Comparing community and facility health providers' delivery of ECD services in Kenya

Background

There is sound evidence that well-designed and supported household visits that include demonstration and practice of responsive play can affect child development both short- and long-term[1]. With this in mind, it is often assumed that asking community health workers (CHWs) to integrate promotion of child development into household visits will lead to positive outcomes. By virtue of living in the community, community health workers are expected to have more frequent contact with the families, more time for understanding family circumstances and for counselling, and more trust from the community, compared with health facility workers.[2]

At the same time, low CHW coverage and large travel distances, insufficient remuneration and increasing scope of tasks coupled with irregular supervision are some of the issues that plague community health systems[3]. Additionally, PATH's human-centered design work in Kenya suggests that CHWs often struggle to select and prioritize their actions during a household visit[4].

Facility health providers, on the other hand, usually have better training and technical competencies to deliver services. Additionally, they may have more frequent contact with caregivers, at least in the first year, due to scheduled vaccination visits. Indeed, a 2021 study in Kenya showed that the median number of visits in the first year was 6, with most children coming to facility in the first year for obligatory vaccines[5]. This corresponds to the 6 visits in the first year recommended by the WHO[6]. At the same time, facility provider contact time with each family is short and may not be conducive to extensive counselling.

In 2022-2023, PATH, as a part of its human-centered design work in Kenya, assessed delivery of ECD services such as developmental monitoring and counselling by facility and community health providers. Semi-structured interviews with caregivers exiting well-child visits (child welfare clinic or CWC, in Kenya) were conducted; and "expert clients" took part in household visits delivered by community health promoters (CHPs). While the assessment focused on evaluating the delivery of co-created ECD counselling strategies, it also provided important insights into care delivered by community and facility health providers.

A community health promoter discussing the contents of the Mother Child Health Handbook with a caregiver during a household visit. Photo; PATH.

Results

Facility providers have more contact with caregivers

According to the data, caregiver contacts with facility providers were more frequent than contacts with CHPs. Over 70% of interviewed caregivers reported visiting a health facility in the last month compared to about 10% who had received a household visit from a CHP in the last month.

Structured interviews with caregivers indicated that caregivers had more frequent contact with facility providers than CHPs. Prior to PATH-supported implementation, less than 10% of caregivers received a household visit from a CHP in the last month. This increased to just over 10% after implementation, much less than the over 70% of caregivers who reported visiting a health facility in the last month. While Kenya

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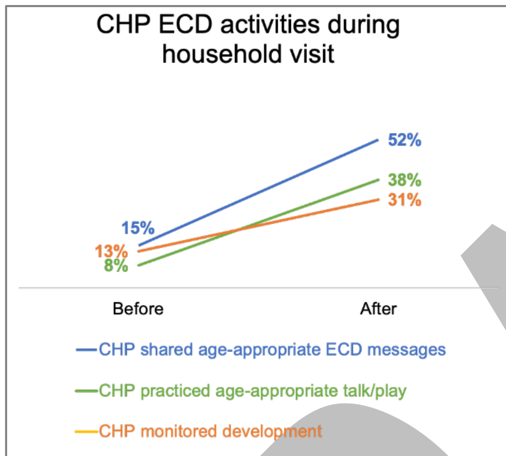
MOH recommends frequent household visits to children under 1 year, this does not seem to be implemented.

Facility providers implement ECD services more fully

The assessment suggests that facility providers at Child Welfare Clinic (CWC) are more consistent in delivering ECD services than their community counterparts. As Figures 1 and 2 indicate, there was about a 50%-point difference between facility and community providers conducting developmental monitoring at the start of



intervention, with more facility providers performing this activity (13% compared with 62%). While developmental monitoring increased among both types of providers after ECD training and mentoring, the gap between community and facility providers remained (31% vs 94%). This suggests that facility providers are more likely to do developmental monitoring than community providers.

Caregiver demonstration of age-appropriate ECD practices

***Figure 1**. Community Health Promoter ECD activities during household visit.*

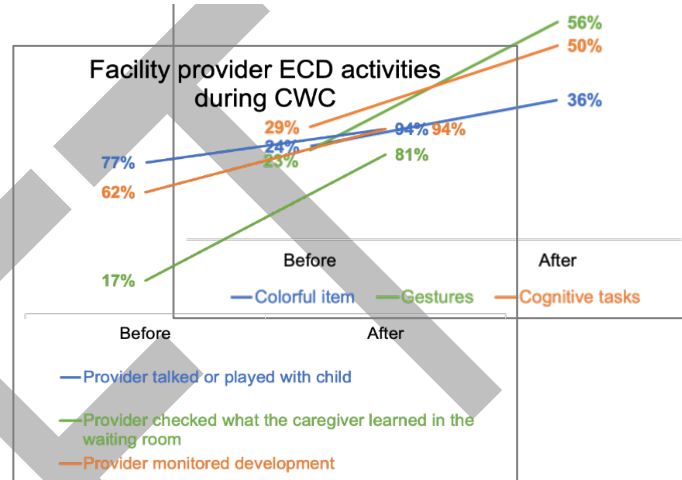


***Figure 2**. Facility provider ECD activities during child welfare clinic.*

Furthermore, as Figure 1 and 2 suggest, facility providers engage in other expected ECD activities (playing with a child and checking on learning in the waiting room) to a greater extent than community health promoters engage in their own mandated ECD activities (sharing ECD messages and practicing ECD activities). Namely, 80-90% of facility providers performed their expected ECD activities, compared with approximately 40-50% of community health providers, even after the ECD training.

CHPs promote quality play in the waiting rooms

At the same time, CHPs seem to be positively contributing to improved caregiver learning of ECD practices in the facility waiting rooms. In Kenya, CHPs take turns to support their health facilities, and in Siaya county they have been trained to conduct playbox sessions in the facility waiting rooms. As Figure 3 suggests, playbox sessions increased age-appropriate play activities among caregivers. These play activities – using colorful item with a baby under 6 months, clapping and signing with 6–12-month-olds, and doing some cognitive games with older children - were among those included in the playbox flipchart. Similar increase in recommended age-appropriate play was not

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observed in Mozambique, where playboxes are supported by informal health facility volunteers.

Figure 3. Caregiver demonstration of age-appropriate ECD practices.

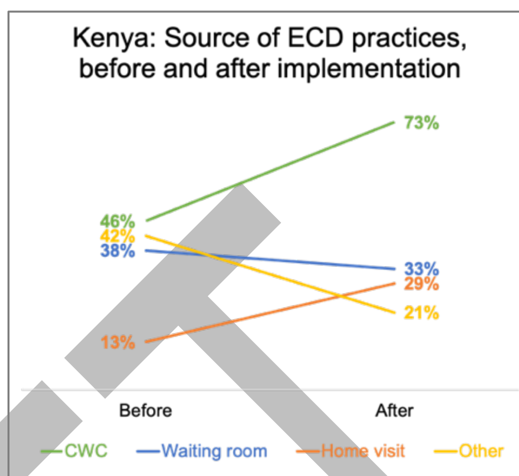

Figure 4. Kenya: Source of ECD practices, before and after implementation.

Facility providers are cited as source of ECD practices

Furthermore, Figure 4 below suggests that, while ECD services are delivered by both facility and community providers, caregivers seem to learn more in the facility than during household visits.

Namely, there is a 44%-point difference between proportion of caregivers citing facility (child welfare clinic, or CWC) providers as a source from which they learned their ECD practices compared to through CHP-led household visits (73% vs 29%). Frequency of contacts may play a role in this finding.

Waiting rooms were initially cited as sources of learning with similar frequency to CWC; however, after ECD trainings, CWC became a more consistent touchpoint for ECD learning, according to caregivers.

Conclusions

Overall, these findings suggest that, while community health promoters may be more trusted by the caregivers, they do not necessarily offer more intensive or higher quality ECD services to the caregivers than facility providers, at least during household visits. Nevertheless, community providers may have an important role in ensuring quality ECD activities in the health facility waiting rooms.

Some strategies to improve intensity and quality of ECD services during household visits may include:

- Enforcing a minimum number of household visits, especially for children under 1 year
- Improving community provider skills by making their training even more hands-on, through training videos and multiple practice opportunities
- Mainstreaming ECD services into community health provider apps, such as learning videos demonstrating age-appropriate play activities[7]
- Finally, promoting group-based learning opportunities facilitated by the community providers, such as play sessions in the facility waiting rooms and parenting support groups in the community, to supplement household visits.

A community health promoter talking about play with a caregiver in the health facility waiting room. Photo: PATH/

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