Exploring Community Health through the lens of the Community Unit in Kariobangi North and the Surrounding Areas

Maya Paris-Saper

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Exploring Community Health through the lens of the
Community Unit in Kariobangi North and the Surrounding Areas

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Abstract

Healthcare is a challenge in countries of the Global South. Not only do climates and trends of rapid urbanization affect the health status of many negatively, but also many health facilities are inaccessible and not of good quality, they lack enough medical personnel and lack the resources to adequately provide for patients who do not have the resources themselves. As the wealth gap increases all over the world and resources continue to be distributed unequally communicable and non-communicable health issues plague those in urban and rural settings at an alarmingly high rate and as health innovation has worked to end these health issues they do not always reach the most marginalized and vulnerable populations – those living in the very rural environment and those living in low-income urban areas and informal urban settlements (slums). New healthcare systems have been emerging all over the global south in hopes of facing these public health issues head. They utilize a strategy based on referral and trying to meet people where they are at – in the community. Community health systems encourage community participation in the community health and strive to provide true basic, primary, accessible health care to all and to attack larger public health issues as community units as opposed to individuals. How do these community units work in informal urban settlements? This study aims to answer that question by looking at a specific area in the Eastlands part of Nairobi, Kenya. It takes an in-depth look at the functioning of the Kenyan community care strategy and the specific issues around it in one specific low-income area.
**Introduction**

Health is the overall physical, mental and social well being of a person. Community Health is the component of health care that is concerned with a wider population or community’s well being as opposed to an individual. Community health heavily deals with the prevention of disease of areas, the social and environmental determinants of health and disease influence overall wellbeing. Aspects of Community Health involve establishing the health status of a community and planning and managing community level services and programs that enable a healthy community. Those that focus on Community Health usually are drawn to questions of community empowerment and mobilization and explore health promotion preventive, curative, and rehabilitation services.

When understanding illness we need to comprehend that sickness and disease are not a bunch of individual phenomenon. Not only do social and environmental factors like gender, socio-economic status, and geographical location affect a person’s health, but good health or lack there of is dependent upon communities and thus is a community issue. The development of disease is dependent upon what households and institutions within a community do or do not do.

In the field of Community Health it is vital to understand what makes up a community. To understand who is part of it and how it works. A simple definition of a community is a group of people or families sharing common goals, needs, and resources, usually within the same geographic entity. Further it is made up of various components including social structures and systems, environment, the boundaries, and its goals. These different social, political, geographic and economic facets all intersect to affect a community health. From a community health
perspective, the goal is the same as in individual medicine – solve the health problem. The
diagnosis, planning and implementation, treatment and evaluation processes look different
however. In order to diagnose, community health workers incorporate demographic data, the
local environment, disease patterns, and available health services, social factors into their final
diagnosis. To find and promote a solution they put forth a community diagnosis and priorities
and proceed to implement community health interventions. ¹

In Kenya, the overall health care system is made up of 6 levels, with the first level being
the community level. The Kenyan government aims to run a sustainable system where
community volunteers can be the basis for primary health care in communities, rural and urban.
Theoretically the community level of health care has two stratums, the community healthcare
worker – a volunteer from the area and the health technician a government employee. The
health workers attempt to perform health care at the household level and work to be accessible.
A community health worker is supposed to take care of 20 households on average. There should
be 50 community health workers per area, and they work under the health technicians. These
community units receive basic training in curative and preventive health practices. Not only can
community workers provide basic individual health services to community members, but also
educate the community on issues of public health and try to work with the community to
maintain good community health, which acknowledges the environmental, social factors in
health. This idea manifests itself in the practice of public dialogue days, where the whole
community gets together to talk about a specific issue or communal chalkboard that acts as a
public health info center for the community members. ²

² Lecture by Dr. Karama, September 2015
The Ministry of Health created the community care strategy in 2006, as a result of deteriorating health in Kenya and a failure of the previous Health Sector to meet the needs of the people. The previous health system was inaccessible and not affordable to the majority of Kenyans. According to the Ministry of Health’s publication introducing the new community package in 2006, “A large proportion of Kenyans continue to carry one of the highest preventable burdens of ill health in the world. Much of this burden can be lifted and prevented with existing knowledge and resources. Poverty compounds powerlessness and increases ill health, as ill-health increases poverty. Both have become progressively worse since the 1990s, with appalling disparity within and between provinces. The situation is further complicated by the emergence of new and resurgence of old communicable diseases. The community systems are faced with the challenge of coping with the growing demand for care, in the face of deepening poverty and dwindling resources.”

Whether in the slums of Nairobi or rural parts of Northern Kenya the Health care system and the approach to public health were failing the people. Communicable diseases were on the rise and people lacked the medicinal resources for treatment and the knowledge for prevention. Also in 2003 a Kenyan Demographic and Health Survey found that:

- 30.7% of children fewer than five years are stunted.
- Only 2.6% children are still exclusively breastfeeding at six months, while 56.8% are still breastfeeding by the end of 23 months.
- 61.5% of under-fives had child health cards.

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• Only 59.2% of children in the second year of life are fully immunized.

• Only 4.3% of under-fives and 4.5% of pregnant mothers sleep under ITNs.

• Only 40.8% of deliveries are assisted by a health professional and only 39.4% occur in health facilities.

The goal of the new health system was to incorporate preventive, curative, and promotive and rehabilitative medicine into all health facilities and health structures. The community-based approach that was created in 2006 also wanted to make households and community members take an active role in health and health related development issues. Again it was about understanding Health as a community issue and promoting all members to involve themselves in the process.4

The aims were to ensure that all level 1 (Community level) services were provided for all life cohorts and socioeconomic groups, including the “differently-abled”, taking into account their needs and priorities. To build the capacity of the community health extension workers (CHEWs) and community-owned resource persons (CORPs) to provide services at level 1. To strengthen health facility–community linkages through effective decentralization and partnership for the implementation of LEVEL ONE SERVICES. And finally, to strengthen the community to progressively realize their rights for accessible and quality care and to seek accountability from facility-based health services.5

Many of the most vulnerable populations in Nairobi living in low-income estates and


5 Kenya Ministry of Public Health and Sanitation, Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services (Nairobi: 2006)
informal urban settlements have traditionally had poor public health situations and lack of access to quality healthcare. How has the community strategy reached these populations? How have these interventions assuaged or perpetuated issues that these communities face when it comes to public health? Are these level one services working in the way that makes sense for these communities? By looking into a specific – largely non-researched – informal urban settlement, one can get a better understanding of community health in urban slums and if and how the strategy is working in these specific community contexts.

STATEMENT OF THE PROBLEM

Since 2006 not every single community automatically got a government funded health care facility with a trained technician and 50 health workers. How has this community package been implemented all over Kenya? What do these level 1 services look like on the ground? How do socio-economic and geographic factors affect the practice or even existence of the community health facilities and the community health workers? What is specific to Kariobangi is that the government does not provide many of the resources it is supposed to? The population is so large and migratory that creating sustainable relationships with patients is hard? How do community units and community health workers work through those issues? I will be exploring the problems specific to largely ignored informal urban settlements which include lack of resources, large population, lack of community participation, marginalization, as well as overcrowded and unhygienic living spaces.

Kenyans living in low-income urban settings do not always have access to good, clean drinking water and regulated sanitation and sewage facilities do not always exist. Small spaces with many people living and working in them can lead to many diseases. These diseases are
brought on by proximity to the sick, air pollutants or contaminated food and drinking water. It is crucial to examine and evaluate if the key objectives and structures set up in the Ministry of Health’s Community Care package are happening in communities, once examined it is important to understand all the factors at play. 

In the majority of Kenya, only 40% of people live within 4km of a health facility. Even if they can access a community health facilities, the facilities do not always have the resources the patient needs, whether that be experienced workers, medicine or public health information. Disease burden is high when communities do not have access to the right medicine or right information about preventive and promotive health.

In many low-income urban settlements, disease burden is so high that the health facility cannot fully serve the community in the way it needs because of population, environment, and a lack of resources and lack of government support. Urban slums either have a complete lack of resources that enable positive community health or they have a plethora of community based organizations that do not work together or completely in touch with the full needs of the populations. Do communities that do not have resources or that are informal, whether rural or urban fully receive the community health care they need?

Evaluating how the social, political, economic demographics of the area is critical to understanding how the community level of health care is being implemented, and why certain services are provided or not provided. It also directly relates to why certain public community health institutions do not have enough resources.

How have the county governments impacted the community health of the area? How has the official implementation community care strategy with a community unit (CU) affected the overall health of the community? How has the county governments and the MOH been held accountable in terms of community and primary health services? How and who are these communities being provided for or worked with to work towards erasure of communicable disease burden, and overall community well-being. What role to community-based organizations and NGOs play in community healthcare? Exploring how those relationships play out on the ground and the complexity of care provided by the government as well as the CBO is crucial to understanding how community health can work well in an informal urban settlement.

**OBJECTIVES**

1. To understand the factors associated with the function of community health workers (CHWs) in the area, to ascertain what is lacking and what the community needs

2. To evaluate the community unit in relation to the strategy and in the urban situational setting

3. To explore the community perceptions on the service provided by the CHWS

4. To identify factors that influence sustainability of the community unit (CU)

**Setting**

The study will take place in Kariobangi (North) and the Baba Dogo areas of Nairobi, Kenya. Kariobangi is a low-income residential informal urban settlement in the northeastern side of Nairobi. It is made up of permanent housing as well as many “slum-like dwellings”. The people living there come from many different ethnic groups and live in permanent to non-permanent housing. The populations lives with many hardships; debilitating public infrastructure, lack of
water, poor sewage and waste disposal systems, unemployment, high rates of crime. HIV/AIDS is an issue in this area but due to education and access to ARV, a rise in prevalence is not extreme. Tuberculosis is a pressing issue as it such a contagious disease, and the socio-economic context of this area enables the rapid spread of TB. Overall the poor infrastructure, lack of government interest and attention, and intense poverty levels greatly disadvantage this community in regards to health. There are active CHWs in this area and a community health facility that they refer to called the Baba Dogo health facility.  

Manufacturing Area, Kariobangi

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7 Wofak.or.ke

8 Kariobangi.com
Map of Health Centre Area

View of houses and apartments in Kariobangi North
Literature Review

“Community Strategy Evaluation report October 2010” by UNICEF and Kenyan Ministry of Health

The premise of study was to evaluate how the Level 1 services were being implemented all across Kenya, and to evaluate the Community Healthy Strategy about 4 years later. The broadness of this study was important in understanding the larger Kenyan context of the Community health care four years after it was introduced. It provided key entry points for a different study of a specific location or specific community health facility. This study had a mixed research design; it was qualitative and quantitative. The researchers conducted Focus discussion groups, Key in-depth interviews, household surveys and questionnaires.

The evaluation found that generally, retention of community health workers (CHWS) was in part due to a good incentives package. It also importantly notes that the topics of water safety, food hygiene and solid waste disposal were covered much more comprehensively that other components of preventive healthcare and public health.

From key informant interviews, the established link between the community and the health facilities was important. There was good coordination and communication between The CHEW and the CHWS (who identified illnesses and then referred them to the health facility). The community was increasingly becoming aware of their rights to quality health care, after interviews and larger discussions, however there was no direct structure of empowerment; people didn’t feel empowered to demand for services or not many clear structures for addressing their issues. The community based health information management was not very effective, sometimes data wasn’t collected properly, or CHW were not even introduced to the
practice and thus guiding community health interventions based on this data is a challenge. The report outlined the main lessons learnt from the evaluation are as follows;

- Participation of community members in strengthening health systems elicited grassroots acceptance, support and sense of ownership. This resulted in increased demand
  For health services at level 1 therefore improving health of the target population.
- Active supervision and linkages forged between DHMT, CHEWs, CHWs, and CHC played a key role in the sustainability of the programmed.
- Creating community demand for health services by government and partners must be matched with the availability of improved services within health facilities.
- A comprehensive, integrated approach to a multidimensional health programmed helps ensure that communities ultimately access the services they need.

The study found that mobilizing resources is a key issue. It was found that the training of CHWS needed to improve. There needs to be more comprehensive training as well as trainings in installments. The trainings do not always address the health issues people face at all stages of the life cycle.

“Hidden Cities: Unmasking and Overcoming Health Inequities in Urban Settings” by UN-Habitat and the World Health Organization

This report lays out the current growth of cities in developing countries and the current health issues that are coming up with them, Cities seem to be the concentration of jobs and wealth as well as the biggest health hazards and risks. 1 and 3 urban dwellers live in informal
urban settlements, which are usually crowded; less policed, and has high air and water pollution rates. These social and economic inequities lead to health inequalities on a monumental scale. It shows the dire public health situation that these urban dwellers face, while also demonstrating how the distribution of the disease burden is inequitable. It reports that is important to segregate the health status of the informal settlements with the health determinants. For a sustainable solution to this health issues and issues of inequality all different sectors have to be cooperating together. Not just the health sector should take on interventions, but the health sector needs to work with the local government and other aspects of society. Local leader needs to be playing a role in urban health equity is there is going to be a shift in the current situation.

**Methodology**

The research – primary and secondary data collection – was conducted during the months of November and December 2015. It was qualitative and evaluative in nature. The study utilized one on one interviews, ethnographic observations, and one small focus group. The primary data collection included interviews with a public health official at the Kenyan Ministry of Health, leaders of the local branch of the NGO, Women Fighting Aids in Kenya (WOFAK), the CHEW of the CU at Baba Dog, the deputy nurse of the Baba Dog community health facility, counselors at Baba Dog and a small amount of Community Health Volunteers - formally workers - (CHVs). The interviews were mostly conducted in English with a very minimal amount of Kiswahili used.
This study also relied on observations of the health clinic. This coupled with the interactions between the health workers and community members also heavily contributed to the analytical conclusions.

Due to unforeseen circumstances this study is not the most in-depth as it could have been. As I was not a community member and I was not spending all my time in the community – having an immersive experience in they are could not be achieved. Also the process of receiving authorization from certain organizations that I was working with proved a bit overdrawn and delayed my research. I was also unable to administer questionnaires to a large contingent. These were the limitations of my study. However I was able to have many in-depth interviews and spend a significant amount of time at the health facility.

In this study, ethical engagement with the community was the highest goal. Consent was always gotten before conducting an interview or doing an observation. Consent to be recorded and included in this paper was always received before moving forward. I worked to never shame or embarrass the community members I was engaging with, as I understand this is their day-to-day reality and technically I am an outsider doing research.

**Results and Analysis**

In this area the community unit was officially formed in 2013 and has a CHEW (community health extension worker) and CHVs for three areas, in the geographic and theoretical center is the Baba Dog Health Facility. The process of the implementing the government strategy community unit is as follows: The Ministry of Health looks for partners and selects the village elder or elders. The elders select people for a chief barraza, this chief barraza includes youth representatives, those living with HIV, those with disabilities, community leaders, those active in the community – a range of voices are important to include.
This chief barraza of about 12 people makes up the community health committee and is regarded as the governed body of the CU. They go for a training of about one month on skills needed to govern well, administrative sills, disciplinary tasks.

Once the training is complete, they go and identify who it makes sense for to be a CHV. Once the CHVs are identified the committee talks to them and begins with 2 weeks of training, an evaluation/observation occurs and then they begin working fully as CHV. The initial training is done by donors or outside people – either MOH or NGO people – and provide then with tools (medical and otherwise) for the field. They go out “armed”, as one WOFAK worker put it. While they are CHVs, the CU has monthly meeting to express and discuss the issues they face as well as receive more training on specific health issues. A specific critique of the current situation by a WOFAK worker and long time CHV is that right now the CHV “aren’t armed” in the way they need to be in the field. For example, they do not have HBC kits and VCT kits that they can bring on their usual home visits. In the past WOFAK has been able to provide these, but right now they do not have the funds and the county government is not providing these kits to the CHVs. Thus this type of testing and care cannot happen in the most accessible way. They do not have all the tools because of the lack of funds. What is important to note is that before the government came in, organizations like WOFAK were carrying out a similar strategy. Asking for volunteers, training them and then sending them out into the field. The Community strategy changed the system a bit and institutionalized the community unit. Now it is not just the CBOs or NGOs and the CHVs, but the MOH and county government plays a larger bureaucratic and facilitating role in the community health plan.

The Community Health Volunteers (CHVs) have varying levels of experience and various amounts of household under their jurisdictions – it depends on the populations and how many
houses are in their area. The CHVs – mostly trained by WOFAK employees understand the importance of their role. They do house to house visits, addressing simple health issues of hygiene, sanitation as well attending to patients who they know are HIV positive or have Tuberculosis. They listen to people’s symptoms and usually refer them to the health facility – sometimes taking extra measure to make sure they go. They are trained on up to date health information in terms of sexual and reproductive health, proper hygiene, antenatal and post-natal care, first aid, VCT, primary care, gender- based violence recovery. The community health volunteers that were interviewed had been community health workers for a very long time – long before the formal community unit was set up. Community organizations in the area employed the use of Community Health workers. One woman has been a CHW – now CHV- for 17 years. She became one because as she said, “many people in the community were sick and there were not that many people to take care of them. There were many challenges, TB and HIV were expensive to treat and I wanted to help.” Another woman who has been a CHV for about 7 years became a CHV because her mother was very sick and she wanted to know all the proper protocol for giving her the best home based care and then that transitioned into using those skills for everyone in the community. They all have between 30 to 50 households in their jurisdiction. The amount of households they visit depends on the population of their community. Daily activities include home- based care, home visits, and educational sessions, time spent at the facility. If patients are taking drugs they make sure the drugs are right and that the patients are on the right regimen. Especially if patients have disabilities or are bed-ridden they make sure to visit them in there homes. If they the CHV are needed at the Health facility, they go there and make sure follow up happens with a patient that they referred to the health facility. The Health facility is right off of Baba Dogo road and thus accessible to people by matatu as well as walking or other means of
transport. It is in the center of there different communities and thus services them all. It advertises that it offers PMTCT, immunizations, primary care, antenatal and postnatal care, family planning, growth monitoring and many other services. The deputy nurse gives Health talks every morning for a half an hour to whoever is in the waiting room. They tailor the talks to current health issues in the area and to the current environmental situation that is causing health issues. The deputy nurse cited these talks in current and past reductions to certain preventable and contagious diseases. For example, during the rainy season, proper precautions are addressed as too prevent water borne illness that spread faster with a poor sewage system. She also spoke to the fact that she is overworked and that the biggest challenges are not being able to see all the patients in one day and not be able to prove the right medicines since they are not available at the clinic. Vaccines and immunizations are available for applicable patients, however drugs are not present due to funding issues – thus the promise of free treatment cannot be followed through on.

The Chew at Baba Dogo supervises the CHW, keeps track of referrals, does monthly reports, facilitates monthly meeting, and keeps the public health board up to date. He has been a Chew for four years. He seems like he organizes the CHVs well, with help from WOFAK, and provides important spaces for them each month to address their concerns and challenges. At the times of the health center visits – the public health statistics board was not properly filled in and up to date however.

The WOFAK employees that were interviewed, as well as the CHVs that were interviewed, did not seem to particular favor this new formal community unit. With the institutionalization of this community strategy they expressed that there was more bureaucracy and still not a lot of funds at all for the proper care. Serphine, the head of the Home Based Care in Kariobangi with WOFAK expressed that is was easier to get things done when it was just the
NGOs working the CHVs. The CHVs were in much more direct contact with those implementing
the health interventions and those providing the trainings and the donation, now the MOH more in
between WOFAK and the CHVs. At first there was also compensation to the CHVs and no there
is not at all. When asked the CHVs feel very little support from the Ministry of Health – as
volunteers they are in no way compensated and the people who train and support them are mostly
NGOs like WOFAK. They do not really feel like the MOH actively works to end the problems in
the community and the challenges they face as CHVs, they always get a “God will pay you/Solve
your problems response.” Which of course frustrates them. The idea that God is the one they are
supposed to be looking to provide compensation or give more resources to the Health facility
outlines that the government and provide funds are does not want to – perpetuating the continual
marginalization of the community members. The attitude that God will provide for you does not
help the CHVs do their jobs better or support their lives. One of the CHVs outlines it by saying,
“You come home and you have things to take care of, your children have to eat, have to go to
school, thanking GOD won’t always provide the necessary material needs to live.”

Does this government strategy truly help or hinder the community health of the area?
From the above statements, it does not really. However on a larger national scale it has been
proven by studies, that communities that have implemented the Community care strategy have
much better health indicators than those where one was never set up. The existence of CHVs in
this area, with the existence of the Health facility and Baba Dogo have greatly improved the
health of community members, but can that be totally attributed to the Community strategy
implemented in 2013 here out of Baba Dogo? It seems to be more the concept of community
healthcare and the administrative idea of referral and public health data that has improved the
health status of the community. What the community strategy has done is implement the dialogue
days, which have now become action days. The CHEW and the CHVs have all said that these were and are really important for the broader public health of the community. In this CU, the dialogue days started as not only a space to talk about public health issues with a large amount of the community, but also a meeting space for the community to talk about what they feel the top concerns are – what and how they want to tackle public health issues. In this sense the strategy of community participation and investment has been fully realized. A program that falls within the community strategy that WOFAK has also implemented is a CARE group. These are groups of CHVs that identify the key health issues in their community and go door-to-door disseminating health information and try and curb the disease burden and promote healthier living. Currently the CHVs are working on maternal and child health in the area. The issue is that this program and other like it are dependent on donor money. Serphine at WOFAK said while the dissemination of health information should be based on what the community needs it sometimes has be driven by what the donor wants out of necessity.

The toll of being a CHV, making sure you get all the visits done, care for everyone etc. is wearing down on the volunteers and the material support from NGOS - and the MOH as stated above is very lacking – does not adequately support your life. The funds from the county government are not there and donations and aid going to NGOS that propel the community health unity have gone down in the past few years. The CHVs all said that it is a very hard job. On your feet all day, going from place to place or running a health tent – mobilizing the community. They do not always have water or other provisions; one comes home tired, hungry and does not receive the proper compensation for their labor. The CHVs that were interviewed all said that they do this
job because it is important and it gives them joy to help people – it is meaningful, and that is what keeps them going.

Sustainability seems like a hard state to achieve right now. After taking to the CHVs, WOFAK, the nurses at the center, and the CHEW it is apparent that the funds from the county government are not there and thus medicine that cannot be bought. When the medicine cannot be bought for the public health facility than those looking for much needed free medical care will not actually be able to receive it fully. The biggest challenges various people involved the community health unity are the lack of funds to provide adequate, good-quality, and free health care to the people of the area. As well as adequately compensate all the CHVs and medical workers for the work that they do. Programs cannot rely on donor money and the MOH does not have the funds to supply the needed materials or is not paying attention to these specific communities. When asked how this situation can change, MOH personnel bring up the idea of CHVs starting a social enterprise together and then being able to make money off of that. The issues with that is that there needs to be capital to begin with to start off and that does not usually exist, as well as the fact that CHVS cannot dedicate time to running a social enterprise while also being committed CHVs in the area. This idea also does not address the issue of making sure the Health facility has all the proper medicine and equipment.
Conclusions

What are crucial to the community unit functioning well community are the best donors and partners as well as the right resources. WOFAK and another organization, Goal Kenya, have stepped in and are true partners to the public health facility, providing trainings and tools. However organizations are loosing funding and it is evident the county administration and the MOH are not providing enough room in their budget to compensate the CHVs, give them the proper medical equipment and provide enough medicine to the public health facility. Working with NGOs and CBOs is key to a successful community health strategy; however it seems like the county budget is at fault for not providing adequate percentages to the community health sector.

People cannot receive care and the disease burden will not reduce if the treatment is economically inaccessible. The CU is not sustainable if the CHVs do not have the resources they need – for themselves and the community members that they see everyday. The CHVs also do not have enough time to engage in other ways of making a living. They dedicate there time to their families and to their role as a CHV.

Despite these issues that are part of the broader system in which this CU operates in, The CHVs, NGO members, and medical personnel at the health facilities seem to genuinely do there job to the best of there ability and have the health status of the community in there minds. They are combatting urban inequalities in an extreme form and they are mobilizing community members to take intiative in their overall community’s health. The CU is working to the best that it can with the resources it has. More resources – money, tools, and experience personnel – would just improve what is being implemented in this area. There is investment in overall
public health as well as more easily accessible people and a facility to go to in terms of health issues.

**Areas for Further Study**

Since time was an issue for me, I would recommend further in-depth looks at the community health and public health situations in informal urban settlements in Kenya. Another area to focus on further would be accessibility of the CU and facility as well as what mobilization looks like on the ground. Another area of further study could be how communities could work to shift their marginalized status, especially in regards to the social and environmental determinants of health.
Appendix

These formal questionnaires guided my interviews and conversation with people while I was on site. While I was in the field, the questions became malleable and what I asked depended on the context.

Questions for Community Health Workers

Name (will remain confidential):
Age:
Marital Status:
Education level:
Location/Residence:

# Of Children

Other employment (if any):

1) How did you become a community health worker? Why did you become a CHW?

2) How long have you been a CHW in this area?

3) Describe your daily activities?

4) How many people do you see in a day?

5) How much time overall are you able to commit to being a CHW?

6) Do you like being a CHW?

7) What are the good things?

8) What are the challenges? Especially in this urban context?

9) What do you do in disease outbreaks? How do you report it? What actions do you do to try and contain it?
10) What is your training like?

11) How prepared do you feel for the activities you need to perform as a CHW?

12) How often are you able to run public health dialogues and sensitization sessions?
    What are they like?

13) When you run public health programming, is the community responsive?

14) What are the most common health issues people have in this area?

15) How often are you able to disseminate public health information, statistics, updates about the community to the community?

16) As a CHW, who are your best partners are in regards to community health?

Questions For NGOs and Ministry of Health

**WOFAK**

1) Can you talk about what your organization does specifically in this community in regards to physical and mental health in this area?

2) Were you working/volunteering here when the community health facility was set up? Can you talk about that process from your organizations perspective? Your personal perspective?

3) What has been and is WOFAK’s role in the community health facility and the community health of this area in general? Economically, socially, ECT?

4) What do you want your ongoing relationship to look like?

5) What do you think the community perceptions of the CU are in the wider community?

**Ministry of Health**

1) What is your name and position?
2) What are your thoughts about the current health issues in Nairobi’s slums?

3) How do you think healthcare has changed in low-income urban areas of Nairobi since the implementation of the community care strategy?

4) How do you feel the community strategy has played out since its implementation?
   Specifically in urban slum settings?

5) How do you think the community units deal with these health issues?

6) How do you as a Ministry fund these community units? How much of the health budget is allocated to CU and CHEWs?

7) Do you feel like they have enough economic and professional (like the right, trained people) resources?

8) How do you think the community strategy is working to improve health and healthcare in this area?

**Interview Questions for CHEW**

1) Name:

2) Occupation:

3) Location/Residence:

4) Education level:

5) Marital status:

6) # Of Children:

7) How long have you been the Community Health Extension Worker for this CU?

8) Were you here when this community unit was being set up?

9) If yes, can you explain/tell me about that process? How did it happen?
10) What do you feel like the biggest health issues are? In this community? With consideration to geographic and socio-economic context?

11) What does preventative and promotive healthcare look like at this facility?

12) What is the facilities relationship with the nearby WOFAK facility? With other NGOs? FBOs? The Ministry of Health?

13) What is the community involvement and investment like for this CU?

14) How do you encourage community participation and involvement in health care issues?

15) What do you think the people in the area think and feel about the Community Health facility and the CHWs?

16) How do you recruit CHWs?

17) What is the training like?

18) How do you receive funding and resources to provide the services that you do?

19) In what areas do you feel like you resources meet the need? In what areas do you feel like you cannot meet the need?

20) Does this Community Unit use technology including SMS)? If so, how?

21) How do you deal with disease outbreaks here?

22) Do you like the community strategy? How do you think it is working here? Well? Poor?

Questions for Community Members

1. What is your daily life like?

2. How often do you suffer from poor health?

3. Do you know of the CHWs here?

4. Do you see them around this area?

5. Do they come visit you at your house?
6. What do you think of the community unit in this area?

7. When you are in need of medical care or have a public health question, whom do you go to?

8. How do the CHWs and Community Unit meet your medical needs?

9. How involved are the CHW in the community as a whole?

10. How do you feel like the CHW and the CU are dealing with public health issues in this community?

11. Do you go to any of the public health dialogues, sensitization programs that they run?

12. Are the dialogues, programming, etc. accessible to you?
Bibliography


Unicef, JOHN PAUL OYORE 2010 “Community Strategy Evaluation report October 2010”
DIVISION OF COMMUNITY HEALTH