Using innovative community organizations to improve the survival of rural children in Kenya

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KIDCARE Child Survival Project

Kilifi District Coastal Area Replication and Evolution

- $2 million USAID-funded project
- Five years: Sept. 2004 to Sept. 2009

Project scope

Interventions for malaria, diarrhea, nutrition, immunization, pneumonia, and HIV/AIDS

Project Area

357 villages in five of seven divisions of the Kilifi district

Target Population: 257,522

- Principle beneficiaries: 46,354 children under five and 64,381 women of child bearing age
- Together comprise 43% of the population

Goal and Objectives

Goal

To sustainably reduce the morbidity and mortality of children under five and women of reproductive age.

Objectives

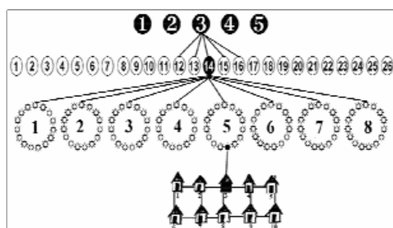
1. To promote key family and community health practices;
2. To increase family and community access to appropriate quality health care and health information;
3. To build capacity of MOH personnel, Community Health Workers, and other service providers to practice appropriate management of sick children; and
4. To strengthen Facility Health Committees (FHCs) and local community-based organizations (CBOs) that allow for sustained child survival activities.

Summary of Methods (1)

- **Community mobilization through care groups**
  - The end of community mobilization is to generate dialogue among various stakeholders, to challenge the status quo, and to plan for change.
  - Facilitating support groups like these helps to reach vulnerable members with support services to provide:
    - Social pressure for behavior change;
    - Critical mass to generate and analyze information for local action; and
    - Small successes that breed confidence and empowerment.
  - Community mobilization also incorporated Village Health Committees (VHCs).

The Care Group Approach

Care groups are an effective approach for reaching all households and caregivers in the catchment area.



Summary of Methods (2)

- **Community organization capacity building**
  - Training CHWs and VHCs on c-IMCI; PD-Hearth; CLTS
  - Follow up and mentoring
- **Health system strengthening**
  - Training of health workers – IMCI; EPI; PD-Hearth
  - Supplies and logistics provision – antibiotic buffer stocks; ITNs
  - Support for health outreach
- **Child-to-child clubs**
- **Lots Quality Assurance Sampling - monitoring**

Indicators

Intervention area	Indicator	Baseline	Target
Malaria prevention and control	Children sleeping under ITN	21	50
	Women taking prophylaxis during pregnancy	39	60
	Sick children receiving correct treatment with 24hrs of fever	21	50
Prevention and management of malnutrition	Children 0-23 months <2SD weight	26.6	21.6
	Children 0-6 months exclusively breastfed	21	31
	Mothers receiving Vitamin A within 6 weeks postpartum	5	30
Diarrhea prevention and management	Mothers wash hands at critical times	4	14
	HHs treating drinking water	1	10
	Mothers who know to prepare ORS correctly	32	50
Increased immunization coverage	Children 12-23 months	62	74
	Mothers with TT2 before birth of last child	24	60
Pneumonia case management	Mothers who know at least one danger sign of pneumonia	38	60
	Cases of cough and difficult breathing that receive care	79	90
HIV/AIDS prevention	Mothers able to give 2 ways of avoiding HIV infection	41	70
	Mothers seeking VCT service	18	90

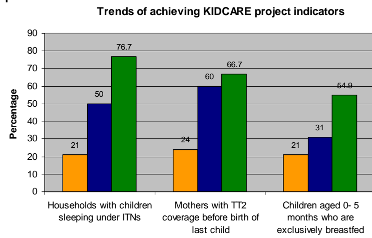
Results (1)

From 2004 to 2009:

- 1,400 care groups were mobilized.
- Skilled birth delivery rose from **13** percent to **35** percent.
- Proportion of underweight children fell from 27 percent to 14 percent.
- Number of lives saved was estimated at least 989.

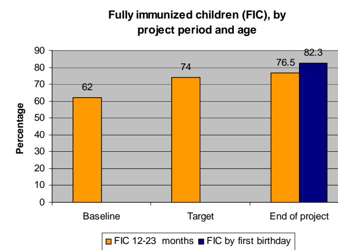
Results (2)

- Use of insecticide-treated nets rose from 21 to 77%.
- TT2 coverage rose from 24 to 67%.
- The rate of exclusive breastfeeding rose by 24 percentage points.



Results (3)

- Immunization coverage rose by 15 percentage points (62 to 77%).



Views from Participants

We now do not attend many funerals like we used to. It is rare to hear of a woman dying at child birth. The same is true for young children.

Kazungu Charo, male FGD respondent
Lutsangani village

After seeing that children exclusively breastfed for six months are healthier, old people who prohibited their daughter-in-laws to exclusively breastfeed now support the practice.

Irene Mbodze, CHW
Jaribuni Village

Conclusions

1) The care group is an effective community mobilization tool.

2) Community-based health programming is more sustainable.
- CHWs are linked to households and dispensaries.
- VHCs supervise and support CHWs.
- CHWs are rolling out PD-Hearth and CLTS in the community on their own.

3) Community-based health programming is empowering to communities.
- Participate in health services management
- Link with formal health system
- Demand and negotiate for improved services

Challenges

- Community mobilization takes time; the first two years were dedicated to mobilization.
- High volunteer/CHW attrition rate is a threat to community-based health programs.
- Droughts/food insecurity make it difficult to sustainably reduce malnutrition.

Recommendations

1) Scale up care group model to other health program areas, such as HIV/AIDS.
2) Mechanisms should be sought to enable CHWs give basic treatment effectively, e.g. ORS.
3) Volunteers should receive a form of compensation/motivation/incentive.

Thank you!

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