AKHS Kenya
Community Health Department

Policy Brief No.3

Best Practices in Community-Based Health Initiatives

'Do not underestimate the capacity of the community;
they are smarter and more capable than you think'

Sustaining Community-Based Health Initiatives

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This is the third of a series of 'policy briefs' produced by the Community Health Department of the Aga Khan Health Service in Kenya. It focuses on what has been happening in the target areas of the Kisumu Primary Health Care Project. This was a pioneering PHC project that ran from 1983 to 1997 in Kisumu District, in the west of Kenya and beside Lake Victoria.

The brief is based on a review of reports – and on a visit made to some of the Kisumu PHC target areas in December 2002 by Dr Salim Sohani, Head of the Community Health Department, AKHS, Kenya, and John Fox, Managing Director of IntermediaNCG, Kenya. Their main concern was to find out what kind of health care and health education were now being promoted – five years after the Kisumu PHC project had ended.

What had happened to all the voluntary health workers that had been trained by KPHC?

How well were the facilities being maintained?
To what extent were health care and health education programmes still being promoted?

These briefs are primarily intended for directors and managers of community-based health care programmes – whether working within ministries of health, international donor agencies or non-government organisations. For these people this third brief takes up three main questions related to the sustainability of such programmes:

When the donor has withdrawn, if the communities are carrying on with the health care activities, how are they doing so, and why are they doing so?
What can a programme to do encourage such persistence?
What lessons about sustainability from the Kisumu project – positive or negative – can be applied elsewhere?

Goals of the Kisumu PHC Project

- To increase awareness in local communities of people's health problems and motivate them to undertake disease prevention and health promotion activities.
- To increase the availability, accessibility and acceptability of health services by applying community-based health care approaches and training community health workers and traditional birth attendants.
- To improve environmental health conditions, particularly clean water supply and sanitary waste disposal, principally through community participation and self-help efforts.
- To improve the effectiveness of rural health services, principally by establishing a practical health information and management system.
- To reduce infant and child morbidity and mortality, maternal morbidity and mortality – by increasing health promotion, disease prevention and contraception practice.
- To reduce malnutrition among children and women, primarily by promoting growth monitoring, improving weaning practices, improving food selection and preparation, and increasing local production of nutritious foods.
- To the extent possible, increase family and community income through various innovative family and community projects.

The Context

Kisumu, Kenya's third largest town, lies on eastern shore of Lake Victoria. The project operated in three locations of Kisumu District: North Nyakach, Central Nyakach and Kajulu. The Nyakach locations are rural areas, with poor soils, unpredictable rainfall and an inadequate water supply. Kajulu is a peri-urban area, and its soils are more fertile.

In 1990, the combined population of the three locations was estimated at 63,500.The project concentrated on the most vulnerable of that population: the 11,200 children under the age of five, and the 12,400 women aged between 15 and 49.

The Challenge

A base-line health-status survey was carried out in 1984. It showed that the major health problems were measles (against which only 11% of the children were immunised), malaria, anaemia, scabies, parasites, schistosomiasis and acute respiratory infections. The leading causes of death were diarrhoea, measles, acute respiratory infections and malaria. Moreover, the area had a history of cholera outbreaks.

Diarrhoea was a particular scourge. At the beginning of the project, it accounted for 27% of the deaths of children under five. The main cause was the unclean water and poor sanitation. Only 14% of the people had access to safe water.

Malnutrition was a serious problem among young children – especially girls. Poverty and lack of food were the chief causes. Particularly, the lakeshore is densely populated. The farms are small and the soil is infertile. Yet

CONTINUED ON PAGE 4

THE CHALLENGE: FROM PAGE 3

most families had to depend on subsistence farming – or on fishing. However, an increasing number of young men were leaving the area to look for work in Kisumu or the large towns further away.

The supply of essential drugs was unreliable and, anyway, inadequate – particularly in the more remote rural places. Even when drugs came to the District centres, from there distribution was frequently difficult because of the poor access roads, especially in the rainy seasons.

The Process

Community Participation

The design of the KPHC Project put a great emphasis on community involvement – through the organisation of village health committees, and through the training and deployment of community-based health workers. This called for an initial and concentrated process of sensitisation – to key health issues, through both informal and formal discussions and workshops.

This is how one of the early Project Managers, Esther Nagawa, described the process when she was interviewed in 1997: 'Our policy was to work through the local leaders and the existing organised groups. We had experienced so many projects in that region that had failed. We had seen so many projects come: the donors gave out things there, they go – and that is the end of it. So the concern of this project was that, whether we remained there or not, the improvements achieved by local communities would be sustained – that the people would continue to help themselves. The only way we could be sure that would happen was by securing community understanding and involvement.'

Community Health Workers

After these discussions – what the project staff called 'dialogues' – came the selection and training of the volunteers: members of village health committees, community health workers and traditional birth attendants. Supported by the three 'front-line' community nurses employed by the project, the voluntary workers made home visits to give health education, carry out growth monitoring of children, and to identify any high risk families. They talked at *barazas* – the open-air meetings presided over by the local chiefs. They gave talks in schools. They operated both static and mobile clinics where they promoted maternal and child health, family planning, malaria prevention techniques, and immunization services.

Water Facilities

At the water points, the project's field workers built the capacity of community groups to manage the facilities – and they encouraged a sense of community ownership. This was of particular importance, because it was designed

to challenge dependent attitudes that had been formed over a considerable period. Nyakach, particularly, is an area where cholera epidemics were quite common – and, in response, the government had provided a number of wells. Although the people benefited from them, they used to call them 'government' or 'cholera' wells. They made little or no effort to protect or maintain the wells – and eventually they became unsafe for drinking.

To instil a greater sense of responsibility, the project encouraged the communities to identify the groups that needed new water points, to agree on the suitable sites, to provide local construction materials and unskilled labour, to accommodate the skilled workers, and to maintain, protect and clean the water sources. And the project contributed by paying the skilled workers, buying pumps and pipes, and providing any needed technical assistance.

Drug Supplies

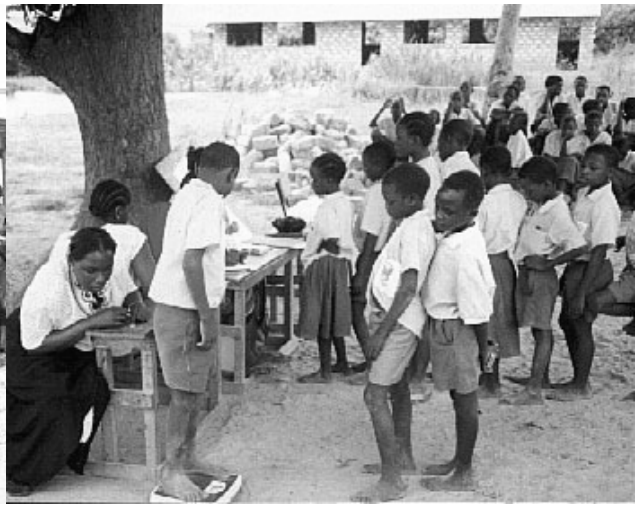
To overcome the problems of associated with the supply and cost of drugs – shortages in the government clinics and high costs in the shops – the project trained community health workers to participate in a drug distribution scheme. It taught the CHWs basic skills in diagnosis and treatment, including the use of seven generic drugs. It set up a revolving fund, and, as an incentive, the community health workers were permitted to make a small profit when selling them.

Immediate Impacts

By March 1997, when the project was ending, 1731 people from the communities had been trained to carry out a variety of tasks – tasks ranging from chairing PHC committees to attending at childbirth. The following table shows the categories of CHWs trained:

No doubt it was this well-equipped army of local health workers that was mainly responsible for the raised health awareness and the improved health status in the target communities. The use of safe water supplies rose from 14% at the beginning of the project to 63% by its end. The practice of family planning rose from 13% to 23%. And all other key indicators improved: the immunization coverage, the application of oral rehydration therapies to combat the scourge of diarrhoea, the use of latrines, and the decline in infant mortality rate.

Kajulu/Nayakach	CHW	CBDD	FPM	TOT	TOF	TBA	PHCC
Totals	496	319	136	90	23	237	231



Some Lasting Impacts

In both Kajulu and Nyakach some important components of the KPHC project are being sustained. At Wath Orego in Kajulu, for example, the people have put up a dispensary out of their own resources. It is one of the most remarkable achievements of the Kajulu PHC that was formed to continue the work. But, as the new KPHC Chairman admitted, during the review meeting in December 2002, continuing with the work has not been easy.

'When the Kisumu PHC left us, it was not an easy task,' he said. 'It was difficult to bring the community back. KPHC was famously known as the Aga Khan – so we wondered how we could possibly manage this project on our own. We didn't have funds. But we sat down to think – and that took us almost a year… We decided to set up our own committee. We started Kajulu PHC in 1999…. But sustainability is not an easy thing. It has really taken us time to understand it.

'We discovered that, though we couldn't do everything that the Aga Khan project had done, we could still do a number of useful things. We could collaborate with the Ministry of Health, with other NGOs, and with the municipal authorities. So we could carry on with the immunisation programme. We could still go into schools, with health education messages. We could still promote health awareness within the community – and that has been very important because of the HIV/AIDS epidemic.'

Another encouraging sign is that a number of the CHWs who attended the review meeting in Kajulu were still wearing the badges that they had been given in 1997, during the Kisumu PHC.

'These CHWs are still with us,' said the Chairman, 'because the training you gave them enabled them to do something useful about the diseases in the area. So it has made a big difference to their lives. And that is why they keep going on.'

Of the CHWS from Kajulu trained by the original project, 70% were still active at the end of 2002. Perhaps more importantly, the new Kajulu PHC has gone on to train an additional 60 CHWs since the Kisumu PHC ended.

CONTINUED ON PAGE 6

SOME LASTING IMPACTS: FROM PAGE 5

'To sustain what we are doing,' said the Chairman, 'we have to train new people to take over from us.'

In Nyakach, too, many of the old CHWS are still active – and new ones are being trained. Many of the wells and pumps are still operative.

'When you came here,' one of the CHWs said, 'you didn't give us fish – but you taught us how to fish. And we are still fishing!'

'You taught us the importance of having clean water,' said another. 'This place used to be known for cholera… But there is no cholera now.'

What has happened in Kajulu and Nyakach bears out an optimistic statement from the Kisumu PHC's report of 1991:

'Do not underestimate the capacity of the community; they are smarter and more capable than you think. They have lived through decades and centuries without becoming extinct, without outside help. They have a lot of knowledge and experience that one can build on.'

The Lessons Learnt

1. Be patient.

The same 1991 report emphasised the importance of taking time at the beginning of a project – and not being put off by early setbacks: 'To achieve sustainability takes time. It has to be done painstakingly and frustratingly, but it can be done. It is better to invest at the beginning, rather than mess things up by rushing into the process and paying later.'

It takes time for the community members fully to appreciate the capacity-building rather than service-delivery objectives of a project – and willingly to understand what is expected of them.

2. Be clear about objectives and expectations

'You didn't promise us that you would go on,' said one of the CHWs at the Kajulu meeting, 'you made it clear that we should go on by ourselves, with our own resources.' So those community members who participated in, or benefited from, the project were in no doubt that the implementing agency would one day bring the project to an end – and that, if they wanted to continue its work, then they would have to do so, mainly, by themselves.

3. Don't make rash promises

Continuing the topic of promises… one important lesson of the Kisumu PHC is that project staff should be careful not to encourage unrealistic expectations. For example, it seems that, at the beginning of KPHC a number of people assumed that the Aga Khan Health Services was going to construct a hospital in the project area. Also, a number of people who put themselves forward as CHWs believed that, after training, they would be able to secure paid employment.

4. Facilitate community organisation

One of the most important conditions for sustainability is the capacity of the community members for organising themselves. And it is perhaps one of the most important achievements of KPHC that the local people had been mobilised in such a way that they were able to carry on solving their own problems and securing the health services that they wanted. Right from the beginning, the project staff encouraged representative groups to identify and

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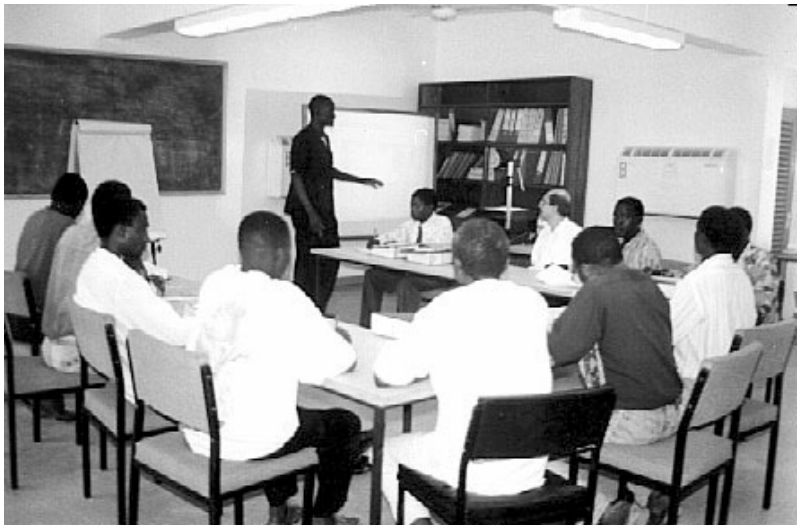

LESSONS LEARNT: FROM PAGE 6

prioritise their needs, to contribute money for the construction and maintenance of water points and other facilities, and to select their own health workers.

It is crucial for the continuation of the project's work that, in both Kajulu and Nyakach, committees have been formed to coordinate the efforts of the volunteers, to secure support of the Ministry of Health, donors and NGOs engaged in health care and health education, to promote the training of CHWs.

5. Give training a high priority
When Doctor Sohani asked the Kajulu CHWs why they were still active, the answer was unequivocal:
'Because you trained us. Because of the knowledge that you invested in us…That is why we are still going. You trained us – so that we could depend on ourselves.'

6. Maintain close contact with the professional health services
However well-trained and confident they are, the CHWs of Kajulu and Nyakach, will still need the support of the Ministry of Health staff working in the area. One of the most encouraging aspects of the current situation is the excellent relationship between the committee members, the CHWs and the staff of the Ministry of Health facilities.

Also, one of the significant factors in ensuring continuity has been the decision of the Community Health Department of AKHS to allocate a nurse to provide technical support to the Kajulu and Nyakach committees and volunteers – advice on programming, assessment of training needs, and provision of training.

7. Trust that success will breed success
'Before KPHC, often there was sickness in my home,' said one of the CHWs. 'The children were suffering from sicknesses such as malaria and diarrhoea…. But then we learnt some simple things. And the death rates among children have gone down…. The PHC has become like a gospel… It is a continuous thing.

Perhaps there can be no finer tribute to a community-based health project – and no better reason for the people to carry on doing those 'simple things'.

Some Conclusions

To return to the three questions posed at the beginning of this policy brief:

When the donor has withdrawn, if the communities are carrying on with the health care activities, how are they doing so and why are they doing so?
It seems, from the experience of both Kajulu and Nyakach, that the communities have realised the importance of being organised – or, rather, of organising themselves. Their ability to carry on with promoting awareness-raising activities, with training community health workers, with maintaining water supplies, with securing funds….. all these things depend on having the local committee structures that harness local leadership talents. And so, any community-based health care project should put great emphasis on building the capacities of those who volunteer to assist in the management of the various health care or health education initiatives.

In a country like Kenya, where poverty is common and jobs are scarce, some people will volunteer because they hope to secure paid employment. This is understandable. But others will volunteer, and carry on, because they see the differences they can make to the chances of children surviving, of disease outbreaks being controlled, and of the health care for their communities being improved.

What can a programme do to encourage such persistence?
Some key principles of sustainability can be derived from the seven 'lessons learnt' that have been presented above:

- Be aware that building community trust and stimulating community participation in areas such as Kajulu and Nyakach can take a long time.

CONTINUED ON PAGE 8

SOME CONCLUSIONS: FROM PAGE 7

- Be clear about the intention that the community groups will eventually need to take over the management of the health care programmes and to seek collaborative relationships with other health care providers.
- Be realistic and frank about the extent of the assistance to be provided or about the possibilities of permanent employment.
- Work with representative community groups to identify priority needs and to establish their organisational structures.
- Give your own high priority to building the management capacities of the participating community groups.
- Encourage close relationships with the government-funded, public health services.
- Be confident that when people see the positive results of health care programmes they will want them to be continued.

What lessons about sustainability from the Kisumu project – positive or negative – can be applied elsewhere?

The Aga Khan Health Services work across a number of continents. The experience of numerous community-based health care projects in different countries shows that the sustainability principles that have been outlined in this project brief are applicable wherever there is a need to stimulate community involvement and to bolster the hard-pressed government-funded health services.

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Training Programme on Dispensary Management

The Community Health Department of AKHS, K has developed a manual on managing first level health care facilities. It is called *Managing a Dispensary* and it is available in three parts:

1. A Participatory Model: an introductory pamphlet;
2. A Handbook for Committee Members and Nursing Staff;
3. Guidelines for Facilitators.

The training package is available in printed form and on a CD. It can be obtained from:

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