MCOH".

Outline of the Process

The full spectrum of this analysis was conducted between January 6 and February 15, 2011, with the in-Kenya portion taking place between January 16 and 31, 2011. In order to conduct the assessment within the short-time frame that was available for this work, and to focus on the needs of the grassroots, the consultants decided to use Participatory Rural Appraisal methodology. This process allows getting a broad perspective of the community being studied, while focusing on key informants and stakeholders. This is a sequential process where each step informs the next; ensuring enough flexibility to be responsive to the needs on the ground and enough structure to effectively produce meaningful results. Underpinning the established work plan was a unique approach that was based on:

- Sensitivity to the realities of the vulnerable communities
- Using collaborative and participatory practices
- Respecting the participants time and reducing the barriers to their participation i.e. meeting them in their communities and where they work

Prior to embarking on the stakeholder interviews and the focus groups, an extensive literature review was conducted in order to inform the process. This was done in order to identify best practices in implementing community based care, secure a clear understanding of the Ministry of Health guidelines and strategic objectives, and to ensure the project builds on existing lessons learned and does not duplicate efforts. Some of the documents reviewed include key government of Kenya policy documents including Vision 2030, and government strategic plans as they pertain to health care policy in Kenya.

In order to foster a collaborative relationship, and ensure common understanding of the needs, priorities, goals, objectives, roles and responsibilities, and to establish the work plan for this work, the consultant followed the following process:

- Worked with MCOH representatives in order to clearly define priorities before arriving in Kenya, and to get their recommendations on key stakeholders to be consulted
- To make the process participatory key internal staff such as Antony Kirigia, Program Director of MHCDO, Cynthia Mithoni, Chalice Director as well as members of MHCDO Advisory Committee were also consulted to get their input on who the key stakeholders were and which communities needed to be included in the focus groups
- The list was then validated with Antony and Fr. Bernard (Chair of the Advisory Committee), who then took the initiative to set up the meetings.
- The consultants maintained flexibility to connect with additional people as needed
- Continually analyzed information on an ongoing basis to inform each step of the process

General Demographics

TIGANIA EAST PROFILE - Census 2009

	Place	Male	Female	Total	Households	km2	Density
1	**AMUGAA**	4,348	4,597	8,945	1,878	25.4	352
	NKWILA	1,130	1,165	2,295	475	4.1	558
	CHURUI	1,517	1,611	3,128	640	14.0	224
	AMUGAA	1,701	1,821	3,522	763	7.3	480
2	**ANKAMIA**	4,121	4,269	8,390	1,749	11.3	744
	ANKAMIA	3,093	3,255	6,348	1,351	7.4	864
	IGUURUNE	1,028	1,014	2,042	398	3.9	520
3	**THANGATHA**	8,120	8,190	16,310	3,521	53.2	306
	GITHU	2,600	2,625	5,225	1,103	8.6	609
	NGUTU	800	779	1,579	342	5.4	292
	KUNATI	3,483	3,638	7,121	1,483	29.1	245
	KATHITHINI	1,237	1,148	2,385	593	10.2	234
4	**IGARII**	3,275	3,270	6,545	1,289	23.4	279
	IGARII	2,325	2,314	4,639	895	13.5	343
	NKANDI	950	956	1,906	394	9.9	193
5	**MICIIMIKURU**	4,539	4,871	9,410	1,983	21.8	432
	MICIIMIKURU	3,455	3,745	7,200	1,556	20.3	355
	AMETHO	1,084	1,126	2,210	427	1.5	1,511
6	**KIGUCHWA**	4,746	5,016	9,762	1,973	16.7	585
	KIGUCHWA	2,936	3,125	6,061	1,227	9.6	631
	ABODII	1,810	1,891	3,701	746	7.1	521
7	**MIKINDURI EAST**	7,856	8,230	16,086	3,196	46.9	343
	ATHWANA	2,378	2,621	4,999	992	10.1	498
	AKAIGA	5,478	5,609	11,087	2,204	36.8	301

	Place	Male	Female	Total	Households	km2	Density
8	**MIKINDURI WEST**	8,790	8,920	17,710	4,042	35.1	505
	KIGURU	1,792	1,823	3,615	860	12.1	300
	ANJUKI	4,317	4,363	8,680	2,013	8.7	996
9	**MUTHARA**	1,816	20,912	22,728	8,178	305.7	128
	MUTHARA	11,938	13,806	25,744	5,420	33.5	768
	ATHINGA	1,828	2,170	3,996	848	4.6	868
	ATHANJA	1,960	2,272	4,232	887	7.2	485
	KITHARENE	2,563	2,982	5,545	1,219	6.8	813
	THUMBUKU	3,838	4,218	8,056	1,672	11.4	706
10	**BUURI**	4,623	5,460	10,083	2,075	177.1	57
	LANYIRU	1,423	1,652	3,075	653	83.8	37
	MABURWA	1,363	1,604	2,967	601	57.3	52
	LAILUBA	1,837	2,204	4,041	821	36.0	112
11	**NGEREMARA**	1,555	1,646	3,201	683	95.1	34
	TIRINGWII	155	1,646	1,801	683	95.1	34
12	**KARAMA**	8,067	8,476	16,543	3,249	29.4	563
	AMETHO	2,814	2,935	5,749	1,103	18.3	314
	URUU	2,240	2,361	4,601	869	3.8	1,219
	BARANGA	3,013	3,180	6,193	1,277	7.3	850
13	**MULA**	861	790	1,651	337	76.2	22
	KALOTHERA	317	282	599	140	44.7	13
	KAMBERIA	544	508	1,052	197	31.5	33
14	**ANTUANDURU**	3,357	3,509	6,866	1,415	25.0	275
	GITUNDU	1,598	1,639	3,237	616	9.0	361
	ANTUANDURU	1,759	1,870	3,629	799	16.0	227

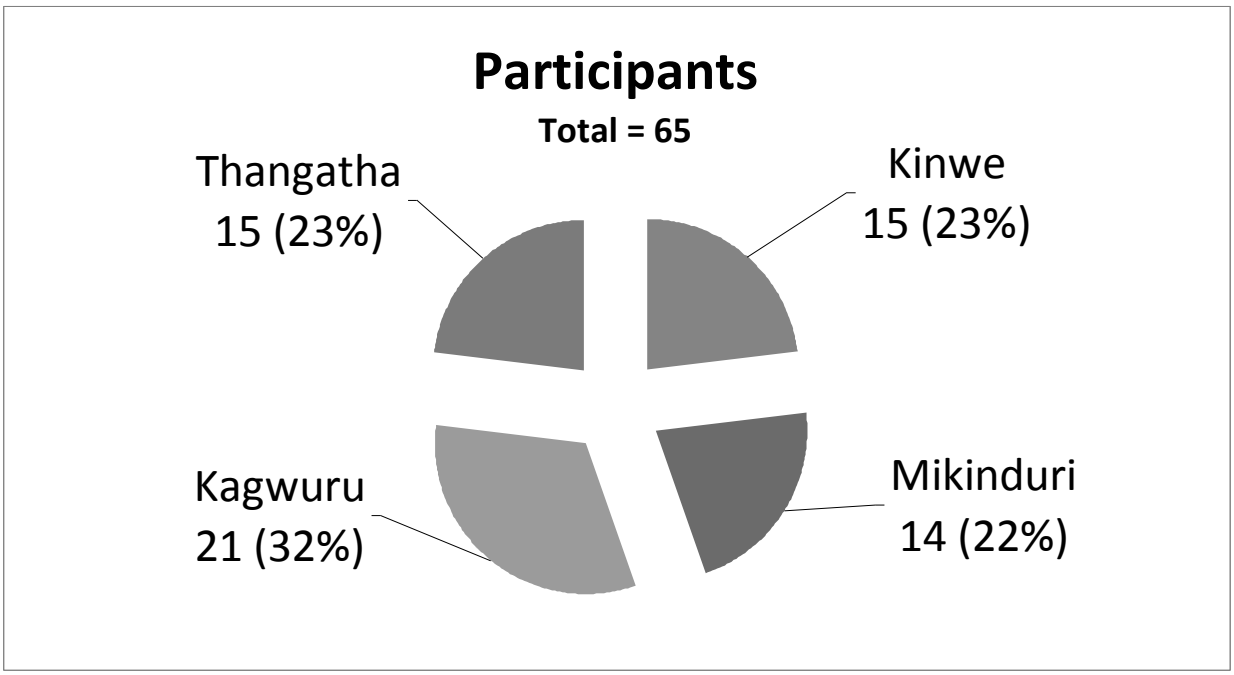
Population of Tigania East

The chart above provides the breakdown of the population of Tigania East based on gender, total population, the area they live in, and population density,

Focus Group Discussions: General Observations (see Annex V)
After lengthy consultation with both the MCOH representative and MHCDO representatives the following four focus groups were selected to participate in the focus group discussions:

- Kinwe Unit Representatives - Kinwe feeding center
- Mikinduri Unit representatives - Kinwe feeding center
- Kagwuru Unit: Venue - Kagwuru school
- Thangatha Unit (Kamujine) - Venue - Kamujine farm

A total of 65 participants took part in the 4 discussions: 21 in Kagwuru, 15 each in Kinwe and Thangatha, and 14 in Mikinduri.



Average Household	**6.6**	**Average Age**	**38.4**	**Gender**	
Max	15	Max Age	70	Female	43 (66%)
Min	1	Min Age	15	Male	22 (34%)

The members of the groups are recipients of MHCDO or Chalice support, and meet on a regular basis. As such, they are known to the organizations and staff. The Kinwe and Kagwuru groups were previously consulted by MCOH members about their health care needs.

This section will describe some of the key characteristics that are common among all the 4 focus groups.

Livelihoods

- All participants identified themselves as subsistence farmers, with small land holdings.
- All of them also stated that they work as casual labourers “kibaruas” in order to earn cash. During dry/drought season like the one they were currently experiencing, there wasn’t much work available therefore cash flow was a major issue. When they worked, they earned Kshs. 100-150 a day.
- Lack of capital for micro-business and access to markets was also identified a major issue by all the groups

Gender

- Complex gender dynamics and cultural practices such the women marrying quite young, and being the main providers to their families since most of their husbands were unemployed and many spent time drinking locally brewed alcohol.
- Polygamy was still practiced in certain areas, which meant that some of the men had multiple wives, and as such they had large families.
- Women were very conflicted about family planning. They expressed a deep desire to have smaller families, but felt they had no choice because if they stopped having children they feared their husbands would leave them or take an additional wife.

Basic Needs: Food, Shelter, Water

- Access to clean water was a major issue to most of the communities. They had to walk at least for 2 hours to the nearest river or stream. Very few members stated that they had access to tap/piped water
- Poor dwellings/housing – most of them stated that they live in poor houses, and some said that they might as well sleep outside as their houses did not protect them much from the elements.
- In terms of education, most of them stated that they had difficulty paying school fees to educate and to keep their children in school
- At the time of the interviews, they were all experiencing drought, and as such access to food was identified as a major concern
- Many live in remote areas with limited access to transportation, and their dwellings were sometimes far apart, therefore isolated from others

Health Care

- There were no health facilities close to where they lived. The participants stated that they have to walk a great distance to access medical services. Majority of the time the medical services accessed were overcrowded and not adequate. Medical fees paid were also a great barrier to accessing services. They also stated that most of government run facilities were understaffed, did not carry enough drugs, and when they did, they were cost prohibitive
- Of the major Illnesses identified by all the groups were: Malaria; Upper Respiratory Infections; Skin Infections; Rheumatism; Intestinal Worms, and Typhoid. This seemed to match the information obtained from the district hospital.
- When asked about if they have heard of or knew a community health worker in their community they stated that they have come across some community health workers who specialize in only HIV/AIDS and Malaria. One of the group members stated that she had received training from the Samaritan Purse to do so.
- When asked if they would be interested in having community health workers in their community, they all agreed that it would be a great program. In terms of the kind of support that community health workers would need, they stated that it will important to provide:
    - Some kind of compensation or honorarium to sustain their families since they are poor
    - Uniform, First Aid Kits and painkillers
    - They also wanted the CHWs to be from their communities, and had to formally introduced to the community as well

Communities In-Depth: Insights from Each Community

This section will provide a summary of the focus groups conducted. While the section above has identified some of the common challenges facing the communities, this section will provide a brief description of some of the challenges that are unique to each community, or how the above listed challenges affect each of the community.

Kinwe Unit

Participants:	**15 people**
Average age:	**35.9 years**
Gender breakdown:	**9 women; 6 men**
Average household size:	**7**
Sample of village representation:	**Marega, Anuki, Kianda, Mwiganda, amongst others**

The group was quite engaged and they spoke openly and candidly about their experiences. They seemed to work well as group and were comfortable with each other.

The participants stated that they all worked very hard to provide for their families, yet they were all quite poor. The members stated that they are subsistence farmers, with small land holdings, and a few stated that they also kept some livestock. All worked as casual laborers "kibaruas" in order to earn cash to be able to pay for school fees for their children feed their families, access medical services, clothing etc. They also stated that they are currently facing a drought.

Some of the challenges faced by this group include:

- **Water** – lack of clean and safe drinking water, majority of the participants had to walk for at least 2 hours to get water from the river. Only 2 participants had access to piped water.

- **Health** –. Access to health care was a major barrier due to lack of transportation, affordability and the quality of services that were available, nine members out of this group stated that they currently ill. When asked about where they asked medical services, they normally go to Miathene, Kabuline, Chaaria Hospital, Meru General, and Mikinduri Dispensary. When asked whether or not they saw herbalists or used other forms of alternative/complementary health care, this group unanimously stated that they do not do so, due to lack of standardized dosage for such medicines. Common diseases included: Malaria, rheumatism, skin diseases, intestinal diseases, Tuberculosis, dental problems, typhoid, and upper respiratory diseases

- **Shelter** – whole family, plus livestock, living in small dilapidated single rooms

- **Education** – due to lack of school fees, and uniform many children are sent home

- **Clothing** – the money earned is was not enough to buy clothing for the whole family

- **Capital** - Lack of capital to start micro-businesses in order to diversify their income

- **Gender dynamics** – it is the women who do most of the work and provide for their families. They stated that the majority of the men are "lost in local beer"

Mikinduri Unit

Participants:	**14 participants**
Average age:	**41.3 years**
Gender breakdown:	**10 women; 4 men**
Average household size:	**9**
Sample of village representation:	**Athwana, Kithiru, Mukono, Akairu, Kaangwene, Kamithega, Mayoe and Mwethe, amongst others**

Similar to the Kinwe Unit, this group was also quite engaged. They spoke quite eloquently about challenges facing their community, and what their priority needs were. The groups also seemed to know each other quite well.

Some of the challenges identified:

- **Land** – Small land holdings, and had many children. Lack of fertilizers for their crops. Some also said that they did not own land

- **Health care** – Similar to the Kinwe group this group also articulated the challenges of accessing adequate health care services, particularly lack of funds to pay for the medical services. For example, prior to getting treatment, one had to pay for transportation to the health care facility, pay for registration, pay for blood test, and then get a prescription, which one had to go to the pharmacy and buy, and most of the time they were not available at government dispensaries. Due to this, the individuals talked about going to the pharmacy right away, and getting medication directly. Some also stated that sometimes they were referred to another health care facility such as Meru General Hospital, and meant that they had to start paying.

- **Access to water** – they walked a long distance to fetch water. 9 people walked at least 2 to a river, and only 2 people had tap water in their community.

- **Education -** Lack of school fees, and uniform was a major issue. One participant stated that her child was quite bright and had managed to go to secondary school, however, her daughter has been sent home due to lack of school fees. Several other members also stated that access to higher education was quite a concern for their community. Another issue that was discussed was that there were too many students in the classrooms which compromised the level of education that their children were receiving.

- **Drought –** lack of adequate food to feed their families

- **Single parenting –** Several members stated they were single parents, two of the women in the group said they were widows and were raising their children on their own

- **Housing: -** The whole family sleeps in a single dwelling and cooks in the same room. This group also stated that when one was lucky enough to acquire any type of livestock, they will spend the night in the same room because of fear that they will stolen.

Kagwuru Unit

Participants:	**21 people**
Average age:	**34 years**
Gender breakdown:	**10 women; 11 men**
Average household size:	**5**
Sample of village representation:	**Gituu, Karatina, Ngage, Rurii, amongst others**

The Kagwuru school, where the focus group discussion was held, is located about 25 Km from Mikinduri town. The impact of the drought was evident in the area: the maize fields were scorched before they could be harvested, and the climate was much drier and hotter compared to the other communities. The level of poverty in this community was quite apparent. At the school, there is tap water, and the children are currently fed two nutritious meals a day both of which the community deeply appreciated.

Compared to the other two groups interviewed this group was initially a bit reserved, and it took a bit of time to warm up, however once they started speaking, they spoke quite passionately about the challenges facing their community. Unfortunately, the women were largely silent through the session and were reluctant to answer questions directly addressed to them. In order to ensure that the voices of the women were also heard, a separate, women-only session was held immediately after the main session.

Some of the challenges identified:

- **Isolation** – there were no "matatus" – public transportation serving this are. One had to walk to the nearest town to get transportation. The road conditions were also quite poor.

- **Health –** Because their community was isolated, accessing health services was a challenge, both due to the distance to the nearest health facility, and also because they were quite poor, both transportation and medical fees were major barriers. The nearest health facility was at least 8 km away, and as such people walked for at least three hours to access health services. If they had to take a person to the hospital, they would make stretchers and carry them there, and many would die on their way to the hospital.

- **Education** – Of all the 4 groups interviewed, this group talked in length about how lack of education affected their community. Most of them stated that majority of the adults had low levels of education, if they any. For their children, those that were lucky enough to go to school had to walk a long way to go to the nearest one.

- **Use of Herbal/alternative medicine** – this is the only group that stated that they regularly saw herbalist and other healers, since that was the only service available in their community. Some also said that they did have some knowledge of medicinal plants that has been passed on to them by their elders.

Women only Session

- **Sexual and reproductive health:** The women stated that almost all of them gave birth at home, and most of their children were not vaccinated. The health facilities were too far, and cost prohibitive. Family planning was major challenge, since their husbands did not support it. If one did manage to access the service, and the husband found out, or did not give birth again within a certain period of time, the husband would leave her and marry someone else. Support after accessing family planning services was also a challenge. Those that did access such services do so without informing their husbands, however they were always

fearful of getting complications and having to tell their husbands. The women also stated that they had challenges accessing prenatal and post-natal care in their communities.

- **Polygamy** – Most men in the community married several wives, and each woman was sole provider for the children

- **Nutrition** – Providing adequate and nutritious food to the children was a major challenge

Thangatha Unit

Participants:	**15 people**
Average age:	**44.2 years**
Gender breakdown:	**14 women; 1 man**
Average household size:	**6**
Sample of village representation:	**Kiguma, Kiagu, Mukono, Kaathi, Gikoone, amongst others**

This group had a health clinic that was located at the centre. There was nurse, and lab technician that operated at the centre. Basic medical services such as Malaria tests, and other primary health care needs could be accessed here at a subsidized cost. The centre also had a small pharmacy. The nurse stated that when a patient was not able to pay for treatment, they would either subsidize their treatment, or offer it for free. This kind of set up was what almost all the other three communities would ideally like to have.

Some of the challenges identified by this community include**:**

- **Land** – small land holdings, lack of agricultural inputs

- **Health** – affordability was an issue, and when one needed specialized care, accessing such services could be quite cost prohibitive

- **Market and transportation for their crops** – Most of them carried their crops on their backs, or transported them individually to the nearest town rather than selling them each as a group.

- **Water** – most of them had to walk for at least one hour and thirty minutes to the nearest river or spring.

- **Herbal/alternative medicine** – at least 1/3 stated that they did consult herbalists on a regularly

Frontline Community Health Workers

Individuals interviewed

- Ms. Priscilla Lithira - Community Health Worker – Linked to Mikinduri Su-District Hospital
- Ms. Gladys Kanini Community Health Worker – Muthara District Hospital
- Ms. Margarethe Nchebere – Community Health Extension Worker /Nurse – Muthara District Hospital

Summary of Meetings

- All three individuals were trained by Pathfinder International, with support from The AIDS, Population and Health Integrated Assistance (APHIA II) which was an initiative of USAID. Pathfinder International has also provided them with on-going refresher training, food, and training allowance
- The CHWs were selected by their communities to attend the training
- The CHWs are volunteers, while CHEWs are professional nurses or public health officers who receive specialized training to become CHEWs
- They are each attached to a local hospital, a district or sub district hospital. For example, there are 4 CHWs attached to Mikinduri Sub-District Hospital, and they each work in different areas. They report to a CHEW who is located at the sub-district hospital. When they see patients, they fill out referral forms for them, and submit their reports on a monthly basis at their local hospital.

Some of the challenges they identified were:

- lack of uniforms, and badges to identify them as professionals;
- the need formal introductions to the community to enable them to do their work properly,
- tools such as First Aid kids and painkillers in order to do their work well
- CHW also talked about receiving some sort of honorarium, or compensation for their work, and almost all of them are poor, and have to cover huge areas. They also said provision of money for at least lunch, and to provision of transportation would of great help
- They all stated that there is a need to have more CHWs and CHEW's trained in order to offer services to more areas. They also stated they needed to have more ongoing training

Potential role for the CBHC Project:
All three individuals could act as a great resource during recruitment of new CHWs, training, and placements

Ministry of Health Staff

Individuals Interviewed

- District Public Health Officer - Mr. Wario Sala
- District Clinical Officer - Mr. Angelo Kanelie
- Division Public Health Officer in Mikinduri sub District Hospital Mr. Joel Kaberia
- Nurse in charge in Mikinduri sub District Hospital Mr. Daniel Nganga

Key Observations
All individuals interviewed were very enthusiastic about the plan to start a community based health care project as it fit with the Ministry of Health's strategy to reach remote areas, and how

it could help the community access better services. Furthermore it will also act as a great way to get public health information from the communities and as such, better inform the planning process for service delivery.

In terms of where the implementation process of the plan was, they stated that they are currently in the process of hiring 10 more CHEWs at the district level. They also stated that they would like to have more CHWs however currently there were no funds available to recruit and train them. They stated that they are ready to partner with MHCDO to provide training of the CHW, and ongoing support, including supervision of the CHW's. When resources are available, they would also provide uniform, badges, and request bicycles and motorbikes to facilitate their work. Currently, the government is planning to pay the CHEWs, but not the CHWs.

Potential role for the CBHC Project:

- Help with the recruitment process of new CHEWs
- Provide training to the CHW, and on-going refresher training
- Link them up with available support systems i.e. with a CHEW to provide on-going supervision and support
- When possible provision of tools, such as First Aid Kits, uniform, bicycles etc.

Local Hospitals

Individuals Interviewed

- Chaaria Mission Hospital- Dr. Giuseppe Gaido
- Meru General Hospital- Dr. James Gitonga
- Mikinduri Catholic Health Centre- Sr. Alex
- Embu General Hospital- Dr. Charles Muli

Key Observations

Similar to the Ministry of Health staff, all three were keen on seeing the project being implemented. Dr. Gaido, who had met representatives from MCOH on a number of occasions stated that he will be willing to provide some of the training to CHW's, for example on how to screen for Rheumatism, as well as offer his feedback on the training materials, to make sure that it is accessible.

Mikinduri Catholic Health Centre had identified 52 community members to be trained as CHW, however due to lack of resources, the project was not implemented.

Potential Role for the CBHC Project

- Dr, James Gitonga, District Medical Officer of Health at Meru General, would be great person to keep in the loop when the project moved forward
- Dr. Gaido has shown great enthusiasm for this initiative, and has offered to provide specialized training to the CHWs

Local Leadership

Individuals Interviewed

- District Commissioner- Mr. Meru Mwangi
- Chief- Alexander K. Mukindia

Key Observations
They were both familiar with the government strategy, and were keen on having their community members have better access to health service delivery

Potential Role for the CBHC Project
- Chief Alex is a member of the Advisory Board and as such is already engaged
- The District Commissioner, Mr. Mwangi would also be a good person to continue to keep him informed of this initiative

Other Civil Society Partners
- Disability Community Centre – Ms. Jane Muthoni, Community Worker
- Ripples International - Ms. Mercy Ogbonna and Mr. Chidi Ogbonna
- Mr. John Nyaga (previous manager of a CBHC programme)
- Association of People with Disabilities Kenya Embu Branch (Peter Kariuki)

Key Observations
Disability Community Centre (DCC) does currently provide services in Mikinduri, they refer patients to APDK. They work with Disability People's Associations to identify individuals who then receive training to become Disability Support Workers, individuals who will provide care and training for people with disabilities, and training for family members of people with disabilities. They are currently also implementing self-help projects.

Ripples International (RI) is a faith-based organization that is based in Meru, and they provide holistic services to their communities including mobile health clinics. They have just built a paediatric hospital that is currently offering out-patient care. They have one USAID project that is currently based in Mikinduri.

APDK Embu has met with MCOH on a several occasions, and are in communication with the team to provide services for the community in partnership with staff based at Meru General.

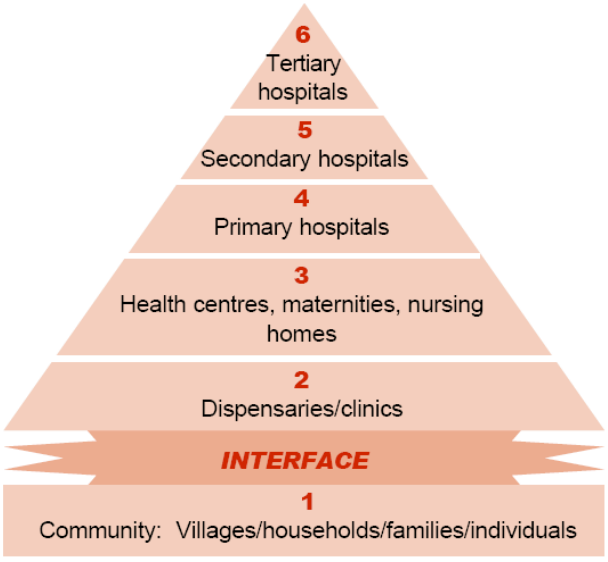
Potential Role for the CBHC Project
- DCC does provide services in Mikinduri, they could be connected with the trained CHW for referral, or can provide cross-training with their Disability Support Workers.
- Ripples International would be a great organization to have a follow-up meeting with, as they have several programs, including their mobile clinics that are staffed by health workers from local hospitals. They were also planning to hold a medical camp in the near future. Their new paediatric hospital could also be a good referral centre.

The concept of "*community based health care*" has a multitude of names, definitions and connotations. The World Health Organization broadly defines Community Home Based Care as "*any form of care given to ill people in their homes. Such care includes physical, psychosocial, palliative and spiritual activities*. "[5] In the face of fractured social systems and dire shortages of health professionals, such models are essential in providing accessible care. However, for these strategies to work, they depend largely on trained community members (i.e. lay-people) to provide direct care. Task shifting – the process of delegating certain tasks (e.g. health promotion, basic first aid, HIV testing, administering treatment, counseling, follow up etc) to less specialized workers in order to expand access to care[6]- is being looked upon as a key approach in addressing health skill shortages. These models have often been utilized within the context of the response to HIV and AIDS in Africa.

The Government of Kenya Ministry of Health (MOH) is operationalizing and expanding these concepts of community-based care using a formal policy framework called the "Community Strategy" where "*households and communities take an active role in health and health-related development issues*"[7].

Overview of Kenyan Health System

In order to grasp the specific plan outlined in the Community Strategy, the context of the Kenyan health system must first be understood. As the illustration on the right indicates, the MOH organizes the provision of services based on a series of levels, 1 through 6, where level one represents the community (villages, households, families and individuals) and level six represents tertiary hospitals (i.e. nation-wide facilities).



Source: Community Strategy Implementation Guidelines for Managers, Government of Kenya Ministry of Health, *2007*

This diagram recognizes that the first line of service delivery is provided at the community level. Indeed, the majority of Kenyan women still give birth without ever reaching a formal health facility- either for prenatal care or delivery. Given this context, community members are essential actors in the health care continuum.

The table on the following page outlines the service delivery matrix by age group (cohort) and level. This provides a useful summary of which tasks can be undertaken by level one service providers (i.e. in the community) and which need to be escalated to subsequent levels (i.e. formal health facilities).

[5] *Community Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002.
[6] WHO
[7] *Community Strategy Implementation Guidelines for Managers,* Government of Kenya Ministry of Health, *2007*

Table 6.3: KEPH service delivery matrix by cohort and level

Cohort	KEPH level 1	KEPH levels 2 and 3
1. Pregnancy and newborn	▪ IEC on early recognition of danger signs; referral ▪ Birth preparedness ▪ Health promotion ▪ Community midwifery	▪ Focused ANC, IPT for malaria ▪ VCT, PMTCT or referral ▪ Basic emergency obstetric care, post-abortion care, referral services ▪ Oversight of CHW services ▪ Maternal death review
2. Early childhood	▪ Behaviour change communication (BCC) to promote key household care practices in prevention, care of the sick child at home, service seeking and compliance, promoting growth and development ▪ Community dialogue and action days ▪ Referral services	▪ Immunization, growth monitoring, treatment of common conditions (pneumonia, malaria, diarrhoea) ▪ Community dialogue ▪ Oversight of CHW services ▪ Essential drugs list ▪ Referral services
3. Late childhood	▪ School enrolment, attendance and support ▪ Support for behaviour formation and good hygiene	▪ Screening for early detection of health problems
4. Adolescence and youth	▪ BCC and IEC ▪ Community-based distribution (CBD) services ▪ Peer education and information ▪ Supply of preventive commodities ▪ Referral services	▪ All basic youth-friendly services, BCC and IEC ▪ Syndromic management of STIs ▪ Lab diagnosis of common infections ▪ Essential drugs list ▪ Referral services ▪ Oversight of CHW services
5. Adulthood	▪ BCC and IEC, community dialogue ▪ CBD services; home care, treatment compliance (TB, ART) ▪ Supply of preventive commodities ▪ Water and sanitation ▪ Referral services ▪ Promotion of gender and health rights	▪ BCC and IEC, VCT, ART and support groups ▪ Syndromic management of STIs ▪ Diagnosis and treatment of common conditions; TB treatment ▪ Essential drugs list ▪ Manage clients' satisfaction ▪ Referral services
6. The elderly	▪ IEC and BCC to reduce harmful practices ▪ Referral services	▪ Advocacy; management and rehabilitation of clinical problems ▪ BCC and IEC ▪ Screening, early detection of disease and referral

Source: Community Strategy Implementation Guidelines for Managers, Government of Kenya Ministry of Health 2007

Based on this matrix, the key tasks that the community will take on at level 1 include information, education, and communication (IEC), referrals, community mobilization, support in accessing social support , and the provision of basic medical care.

Community Strategy

The Community Strategy (CS) represents the MOH's mechanism for delivering all level 1 services. The objectives of the Community Strategy are[8]:

- Providing level 1 services for all cohorts and socioeconomic groups, including the "differently-abled", taking into account their needs and priorities.
- Building the capacity of the community health extension workers (CHEWs) and community health workers (CHWs) to provide services at level 1.
- Strengthening health facility–community linkages through effective decentralization and partnership for the implementation of LEVEL ONE SERVICES.
- Strengthening the community to progressively realize their rights for accessible and quality care and to seek accountability from facility- based health services.

The Community Strategy is a detailed and complex framework (see Annex I). For the purposes of this analysis, the key aspects are as follows (it is important to note that the following list

[8] *Community Strategy Implementation Guidelines for Managers,* Government of Kenya Ministry of Health, *2007*

represents the intended plan. The level of current implementation will be explored in a subsequent section):

- The core of level 1 services will be delivered by specially trained volunteers- called Community Health Workers (CHWs) - that each community will select. Each CHW will be responsible for 20 households and will be "attached" to one specific health facility to which all referrals and reporting will be done.
- CHWs will receive comprehensive, progressive training that is divided into phases[9] with each phase being between 10 – 12 days. This training is provided by the MOH and each CHW will receive a certificate for upon the successful completion of each phase.
- CHWs will be supervised by Community Health Extension Workers (CHEWs). CHEWs are trained professionals (i.e. nurses, public health officers, etc) that are employed by MOH. Each CHEW will be based at a health facility and will supervise 25 CHWs that are linked to that institution.
- To facilitate the work, the MOH will provide CHEWs with motorcycles and CHWs with bicycles. CHWs will also receive a name badge, bag, t-shirt, first aid kit, referral forms, household register, and a file.
- The basis of the Strategy is the "community unit" which is made up of approximately 1,000 households or 5,000 individuals (it is estimated that 5 people reside in the same household). As such, each unit will be served by 50 CHWs and 2 CHEWs.
- The "community health committee" (CHC) is a body that will oversee and guide the health activities within a specific community. This includes identifying health priorities, organizing action, conducting monitoring and evaluation etc. The CHWs report to the CHC through the CHEW. It is expected that the secretary of the committee be a CHEW.

Below is a summary of the functions of the Community Strategy workforce:

Function	Level 1 CHW	Level 1 CHEW	Level 2 In-charge	Level 3 PHO	Divisional PHO	District DHMT
Registers and record keeping	✓					
Report writing	✓	✓	✓	✓	✓	✓
Facilitating HH and comm. dialogue	✓	✓	✓	✓	✓	
Facilitating evidence-based planning		✓	✓	✓	✓	✓
Action monitoring and follow up	✓	✓	✓	✓	✓	✓
Coordinate CHWs activities		✓				
Distribute CHW kits		✓	✓			
Training of CHWs		✓	✓	✓		
Training of CHCs		✓	✓	✓		
Training of level 2 and 3 committees				✓	✓	✓
Supervision and follow up		✓	✓	✓	✓	✓
Training of CHEWs and PHOs					✓	✓

Analysis of Current Status of Community Strategy Implementation

While understanding the theory and concepts behind the Community Strategy is important, it is equally important to analyze the progress of implementation and understand both the practical strengths and challenges in providing accessible, quality health care to all who need it.

The Community Strategy, while arguable overly complicated, prescriptive and bureaucratic, demonstrates a clear plan of action to facilitate accessible health care, including a significant focus on community based health care. It also represents a powerful basis for advocacy and a clear set of standards and commitments that all Kenyans can use to hold the government accountable. Civil society has an important role to play in pushing for the prompt, efficient implementation of the *essential* elements of the Community Strategy (i.e. the aspects that will

[9] It is unclear the number of phases in the CHW training programme. There are 3 phases documented in the CHW Training Manual, however discussions with both the District Public Health Officer and a trained CHW indicated there are 4 phases.

have the most tangible effects on people's lives) and to work towards a common aspiration of an effective, state-led system of accessible health care for all.

As per various meetings with MOH employees, it is clear that there is the political will to implement the plan and some steps have been taken. These include:

- **Training a limited number of CHWs in phases one and two of the training programme**. The District Public Health Officer (DPHO) confirmed that 20 had been trained and an additional 30 were needed.

- **Hiring a limited number of CHEWs**. There are currently a handful of CHEWs on staff at health facilities in Tigania District (including at Muthara Hospital, Mikinduri Hospital, and Meru General). The DPHO also confirmed that interviews were being conducted for an additional 10 CHEWs that should have been on-board by February 1, 2011. It is important to note that at present, the number of CHEWs is not a barrier considering so few CHWs have been trained. At Mikinduri Sub-District Hospital, for example, the one CHEW on staff is managing only 4 trained community health workers that are attached to that facility. As per the Community Strategy, each CHEW has the capacity to supervise 50 CHWs.

- **Some members of community health committees have been selected**, although it is unclear how active the bodies have been.

- **Some openness to work with civil society and international partners.** A great deal of the Community Strategy's implementation to date has been supported or facilitated by international donors and national non-governmental and community-based organizations. Although it is important to note that many civil society stakeholders interviewed expressed frustration at the perceived unwillingness of the MOH to respond to the needs at the community level if they fell outside of the MOH's seemingly rigid annual plan (this was contrasted against the positive feedback received on the Ministry of Agriculture which was very highly regarded on their track record of supporting the community and the work of grassroots organizations). However, the MOH in Tigania District seems quite motivated to move the Community Strategy forward and expressed sincere interest in collaborating with partners.

However, the progressive plan and the modest action cannot divert attention from the long queues at health facilities or the frustration amongst community members. Significant gaps and bottlenecks in the implementation of the Community Strategy have prevented the plan from having a significant impact on people's lives in the communities studied. These gaps include:

- **Difficulty mobilizing community members in order to select CHWs**. By MOH's own calculations, each community unit (i.e. 1000 households) needs 50 CHWs however MOH staff have reported significant challenges in mobilizing the needed numbers of CHWs. By their own account, they admit to their difficulty in reaching the community level, particularly in remote areas. To further highlight the scale of the problem, while some CHWs have been trained up to phase two of the material, to date, no CHW in Tigania has been trained in all phases.

- **Long bureaucratic process to access funds and procure resources**. Although there is a current emphasis being placed on the decentralization of resources and decision-making to the district and community level, there are still significant bureaucratic barriers in accessing promised support. Government systems are painfully slow. For example, the MOH at national level has indicated that motorcycles and bicycles are available to CHEWs and CHWs respectively, yet these resources are extremely difficult to acquire. Even when requests from the district level are approved by the national office, the

timelines are very long. When interviewing MOH staff at the Muthara District Hospital, they were currently experiencing a significant shortage of referral forms which they were waiting for the national office to provide.

- **Resistance amongst health professionals about the types of services that can be provided by community workers**. There exists concern amongst some medical staff regarding shifting any medical responsibilities to the community level. Rather they believed that CHW should only provide information and referrals. While it is true that quality assurance and supervision mechanisms must be in place in order to ensure quality care, many have felt that the reluctance on behalf of medical staff is more due to reluctance to embrace a new system in which community-based care is being encouraged. Since the relationship between the community and the health facility is so critical, this reticence on behalf of the health professionals can weaken a CBHC system.

- **Concern over the upcoming completion of APHIA II**[10] (AIDS, Population and Health Integrated Assistance Project). APHIA II is a programme of the US government that is credited with pushing forward much of the Community Strategy to date. It was through APHIA II that the CHWs were able to be trained and provided with tools such as kits, t-shirts, badges, etc. APHIA II is set to wind down in March 2011. It is unclear about what will happen once it is completed, but there have been unconfirmed accounts that there will be a new programme called APHIA +. It is also unknown what, if any, further support a fund (if it indeed comes to fruition) would provide to the Community Strategy so there is concern that the momentum of the MOH's action may be jeopardized.

It is essential that MHCDO/MCOH understand Kenyan Ministry of Health priorities and the Community Strategy both in order to navigate the system and to ensure that any programmatic decisions/planning related to the provision of health related services strengthen existing structures. This is the most strategic approach in order to make the most effective use of resources and to develop sustainable interventions that serve to enhance local support mechanisms.

[10] "The APHIA II framework is designed to contribute substantively to the United States Government (USG) and Government of Kenya (GOK) goals in HIV and AIDS, TB, and to a more limited extent, Reproductive Health/Family Planning (RH/FP), malaria and maternal and child health (Maternal Child Health). The activity objective of APHIA II is Healthier behaviors and increased use of high quality HIV/AIDS, RH/FP and MCH services." APHIA II Kenya, www.aphia2kenya.org/

One of the original deliverables guiding this project was to assess the community's readiness to take a community based health care programme forward. Certainly, everyone is "ready" to be healthier and indeed has the right to access a health system that responds to his or her needs. This was confirmed via focused group discussions (as outlined in earlier sections of this report) where communities surveyed listed quality, accessible health care as one of their top priority needs.

This analysis therefore focuses on two, more salient, questions:

1. Is community-based health care an appropriate model to meet the identified needs of the Mikinduri community?
2. Is community-based health care a priority for MHCDO/MCOH?

Is community-based health care an appropriate model to meet the identified needs of the community?

It is the assessment of this analysis that **yes, community based health care is an appropriate model** to meet the needs in the community.

- **Strong community support for the model[11].** One of the objectives of the 4 focus group discussions was to gain insight into the community's feelings towards the concept of CBHC. Each of the four communities surveyed were enthusiastic in their support for the nature of the model. This is extremely important as it is essential for the community to own the establishment of a CBHC programme.

- **Represents an efficient and cost-effective model to provide accessible, quality health care, particularly in rural areas[12].** During the focus group discussions, transportation and cost were reported as the greatest barriers to accessing health services. A well-designed, holistic CBHC programme effectively addresses both of these issues. As a model, CBHC can work to 1) identify people who otherwise would not enter the formal health care system whether due to distance, poverty, lack of awareness, or apathy 2) Facilitate/encourage health seeking behaviour by giving relevant health information, identifying illnesses, assisting with follow up (e.g. treatment adherence, monitoring status, etc) 3) Support access to health services/facilities by providing basic care in the home, referring patients to the appropriate facility, assisting patients navigate the formal health system, advocating for the best possible patient care.

- **Works with the way that people are already accessing health services**. Families and communities have traditionally been the first mechanism for health and social support. Embracing a structured CBHC approach therefore builds upon existing capacities and integrates training and supervision to ensure that the best possible care is provided. It also provides care that is both culturally and linguistically relevant,

- **In line with existing Ministry of Health priorities.** There is a great deal of momentum and political support for CBHC. Specifically in Tigania District, the District Public Health Officer was very keen to work with partners to move the Community Strategy forward.

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[11] "It is important that community members view CHBC as being part of the overall care and well-being of the community. Members of the CHBC team can help to promote this community ownership by consistently involving community members and organizations in the planning and by raising community awareness of CHBC." C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002.

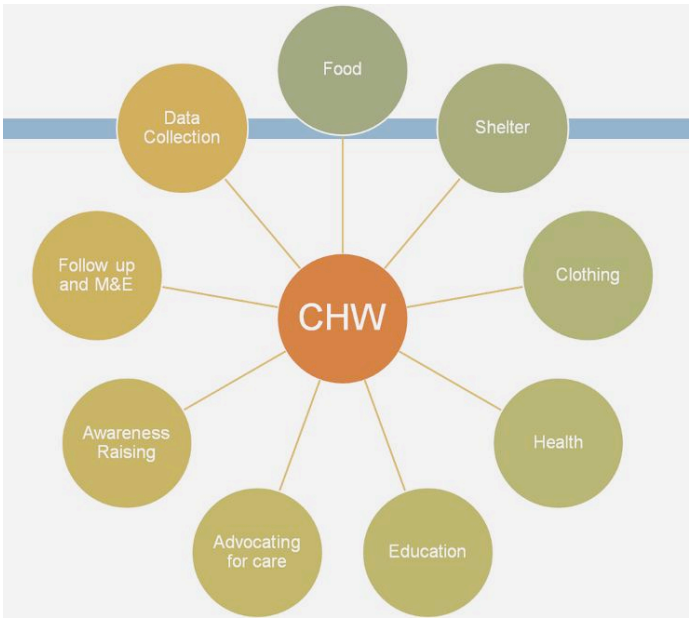
[12] "It is possible to *build capacity at village level to manage community-based activities* effectively. Communities can be organized into functional units such as villages or sub-locations that are linked to or part of the legal structures of the country, for effective action for health." *Community Strategy* Government of Kenya Ministry of Health, 2007

This speaks to a great opportunity for community based actors to lend their efforts towards promoting a future with a sustainable, government-run health care system that meets patient's needs.

- **Creates a systematic means for community-based data collection**. CBHC represents an immense opportunity to form a robust data collection mechanism at the household level, particularly in the rural areas. This data will augment and enhance planning, decision-making, resource allocation and advocacy and can result in stronger provision of health and social services. Through this data, CBHC can also push the formal health care system to better respond to the needs at the community level.

Is community-based health care a priority for MHCDO/MCOH?

It is the assessment of this analysis that **yes, CBHC is a priority for MHCDO/MCOH, but it must go beyond health care**. Health status is determined by a multitude of different factors including poverty, nutrition, shelter, gender, etc; which demands that a CBHC system integrate a multitude of support. As the WHO, Africa Region states: "*health inequities and inequalities…contribute disproportionately to high incidences of preventable illness, disability and premature deaths across population groups particularly the poor, women, children, elderly and displaced populations. As these determinants of health exist outside the Health domain, multisectoral and interdisciplinary approaches are required.*"[13]



For a CBHC programme to be a priority for MHCDO/MCOH, it must be well-supported and recognize the multidimensional role of the CHW as the fulcrum for support at the household level[14]. CHWs build relationships with each of the households in their care and they will seek out available support: medical care, counseling, food, clothing, school fees, etc. Based on their understanding of the circumstances of each household, CHWs 'customise' their messages and address risky behaviour. They will help explain often confusing and hastily prescribed drug regimens. Often a CHW is the only one who will take action on behalf of a child-headed household, or when they observe a grandmother struggling to care for young grandchildren upon the loss of her own child. They will push through the deadly bureaucracies of health facilities to advocate for patient care. It is the CHW that will take on complex issues of harmful cultural practices and initiate community dialogues in homes, churches, schools, and markets.

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[13] *Social and Economic Determinants of Health*, WHO Regional Office for Africa www.afro.who.int/en/clusters-a-programmes/hpr/social-a-economic-determinants-of-health.html

[14] Community volunteers usually form the backbone of the CHBC team. Volunteers usually have clearly defined responsibilities that include visiting ill people and families regularly, providing basic nursing and palliative care, finding cases, providing emotional and spiritual support, providing nutritional advice, referring ill people and families, educating ill people and families and arranging for ill people and families to receive welfare support such as food, blankets, clothing, transport and assistance with funerals. These volunteers also carry out practical jobs such as cooking, cleaning, washing and fetching water and firewood. C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002.

For MHCDO/MCOH, developing a holistic CBHC programme that recognizes and mobilizes a cadre of committed and supported CHWs and other community-based practitioners (coordinators, nurses, social workers, etc) can have a powerful impact on strengthening the organization's work and help fulfill its to mission *to help relieve the effects of poverty and provide appropriate resources and knowledge to assist the people of Kenya to help themselves*. Specifically, a CBHC programme could provide MHCDO/MCOH with mechanisms for:

- **Enhanced ability to provide holistic support to the most vulnerable.** CHWs are incredibly insightful "eyes and ears" on the ground ensuring that project support is going to the right place. They also have the added capacity to understand the full spectrum of needs within the home. They will not only see the ill person, but also the child who is unable to attend school, the roof that is leaking, etc. In this regard, the CHW can work to address the priority needs and assist to coordinate care[15]. CHWs can also inform the organization where acute needs exist. This feedback loop will strengthen the organization's ability to provide holistic care where it is most needed.

- **Better link between the community and organizational programme implementation**. CHW's work in the communities in which they live. In fact, the Community Strategy lists "permanent residence" in a community as one of the criteria for selection. If CHWs are meaningfully integrated into the decision-making and planning functions of the organization, MHCDO/MCOH can benefit from their insight and knowledge to design and deliver more effective project interventions.

- **Enhanced data collection, monitoring and evaluation (M&E), and follow-up**. Since CHW's work within the household level, they have a unique ability to collect data and conduct ongoing follow up and M&E. This is extremely useful in measuring the impact of project activities, tracking the progress of beneficiaries, and planning future interventions as a result of evidence-based analysis. This is particularly important for MHCDO/MCOH because the project area includes rural and remote areas which so rarely become the focus of data gathering activities.

- **More effective use of resources**. CBHC can enhance the way in which MHCDO/MCOH allocates resources in numerous ways. First, the more strategic information that is known about a community and its needs, the more effective interventions can be designed and executed. This has the power to make service planning and delivery across MHCDO/MCOH programmes more efficient and effective. Also, specific activities such as the annual medical camps can be practically supported by a CBHC programme. CHWs in the community will have first-hand knowledge of need and will be able to sign community members up without them having to travel to the office. CHWs can also reach those who are acutely vulnerable but who may not know about or be able to access the camps. CHWs will also be working year round to ensure that people can access support on an ongoing basis, and not simply wait for the camp to begin. This way the resources of the camp can be better focused on those who have the greatest need.

[15] People with chronic illnesses will most likely also access different services. These services are usually organized through vertical programmes, and coordination between these services is rare. As a result, ill people and family members often go from one service to another, and the records of these visits stay within the service. Although the CHBC team cannot be responsible for the overall coordination of services, a member of the CHBC team may be able to take the role of managing cases and coordinating care of ill people. This would help to avoid gaps or duplication in the care of ill people and families. C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002.

- **More informed and strategic advocacy** that is linked directly to grassroots priorities. With closer connections to the community comes a greater ability and stronger responsibility to engage in advocacy to create systemic change. This ensures that project activities do not serve to undermine efforts for government accountability or other domestic or international structural change.

Role of MHCDO/MCOH within a CBHC Programme

The MOH's Community Strategy is a clear framework from which to begin identifying which roles are a priority for MHCDO/MCOH; which are strategic; which are sustainable; and which serve to address gaps (i.e. strengthening services versus creating them). In this sense, MHCDO/MCOH would not create a parallel system from scratch. Rather it would work with existing stakeholders to strengthen the framework that is in place.

- **Facilitating selection of CHWs**: It is critical that the selection of the CHWs remain solely in the hands of the community members[16]. MHCDO/MCOH can facilitate this by working with local leaders (chiefs, assistant chiefs, etc) in the project areas to organize meetings/barazas in order to select CHWs. MOH should also be involved/aware of this process as CHWs will need to be registered, trained, and attached to a health facility.

- **Facilitating training and ongoing refreshers:** The MOH is committed to providing trainers and materials; however they struggle with organizing the training sessions and mobilizing CHWs. Once MHCDO/MCOH has worked with the community to identify CHWs, they can facilitate training by booking venue, organizing transportation, food, etc and then making a request to the MOH to provide the trainers. Note that the MOH may request an amount for "daily sustenance" for the trainers. MHCDO/MCOH can and should also bring CHWs together regularly (e.g. monthly) to gather reports and provide ongoing opportunities for skill-building. Training is one of most important motivators that an organization can provide to a CHW.

- **Mobilizing and supporting existing CHWs:** Donors such as Samaritan's Purse and Pathfinder International have already trained existing CHW's. Pathfinder has been bringing together all of the CHWs in the region (100 in the district of which 4 are from the Mikinduri area and 16 from Muthara according to one interviewee) together every 2 months to debrief and share reports. These bi-monthly meetings were greatly valued, however will no longer be convened. The CHWs from Mikinduri could be mobilized and supported within an MHCDO/MCOH programme.

- **Leverage programmes for more holistic support:** CBHC can support MHCDO/MCOH programmes by, for example, informing where future water or farming projects may be planned. CBHC can also be strengthened by the ability to provide food/farming support or water to vulnerable households.

- **Provide tools to do the work**: CHWs must be provided with tools to do their work. These include such things as bicycles, umbrellas, rubber boots, uniforms, CBHC kits[17],

[16] To the extent possible CHWs should be accepted by the whole community as they are the link-pin between the household system and the health system. It is therefore critical that the community be briefed on the functions of the CHW to enable them to select persons who can work effectively with them in promotion of good health among households. *Community Strategy* Government of Kenya Ministry of Health, 2007

[17] "Decisions about basic supplies and equipment should be based on priority needs. The priorities depend on the availability of funds and on the health care needs of ill people. Most countries have a national list of essential drugs. In addition, there is usually a list of necessary drugs to treat illnesses most prevalent in the community. For example, health centres may have pain medication, basic treatment for opportunistic infections, tuberculosis medication and

referral forms, files and pencils. Not only does this create a supportive environment to provide the best possible care, but it will also serve to motivate the CHW to remain committed to the organization over the longer term.

- **Strengthening referral networks:** MHCDO/MCOH can play an important role in building relationships with service providers in the Mikinduri area. This networking is essential in order to facilitate and coordinate care and reduce duplication. These referral networks must be driven by the needs of the community.

- **Providing supervision to ensure quality care**: While the MOH has a system in place to supervise CHW (i.e. through the CHEW and the Community Health Committee), MHCDO/MCOH could help provide an added layer of oversight and expertise.

- **Advocacy:** Within a CBHC system, MHCDO/MCOH could advocate for a variety of issues such as:
    - **Faster implementation of Community Strategy**: This is essential to ensure that MHCDO/MCOH efforts are working towards a goal of an effective, *state-led* health care system that is accessible to all.

    - **More streamlined referral networks**: Currently a CHW worker must refer all cases to the health facility to which they are attached. This creates a needless, potentially deadly bureaucracy when the CHW knows that the services needed are not offered at that facility. For example, if a CHW in Mikinduri has a patient that needs to be admitted to hospital, the current system states that she must refer that patient to Mikinduri Hospital (which does not have an in-patient ward) even if she knows that they will simply refer the patient on to Meru General (the closest in-patient facility). The CHW cannot provide the referral to Meru General directly.

    - **Additional resources from national and international partners**: MHCDO/MCOH can call for increased domestic and international support for community based care. These efforts can be focused on national sources such as Community Development Fund and/or through advocating for the continued support of international partners such as USAID (though the continued work of APHIA or another programme) or the Global Fund, amongst others.

Assets of MHCDO/MCOH to Establish a CBHC Programme

MHCDO/MCOH is well placed to launch a CBHC Programme due to:

- **Engaged leadership** both in Canada and in Mikinduri that are committed to the concepts and values of grassroots-led community based health care.

- **Motivated, passionate, and skilled local staff**. Communities and stakeholders who were surveyed during this analysis spoke in a common voice highlighting the importance of staff who were familiar with the local language, customs, and traditions. MHCDO/MCOH is therefore well equipped with capable, committed staff who are from the project area.

- **History in the area**: MHCDO/MCOH has been operating formally in Mikinduri since 2003. It has a track record of results and activities with the community.

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some treatments for prevention (such as TB and HIV*)."* C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002.

- **Complementary programmatic work**: As mentioned above, CBHC demands a multidisciplinary approach. MHCDO/MCOH's existing programmes could both benefit from and support a CBHC programme.

Potential Key Organisational Partners in Tigania District for a CBHC Programme

Partnerships are an essential component of a holistic and effective CBHC programme, however partners cannot drive MHCDO/MCOH's community-based health care programme forward. Rather, the partnerships must be formed based on the community's needs.

When interviewing stakeholders regarding key criteria for partnerships, four characteristics emerged:

- Compatible philosophy of care
- Senior leadership support for partnerships
- Complementary service offerings
- Collaborative spirit of openness, trust, honesty, and commitment

This is echoed by the WHO: *To avoid fragmentation and to ensure the coherence of all health and home-based care within the health system, collaboration should be based on trust, responsiveness and openness and clearly indicate the objectives sought, the commitment of each party and how these commitments are to be respected*[18].

Using this knowledge as a foundation, the following chart summarizes a number of potential partners that were identified with which MHCDO/MCOH may wish to explore more formal relationships should a CBHC programme become a reality.

Key Role	Organization
Existing Knowledge and Practice	Trained CHWs and CHEWs
Key Clinical Partners	Sub-District Hospital, Mikinduri District Hospital Muthara Meru General Hospital Chaaria Hospital
Key Educational Partners	Ministry of Health Chaaria Hospital APDK
Potential Educational/Clinical Partners	APDK, Embu Hospital, AMREF, Ripples International, Disability Community Centre, Mikinduri Catholic Health Centre
Political Leadership	District Commissioner Chiefs and Assistant Chiefs

[18] *The role of contractual arrangements in improving health systems' performance,* World Health Organization, 2002

Key Enablers

While all of the stakeholders interviewed were insightful and important, a handful stood out as *key enablers* if a CBHC programme were to be established. These people seemed incredibly motivated and willing to take active roles to support a new programme:

- Mr. Wario Sala, District Public Health Officer
- Mr. Joel Kaberia, Division Public Health Officer
- Dr. Giuseppe Gaido, Chaaria Mission Hospital
- MHCDO Staff
-

PART SIX: KEY LEARNING ON CBHC PRACTICE RELEVANT TO THE MIKINDURI AREA

There is a large and growing body of research and analysis on community based care structures. There is a consensus that such models are essential in addressing health skill shortages.

Based on the focus group discussions conducted, the impact of CBHC in the Mikinduri area to date has been minimal. Many participants had heard of the system, but had not had a direct experience with a CHW. This outline of key learning therefore seeks to provide some guidance on developing a CBHC programme that responds to the specific context, needs, and concerns of the Mikinduri area. The following consolidates information from both the primary research done during this project and the broader body of knowledge. The first-hand experiences of frontline practitioners such as Priscilla Lithira (trained CHW), Gladys Kanini (CHW), Margarethe Nchebere (CHEW), Jane Muthoni (Disability Community Worker) combined with the insights from community members surveyed in Mikinduri, Kinwe, Kagwuru, and Thangatha were all precisely reflected in the secondary research.

- **Community needs must drive community-based health care programmes**[19]**.** It is essential for the community to see their priorities and aspirations at the core of a CBHC programme. It must be a programme that they own and drive. Communities must also be engaged in the process of selecting CHWs and being informed of the training that CHWs receive so that the can feel confident in the care they are accessing and the people they welcome into their homes[20]. Simple things like uniforms and badges also reassure the community regarding the legitimacy of care work.

- **Start slow, with the resources available**[21]**.** It is easy to get overwhelmed by the various dimensions required within holistic community-based health care programme. However, starting slow with what an organization has provides the chance to develop expertise, form partnerships, mobilize additional resources, and learn valuable lessons.

[19] "The goals and objectives for the CHBC programme should be based on the identified priority needs of the target group and the broader community. The goal for CHBC should reflect the norms, values and philosophy identified by community and agency representatives in the planning phase. Once the overall goal or mission statement has been created, then specific objectives for CHBC can be developed. These objectives should include the priority needs of the target group as well as those of the broader community." C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002.

[20] ''It is important that community members view CHBC as being part of the overall care and well-being of the community. Members of the CHBC team can help to promote this community ownership by consistently involving community members and organizations in the planning and by raising community awareness of CHBC". C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002.

[21] ''The philosophy of starting easy is useful. Start with resources that are available, affordable and accessible for CHBC. Then, based on the needs assessment, set priorities among the needs and develop a plan to implement these resources." C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002.

Piloting a new CBHC programme in a small area before expanding widely is a useful approach.

- **Expectations need to be clearly articulated:** CHW is serious work and it is essential that during the initial orientation, selection, and training phases of the process that expectations are clearly laid out. This includes the scope of the work, the expected time commitment, and the incentives provided.

- **CHW's are resoundingly middle aged, economically disadvantaged women**. CHWs are recruited from communities, so the line between worker and beneficiary can be blurred. A recent study conducted of community health workers in 13 countries across Sub-Saharan Africa found that "*more than two-thirds of volunteers surveyed were [women] between 30 and 49 years old, ages when a woman usually has significant responsibilities in terms of her children and family*.[22]" This context is important to understand the unequal burden of care work on women- both within the family and the community. Thus, a pro-active approach to women's rights and gender equality are essential elements of CBHC. This includes tackling the underlying factors that sustain gender inequality by creating responses (either directly or through partnerships/referrals) to livelihoods, violence, abuse, rape, exploitation, family planning, sexual and reproductive health, and harmful cultural practices that plague communities. It also points to the challenges of expecting CHWs to engage in this work without incentives or compensation, given their substantial household responsibilities and economic difficulties.

- **Compensation for CHW must be carefully considered**. While there is no doubt that the spirit of volunteerism and community ownership holds African communities together, a clear distinction needs be made between a "volunteer" and an unpaid worker. Across Africa community health workers do full-time work with little or no pay, sometimes distributing food support and care to needy clients when their own families go without. The Community Strategy is based on community health workers being volunteers; however the MOH acknowledges that incentives are essential to keep staff motivated. It also suggests "organizing [CHW] work into fixed number of days in a quarter/year, beyond which they must be financially compensated"[23]. This approach is confirmed by the WHO: "*Countries should recognize essential health services cannot be provided by people working on a voluntary basis if they are to be sustainable. While volunteers make a valuable contribution on a short-term or part-time basis, trained health workers who are providing essential health services, including community health workers, should receive adequate wages and/or other appropriate and commensurate incentives*."[24] Incentives are absolutely essential, however, there can be destructive effects on the strength of CBHC programmes when stipends are provided and then taken away. It is important to think creatively and sustainably about how to incentivize the work, whether through cash stipend or non-cash incentives such as access to income generating activities, preference for paid work, free access to health care, farm inputs/gardens, training, uniforms, tools, etc.

- **Support supervision is critical to ensure quality care.** CBHC must represent a model where communities receive quality care from well-trained individuals. Fundamental to the model is a system where a CHW is able to identify when a patient demands care beyond her capacity and when there is a qualified supervisor to which she can provide a

[22] *Valuing and Compensating Caregivers for their Contributions to Community Health and Development in the Context of HIV and AIDS: An Agenda for Action*, Huairou Commission, 2010

[23] *Community Strategy Implementation Guidelines for Managers*, Government of Kenya Ministry of Health, 2007

[24] Recommendation 14, *Task shifting, Global Recommendations and Guidelines*, WHO, PEPFAR and UNAIDS, 2007

referral. Support supervision also includes mechanisms to evaluate skills for all members of the CBHC team on an ongoing basis.[25]

- **Partnerships are essential.** It is not realistic for one organization to meet all household needs. Referrals and partnerships are necessary for providing quality service. Nurturing partnerships can often be challenging within an environment that often promotes isolation and competition. Organizations must be prepared to spend time and resources to build and nurture strong referral networks.[26]

- **The scope of care work is expanding.** The demands being placed on CHWs within vulnerable households is expanding. Support to orphan and vulnerable children, providing guidance on treatment adherence, identifying illnesses and warning signs, providing psychosocial support, bereavement, and palliative care. Training must prepare CHWs for the demands that they will face at the household level.

- **Care for carers**: Care work is difficult: physically, emotionally, and financially draining for those who do it. "*Family caregivers and members of the CHBC team frequently experience burnout. Burnout is a result of excessive emotional and physical strain without the necessary care to support the caregiver. This leads to excessive fatigue, poor motivation, anxiety and depression. Building in support sessions, ensuring recreational breaks and rotating staff help to reduce burnout. In addition, friends, spiritual leaders, neighbours and community volunteers can provide support to help ill people and family caregivers*".[27]

- **In-patient care is important.** The most successful programmes have access to and the assistance of an in-patient unit (a hospice, hospital or respite facility), either directly or through defined referral networks. This is important because not all illnesses can be adequately addressed within the home. The capacity for in-patient care, particularly in emergency settings, is essential. It is also psychologically very reassuring for ill patients to know that there is another level of more intensive support should they need it. In-patient care also has the indirect benefit of providing some measure of restorative time for household caregivers who are exhausted and under immense stress.

- **Transportation and ambulatory care must be addressed.** Transportation is one of the most critical challenges for households and CHWs within Mikinduri (indeed across the continent). Vehicles and bicycles are essential tools to enable CHWs to reach deep into rural areas. When clients in remote or underserved communities need to get to hospital, they often lack access to scarce ambulance services, are refused public transit or cannot afford it. In rural areas, bicycles do not solve all transport problems when unpaved roads are muddy or otherwise impassable, but they do expand the scope, reach, safety, and effectiveness of care workers who can use them. When roads are treacherous or distances are extensive, vehicles are necessary.

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[25] "Supportive supervision and clinical mentoring should be regularly provided to all health workers within the structure and functions of health teams. Individuals who are tasked with providing supportive supervision or clinical mentoring to health workers to whom tasks are being shifted should themselves be competent and have appropriate supervisory skills". Recommendation 11, *Task shifting, Global Recommendations and Guidelines*, WHO, PEPFAR and UNAIDS, 2007

[26] General agreements should also be made on how [organizations] will partner and communicate with one another. Thus, the roles, responsibilities and types of communication should be determined and partnership agreements made at the onset of planning a CHBC programme. Establishing and maintaining relationships between organizations (especially public and private) as well as between sectors can be challenging and staff intensive, requiring diplomacy and frequent communication. C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002.

[27] C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002.

PART SEVEN: LIMITATIONS OF RESEARCH AND RECOMMENDATIONS FOR FURTHER RESEARCH

It is felt that this research has provided an accurate representation of the community needs. However, it is important to note some key limitations:

- **Time and budget**: Due to time and budget constraints, the planning phase and in-country component were limited.

- **Language**: One of the consultants is fluent in Swahili, this was a significant facilitator of the data collection. When interacting with groups who were unable to communicate in Swahili, there always presents the risk that the nuances of the feelings are "lost in translation". This was mitigated by the solid translation assistance provided by MHCDO staff.

- **Demographics of the focus groups**: This work only focused on communities that were already recipients of services offered by either MHCDO or Chalice. This facilitated the research because, due to the tight timelines, these groups were already mobilized and met on a regular basis. They also knew each other and thus seemed to feel comfortable speaking frankly about their lives and opinions. However, because they were all benefiting from the sponsorship programme, they were all receiving some essential household support. While this can be a valid representation of beneficiaries of MHCDO/Chalice, they do not necessarily represent all the community members that live in the area. It should therefore be kept in mind that it is likely that the group surveyed was less vulnerable than others in the community who receive no outside support.

Recommendations for Further Research

It is felt that MHCDO/MCOH can proceed with the current level of knowledge and consultation, and thus further research is not recommended before action is taken regarding the establishment of a community-based health care programme. A CBHC programme could also represent a powerful opportunity for action research led by CHWs within the community.

However, future research can be conducted in the following areas:

- Conduct a needs assessment of broader community members (i.e. beyond current MHCDO/MCOH beneficiaries)
- Deeper analysis on gender issues in order to infuse locally relevant programmes to address the special needs of women and girls
- Examine the stigma and discrimination of HIV/AIDS with in the Mikinduri area
- Conduct a formal evaluation of MHCDO/MCOH programmes to date
- Individual case studies/profiles of clients served by the CBHC programme

PART EIGHT: OVERALL RECOMMENDATIONS

Based on the momentum on the ground, and consolidating all of the groundwork that has been done to gather information about the community-based heath care project, the following actions are recommended:

- **Read and be intimately familiar with the Ministry of Health's Community Strategy and National Health Sector Strategic Plan (NHSSP) II.** It is essential that MHCDO/MCOH are well-versed in the strategic priorities of the Ministry of Health so that programmatic and advocacy platforms be focused on strengthening existing efforts as opposed to creating new, parallel systems. The Community Strategy is particularly relevant for establishing a community-based health care programme.

- **Establish a sub-committee of the Advisory Committee/Board with some expertise in community-based health care that will focus on establishing a CBHC programme.** The role of this committee would be to develop a programmatic strategic plan for CBHC in consultation with key community representatives. This committee should be comprised of individuals residing in Mikinduri and Canada. There should be solid expertise regarding CBHC. Ideally this programmatic strategic plan would be linked with a 3-4 year internal strategic plan for the organization as a whole; however, the development of this strategic plan should not hold back the work of the CHBC sub-committee or the community level action. The needs of vulnerable households are urgent.

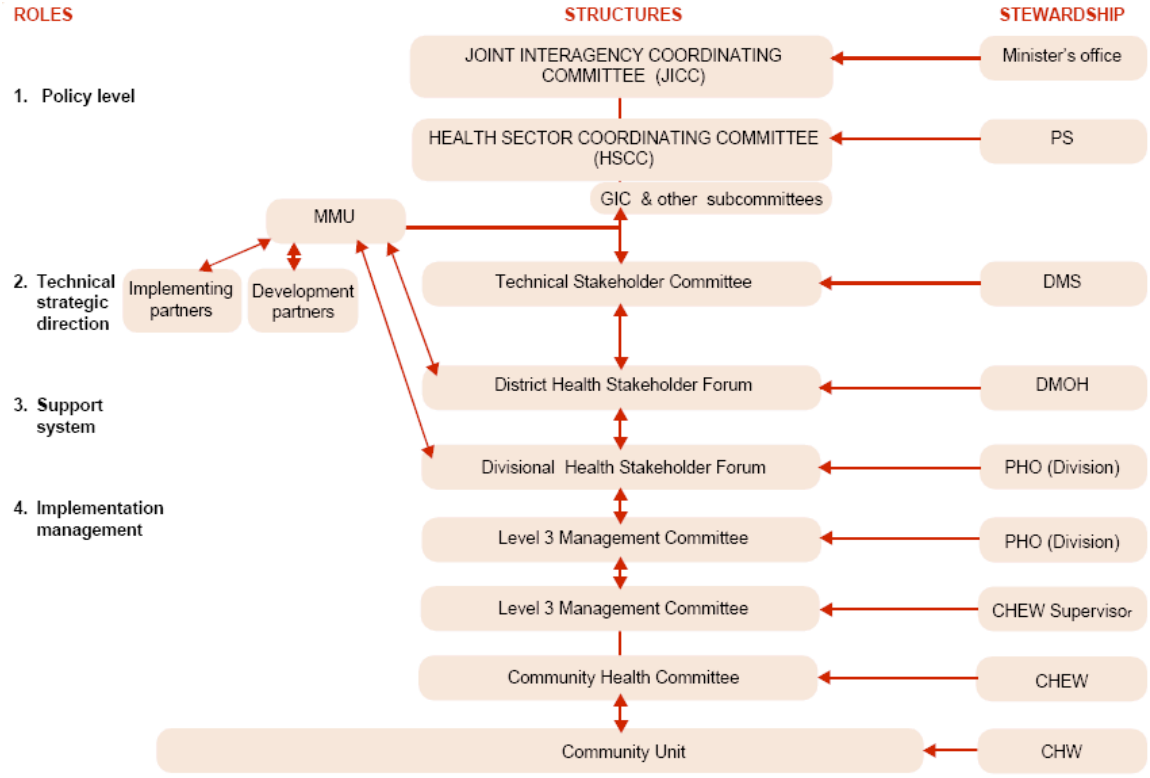
- **Hire a project coordinator, based on the skills set identified in the CBHC plan.** It is a substantial amount of work to coordinate the establishment of a CBHC programme. While existing staff are very enthusiastic about the programme, and would likely be capable to do the work, it would be very challenging for them to be able to take this on in addition to their current workloads. It is recommended that MHCDO/MCOH hire a dedicated project coordinator who has the necessary competencies, is passionate about CBHC, and committed to empowering the community.

- **Present CBHC plan to the community.** It is essential for the community to validate whatever plan the sub-committee develops. It is very important that this consultation is conducted with the groups that took part in this situational analysis **and** the broader community (i.e. through a baraza or other mass community forum). For the groups that participated in this research, they must feel confident that sharing their needs and challenges with MHCDO/MCOH will lead to action in a timely way. This will encourage them to continue sharing their needs, knowing that it will contribute to tangible results. Additionally, it is acknowledged that the groups engaged for the focus group discussions are currently receiving some level of essential support through the Chalice/MCOH sponsorship programme. Thus, it stands to reason that there are many households in more urgent need. All people, with a special attention to the most vulnerable of the vulnerable, must be actively engaged in validating any programme that is developed.

- **Develop partnerships as driven by the priorities and needs outlined in the programme strategic plan.** Partnerships cannot drive the service offering of CBHC. Rather, partnerships must come as a direct result of the community needs. Once a CBHC plan has been developed and validated by the community, it then becomes very clear what partnerships/networks are needed. This will ensure that the network of partnerships serves to strengthen the CBHC programme to meet the priority needs of the community. Without this strategic partnership development, one risks being pulled off course or in multiple different directions due to the varying objectives of other entities.

- **Pilot a project in a defined area, evaluate the results, integrate lessons learned and expand as needed**. It is recommended that MHCDO/MCOH starts small with the resource available before rolling out to all project areas. This will afford the time needed to learn important lessons, refine the programme, develop systems, and build a track record of service provision. This will also strengthen future resource mobilization efforts as requests can be made based on evidence-based experience. It is recommended that communities participate in selecting the pilot location(s) so that they can feel invested in the outcome.

Annex I: Health Sector Coordinating Structure



Annex II: Essential Elements of CHBC

Source: C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002

Table 2. Essential elements of CHBC

Category	Subcategory
Provision of care	Basic physical care Palliative care Psychosocial support and counselling Care of affected and infected children
Continuum of care	Accessibility Continuity of care Knowledge of community resources Accessing other forms of community care Community coordination Record-keeping for ill people Case-finding Case management
Education	Curriculum development Educational management and curriculum delivery Outreach Education to reduce stigma Mass media involvement Evaluation of education
Supplies and equipment	Location of the CHBC team Health centre supplies Management, monitoring and record-keeping Home-based care kits
Staffing	Supervising and coordinating CHBC Recruitment Retaining staff
Financing and sustainability	Budget and finance management Technical support Community funding Encouraging volunteers Pooling resources Out-of-pocket payments Free services
Monitoring and evaluation	Quality assurance Quality of care indicators Monitoring and supervision Informal evaluation Formal evaluation Flexibility

Annex III: Recommended Reading

Four main documents were cited in this report, although many more were reviewed during the analysis. These are highly recommended, comprehensive, evidence-based resources to understand community-based health care.

- *Community Strategy Implementation Guidelines for Managers,* Government of Kenya Ministry of Health, *2007*
- C*ommunity Home-based care in Resource-Poor Settings, A Framework for Action*, WHO, 2002
- *Task shifting, Global Recommendations and Guidelines*, WHO, PEPFAR and UNAIDS, 2007
- *Valuing and Compensating Caregivers for their Contributions to Community Health and Development in the Context of HIV and AIDS: An Agenda for Action*, Huairou Commission, 2010

Annex IV: Overview of Meetings with Stakeholders and Community Groups: January 17 - 29, 2011

Date of Meeting	Name	Position	Organisation	Meeting Location	Phone Number
18-Jan-11	Antony Karigia	Program Manager	MHCDO	MHCDO/Chalice Office	
18-Jan-11	Cynthia	Manager	Chalice	MHCDO/Chalice Office	
18-Jan-11	Jane Lucy Muthoni	Comm. Worker	Disability Community Center	MHCDO/Chalice Office	72349676
18-Jan-11	Fr. Bernard; Alex	Advisory Committee Chair; Committee Secretary	MHCDO	Fr. Bernard's Parish	
19-Jan-11	Board	all Except Rose and Joseph	MHCDO	Fr. Bernard's Parish	
21-Jan-11	Dr. Giuseppe Gaido	Medical Director	Chaaria	Chaaria Hospital	
21-Jan-11	Priscilla Lithira	CHW	MHCDO	MHCDO/Chalice Office	
24-Jan-11	Wario Sala	DPHO	Muthara District Hospital	Muthara District Hospital	
24-Jan-11	Angelo Kanelia	DCO	Muthara District Hospital	Muthara District Hospital	724978994
24-Jan-11	Margareth Nchebere	CHEW/Nurse	Muthara District Hospital	Muthara District Hospital	720944886
24-Jan-11	Gladys Kanini	CHW	Muthara District Hospital/Kitharene	Muthara District Hospital	724114994
24-Jan-11	Meru Mwangi	Dist. Comm.	Tigania East	DC office	
25-Jan-11	Joel Kiberia	Div.PHO	Mikinduri Sub-District Hospital	Mikinduri Sub-District Hospital	
25-Jan-11	Daniel Nganga	Nurse	Mikinduri Sub-District Hospital	Mikinduri Sub-District Hospital	
25-Jan-11	Kinwe Group		Focus Group	Kinwe Feeding Centre	
25-Jan-11	Mik. Group		Focus Group	Kinwe Feeding Centre	
26-Jan-11	Kaguuru Group		Focus Group	Kaguuru School	
26-Jan-11	Sr. Alex		Mikinduri Catholic Health Centre	Mikinduri Catholic Health Centre	
27-Jan-11	Dr. Gitonga	DMOH	Meru General Hospital	Meru General Hospital	
27-Jan-11	Thangatha Group		Focus Group	Kamujine Farm	
27-Jan-11	John Nyaga	Former head of Tharaka Primary Health Care Centre	Consolata Hospital Nkubu - Administrator		Fr. Bernard's Cousin
28-Jan-11	Peter Kariuki	Dir. APDK Embu Branch	APDK Embu Branch	Embu Hospital - APDK Office	
28-Jan-11	Dr. Charles Muli	DMOH	Embu Hospital	Embu Hospital	

Annex V: Question for the Community Focus Groups

Expected outcomes:

a) To Establish profile of the community
b) To determine health and development needs of the community
c) To assess their readiness/willingness
d) Conduct in-depth one on one – to understand community profile better

Community Profile

1. How would you describe your community to someone from outside?
2. What are the good things about living in this community (i.e. strengths)?
3. What are the biggest challenges facing you and your community/neighbours?
4. If someone were to come and work with you to solve one problem what would that be? If that problem was solved, what would the next most important one be? If those two were solved, what would the next most important one be?
5. What are your biggest health challenges?
6. Where do you access medical services (Mik sub-district hospital, Chaaria Mission, medical camp, herbalists, traditional healers etc)?
7. Where do you get your medication/drugs/treatment from (dispensary, private clinic, shop, etc)?
8. Are there people in your community that have special health needs? Describe
9. What would make it easier for you to access health services
10. One challenge that has been identified is that there are people in the community, who are ill, and the health care providers do not know about them – they are bedridden or trapped in their home. How can such people be supported to access health services?

Community Based Health Care

11. Have you heard about the term community health worker? If so what does it mean to you? Probe
12. Has anyone you know (family, you, community) been visited by a CHW?
13. One of the options being suggested to support this community's health needs is to start a community based health care programme. This would mean that individuals from this area would receive specialized training in order to visit households to provide up-to-date health information (e.g. proper use of mosquito nets, how to prevent illnesses like TB, malaria, and HIV, etc), identify sick community members, provide basic care within the home, and refer patients for additional services at healthcare facilities as needed.
    a. Does this sound like something that would work in this community?
    b. If you were sick would you like a trained community health worker to visit you in your home?
    c. Do you have any questions about this kind of programme?
    d. What do you see as the strengths of this kind of programme?
    e. Do you see any challenges with this type of programme?
    f. Is there anything specific that you think this type of programme would need to include in order to work in this community?

Annex VI: Questions for Key Stakeholders

Stakeholder interviews were held one-on-one, thus these questions only served as a framework for the discussion. Also note that not all of the below questions were relevant to all stakeholders interviewed**.**

1. What health/development services are you currently providing to the Mikinduri area?
2. How would you prioritize the health and development needs of the Mikinduri area? What is unique?
3. Of the health services that you offer, which are the ones most in demand in Mikinduri?
4. How do the services provided in the Mikinduri area differ from the services you provide elsewhere in Kenya?
5. Have the health services that you've provided in the Mikinduri area changed? If yes, how?
6. How would you describe the greatest strengths/assets in Mikinduri for providing healthcare services?
7. Who are your primary partners in providing service in Mikinduri?
8. Who are other key organisations/ groups/ individuals providing health care services in Mikinduri?
9. What do you see as the greatest challenges in providing healthcare in Mikinduri?
10. Where do you observe the largest gaps in service provision?
11. Are you familiar with any existing CBHC projects/groups operating in Mikinduri (formal or informal)?
12. How does the government work with health providers in Mikinduri?
13. What are the key regulations/guidelines that inform CBHC?
14. What do you think are the characteristics that show a community is ready to drive a CBHC project?
15. Do you believe that Mikinduri is ready to drive a CBHC programme? If yes, what are the specific elements/people/conditions that lead you to think this
16. Given your knowledge of the Mikinduri area, what external support/assistance do you feel will needed for a community-led CBHC programme?
17. What do you see as the most important characteristics in a partner with which to develop a CBHC project?
18. In terms of a process, how did you establish your CBHC project?
19. What advice would you give to a group just establishing CBHC programme?