Strengthening Community Health Workforce to Enhance Efforts to Reduce Maternal and Child Death in Kenya

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Introduction

The Constitution of Kenya 2010 recognises that every Kenyan has a right to the highest attainable standard of health. Even then, many Kenyans still lack access to quality health care, and key health indicators remain poor. For instance, according to the 2014 Kenya Demographic and Health Survey (KDHS 2014), maternal mortality ratio stands at 366 per 100,000, infant mortality rate at 39 per 1,000 live births, under-five mortality rate at 52 per 1,000, only 68 percent of children are fully immunised, only 61 percent of deliveries take place in a health facility, and the stunting rate in children remains high at 26 percent.

Community participation is critical in Kenya's efforts to accelerate progress in tackling these health challenges. The Kenya Health Policy (2014-2030) and the Kenya Health Sector Strategic and Investment Plan (2014-2018) have both identified community-level high impact intervention as one of the eight health sector flagship projects that will significantly contribute to the achievement of Vision 2030. For the country to offer quality preventive and basic curative services to communities, the revised Kenya Community Health Strategy Model 2015-2019 sets a workforce norm of five Community Health Extension Workers (CHEWs) and 10 Community Health Volunteers (CHVs) in every Community Unit made up of a population of approximately 5,000 persons as illustrated in the diagram below.

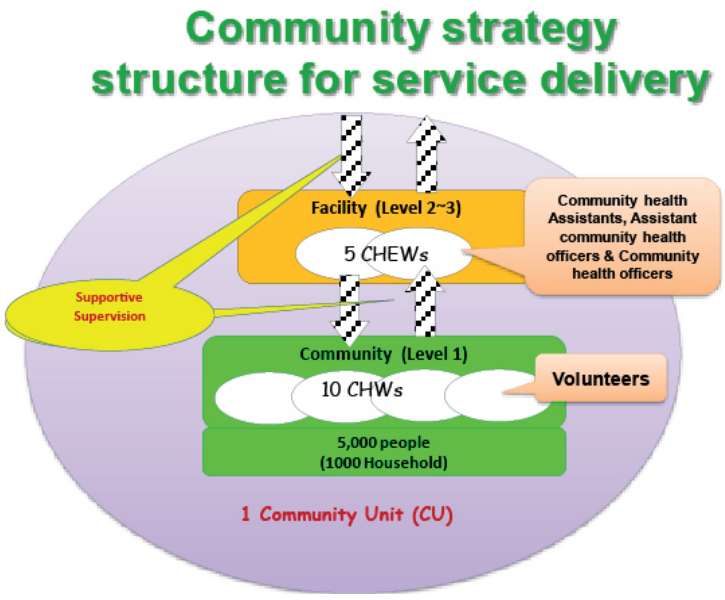

Figure 1. Community strategy structure for service delivery

Key Messages

- The Government of Kenya issued the Community Health Strategy (CHS) in 2006 in recognition of the role of community health in enabling universal access to health care and accelerating progress to reduce child and maternal deaths.
- The CHS model aims to empower individuals, households and communities to take charge of management of their own health and consequently contribute towards the improvement of maternal and child health outcomes.
- However, the community health workforce, the main implementer of the CHS, remains weak and without adequate investments to facilitate its effective service provision.
- Scientific evidence shows that utilisation of different community health personnel such as community health volunteers and extension workers can contribute significantly to the improvement of maternal, newborn, and child health outcomes.
- There is urgent need for the government to strengthen the community health workforce through recruitment, training, deployment, retention and provision of the logistical support needed to accelerate progress in saving the lives of mothers and children.

A big shortfall exists in the community health workforce, which is charged with the function of implementing community health strategy. Currently, the workforce at the community is estimated to be 4,048 CHEWs against an ideal requirement of 40,000 CHEWs for the entire country, thus indicating a gap of 35,952. This represents a shortfall of 89.9 percent (CHDU Report 2015). The main cause of this shortfall is the skewed health leadership preference of having health facility personnel to offer exclusively curative services at the expense of preventive and basic curative services, which need to be offered at the community level.

This alarming shortfall of CHEWs has contributed to a slow scale up of community-level high-impact interventions, consequently contributing to the poor child and maternal health outcomes. Several policy documents support the strengthening of community health workforce to offer some of the maternal and child health services in the country.

They include:

- Kenya Essential Package for Health (KEPH) 2006, which provides guidelines for offering maternal and newborn and nutrition interventions by CHEWs including public health technicians (PHTs) and enrolled community nurses (ECNs), community health workers (CHWs) and forming community health committees (CHCs) in an effort to improve key health indicators
- Revised Community Health Strategy (CHS) 2015-2019, which has widened the CHS workforce to include other cadres like nutritionists, community development officers, social workers and counselling psychologists
- Beyond Zero Strategy (BZS) 2013-2018
- Community Midwifery Guidelines (2012), which recognises the role of CHEWs, CHVs, BCs in mobilising pregnant women to seek maternal health services from health facilities.

In regard to providing guidance on the recruitment, training and retention of the community health workforce, the Public Service Commission of Kenya (PSCK) approved the Scheme of Service for Community Health Service Personnel in September 2013. However, this is yet to be implemented. For the government to make progress in improving health outcomes, especially reducing the high child and maternal deaths, there is an urgent need to strengthen the community-level health workforce.

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Methodology

The development of this policy brief was based on a review of secondary sources of information and research evidence. Internet searches of evidence were conducted through the Google, Google Scholar and Pubmed search engines. These searches generated a total 34 articles; out of these, five were systematic reviews, sixteen were cross-sectional studies, three were intervention studies and 10 were Kenya government policy documents.

Discussion of Policy Options

Existing evidence demonstrates the need for prioritisation and increased investments in community healthcare as discussed below. The Government of Kenya could draw some lessons from this evidence to inform its efforts to address the community health worker shortage in the country.

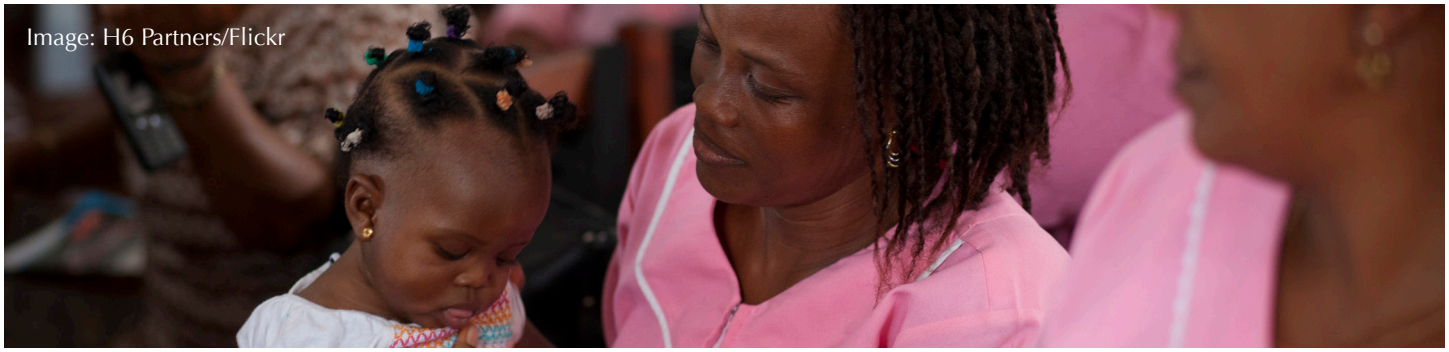
Investments in the community health workforce could alleviate the impact of the severe shortage of professional cadres of health workers

Several countries in Africa and Asia operate community health models, which use a combination of a trained and untrained work force. Findings from a systematic review conducted in 68 countries from Africa and Asia (Gupta et al 2011) showed that availability of skilled health workers was positively correlated with coverage of skilled birth attendance. However, close to four out of five (78 percent) of the target countries faced acute shortages of highly skilled health personnel, and large variations persist within and across countries in workforce distribution, skills mix and skills utilisation. For instance, in India the government partnered with non-governmental organisations and the WHO to provide basic training for community health workers in management of sick children. In Malawi, community-based health surveillance assistants have been widely deployed as part of a nation-wide programme to facilitate access to and utilisation of essential child health care services, especially in hard-to-reach areas. In Ghana, the challenge of providing equitable health services with inadequate numbers of skilled health workers necessitated a strategy of expanding primary health care and close-to-client services. The strategy focused on the training of certain cadres of health workers, including midwives, community health officers with midwifery skills, primary health care technical officers, health extension workers and medical assistants.

Investments in community health workforce can improve health outcomes as seen in Ethiopia and Bangladesh

The community health models employed by the governments of Ethiopia and Bangladesh have the main similarities of employing female community-level health workers and generating notable improvements in health outcomes.

The Government of Ethiopia rolled out a community health model in 2009 using female health extension workers. A study conducted by Karim and others (Karim et al 2013) on this health extension programme showed significant improvements in maternal and newborn health. The Ethiopian model recruited, trained and deployed 70,000 health extension workers out of a target of 140,000 in a population of approximately 70 million, which translated to an initial Health Extension Worker to population ratio of 1:1000 against a target of 1:500. This investment in the community health workforce for Ethiopia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resulted in great improvement in maternal and child health outcomes. For instance, between 2008 and 2010, there was a significant increase in the opportunity of receiving antenatal care, which increased by 1.13 times, birth preparedness by 1.31 and opportunity of receiving postnatal care by 1.60 times. The opportunity of initiating breastfeeding immediately after birth increased by 1.10 times.

The government of Bangladesh operates a community health model that uses trained female community health workers. A study conducted on this model by Zahidul and others (Zahidul et al 2013) in rural areas of five districts comprising three intervention and two comparison districts demonstrated a significant increase in the use of antenatal care services. More specifically, the study revealed a significant increase in the utilisation of trained attendants for home delivery in the intervention areas compared to the comparison areas and the change was found to be pro-poor. Use of post-natal care services was also found to be pro-poor. Given their effectiveness, Kenya could learn from these models although the gender bias in the recruitment of CHWs could be a problem given the constitutional provision of the two-thirds gender rule.

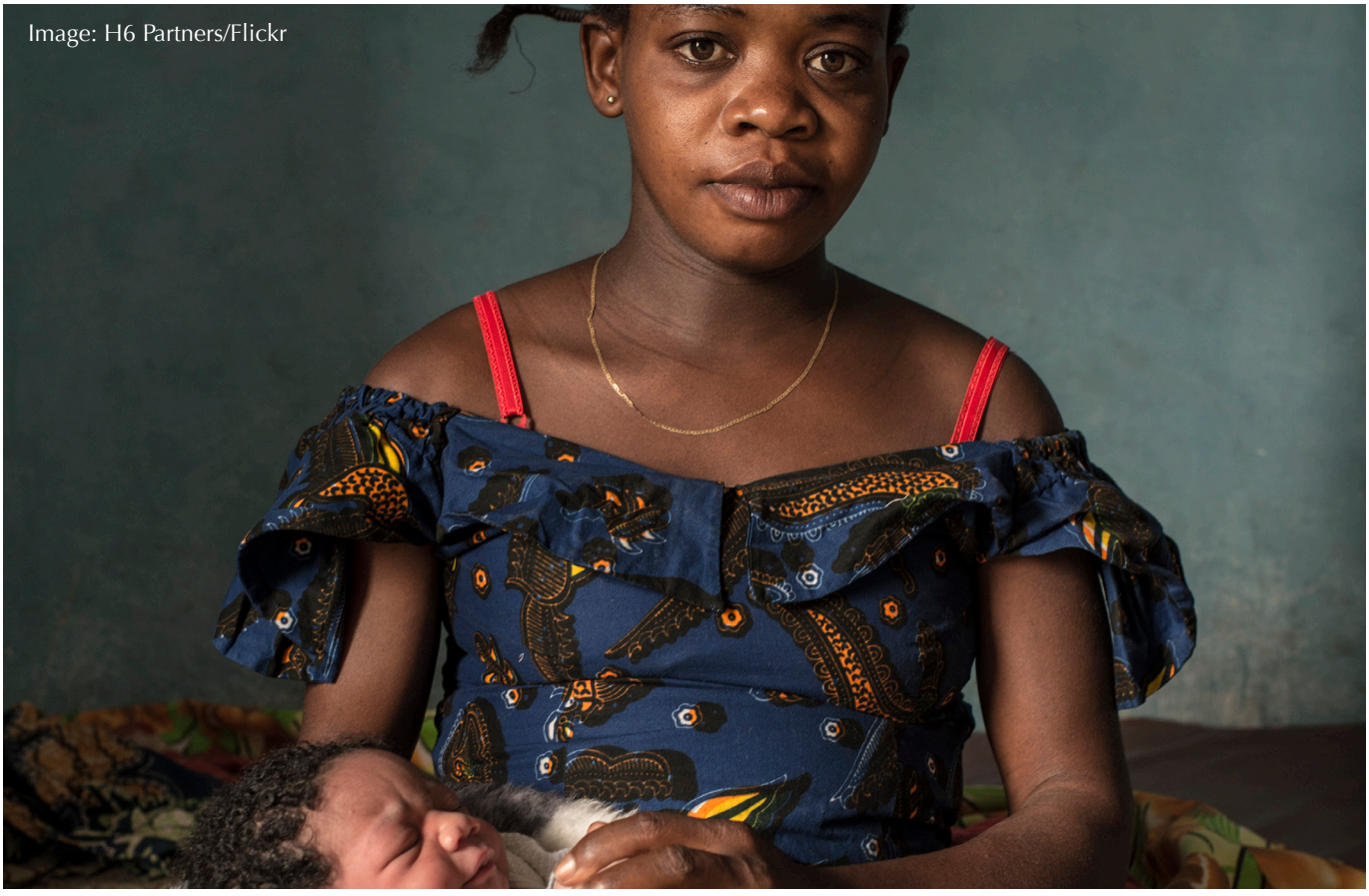
The Kenya community health model has potential to improve health outcomes

The Government of Kenya rolled out a community health strategy model in 2006 with the key implementers being CHEWs and CHVs. According to a comparative cross-sectional study conducted to evaluate the impact of this model using intervention and control sites, significant improvement in key maternal and child health outcomes were realised (Mwitari et al 2015). This was a countrywide study in community units where community health strategy was being implemented compared with units where no implementation was taking place among six provincial regions of Kenya in 2010. The purpose was to assess the impact of the model following two years after implementation was initiated.

The outcomes that specifically showed significant improvement were reduction of fever and diarrhoea for the under-five children; almost three out of four (74 percent) of children in intervention sites were fully immunised compared to slightly over half (52 percent) in the comparison areas. Close to two out of five (37.4 percent) pregnant women from intervention sites attended at least four antenatal clinic visits compared to slightly less than one-quarter (24.8 percent) in comparison sites. More than three out five (62 percent) women aged 15-49 in the intervention sites reported sleeping under a mosquito net the night before the survey in the intervention sites compared to two out five (40 percent) of women in the comparison sites.

Recommendations

Based on the research evidence discussed above, it is clear that community health workforce plays a significant role in improving maternal and child health outcomes. However, much as the Kenyan community health model was found to respond significantly in improving health outcomes, it is very weak because of the severely inadequate numbers of community health workers. It is therefore recommended that investments be made to enable the recruitment, training, deployment and retention of more community health workers as per the provisions of the career progression guidelines. Furthermore, the revised community health strategy should be implemented to address the staffing shortage as well as tackle other challenges hindering the provision of community health care services. This will go a long way in improving maternal and child health outcomes as demonstrated by evidence from Ethiopia and other countries.



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