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Empowering Community Health Volunteers in Rural Kenya: Case Study of Orongo Widows and Orphans Program

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Abstract
The purpose of this study was to determine the popularity of Group Income Generating Activities (IGAs) as a way of reducing socio-economic challenges for the typical community health volunteer in Kisumu East District. Kenya. The methodology was descriptive research; a case study of Orongo Widows and Orphans Project International. Kenya. Volunteers were mainly middle aged widows or married women living below the poverty line and doubling up as the main breadwinners for their families. Their biggest challenges were work demands and high expectations while group income generation was found to be highly popular. Volunteers felt that IGAs would both improve teamwork amongst them and enhance their performance. They felt that Group IGAs should be initiated for them either by government agencies or the not-for-profit sector. It is the recommendation of this study that further research is needed to determine the most appropriate ways of establishing these group income generating activities.
Key Words: *Volunteerism. Empowerment. Motivation*

1.0 Introduction

1.1 Background

The scarcity of health systems resources in Africa has meant that decision makers employ efficacious and effective health interventions using available resources and mobilizing more domestic as well as external resources at the right time and in the right quantities (Kirigia. 2009). Community strategy. a flagship government of Kenya program began in 2006. The approach includes establishing a level 1 care unit of 25 well-trained Community Health Volunteers (CHVs) who would each provide health services to twenty households at the village level (Level 1). Each such batch of twenty five CHVs would be under the supervision of one government employed Community Health Extension Worker (CHEW). The overall goal of Community Health Strategy is to improve community access to health care in order to help productivity and in the process reduce poverty. hunger and child and maternal deaths as well as education performance across all the phases of the life cycle (Ministry of Health. 2006). According to the National Health Sector Strategic Plan for 1999 – 2004 (MOH. 1999). the vision of the Ministry of Health for Kenya is "to create an enabling environment for the creation of sustainable quality health care that is acceptable. affordable and accessible to all Kenyans".

1.2 Statement of the Problem

A report in the 'Nation' Daily Newspaper of Kenya best captures this problem: "Volunteer Community based health workers from Nairobi slums have asked players in the health sector to consider paying them allowances. The more than 150 workers attached to the urban slums development project that is managed by the Nairobi city council and other stakeholders received certificates and trophies. which they said would not feed their families" (Daily Nation Newspaper. 6th Jan 2010). This captures the dilemma of using human resource from poor communities. in spite of their poverty. to provide much needed volunteer services in the health sector. It is also worth noting that of the Ksh266.7 billion that was expected to be spent on health over the four year period ending 2010; only 0.1% goes to facilitating an enabling environment (NACC. 2009).

"The community systems are faced with the challenge of growing demand for care in the face of deepening poverty and dwindling resources. The cost of health services has also escalated well beyond the financing capacity of the MOH (Ministry of Health. 2006). The Ministry of Health Joint Program of Work and Funding and the Ministry of Public Health Strategic Plan 2008-2010 articulate the prioritization of implementation of Community health services in Kenya with the target of reaching 3.2 million households in four years (TICH. 2006). The development of partnerships between health systems and communities is advocated as a way of enhancing overall community capacity to address priority health concerns. and to reduce escalating health care costs and inequities. Health volunteers have many capacities well suited to collaborative activity (Coady. 2009).

1.3 Purpose of Study

The purpose of this study was to determine the popularity of group income generating activities as a way of reducing socio-economic challenges for the typical community health volunteer in Kisumu East District. Nyanza

Province. Kenya. The research questions that guided the research were as follows;

- What is the demographic profile of the typical Community Health Volunteer in poor rural communities of Kenya today?
- What problems do Community Health Volunteers experience in the course of and as a result of their work as volunteers?
- Would Group Income Generating Activities enhance teamwork and tackle socio-economic challenges facing Community Health Volunteers?

This research was geographically limited to East Kolwa Location of Winam Division. Kisumu East District. Nyanza Province. Kenya. The population was the forty community health volunteers working under Orongo Widows and Orphans Project International. a young nongovernmental organization supported through a USAID funded consortium. and the five social workers who supervised the community health volunteers. It was intended to assist policy makers. academics. researchers and civil society managers in charge of designing health interventions at the grass roots.

2.0 Literature Review

2.1 Demographic Profile of the Typical Community Health Volunteer

The importance of volunteers to society was formally recognized by the United Nations General Assembly in 1997 with the declaration of 2001 as the International Year of Volunteers (Dreary. Leonie. Leo. Lockstone and Margaret. 2002). Brand. Kerby. Elledge. Burton. Coles and Dunn (2008) found that in order to retain volunteers' public health and emergency management. volunteer programs need to address the social. interpersonal and educational desires of volunteers. In Olagoke Akintola (2008). a population based study revealed that in the United States of America. 3.2% of adult population provides care for a friend. spouse. relative or lover with AIDS. In Bangladesh. Community health volunteers or 'Shasthya Shebika' are ideally married and aged at least 25. They deliver preventive and basic curative health services through door to door visits with each one covering an average of 250 households. Their number has risen over the years from 1.080 in 1990 to 70.000 in 2007. Their supervisors are referred to as 'Shasthya Kormi' and each such supervisor is in charge of ten 'Shasthya Kobika' (Faruque. 2009).

2.1.1Poor Rural Communities

In a US based research. Thibault (2007) observes that much of today's reality within community development consists of an environment where funding conditions undermine community power and community development and trumps community organizing. Competition for funding causes organizations to spend too much time on the funders' needs rather than the community needs. Lekoko. Rebbecca and Marietjie (2006) characterize the concept 'Rural' in Botswana to recognize the fact that unlike urban dwellers. rural people are deprived on several counts. For instance. some development policies fail to recognize that the rural poor can identify and define their own basic needs. Poverty in Kenya is a function of interrelated factors including untapped or poorly used human resources. Tackling poverty is therefore essential in dealing with the pandemic. hence the advocacy for an all-round approach. The two major economic effects of HIV/AIDS are a reduction in labor supply and increased costs. About 80% of Kenyans live in rural areas. and of these. 90% earn their livelihood from agriculture. The household impact of AIDS begins as soon as a member starts to suffer from HIV related illnesses. Other members of the household. usually daughters and wives may miss school or work less in order to care for the sick person (Bollinger. Stover and Nalo. 1999). The same authors write that if two adults and a child die of AIDS in a household. the rural household income loss is between 116% and 167% of its income. Households then adopt strategies like withdrawing children from school or sending them to stay with relatives so as to cope. Ndegwa and Hansen (2007) discuss the food poverty problem of the Luo community. who happen to be the main inhabitants of East Kolwa Location. the geographical area in the scope of this study. The study found that with worsening agricultural production among the Luo. there is a greater tendency to secure money from other forms of subsistence such as fishing and reliance on remittances from employed relatives. Episodic or seasonal food shortages occur almost annually because of poor harvests due to inadequate rainfall.

2.1.2 Kisumu East District

The entire population of Kisumu East District comprises of some 68.925 female rural dwellers and 53.502 male ones. The total number of households is 84.963. which implies that at 20 households for each community health volunteer. the entire rural population in the district needs some 4.246 volunteers (Kisumu East District Information Office. Table I). The poverty levels are high with absolute poverty standing at 49% while among the rural poor it is 58%. Food poverty is at 61% yet agriculture is the main source of income for 70% of the population. There is a high school dropout rate at 59% raising serious concerns on the level of literacy of the average volunteer. On health. doctor to population ratio is 1:15.182 while a nurse to population ratio stands at 1:2.069. The HIV prevalence rate is 11.2%. one of the highest in the country (Table I). These statistics give us an idea of the nature

of the typical community health volunteer in East Kolwa location. Malaria is another major health problem in this area. Areas with malaria prevalence are impacted negatively even in economic terms. Opiyo et al (2007) write that the economic burden of Malaria for households can be extremely high. Treatment costs for small scale farmers in rural Kenya have been estimated to be as high as 7% of the monthly household expenditure. not considering any costs of prevention measures. Population projections for Kisumu East District indicate that by 2012. under 19 year olds will form the largest percentage of the entire population. placing a huge burden on the actively productive segment and having implications on health service provision at level 1. Community Strategy. The high school drop-out rate also has implications that this active segment of the population may not be well endowed with the skills to confront challenges in society. including acting as useful volunteers within their communities (Kisumu East District Information Office. Table I). In the next section. we will notice the significance of having capable team members with complementary skills.

2.2 Problems Facing Community Health Volunteers

Jeffrey L. Brudney (1993) talks about the difficulties that volunteerism faces in the USA. Issues to do with reimbursements for work related expenses. provision of liability or relevant insurance in the risk prone work. the over engagement of paid workers in training of volunteers. high levels of absenteeism and turn over on the part of volunteers. unreliability of volunteers in meeting work commitments. recruitment and the possibility of tensions with labor unions should there be an over reliance on volunteers rather than paid staff. In order to get the best out of volunteers. they need to be chosen well. placed with imagination. given satisfying work to do which matches their skills and interests. and managed with skill. They are not simply there to be deployed as cheap labor in the worst of jobs (Botting and Norton. 2001). According to Lankester (2002). the role of the CHW is triple-fold; health educator. health provider. and agent of change. but their functions or job descriptions vary greatly depending on the needs of the community. the availability of other health care nearby. the plans and policy of the government and the aims of the project.

2.2.1 Work/Family Balance

Margaret Gooch (2005) found that satisfied volunteers were those who managed to balance volunteer work with other aspects of their lives. apart from other issues.

2.2.2 Organizational and Managerial Factors

Deena Buris (2007) contends that the multi-layered management structures created between NGOs and Government in Developing countries often leads to chaotic monitoring. reactive policies and conflicts over jurisdiction. A study by Milligan and Fyfe (2005) suggests that the organizational set up and planning does indeed influence to a great deal the kind of input that volunteers make. From Research in the US. it is noted that a well-designed and operated volunteer program can be expected to increase the job skills and deepen the experience of participants. improve agency relationship with community and promote greater public awareness of pressures and constraints on Government (Brudney. 1993). Lankester (2002) further observed that many programs will normally be run in close association with government. For instance. in China. the government is the lead partner. In other scenarios. governments contract out CHW training and supervision to NGOs.

2.2.3Personal Challenges

Olagoke (2008) lists some problems faced by care givers looking after PLWHAs as confronting poverty and limited ability. Literacy and especially innumeracy is a major challenge to the less educated volunteer. Lankester (2002) holds that good CHWs offer their services out of social concern. interest in the job and personal commitment. However. they usually come from poor backgrounds while their families may also depend on them for their livelihood. It would therefore be unreasonable for such people to serve more than one or two days each work and receive nothing for their effort. It is also observed by Shikwati (2003) that the link between health care and economic prosperity shows that countries that are wealthier tend to be healthier. He further observes that the urgency of empowering people economically as a lasting solution to tackling health care is well illustrated.

2.2.4 The Job Itself

Barbara Stilwell (Capacity Project. Chapel Hill) has proposed the use of Task Shifting as a way of improving the effectiveness of Community Strategy in Kenya (www.hennet.or.ke/page.php). Task Shifting involves transferring the roles previously done by professional health cadres down the service delivery levels until you get to the patient who is slowly rehabilitated into handling aspects of their own care without much input from a volunteer or any such assistant. The volunteer's job needs to be designed to fit into the peculiarities of volunteerism such as the need for flexi time. In Bangladesh. under the BRAC program. services delivered by the community health volunteers include health and nutrition education. family planning methods. pregnancy related care. basic curative care of ten common diseases. Tuberculosis control and social mobilization (Faruque. 2009). In a study by Snider and Omoto (2006). it was found that a persistent frustration in volunteer programs is the high attrition among

volunteers. The only difference between those who quit and the ones who stayed on in volunteering a year after the start was in the cost of the volunteer work. Those who quit. much more than the ones who stayed reported that volunteering had taken too much of their time and also caused them to feel embarrassed. uncomfortable and stigmatized. The study found that the volunteer attrition seemed not to be associated with the relatively "self-less" or other-focused motivations as one might expect. but with more "selfish" desires of feeling good about oneself and acquiring knowledge and skills.

2.2.5 Rural Infrastructure

In McCann. Ryan and Mckenna (2005). one of the themes was the difficulties associated with getting volunteers to work in rural areas where they had to travel long distances. In Africa. this infrastructure problem is further aggravated by impassable roads or lack of them especially during the rainy seasons. Kibaru. Omolo and Mulatya (2005) observe that although overall coverage and physical access to health care services seem quite good in Kenya. with almost 80% of the population living within 5km of a facility (KDHS. 1993). there is still the challenge of facilities serving very large populations.

2.2.6 Societal Factors

These are factors that relate to the wider society. Leblanc and Wright (2000) observed that "…not only can care giving involve imbalanced exchanges of support; assistance may not be acknowledged in many instances. In fact. care givers may find themselves being resented or the target of vented frustrations and anger. even vilified by the care recipient". Brudney (1993) lists the pressures and constraints involved in volunteer work in the delivery of public services as; 'Reimbursements for work related expenditure. paid staff time being allocated to training and supervising volunteers almost always at a premium. volunteers often accused of being poor workers. high levels of absenteeism and turn over on the part of volunteers. unreliability of volunteers in meeting the work commitments. recruitment. and the possibility of precipitating political and labor tensions'.

2.3 Income Generating Activities and Teamwork among Community Health Volunteers

2.3.1 Team Work and Community Health Volunteer Groups

Scarnati (2001) discusses teamwork as a synergic process in which the effort of the cooperative group surpasses individual effort. In synergy. 2+2=10. a magnifying effect. Performance can be enhanced and obstacles overcome by the synergy of teamwork (Rabey. 2003). Brooks (2003) refers to group cohesiveness as the 'pulling power' of the group. its magnetism. the ability to retain its members. The size of the groups or teams matters as larger groups tend to have less commitment. difficult interaction. unclear goals and clique development. Would the creation and sustenance of such teams be promoted by the inclusion of Income Generation in the activities of Community Health Volunteer groups?

2.3.2 Income Generation

In Bangladesh. in a low-lying area that depends on agriculture and suffers regular flooding just like East Kolwa location. Sikh (2005) writes that they came up with a comprehensive model. the 'Gram Bangla Model' for poverty alleviation and self-reliance. which the authors claim appears to be the first of its kind in the world. to try to solve the problems of these rural Bangladesh communities. Barad. Maw and Stone (2005) write that interest in earned-income nonprofit ventures is rocketing. It is unfortunate that despite the vast experience with community health workers. relatively little scientific evidence is available to answer some of the basic questions such as some of the financing strategies to pay community health volunteers in a regular and sustainable manner and the critical functions that are achieved by different incentives (Bhattacharyya et al. 2001). Lankester (2002) addresses the question of sustaining these programs. When available. she notes. government funds should be used but these should be paid as block grants with minimum conditions while keeping other funding options open. In any case. she continues. where payments are made. they should not be seen as wages and should be paid in time and in full to avoid demotivation. Mair and Marti (2007) argue that where the absent or weak institutional arrangements impede peoples' effective participation in markets and society. entrepreneurial actors step in and fill these voids by building platforms for participation. The idea in Health Sector Reforms (HSRs) is to expand community based health care (CBHC) principles by decentralizing to formalize peoples' power in determining their own health priorities and to link them with the formal health system in order to reflect the peoples' decisions and actions in health plans. People would then participate in resource mobilization. allocation and control (MOH. 2006). It is in here that this study engages community health volunteers to determine how popular group income generating activities would be in mobilizing resources for their own self-sustenance. Some of the past lessons from community based health care include the fact that it is possible to build capacity at the village level to manage community based activities effectively; that health actions can be self-sustaining if properly governed by the community. but systems of accountability and transparency must be established (MOH. 2006). In Bangladesh. incentives given to the community health volunteers include income from sales of essential drugs and health

commodities and access to micro-finance. Among the lessons the Bangladeshi have learnt from their programs include the fact that the community volunteer model is sustainable (Faruque. 2008).

2.3.3 Sources of Funding

Bezuidenhout (2008) wrote that there are four main sources of finance for the health sector. These are the government (which is the largest contributor). households (through medical schemes). employers and donors and other NGOs. Muga (2006) writes that "the model of public health technicians or enrolled community nurses at sub-locational level supporting community health volunteers was tested by CARE Kenya in Siaya District with excellent results but the main problem. as usual. was lack of sustainability as it was donor dependent. If the scheme could be state supported as provided for under the Kenya National Health Sector Strategic Plan II. it would be a sure way of improving the health status of Kenyans. Among the recommendations in the Kenya government plans is the need for government to generate additional resources for bridging the financial gap (NACC. 2005). The NACC document further confesses that there is need for greatly increased understanding by policy makers and planners of the impact of HIV/AIDS. particularly for vulnerable groups and sectors (NACC. 2005). Sources of funds for income generation in Kenya are many. and include government initiated kitty such as the women enterprise fund which was launched by His Excellency the President. Mwai Kibaki on 10. January. 2010 in Nairobi (Daily Nation Newspaper. 10/1/2010). Bhattacharyya et al (2001) wrote that experience from a pilot advocacy campaign showed that with adequate information and motivation. local government units are willing to provide financial and logistical support. In 2004. K-MET (Kisumu Medical and Education Trust) introduced the revolving loan facilities (RLF) for private network providers as one of its sustainability strategies. These loans are also made available to Community based volunteers in their villages to help alleviate poverty in the communities. The loans are typically used to expand the quality of rural health services. living standards and the conditions of orphaned and vulnerable children (OVCs) left behind (www.kmet.co.ke/kmetcomplex.html). This subject of income generating activities for community health volunteers is arousing interest for many stakeholders. The Eldis Community group placed an advertisement on the internet. and I quote;

> **Post November. 20. 2009 by P. S. Herris**; "Does anyone know of examples of projects that help community units set up income generating activities to specifically support community services; in this case community health volunteers? I work in Western Kenya with 'Matibabu' Foundation which is currently partnering with PEPFAR and MOH to train 550 community health workers in 11 community units. Literature and experience suggest that systems based on community health workers are sustainable. have high drop-out rates and often collapse promptly. The Kenyan government and PEPFAR do not provide for Community health workers' financial incentives. 'Matibabu' resources are not sufficient to do so either. In discussing with community leaders. we are always asked about helping them set up community based income generating activities. the profits of which would be devoted to supporting the community health worker…They also tell us it will help bond community health workers into teams (www.community.eldis.org/?14@@.59ce4d16/0).

Holden (2003) suggested that NGOs providing micro-finance through community groups ought to consider starting complimentary partnerships with AIDS support organizations which want to begin IGAs that help sustainability of programs. Holden notes that through internal and external mainstreaming. the NGO can meet its challenges.

3.0 Research Methodology

3.1 Research Design

This study was descriptive case study. The questions the research sought to answer solicit the opinions of the target population. Since the targeted population was only forty five in total. it was felt that it would be more appropriate to do a census instead of using a sample of the population. The 40 community health volunteers had 5 leaders and it was also appropriate to interview all the 5 leaders. For this study. questionnaires and interviews of the five group leaders were sufficient. apart from the secondary sources used. The questionnaires were undisguised and administered in person by the researcher or a research assistant. The questions were a mixture of open-ended and structured questions lasting a maximum one hour to complete. The interviews were semi-structured and were conducted in an area the researcher is well conversant with. They targeted existing group leaders among the community health volunteers. Interviews were conducted in the early afternoons to avoid interfering too much with other domestic chores schedule of the respondents and to secure ample time for the interview. A pilot study was conducted to test any loose ends with the instruments and tidy them up. Once this was done. the interviews went ahead as planned.

4.0 Results and Findings

4.1 Demographic Profile of the Typical Community Health Volunteer

The finding on demographic profile of community health volunteers was that most of them were married or widowed Christian women with secondary level education and incomes below Kshs1000 a week. A majority of the volunteers were in their mid-thirties. Almost all had dependents of their own and were also the main bread winners in those households. All the volunteers were residents of Kisumu East District and most had been resident there for at least 5 years. A majority completed secondary school education more than a decade ago. For nearly all the volunteers. Christianity played a major role as a motivating factor.*4.2 Problems Facing Community Health Volunteers*

Most of the respondents stated the high demand for services they deliver and high expectations of targeted households as the biggest challenges apart from their own difficulties which stem from matters of self-sustenance or livelihood. According to the government plan. one volunteer was meant to be in charge of twenty households. but according to the findings. most volunteers had more than this number of households to attend to. As a result. an overwhelming majority spent less than one hour for every household visit. Most also agreed that lack of money on their part affected their work either many times or all the time. Family obligations also put pressure on most volunteers. They however did not see education and training as affecting their work negatively. On the whole though. nearly all the volunteers felt respected by the society for their work. There were very few men and youth below the age of twenty involved in community health volunteerism.

4.3 Popularity of Group Income Generating Activities

There was overwhelming agreement among respondents that Group Income Generating Activities would be highly effective. in their opinion. in tackling socio-economic challenges and enhancing teamwork. Most volunteers already had some form of income generating activity in which they were involved. They felt that group income generating activities increased their interest in the group and that such IGAs do appeal to them. Most of the volunteers. when asked which kind of IGAs they preferred chose farming as the favorite. They however identified inadequate funds as the single biggest hurdle to their desire to start group income generating activities.

5.0 Recommendations

There is need to attract younger age groups (those below 35) into community health volunteerism as population projections indicate younger people will be the majority in the district by the year 2012. It is imperative that managers of Community Health volunteer programs plan the engagement of volunteers in such a manner that the goals of the volunteers and the volunteer programs are achieved simultaneously. Group IGAs would be a good starting point for volunteers in poor rural settings. There is need to conduct better public awareness on the concept of volunteerism. There is also need to explore innovative ways that have been successful elsewhere such as the 'Gram Bangla Model'of Bangladesh. the Philippine Government's Barangay Health Workers' Act of 1995. rural enterprises run by women in the United Kingdom. and ideas from Dr. Yunis' rural banking system in Bangladesh in its infant years. or Bangladesh's Income Generation for Vulnerable Group Development (IGVGD). In Kenya. such funds as the Youth Enterprise Development Fund could be channeled towards providing funds for deserving volunteer groups in rural areas upon appropriate assessment.

This research exposed areas where further studies could be done. These include an economic evaluation to determine the effect of an effective group Income Generating Activity on teamwork and interest in volunteerism. a study of why younger age groups are not presently involved in community health volunteerism and an exploration of what could be done to attract them to it and to other forms of volunteerism. if this is feasible. The fact that only the opinions of community health volunteers and their team leaders were sought implies there is a gap in this research. Other stakeholders such as government. NGO personnel and community could be included in future research to give a more comprehensive view of the issues in question. And finally. appropriate or unique management styles for managing volunteers in poor rural communities of Africa could be researched on further.

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Demographic Profiles for Kisumu East District. Kenya	
Youth Population (15-30)	
Females	71 481
Males	72 372
Total	251 457
Rural Population	
Female	68 925
Male	53 502
Total	122 427
Total Households	84 963
Average Household Size	5
Female Headed Households	28 399
Poverty Indicators	
Absolute Poverty %	49
Rural Poor %	58
Food Poverty %	61
Sectoral Contribution to Household Income	
Agriculture %	70
Number Employed per Sector	
Agriculture %	30
Rural Self Employment	10
Wage Employment	20
Urban Self Employment	40
Population Working in Agriculture	147 410
Health	
Doctor/Population Ratio	1:15 182
Nurse/Population Ratio	1:2 069
HIV Prevalence %	11.2
Education	
Average School Dropout Rate %	59
Projected Population by 2012	454 398

Table I: Source: District Information Office. Kisumu East District (2009)

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