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Maternal and Child
Survival Program

MCSP Community Health Contributions Series: Kenya

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Background

The US Agency for International Development (USAID)'s flagship Maternal and Child Survival Program (MCSP) operated globally and in 32 countries with the ultimate goal of preventing maternal and child deaths. To support community health structures in these countries, MCSP advocated for institutionalizing community health as part of national health systems, strengthening the capacity of community health workers (CHWs), and supporting community infrastructure in partnership with country governments and civil society organizations. This brief is one of an eight-part series developed by MCSP to review and understand the processes of community engagement in MCSP-supported countries and identify how the community health approaches implemented by the project have contributed to changes in health service uptake and behavioral outcomes.



Kuria mothers attend mother-to-mother support groups facilitated by a community health volunteer where they exchange ideas, share experiences, give and receive information, and offer and receive support in Migori, Kenya.
Photo Credit: Allan Gichigi/MCSP

Kenya has undergone tremendous governmental change with the devolution of decision-making authority to 47 counties nationwide. MCSP played a catalytic role by providing overarching guidance to the national-level Ministry of Health (MOH), and focused technical support at the county and sub-county levels so that local governments can continue to assume and succeed in their role of providing health care to the public. Specifically, the project aimed to: 1) ensure that necessary national-level structures were in place to foster an enabling environment for scale-up and sustainability and 2) strengthen the capacity of county and sub-county health management teams (CHMTs/SCHMTs) to increase coverage and utilization of evidence-based, sustainable, high-impact interventions in public health facilities and community structures, in reproductive, maternal, newborn, child, and adolescent health (RMNCAH), nutrition, and water, sanitation, and hygiene (WASH).

Between 2014–2017 MCSP used a phased approach with three levels of intensity. During Phase 1, MCSP provided continuous support during all 3 years for crosscutting activities and specific project areas such as family planning/reproductive health, malaria in pregnancy, commodity management, and supportive supervision. Phase 2 focused on implementation of RMNCAH, nutrition, and WASH interventions from 2015-2016. Phase 3 occurred in the third year and included building sustainability measures within county health systems. MCSP specifically worked with all of the sub-counties within Migori and Kisumu Counties, as well as three additional sub-counties within Baringo and Meru Counties.

Community Health Focused on Maternal and Newborn Health (MNH) and Nutrition

As part of its support to promote self-reliance in Kenya, MCSP set out to improve linkages between the facility and community to increase coverage, improve health service quality, and foster community ownership of health services. MCSP’s global community health strategy was based on three pillars—community service delivery, community capacity-strengthening, and community social and behavior change. **Table 1 outlines** the activities the project implemented in Kenya to enhance the efforts of the MOH and local governments.

Table 1: Three pillars of MCSP’s community health approaches in Kenya

Service Delivery	Capacity-Strengthening	Social and Behavior Change
<ul style="list-style-type: none"> • Promoted the implementation of integrated community case management (iCCM) activities, including: training and mentoring community health volunteers (CHVs) to mobilize clients and track defaulters; establishing a strong support network for volunteers; developing an iCCM monitoring and evaluation system; and working with county governments to establish iCCM policies. • Worked with the Government of Kenya to develop the country’s first costed iCCM implementation plan for 2016-2020, a legacy document to guide iCCM scale-up, advocate for more resources, and enhance joint planning and partnerships for successful implementation of iCCM. • Provided technical leadership and financial support in developing the Baby Friendly Community Initiative (BFCl) implementation package and rolling it out in collaboration with the MOH, the United Nations Children’s Fund (UNICEF), and other partners. 	<ul style="list-style-type: none"> • Embedded MCSP project managers within the CHMTs in target counties, and provided technical assistance and support to focus implementation of an integrated package of MNH interventions on time of birth, including during labor, delivery, and the early postnatal period, a routine part of the CHMT functionality. • Trained CHVs and community health extension workers on a range of basic and technical topics. • Worked with CHVs to triangulate data gathered during household interviews, and review facility data from the sick child recording form and community referral form. • Rolled out the RMNCAH scorecard for improved data quality and use of data for decision-making at the community level. • Mapped the coverage of community health units (CHUs), and analyzed the link between CHUs and health facilities. • Supported CHU review meetings to document their progress and share the way forward in relation to the BFCl. • Developed and revised tools to help CHVs monitor clients over time. 	<ul style="list-style-type: none"> • Supported county health promotion days, community events, and action days, and convened maternity open days. • Introduced income-generating activities to motivate CHVs and reward high-performing CHUs. • Technically supported Positive Deviance Hearth¹ and cooking demonstrations, and established kitchen gardens and income generating activities among women participating in mother-to-mother support groups. • Developed social and behavior change communication materials on a range of topics, which were distributed to CHVs and health facility providers; for instance, MCSP worked in collaboration with the Ministry of Agriculture, the MOH, and community members to develop recipes for complementary feeding of children 6–23 months.

MCSP’s community health strategy relied heavily on existing CHWs and CHVs who are part of the Kenyan public health system for outreach in communities. In the rural communities in Kenya, CHVs are trusted and respected members of society. As such, they play a vital role in ensuring community acceptance and ownership of health services and in reinforcing messages received from the health facilities. MCSP trained

¹ Positive Deviance Hearth is a community-based rehabilitation and behavior change intervention for families with underweight preschool children. The “positive deviance” approach is used to identify behaviors practiced by the mothers or caretakers of well-nourished children from poor families and to transfer such positive practices to others in the community with malnourished children. The “hearth” or home is the location for the nutrition education and rehabilitation sessions.

CHVs in their respective CHUs² in basic and technical modules. The basic modules focused on interpersonal communication and advocacy skills, basic case management, community health information management, governance and coordination, and basic health promotion. Technical modules included detailed information on MNH³, nutrition, and other health-related areas. MCSP also guided CHVs in household registration and demographic mapping exercises to build a foundation upon which they could assess individual health status and deliver appropriate health services in their day-to-day activities. Additionally, MCSP introduced income-generating activities to motivate CHVs and reward high-performing CHUs because CHVs are often not compensated for their critical role in Kenya's healthcare system. MCSP also focused on strengthening the functionality of existing CHUs in the targeted counties and sub-counties. A functional CHU is defined as having technically trained CHVs who regularly report data and conduct data review meetings, hold dialogue days, lead community action days, and perform outreach activities. To ensure CHVs were able to meet these criteria, MCSP distributed reporting tools and fulfilled outreach needs (e.g., transport) to help CHVs mobilize the community for events.

The project supported various types of community events to help reshape social norms and influence individual attitudes by engaging multiple tactics, including facilitating community dialogues, supporting local champions, and creating an environment for free interaction between pregnant mothers and service providers. CHVs encouraged women, men, boys, and girls, along with key community persons, including area chiefs and assistant chiefs, village elders, and religious leaders, to attend the community events. During planned community meetings, community members and facility staff deliberated on how to improve MNH service provision, access, and utilization, take ownership of their own health agendas, and mobilize resources.

Additionally, MCSP worked to improve the nutritional status of women of reproductive age, along with infants and young children; prevent micronutrient deficiencies and anemia; and attain optimal maternal, infant, and young child nutrition practices in the targeted areas. MCSP provided technical leadership and financial support in developing the BFCI implementation package and rolling it out; including providing training workshops, facility-based mentorship, continuing medical education, and focused supportive supervision targeting CHVs and key community members. Additionally, MCSP facilitated the development of linkages between the MOH, the Ministry of Agriculture and Farm Concern International, an Africa-wide market development agency, which provided different types of seeds to community units to establish kitchen gardens in health facilities and communities.

Achievements

The various community health approaches described here enabled the CHMTs/SCHMTs to increase coverage and utilization of evidence-based, sustainable, high-impact programming, and contributed to increased uptake of MNH and nutrition services, as well as improvements in MNH and nutrition practices. By working with CHVs on the promotion of health interventions at the community level, MCSP, the MOH, and partners contributed to changes in health-seeking behavior and health and nutrition practices by community members. A few highlights of project outcomes are provided below.

- **Timely first antenatal care visits (i.e., before 12 weeks of pregnancy) increased from an average of 48% to 60%, and delivery with a skilled birth attendant increased from 19% to 24%** in the three sub-counties of Baringo and Meru Counties.
- Prior to MCSP's activities, some communities were not using iCCM effectively. As a result of MCSP having trained and equipped CHVs on iCCM in Migori County, CHVs were able to successfully engage with and gain the trust of community members to assess and treat illnesses. According to the iCCM monitoring and evaluation data, by the end of the project, **CHVs were managing 34% of diarrhea**

² A community health unit is a health service delivery structure within a defined geographic area covering a population of approximately 5,000 people. Each unit is assigned two Community Health Extension Workers and CHVs who provide health promotion, preventative health, and basic treatment services.

³ The MNH modules included training on how to identify pregnant women in the community, antenatal care, skilled birth attendance, and postnatal care; socio-cultural factors affecting MNH; danger signs for mothers and their babies; essential care for the newborn, including how to keep the baby warm at home and the importance of exclusive breastfeeding; how to make appropriate referrals for both mother and baby; how to collect relevant MNH data; and respectful maternity care.

cases and 32% of suspected pneumonia cases on average in isolated areas of Nyatike and Suna West.

- At the end of the project, 53 CHUs were implementing BFCI, and CHVs had reached approximately 2,600 mothers with children under 1 year of age through home visits. After 9 months of implementation of the BFCI, an external review conducted by the Kenyan MOH and UNICEF indicated that **initiation of breastfeeding within 1 hour of birth increased from 84% to 89%, pre-lacteal feeding decreased from 25% to 10%, and intake of animal-sourced foods by pregnant women to increase iron levels improved from 75% to 85% in the 53 CHUs.**

Conclusion

The MCSP-supported community approaches contributed to attaining many of Kenya's devolution objectives, including community participation, responsiveness, and accountability. Moreover, the project's various interventions enabled the health system to deliver high-impact interventions that contributed to changes in health service uptake and behavioral outcomes. Collaboration among the project, the MOH, implementing partners, CHMTs/SCHMTs, and community workers and volunteers, as well as active involvement of community members in leading intervention activities and taking ownership, strengthened community health structures. Looking ahead, the Government of Kenya and projects should continue to invest in community health as a means to making progress toward the journey to self-reliance. Nevertheless, attention is needed in areas that can hamper advancement such as unclear guidance, limited capacity to set priorities, and limited genuine community accountability.

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