

UPTAKE OF TASK SHIFTING AS A COMMUNITY STRATEGY IN KENYA

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Abstract

The objective of the study was to evaluate the uptake of task shifting as a community strategy in Kenya. This study adopted qualitative data collection methods in three different contexts; peri-urban, rural and arid Kenya. The results suggest that voluntary counselling and testing, community health education, hygiene, referrals and family planning services should be shifted to Community Health Workers (CHWs) and they should be trained to diagnose and treat some common childhood ailment. There is evidence that CHWs perform an important role in helping to achieve the Millennium Development Goals (MDGs) for health, particularly for child survival and treatment of TB and HIV/AIDS. Effective task shifting requires appropriate utilization of primary health care services, effective training and incentives for health workers to provide services.

Keywords: Task shifting, Community strategy, Community health workers

Introduction

The 2006 World Health Organization report recognized shortages of professional health workers as one of the key ingredients in the growing crisis of providing health

services, particularly in low income countries (WHO, 2006). CHWs are part of a “task-shift” strategy to address the crisis (WHO, 2007; Haq & Hafeez, 2009) and they have contributed to the improved access and coverage of health services in remote areas leading to improved health indicators (WHO, 2007). In many countries, CHWs have acted as a bridge between health system and the community (Haq & Hafeez, 2009). Nemcek & Sabatier (2003) indicate that CHWs enable health programmes to achieve three interconnected goals: building a relationship between the health care provider and laypersons in the community; improving appropriate health care utilization; and educating people to reduce health risks in their lives.

Task shifting is not a new concept, however it has been given particular prominence and urgency in the face of the demands placed on health systems in a number of settings (Hermann et al., 2009; Schneider, 2008; Zachariah et al., 2009). Even in high income country settings, a perceived need for mechanisms to deliver health care to minority communities and to support people with a wide range of health issues (Hesselink, 2009; Witmer, 1995) led to further growth in a wide range of CHW interventions.

There is evidence that CHWs may be able to achieve an important role in helping to achieve the MDGs for health, particularly for child survival, treatment of tuberculosis (TB) and HIV/AIDS (Chen et al., 2004). The growth of interest in CHW programmes, has, however, generally occurred in the absence of evidence on their sustainability and effectiveness. The umbrella term “community health worker” (CHW) embraces a variety of community health aides selected, trained and working in the communities from which they come on various tasks such as that can be preventive, curative and/or developmental.

Important constraints include inadequate training and supervision; insecure funding for incentives, equipment and drugs; failure to integrate CHW initiatives with the formal health system; poor planning and opposition from health professionals (Walt, 1990). These constraints lead to poor quality care and difficulties in retaining trained CHWs in many of the programmes. The 1990s saw renewed interest in community programmes in Low and/or Middle Income Countries (LMICs). This was prompted by a number of factors including the growing AIDS epidemic; the resurgence of other infectious diseases; and the failure of the formal health system to provide adequate care for people with chronic illnesses (Maher et al., 1999).

Problem Statement

Effective task shifting requires appropriate utilization of primary health care services by members of the community, effective training and incentives for health workers to provide

those services, adequate supplies and equipment, increased supervision of less specialized health workers by professionals, changes in referral processes and the resources to pay for this. There have been barriers to accessing public health services for the rural poor, who have a higher disease burden than urban dwellers, include long distances to health facilities, lack of skilled staff, lack of drugs and poor health workers attitudes. The poorest section of society mostly utilizes free public health services, which are widely perceived to offer low quality care (Mumbo et al., 2012). Functional approach and role identity theories have been extensively applied in volunteerism studies in high income countries, but have yet to be applied to health volunteers in Africa. To improve the efficiency of selection and training of CHWs, it is crucial to apply a theory based framework for identifying CHWs, categorizing them by motives, before tasks can be allocated to them based on psychological premise that volunteering serves different functions or motives for different people. Given the debates on volunteerism among CHWs with the argument that without compensation there is high attrition rate, there are volunteers that have served for more than 10 years at the proposed study site (Ochieng' et al., 2009). Such a theory based framework for assessment and categorization of health volunteers in the Kenyan context does not exist, hence the need to develop and test its relevance, validity and reliability.

Literature Review

The role of CHWs in sub-Saharan Africa has evolved over time in response to changing health care priorities, disease burdens and shortages of human resources for health (Health Systems Report, 2008). The Health Systems Report (2008) further demonstrate that evidence on CHWs from The Gambia, South Africa, Tanzania, Zambia, Madagascar and Ghana were not only cost-effective, but enhanced the performance of community level health programmes. For example, CHWs with minimal additional training can deliver treatment for diseases, such as malaria, HIV and tuberculosis (TB). An evaluation conducted by Pakistan's Ministry of Health's enumerated the successes of the 100,000 Lady Health Workers (LHWs) in line with health improvement (Haq & Hafeez, 2009). The LHWs suited well into the definition of CHWs as their programme is considered one of the successful large-scale community programmes.

In Kenya, Academic Model Providing Access of Healthcare (AMPATH) states that basic health care service is still elusive to majority of Kenyans' despite an elaborate health system in place (Correspondent Diary, 2011). It indicates that over 6000 pregnant women and hundreds of children die annually from what the Ministry of Public Health describes as

“largely preventable causes”. At the beginning of 2011, 90 CHWs were accepted by AMPTH officials to start work on basic health care at Kosira division in Nandi County. They visited various homes in the region monitoring pregnant mothers, monitoring immunization growth and nutrition of children under 5, advice on the proper diet and sanitation, monitoring the terminally ill within the community and acting as the link between the community and health facilities (Correspondent Diary, 2011). This is an initiative stipulated in the Kenya Government Essential Package for Health (KEPH) of 2006 which is being implemented in part of Nyanza regions, Western Kenya and the North Rift Valley.

Initially, the role of CHWs was not only seen as primarily health care providers, but also as advocates for the community and agents of social change. CHWs core responsibilities include health promotion, disease prevention, basic curative care and referrals, monitoring of health indicators and creating vital linkages between community and formal health systems (Health Systems Report, 2008). Today, CHWs’ role emphasizes their technical and community management function (WHO, 2007). Therefore, CHWs perform a crucial role in broadening access to and coverage of health services in remote areas and undertake actions that lead to improved health indicators, especially, but not exclusively, in the field of child health. It suggests that to be successful on a large scale, CHWs’ programmes need careful planning, secure funding and active government leadership and community support (WHO, 2007). In order to conduct their tasks successfully, CHWs need regular training, supervision and reliable logistical support.

There is urgent need for effective volunteerism in promoting health and well being at the community level. Literature indicates that more than 30,000 children die every day of preventable illnesses. Women in Africa are 100 times more likely to die of pregnancy and childbirth than their counterparts in the high-income countries; 39 million of the world’s 42 million people living with HIV/AIDS are in the developing world, tuberculosis kills up to 2 million people annually and malaria deaths are currently 1 million per year, but this is expected to double in the next 20 years. There is lack of equity and efficiency in the provision of health services that would have been able to prevent the deaths caused by these kinds of diseases (UNDP, 2003).

The primary healthcare approach adopted by the World Health Organization (WHO) at Alma-Ata promoted the initiation and rapid expansion of CHW programmes in LMIC settings in the 1970s, including a number of large national programmes (Walt, 1990). However, the effectiveness and cost of such programmes came to be questioned in the following decade, particularly at national levels in the LMICs. Several evaluations were

conducted and these illustrate difficulties in the scaling up of CHW programmes, as a consequence of a range of factors.

More recently, the growing focus on the human resource crisis in health care in many LMICs has re-energised debates regarding the roles that CHWs may perform in extending services to 'hard to reach' groups and areas; and in substituting health professionals for a range of tasks (WHO, 2006). The World Health Report (2006) focuses the world's attention on human resources as the key ingredient to successful health systems functioning and highlights the growing human resource crisis, particularly in LMICs (WHO, 2006). The strategy identified "task-shifting" which is a review and subsequent delegation of tasks to the "lowest" category that can perform them successfully. It is in the context of task-shifting that the concept of using community members to render certain basic health services to their communities has gained prominence.

The tasks of community based volunteers

The Chinese barefoot doctor programme is the best known of the early programmes. Barefoot doctors were health auxiliaries who emerged in the mid-1950s and became a nationwide programme (Shi, 1993). Thailand made use of village health volunteers and communicators since the early 1950s (Sringernyuang et al., 1995). The successes of these programmes led countries to experiment with the village health worker concept (Sanders, 1985). CHWs may be the only feasible and acceptable link between the health sector and the community that can be developed to meet the goal of improved health (Kahssay et al., 1998). Their activities included family planning, health education, growth monitoring, nutrition support, immunization and treatment, particularly of diarrhoeal diseases, with remarkable results (Yahya, 1990).

Examples of CHW initiatives in Africa include Tanzania's and Zimbabwe's CHW programmes. Both were set in the political context of wholesale systemic transformation and both focused on self-reliance, rural development. In Ghana, the Ministry of Health introduced CHWs in the late 1970s as part of the Ministry of Health (MoH) activities implementing PHC strategies. In Niger, CHW programmes evolved from the work of volunteer health workers whose work started in the late 1960s in the primarily Agricultural Department (Fournier & Djermakoye, 1975). In Kenya, CHW programmes emerged in the early 1970s, led mainly by Faith Based Organizations (FBOs), while a MoH linked pilot project was undertaken during 1974-1982 period, in Western Kenya. At the beginning of 1980s CHW programmes were launched in Siaya, and Kisumu counties, that have been sustained for nearly three decades and thus provide the basis for this study.

Methodology

This study adopted qualitative research design. Focus Group Discussions (FGDs) were conducted among female, male and youth community members while Key Informant Interview was conducted among the service providers at the four health facilities in Butere, Nyalenda and Garissa. Four sub-location were identified for the study in Butere and Nyalenda sites, while 2 in were identified in Garissa. A total of 10 FGDs were conducted in all sites. More FGDs were conducted in Butere and Nyalenda because these sites have a higher population compared to the arid nomadic land of Garissa. Random sampling method was used to identify those who joined the FGDs from the clients at the health facilities on each particular day. Purposive sampling method was employed to identify the service providers that were interviewed at the health facilities. These were nurses and District Health Management Teams members and 3 were interviewed from each health facility both in Butere and Nyalenda while 2 were interviewed in Garissa. The qualitative data from the FGDs were transcribed, coded and categorized in sub-themes. From the sub themes common emerging issues and concerns were identified and narratives constructed.

Findings

Description of role of CHWs according to the communities in Butere, Nyalenda and Garissa

Butere is a rural set up in Western Kenya; Nyalenda is a semi urban informal settlement in the outskirts of Kisumu town while Garissa is in the arid part of Kenya. These areas are a representative of various geographical regions in Kenya. They represent the minority communities as well as the majority in the Country. In all these areas, there is a consensus among the community members and service providers that CHWs perform a significant role in the community. They appreciate CHWs contribution to the improvement of the health indicators in their community. According to them, CHWs visit their households and advice them on the utilization of the nearest health facilities, check on the quality of sanitation and advice them on personal hygiene. In these communities, CHWs have advised mothers during pregnancy by monitoring their progress and assisted in child delivery when they are not able to reach the health facility. They have referred individuals to health facilities and have taken individual members of the community to health facilities when they are sick. CHWs have gone beyond medical advice to encourage the housewives start some income generating activities that improve their economic status. They inform the community about emerging issues in health such as the importance of circumcision which can be done at the health facility e.g. in Masaba clinic. CHWs are believed to have reduced mortality rates of children under 5 in most of these areas within the communities.

Community members view of CHWs

Some of the community members in Butere and Nyalenda prefer CHWs to visit their households instead of visiting the health facilities because some patients such as the elderly may not be able to walk long distances to seek health care services. This seems to be possible in these two areas but not practical in Garissa because the region is sparsely populated. Moreover, the CHWs are few and cannot adequately cover every household. On the whole, the communities identify with CHWs since they are local people living in the same village and understand the challenges of the locality. However, most of the community members in the three areas felt that CHWs should be given uniform for easy identification and they should be literate.

Tasks that should be shifted to CHWs without losing quality

Majority of the community and service providers at the health facilities in Butere, Nyalenda and Garissa suggested that to ease the burden of disease, the tasks that should be shifted to the CHWs include:

1. The VCT counselling: The CHWs have been informally advising the community on HIV/AIDs related issues and can be given the task of counselling since they are within the community and are more accessible than the health facility visit.
2. Community health education on hygiene, chronic illnesses and family planning.
3. They should be trained to diagnose and treat malaria, pneumonia and diahorrea.

Conclusion

To ensure that the above suggestion are actualized in an effort to improve health indicators in Kenya and by extension sub Saharan Africa, the community strategy should consider incorporating the suggestions below in the primary health policies.

1. CHWs and extension workers should be local people appointed by the community members since they are part of the community and can relate to issues affecting them.
2. CHWs should work among the households in their sub location or areas of jurisdiction.
3. Health Extension Workers should be appointed by the local communities and be given drug kits to work outside the health facilities e.g. at the chief's camp as they support the CHWs who work closely with the households.

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