Frontline Health
Harmonizing Metrics, Advancing Evidence, Accelerating Policy.

RESULTS BRIEF

APRIL 2021

EXPLORING COMMUNITY HEALTH WORKER ROLES, SUPPORT, AND EXPERIENCES IN THE CONTEXT OF THE COVID-19 PANDEMIC IN KENYA

BACKGROUND

Community health workers (CHWs) are critical actors within community health systems and provide a range of reproductive, maternal, child, and primary health information, counseling, and services. As community members themselves, CHWs understand the local context and facilitate linkages to care. In pandemics like COVID-19, CHWs continue to provide routine services in addition to undertaking increased responsibilities. While CHWs are often innovative in their strategies to sustain their work, they operate under challenging circumstances including limited guidance and support as well as potential hostility from communities and/or facility-based providers with whom they interact.

In Kenya, COVID-19 was first detected in March 2020, with over 101,000 cases and 1,769 confirmed deaths in the country as of February 2021 [1]. To steer Kenya's COVID-19 prevention, containment, and mitigation measures, the Ministry of Health (MoH) launched the National Response and Emergency Committee, supported by other ministries and several committees. In addition to several strategies to mitigate COVID-19's spread early, MoH developed interim guidance to support health service continuity, specifically advising health care managers and workers on their provision of essential health services [2].

At the community level, the MoH developed guidance for CHWs – known locally in Kenya as community health volunteers (CHVs) – and other community health actors on the continuity of health services [3]. These guidelines aim to facilitate the provision of critical and essential care and ensure that CHVs are provided with adequate personal protective equipment (PPE) and support as they help households adapt to COVID-19 prevention measures. The guidelines also create links with other sectors and community resources to facilitate involvement of existing community health structures into COVID-19 prevention and response.

This brief presents results from the Frontline Health project's study in Kenya which explores the experiences of CHVs on educating communities, providing care, and reporting during the COVID-19 pandemic.

Photo credit: Population Council, Kenya (Photo taken prior to pandemic.)

KEY FINDINGS

1. During the COVID-19 pandemic in Kenya, CHVs continue carrying out their routine work, with added responsibilities, working more than prior to the pandemic.
2. CHVs are educating households and facilitating clients' advanced care for COVID-19; however, they experience deficient knowledge and training on the pandemic and its management.
3. Providing CHVs with adequate PPE and infection prevention supplies; training them to screen, report, and refer COVID-19 cases; and improving their digital supportive supervision may help alleviate their challenges in educating the public and providing essential services during the COVID-19 pandemic.

This brief summarizes quantitative data from the Frontline Health project's COVID-19 study in Kenya. Data collection took place in September and October 2020 in 42 (out of the 47) counties in Kenya. The information presented in this brief is based on a quantitative survey of CHVs (n= 1,385) performing routine services during COVID-19. This study is part of a larger portfolio of work under The Frontline Health: Harmonizing Metrics, Advancing Evidence, Accelerating Policy project which seeks to advance community health systems metrics, monitoring, and learning to improve the efficiency and performance of CHW programs [4].

POPULATION COUNCIL
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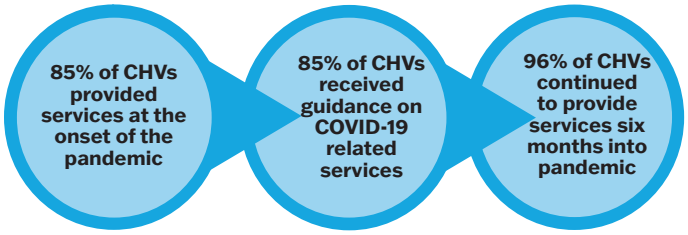
RESULTS

Characteristics of CHVs are similar across study sites.

Quantitative survey results reveal that 68% of CHVs in this sample (n=1,385) were female, most between 36 and 45 years old (29%) or 46 and 55 years old (26%), and almost 70% had secondary or higher education. Most CHVs reported working in their positions for 5 to 10 years (41%) or over 10 years (31%).

During COVID-19, most CHVs (91%) continue to travel to households by foot, and 76% reported using a mobile device in their work. CHV demographics were similar among the study sites, with some variation including travel times to farthest households (Table 1).

FIGURE 1. PERCENTAGE OF CHVS PERFORMING ROUTINE RESPONSIBILITIES DURING THE PANDEMIC (N=1,385)



CHVs continue routine services, with additional responsibilities during the pandemic.

Eighty-five percent of CHVs were able to continue their routine work in the first month of the pandemic, and six months into the pandemic, that figure increased to 96% of CHVs (Figure 1).

TABLE 1. CHARACTERISTICS OF CHVS (N=1,385)

Characteristic	Urban - Informal settlement (%)	Peri - urban (%)	Rural (%)	Total (%)
Gender				
Female	74	73	66	68
Male	26	27	34	32
Age				
19 - 25 years	3	5	2	2
26 - 35 years	23	14	14	16
36 - 45 years	23	37	30	29
46 - 55 years	24	29	26	26
56 - 65 years	16	7	10	11
Above 65 years	11	8	18	16
Time working as a CHW				
< 5 years	25	33	29	29
5 - 10 years	36	39	42	41
> 10 years	39	29	29	31
Received incentives				
Monthly stipend	14	26	40	35
Allowances (transport, lunch, airtime)	47	53	42	43
Non-financial (food, backpacks)	23	32	16	18
None	23	11	10	12
Time to reach farthest household				
Below 30 minutes	76	70	53	58
Between 30 - 60 minutes	12	19	24	22
Between 61 - 120 minutes	2	6	6	6
Above 120 minutes	10	5	18	15
Main mode of travel since pandemic				
By foot	95	91	90	91
Bicycle/boda-boda	2	3	5	4
Motorbike/boda-boda	3	4	6	4
Minivan/bus	1	2	0.1	0.4

Although 85% of CHVs reported guidance on COVID-related activities within the first month, our data indicate gaps in knowledge of various MoH guidelines. Despite 96% of CHVs continuing services six months into the pandemic, only 61% had heard of the guidelines on continued community health service provision, indicating that over one third of CHVs were unfamiliar with the guidelines (data not shown).

Of those who were unable to continue their routine work (n=214), 73% reported medical safety concerns (lack of PPE, fear of infection), followed by a lack of guidelines (48%), and community refusals due to fear of infection (47%) (Figure 2).

CHVs provided more services more frequently during the first six months of the pandemic than prior.

The percentage of CHVs providing various routine services increased during the pandemic. The percentage of CHVs providing counseling and direct primary health care services increased from 78% before the pandemic to 94% six months into the pandemic, and the percentage of CHVs providing immunizations for children increased from 61% to 91% (Figure 3).

CHVs also reported providing higher levels of mental health counseling, education on water, sanitation, and hygiene (WASH), and increased referrals, among others.

FIGURE 2. CHVS' REPORTED REASONS FOR NOT CARRYING OUT ROUTINE TASKS (N=214)

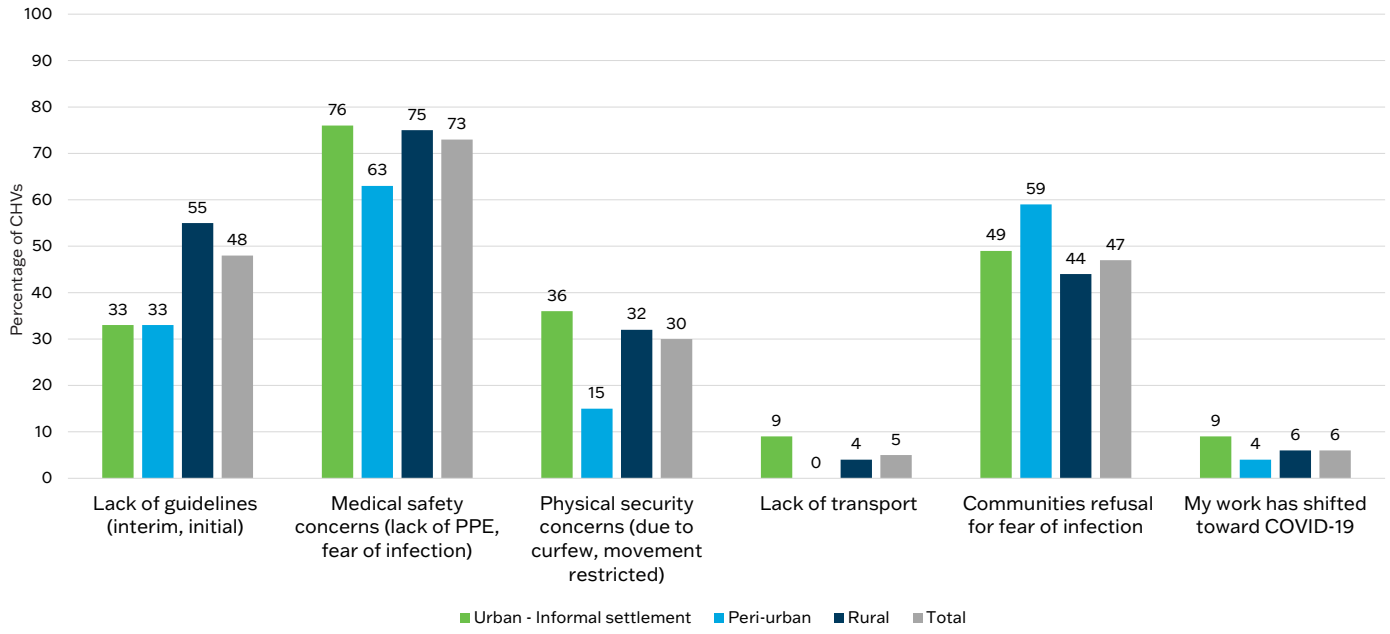
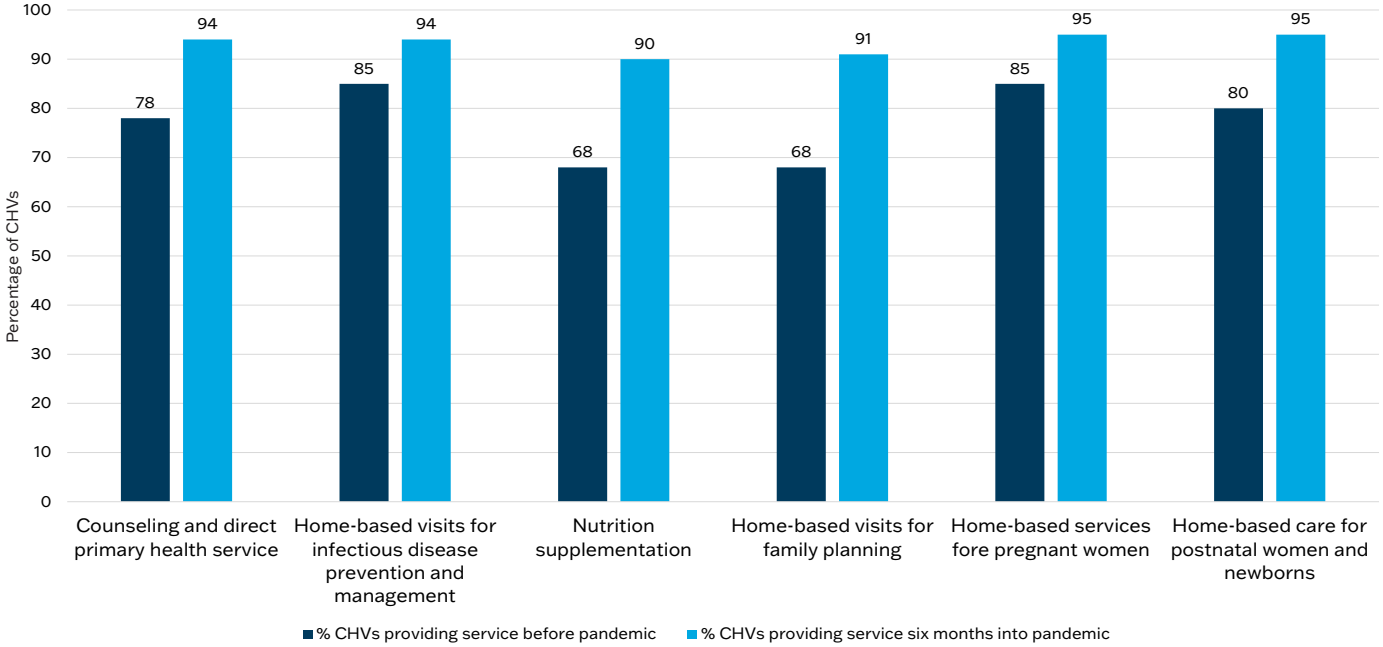


FIGURE 3. CHVS' RESPONSIBILITIES BEFORE AND DURING THE PANDEMIC (N=1,385)



CHVs reported less in-person supportive supervision during the pandemic.

Most CHVs reported being supervised through regular/scheduled in-person one-on-one meetings with their supervisors (71%) or team meetings (77%) prior to the pandemic; however, the percentage of CHVs reporting these in-person methods of supportive supervision lessened to 54% and 59%, respectively, during the pandemic. The percentage of CHVs' reporting use of digital communications or phone calls decreased slightly (data not shown). This signals that CHVs are receiving less frequent supervision and support than they were prior to the pandemic.

CHVs reported engaging in various activities in their communities related to prevention, treatment, and reporting COVID-19.

Ninety-two percent of CHVs reported that they were providing COVID-19 services separate from their routine work at the time of the survey. Eighty-five percent of CHVs reported that they received training/guidance on COVID-19; however, the percentage of CHVs receiving specific guidance varied, which indicates potential gaps in aspects of COVID-19 training (Table 2).

At the time of the survey, 97% of CHVs (n=1,346) reported that they were educating their communities on COVID-19 prevention or treatment (Table 3), including educating them on what to do if exposed to COVID-19 or if they develop symptoms (Figure 4).

Table 3 demonstrates COVID-19 activities conducted by CHVs. Almost three-quarters are educating households on caring for someone with COVID-19, and around half mentioned they refer suspected cases for testing. Less than half describe reporting COVID-19 cases, contract tracing in their communities, and referring people with suspected COVID-19 for further treatment.

Overall, 73% of CHVs reported that they believe they have been able to help their clients prevent COVID-19 (data not shown).

CHVs experienced COVID-19-related challenges while carrying out their routine services.

CHVs reported inadequate or missing PPE, fears of spreading or contracting COVID-19, shortages of commodities, and barriers to travel (Table 4, pg. 5). In addition to these challenges, about one-third of CHVs (31%) reported experiencing hostility or mistreatment by the community due to their work (data not shown).

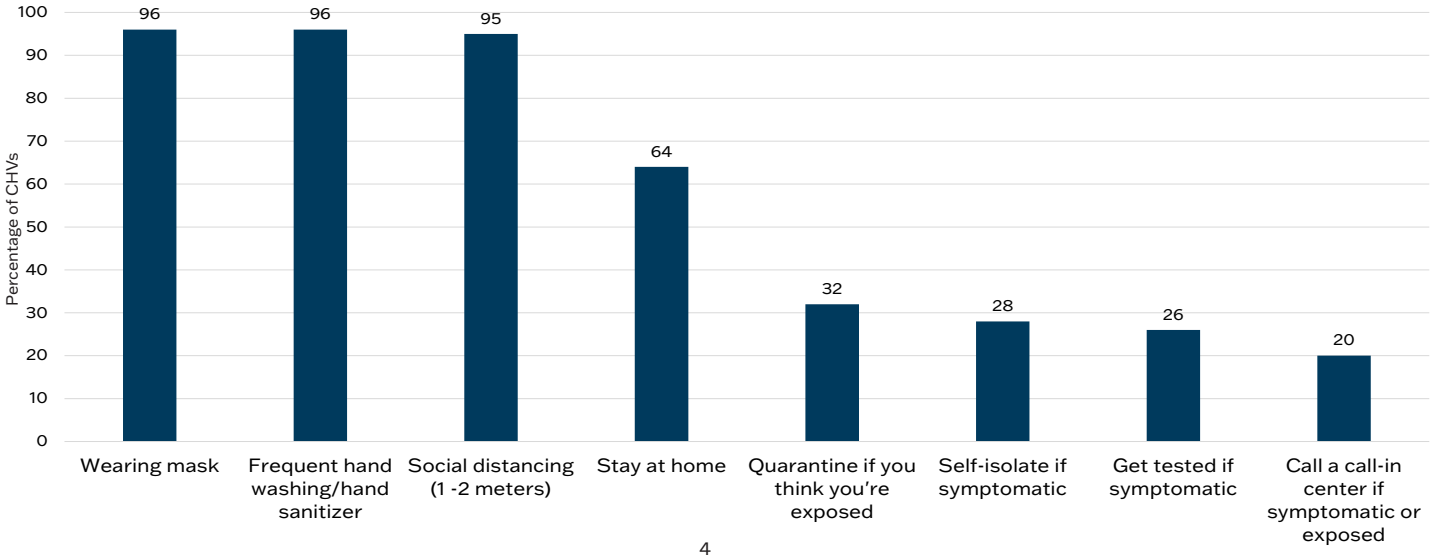
TABLE 2. CHV TRAINING/GUIDANCE ON COVID-19 (N=1,172)

Percentage of CHVs reporting training or guidance on specific topic	%
Preventive strategies (hand washing practices, social distance, self-quarantine, etc.)	98
General information about COVID-19	88
Correct use of PPE (masks, gloves, apron, etc.)	83
Signs and symptoms of COVID-19	81
Contact tracing and community surveillance	29
Home based care of COVID-19 cases	25
Continuity of community-based services	23

TABLE 3. CHV COVID-19 ACTIVITIES (N=1,385)

Percentage of CHVs engaged in COVID-19 activity	%
Educating community members about COVID-19 prevention or treatment	97
Educating communities/households about how to take care of someone with COVID-19 in the home	73
Referring suspected COVID-19 cases for testing	53
Reporting suspected or confirmed cases of COVID-19	49
Doing contract tracing for those who may have COVID-19 in the community you serve	48
Referring suspected COVID-19 cases for advanced care at facilities	46

FIGURE 4. PERCENTAGE OF CHVS GIVING SPECIFIC ADVICE ON PREVENTION AND TREATMENT (N= 1,346)



Among CHVs who experienced hostility or mistreatment (n=426), the most common types were having their advice ignored by clients (70%), being refused entrance into a client's home (59%), and being yelled at or spoken to rudely in the community (59%) (data not shown).

Consistent with PPE shortages, our data indicate that only a little over half of CHVs reported receiving infection prevention supplies such as disposable masks (55%), and fewer reported receiving hand sanitizer (48%), reusable masks (40%), and gloves (29%) (Table 5).

CONCLUSION AND NEXT STEPS

CHVs are a critical source of education and care for their communities during emergency situations such as pandemics. CHVs are continuing their routine services, at increased capacities, in addition to providing new health information and services, such as educating households on COVID-19 prevention and treatment, contract tracing, and referring clients to facilities for testing and advanced care. There are gaps, however, in aspects of COVID-19 training and CHV knowledge of guidelines.

While CHVs reported feeling empowered to help prevent their clients from contracting COVID-19, they reported various challenges: inadequate provision of PPE, some hostility from within communities, and their own fears of contracting or spreading COVID-19.

To improve CHVs' knowledge, alleviate some of their challenges, and provide greater support, we recommend, to policy and program stakeholders:

1. Ensure all CHVs are given mandatory training on COVID-19 education, treatment, and prevention which includes education on various MoH guidelines.

2. Invest in digital/phone-based supportive supervision between CHVs and their supervisors to foster more regular communication.

3. Provide CHVs with adequate supplies of PPE such as masks, hand sanitizer, and gloves to alleviate their own and the community's fears of contracting COVID-19.

4. Explore hostility and positive experiences felt by CHVs further in future qualitative work.

5. Employ different channels of educating communities (CHVs, media, virtual messaging) on misinformation and misconceptions around COVID-19.

TABLE 4. CHV CHALLENGES (N= 1,385)

Percentage of CHVs reporting challenge	%
Cannot travel because of social distancing regulations	33
Do not have adequate PPE to feel safe	73
People fear CHV might spread COVID-19	61
CHV fears she may get COVID-19	50
Had shortage of contraceptives	14
Had shortage of drugs	20
Had shortage of other commodities	31
Public transportation unavailable	13

TABLE 5. PERCENTAGE OF CHVS RECEIVING PPE (N= 1,385)

Percentage of CHVs reporting receiving PPE	%
Disposable masks	55
Hand sanitizer	48
Reusable masks	40
Gloves	29
Soap	27
Cleaning/disinfecting supplies	7

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The Frontline Health: Harmonizing Metrics, Advancing Evidence, Accelerating Policy project seeks to advance community health systems metrics, monitoring and learning to improve the efficiency and performance of community health worker programs.
www.popcouncil.org/research/frontline-health-harmonizing-metrics-advancing-evidence