Documenting Immunization Best Practices Adopted by Civil Society Organizations in Isiolo County

AN ASSESSMENT REPORT

Submitted to:

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List of Abbreviations & Acronyms

AIHD – African Institute for Health & Development
ANC – Antenatal Care
APHIA -AIDS, Population and Health Integrated Assistance
ASAL – Arid and Semi Arid Lands
BCC – Behaviour Change Communication
CHS – Community Health Strategy
CHWs – Community Health Workers
CHU - Community Health Unit
CRS – Catholic Relief Services
CSOs – Civil Society Organizations
DHMT – District Health Management Team
DMoH – District Medical Officer of Health
DVI – Division of Vaccines and Immunization
FGDs – Focus Group Interviews
GAVI – Global Alliance for Vaccine Initiative
GoK – Government of Kenya
HENNET – Health NGOs Network (Kenya)
HSFP – Health System Funding Platform
IDIs – In-depth Interviews
IDM – International Domain Model
IMC – International Medical Corps
KEPH – Kenya Essential Package for Health
KEPI – Kenya Expanded Programme on Immunization
KRCS – Kenya Red Cross Society
MCH – Maternal and Child Health
MDGs – Millennium Development Goals
MoH – Ministry of Health
MTMSG – Mother-To-Mother Support Groups
NHSSP – National Health Sector Strategic Plan
PHS – Primary Health Strategy
PMTCT – Prevention of Mother To Child Transmission
PPP – Public Private Partnerships
TWG – Technical Working Group

ACKNOWLEDGEMENTS

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The study was conducted by an independent consulting team from the African Institute for Health and Development (AIHD). The team was headed by Gabriel Oguda, assisted by David Kisiang'ani and overseen by Dr. Mary Amuyunzu-Nyamongo.

EXECUTIVE SUMMARY

Background: In February 2012 the Global Alliance for Vaccine Initiative (GAVI) offered financial support to the Health NGOs Network (HENNET) through the Catholic Relief Services (CRS) as the grant manager. The grant was intended to support Civil Society participation and ensure more meaningful, effective and inclusive civil society engagement in the Health System Funding Platform (HSFP). Through this project, the Civil Society Organizations (CSOs) under the umbrella of HENNET were expected to acquire capacity, tools and skills to influence the development, adaptation and implementation of the national immunization policy and related wider health sector strategies. The project was in the second phase of implementation (at the time of the assessment) and was expected to conclude in December 2013.

Scope: The scope of the ethnographic study was to:

(i) Document immunization best practices in Isiolo County as reflected in the design, development and execution of child health programmes by CSOs and major health sector players in the County; and

(ii) Present the findings to the HENNET technical working group (TWG) for moderation, critical review and dissemination to the larger membership of the secretariat.

Approach: A wide array of qualitative data collection tools and approaches were used to inform the study results. In-depth interviews, Focus Group Discussions and participant observation were conducted within a period of ten days in several sites in Isiolo County. Most of the respondents were arrived at from a list generated by HENNET from their registered members running child health and immunization programmes in Isiolo. However, the study team also used the snowball sampling technique to reach other organizations doing the same functions but was not included in the initial list.

Key findings: The study generated a series of insights into how the CSOs in Isiolo are organized, and the approaches used by those working in the area of child health and immunization to achieve maximum returns. Some of the key findings from the study can be summarized into;

(i) Isiolo CSOs have a non-formal working arrangement to consult one another in areas where two or more are working together. They pool resources together to achieve maximum impact, and also sharing experiences for roll-out of better intervention activities.

(ii) The high rate of immunization uptake in Isiolo can be credited to the existence of an elaborate public private partnership agreement between the CSOs and the Ministry of Health. Whenever an outreach programme is planned, for example, government agencies responsible for the activity always consult CSOs working in the respective target areas for partnership and consolidated rollout of the interventions. s

1. LITERATURE REVIEW

Best practice models in health care have seen a shift from the traditional solutions in curative approach to a holistic approach integrating the focus on infrastructure, tools and equipment with that of human resource capacity building and attitudinal orientation. Integration of the two models has been proven to work in programmes that are designed and implemented to strengthen existing health systems, in order to ensure effectiveness and sustainable impact (1).

The need to integrate both traditional and modern approaches in health care service delivery is informed, partly, by the lack of focus on disparate groups; especially ethnic minority groups who are at an increasingly greater risk for poor health as a result of experiencing numerous obstacles in accessing mainstream health care.

Best practices are hypothetically sought from regions (counties) that have practices, such as socio-cultural, economic or political, which support uptake of immunization thereby increasing coverage. According to the Interactive Domain Model (IDM), best practices in health promotion/ public health are: *"those sets of processes and activities that are consistent with health promotion values/goals/ethics, theories/beliefs, evidence, and understanding of the environment and that are most likely to achieve health promotion goals in a given situation"* (2). Qualities of care indicators pertinent to child health programmes are well documented in several existing literature. The best practice domains in immunization and child health can be found in programmes using quality of care indicators geared towards the reduction in health disparities at the community level of operation (3). This assessment describes the analysis of field findings extrapolated with documented concepts, provides details of the programmes based on review of documents, and suggests quality care indicators to strengthen immunization and child health programmes by CSOs in Kenya.

The Division of Vaccines and Immunization (DVI), formerly the Expanded Programme on Immunization (EPI), started as a Unit in the Ministry of Health in 1980. Then, the goal was to immunize all children in the country against immunizable childhood diseases. Today, immunization uptake strategies are inspired by and geared towards meeting the Millennium Development Goals (MDG-4)[1]. To achieve this, health service delivery must be people-centred; hence the constant insistence by policy makers on increased community access.

Health care service delivery at the community level, and in resource poor settings, has been a major point of concern for the Government of Kenya (GoK) since independence in 1963. The second National Health Sector Strategic Plan (NHSSP II – 2005–2010), for instance, came up with a new approach to the way the sector would deliver health care services to Kenyans – an approach widely recognized as the Kenya Essential Package for Health (KEPH) which introduced six lifecycle cohorts and six service delivery levels, with the aim of empowering Kenyan households and communities to take charge of improving their own health.

[1] Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

The launch of KEPH was informed by the constant realization that communities are at the foundation of affordable, equitable and effective health care; with the overall goal being to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, and child and maternal deaths (4). To achieve the priority areas set out in the NHSSP II (2005–2010), the GoK were alive to the reality that achieving the above goals needed the collective efforts of public institutions and private organizations. A joint framework between CSOs working in the area of community health and the GoK, though the Ministry of Health (MoH) was developed.

To complement the NHSSP II (2005–2010), the GoK also launched a Community Health Strategy (CHS), which has a policy of free health for children under five years of age, and also some services that are freely available to expectant mothers. The CHS has been recognized as one way of working towards providing health care for all by lowering the costs of health through strengthening primary health care (PHC) and providing low cost interventions at the community levels through community health workers (CHWs)(5). The inclusion of CHWs in the implementation of the CHS has been constantly mentioned as a key component in bridging the gap between the MoH and the CSOs working in the area of community health in Kenya. The adoption of best practices in community health programmes, therefore, hinges firmly on the strong public-private partnership (PPP) links.

2. METHODOLOGY

2.1. Study site

Isiolo County is located in the upper eastern region of Kenya. The County covers an area of 25,336.1 square kilometres with temperatures ranging from 12 degrees to 28 degrees Celsius. Rainfall ranges between 150 mm to 650 mm per annum typical of Arid and Semi Arid Locations (ASALs) in Kenya. Isiolo Town is the administrative capital. It borders Wajir to the North East, Garissa to the South East, Tana River to the South, Meru to the South West, Samburu to the South East, and Marsabit to the North.

Isiolo County was chosen from a multi-stage sampling procedure involving two processes; (i) identifying all counties belonging to the ASAL regions, and (ii) ranking the counties in terms of performance based on the 2011 Kenya County Fact Sheet report by the Commission of Revenue Allocation.

Table 1: Immunization coverage in ASAL regions

County	Immunization coverage	National Rank
Isiolo	77.8	7
Samburu	73.1	11
Narok	71.6	14
Wajir	68.8	17
Marsabit	66.3	20
Tana River	62.7	23
Garissa	55.8	29
Mandera	54.3	31
West Pokot	54	32
Turkana	30.9	46
Kajiado	30.9	47
Source: Kenya County Facts Sheets (2011) [2]		

Isiolo County is headed by a Governor – who is the administrative head in charge of the management of County resources and implementation of devolved functions specifically related to Counties. A Deputy Governor assists him in these responsibilities. There also exists a Senator, who is the political representative to the upper house tasked with legislative matters pertaining to devolution of national functions. The office of the County Governor runs County affairs through a cabinet of county ministers with roles and functions related to specific areas of concern. The Isiolo Secretary in charge of Health falls under this category – and is mandated to design and implement county functions related to health care, and advise the Governor as and whenever appropriate.

In terms of health, the largest health facility in Isiolo County is the Isiolo District Hospital (now Isiolo Level 4 hospital) – which is the major referral facility in the county. A District Medical Officer of Health (DMoH) heads the facility and is responsible for the coordination and execution of all health and health-related national

[2] Commission for Revenue Allocation (2011); Kenya County Fact Sheets https://www.opendata.go.ke/Counties/Kenya-County-Fact-Sheets-Dec-2011/zn6m-25cf

functions. The devolution of health functions to counties took effect in August 2013. Therefore, the office of the DMoH and the resultant functions are currently being restructured to reflect the realities of the new devolved governance structure.

2.2. Data Collection

This was a qualitative study involving two sets of data collection tools – In-depth interviews (IDIs) and Focus Group Discussions (FGDs). Trained research assistants administered a qualitative data collection tool to eligible respondents through face-to-face interviews at each of the measurement time points. Data collection was carried out for ten days. Data collected included practices on child immunization adherence and uptake.

Quality control measures put in place included selecting experienced research assistants and training them for three days, pre-testing the data collection tools, supervision of interviews by observing at least one interview per interviewer on each day, editing completed interviews in the field, and read through the transcripts to ensure consistency with the data gathered.

2.2.1. Focus group discussion content

The study team conducted two (2) FGDs with mothers who have children below two-years of age (24 months) belonging to Mother To Mother Support Groups (MTMSGs) one from Kiwanja CHU and the other from Tupendane CHU. This was done to ensure that only those with children within the KEPI immunization bracket are captured. In the mothers FGDs, the guide elicited cultural experience with parents who were earlier hesitant to vaccinate or refused some or all vaccines. When appropriate, the health providers were probed for specific concerns expressed by the parents, subsequent provider responses, and immunization outcomes (i.e. did the child eventually get immunized and if so, what were the reasons for a change of mind?).

To get more information, mothers with children under two years were asked about their sources of information on immunization, and about the most trusted sources. They were also asked about the process of acquiring this information (i.e., whether they looked for this information or the information availed to them and in which way?). Within the groups of mothers who had earlier refused immunization, we followed up on the predominant beliefs, norms, values and traditional practices hitherto discouraging mothers from taking their children through the KEPI immunization schedule. All the discussions with mothers were facilitated using a non-judgmental tone to reassure them. They were clearly informed that the FGDs were not in any way meant to force mothers to immunize their children rather they were meant to understand the context of immunization in the County.

2.2.2. In-depth interview content

The assessment team also had interviews with CSO programme managers working in maternal and child health programmes with specific attention given to those in immunization-related units of intervention. The study sought to find out components related to the design and implementation of child health and immunization programmes in Isiolo County, the milestones they have achieved, the challenges faced

and future opportunities. Additionally, government officers working in health facilities at every level were also interviewed to weave into the efforts by the CSOs, how both work together to achieve County health targets, the coordinating component of the partnerships and the long term strategies to ensure sustainability of immunization programmes in the event CSOs exit the stage. In total, seventeen (17) individuals from CSOs and GoK were interviewed, details of which are captured in *Annex 1*.

2.2.3. Observation

Being an ethnographic study, one of the qualitative methods of data collection involved employing participant observation. These were captured in the way of field notes, which later acted as a point of reference for case studies. The two study members participated in two immunization outreach programmes conducted by the Isiolo Catholic Dispensary and World Vision. Both outreach programmes involved CSOs travelling with mobile ambulances to programme sites outside Isiolo town (Kipsing and Ngaremara CHUs) meeting mothers and children under 2 years. The mobile outreach clinics employ the principle of programme integration to encompass MCH advocacy activities involving child nutrition, ANC, PMTCT, immunization as a one-stop option for the society's MCH needs. The study team sought to explore the verbal and non-verbal communication codes exhibited by mothers bringing their children to the outreach sites.

2.3. Assessment Team

A team of two researchers from the AIHD moderated all focus groups. In each case, the team was comprised of Gabriel Oguda (a MPhil Health Promotion specialist trained in qualitative data collection and ethnographic method) and David Kisiang'ani (a BSC expert of health systems management and strengthening). Each group also had a note-taker from the research team and was audio-taped in conformity with ethical regulations regarding confidentiality of respondents' information. For the FGDs involving MTMSGs, Beatrice Karuta[3] moderated the sessions.

2.4. Data Analysis

Data gathered from the FGDs were transcribed verbatim into computerized database of text documents that could be searched for specific content information. Qualitative analysis based on grounded theory was done by examining the transcripts as well as through notes taken by the facilitators in each group. Themes defined in the questions/scripts and unanticipated emergent themes derived from focus group discussions were analyzed and recorded. Participants' comments were extracted and referenced within the generated themes, then reviewed again to confirm the validity of the themes.

[3] The Isiolo CSOs seconded Beatrice to the team because of her wide-ranging experience in Isiolo community dynamics.

3. RESULTS

3.1. Coordinated approach to immunization and child health

The study team interviewed representatives of CSOs running child health and immunization programmes, and MoH officials from respective MCH department at every level of healthcare – community, dispensary, health center and District hospital. The list of the individuals and organizations we visited is provided in *Annex 1*.

The CSO programme officers in charge of child health and immunization reported the existence of an elaborate coordination strategy among CSOs working in the County. When a new CSO sets base in Isiolo County, there is a deliberate attempt by the existing coordinating arm of the CSOs to reach out to the new organizations and get to understand their areas of expertise and coverage – in terms of geography and programmatic areas.

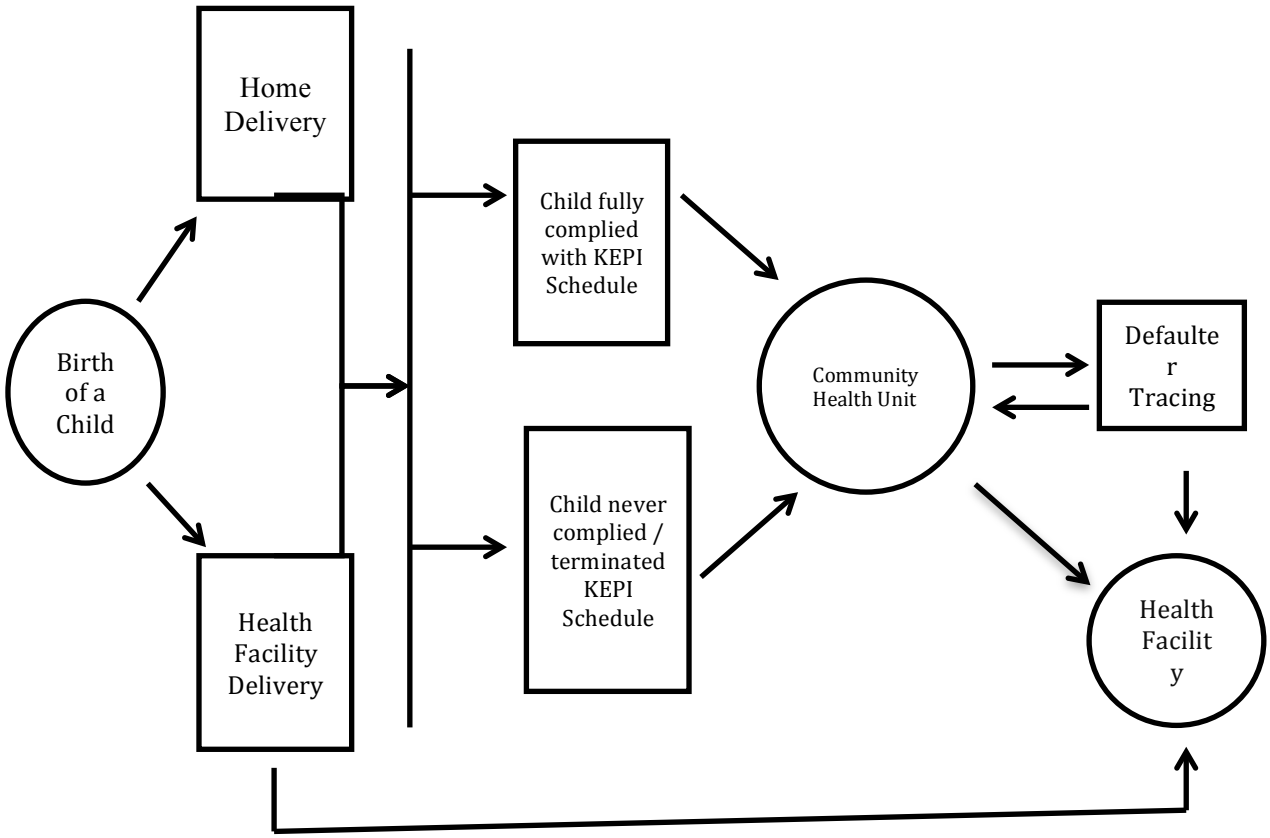
Once a new organization has been mapped out, they are invited to the monthly stakeholders function where the new organization is introduced to the other CSOs working in the same programmatic area after which the new organization is asked to formally join its peers in agreeing to the harmonized CSO plan of action in relation to the programmatic areas of focus. In terms of immunization and child health, the new organization is briefed on the catchment areas where there is need for attention – and gaps to be filled – against those catchment areas that are overcrowded by CSOs. This way, the coordinating arm of the CSOs ensures that far-to-reach areas of the County have an equal chance of benefitting from immunization and child health services as those close to Isiolo town where majority of the CSOs are located. This allocation of tasks is based on the organizational capacity of CSOs in terms of human, financial and equipment resources.

> *"NGOs working in health sometimes find that they are doing the same thing [running same programmes] in the same community health units…so it is important that we meet and discuss how best to use the resources we have to create maximum impact."* (IDI, Gibson Kimani, World Vision)

3.2. Innovative ways to increase immunization uptake

The CSOs working in Isiolo County have adopted innovative approaches towards tackling low immunization coverage among children less than two years, taking into consideration the prevailing climatic, economic and geographical terrain specific to the County. Such approaches have been participatory, and have ranged from adopting health promotion policies of partnership, intersectoral collaboration, and capacity building and community participation. Our study discovered the existence of one approach that the Isiolo CSOs considered very successful, which the study team christened the ***No-Child-Left Behind Approach.***

Fig. 1: The No-Child-Left-Behind Approach[4]



The ***No-Child-Left-Behind Approach*** has three crucial components in its health care service delivery chain.

I. **Birth of a Child** – The MoH KEPI guidelines require that mothers attend ANC sessions from conception. The ANC wing at the MCH department is dedicated to monitoring pregnancy progress, detecting complications and advising the mother on best nutritional and health care practices to follow for a non-complicated, less tedious childbirth process. The birth of a child signals the beginning of this elaborate tracking chain. This is the role of a special unit aptly referred to as the *Community Health Unit*.

II. **Community Health Unit** - If children are born outside of a health facility, the community health systems are activated to trace the children and bring them to the mainstream birth registration system. Isiolo County has a special community health unit responsible for, among other roles, bringing back such cases to the attention of the nearest health facility administrator. A community health unit comprises of: health facility in-charge, community health extension

[4] This diagram was developed by the study team to explain the processes involved in the Isiolo immunization tracking chain.

workers (CHEWs), community health workers (CHWs), and representatives of CSOs running health programmes.

III. **Community Health Workers** – At the centre of the Community Health Unit is the Community Health Worker. The bulk of Isiolo County is far-flung and hard-to-reach, roads are impassable for the most part, and timely government response to health crises is abysmal at best. But CSOs working in these areas have found a way around these problems of health care access by strengthening the role CHWs play in community health delivery systems. The CHWs are the centre-poles of the CHU - they are the link between the community, the MoH and the CSOs working a set catchment area.

> *"Yes the CHW is the one who communicates to us. There is a linkage whereby the CHW informs the nurse and the nurse informs the nursing in-charge and then the nursing in-charge informs the driver who is attached to us on that date."* – IDI, Nurse-In-Charge, Isiolo Catholic Parish Dispensary.

The inclusion of the CHUs in the healthcare service chain was considered a major boost to the rolling out of child health and immunization services by CSOs working in the County. It was a general consensus that the CHU has contributed to the smooth flow of health information from the lowest level of healthcare unity to the highest level because of the inclusivity of every health care stakeholder. However, one major handicap reported was the fear that most of the operations of the CHUs are overly reliant on CSOs for their full functionality, with several examples of inactive CHUs in areas where there is little or no CSOs involvement.

> *"The health facilities run by CSOs have updated immunization reporting tools, for example, the Ngaremara Dispensary but we here (at the District Hospital) we have no immunization charts for 2013 because they are yet to be sent from Nairobi…so we just improvise as you can see here."* – IDI, District Public Health Nurse, Isiolo District Hospital.

3.3. Allocation of areas of operation

Another factor contributing to the high immunization uptake among children below two years of age in Isiolo is the organization of CSOs into cluster groups representing different catchment areas. The study team established that when a new CSO pitches tent in Isiolo, there is a deliberate attempt by the County health to include it in the planning and implementation of health programmes in the County, where it is included in a group depending on programmatic areas of operation and organizational capacity.

One community health unit (CHU) is composed of:

1. A dispensary;
2. A trained community health extension worker – responsible for running the CHU; and
3. 50 CHWs – responsible for household immunization registers, referral
4. Opinion leaders – spiritual leaders, chiefs.

The CHU reports to the health facility in-charge, who then escalates the reporting to the DHMT, Isiolo. Additionally, every month, all CHUs have a monthly meeting at the Isiolo District Hospital where immunization reports are shared and deliberations made on how to improve the uptake of programmes in the County.

The Isiolo County is divided into the following catchment areas distributed among the CSOs as follows:

	Community Health Unit	**CSO responsible**	**Remarks** (by the Assessment Team)
1.	APU	APHIAplus Imarisha	Strong
2.	Eremet	Anglican Church	Not yet strong
3.	GK Prison	African Inland Church	Not yet strong
4.	Oldonyiro	Lentile Conservancy& IMC	Strong
5.	Kipsing	Catholic Church	Active
6.	Ngaremara	Catholic Church	Active
7.	Kambi Garba	Negotiations on-going	Active
8.	Kambi Ya Juu	Negotiations on-going	Active
9.	Tupendane	IMC	Active

3.4. Uniting mothers towards demystifying immunization myths

A key finding from the discussions was the existence of mother-to-mother support groups (MTMSGs) - an idea conceived, designed and developed by CSOs working in Isiolo County, in conjunction with the Isiolo County DHMT, due to the nature of the geographical landscape, and the difficulty in serving a population sparsely populated and largely unaware of the benefits of immunization. The intention of the MTMSGs is to increase immunization coverage in Isiolo by using the **'No-Child-Left-Behind'** Approach (discussed above).

The MTMSGs draw their membership from mothers with children:

I. Below the age of two (2) years (24 months);
II. From a common catchment area; and
III. Served by a defined CHU.

The assessment team documented several success stories narrated by the MTMSG members who attended the FGD sessions. Discussions with the mothers focused on the reasons for formation of the MTMSGs, the progress made since their formation, the challenges faced in meeting the mission objectives of the groups, and the opportunities that lie ahead. The findings are summarized in *Table 2*.

Table 1: **Mother-To-Mother Support Groups (Summary)**	
Why?	• To encourage mothers with children below 2 years to share experiences and learn from MoH, CSOs and child health experts • Migratory patterns play a key role in non-adherence to the KEPI schedule. As the communities move, the MTMSGs also move and stay intact. This makes it easy for CHWs to trace them and immunize the children.
When?	Groups are formed and disbanded after every 2 years – after the children have finished the full immunization schedule. New mothers then form new groups.
How?	Mothers are drawn from one CHU; if they are many they are split into smaller groups for easy learning and personalized attention. They are registered by respective CHWs and linked to the health facility in the respective catchment area.
Successes	• Increased child health literacy among expectant mothers and mothers with children below 2 years. • Stronger linkages between health facility, CSOs and the communities in the catchment area • Easy tracing of children on the move, during migration. Ensures sustained immunization adherence. • Increased immunization uptake.
Challenges	• Erratic or lack of CHW remuneration. Most of them are volunteers, affecting their morale and interfering with the CHU performance • Delay in procurement of reporting tools for CHWs – immunization registers, etc thus interfering with record keeping and, subsequently, affecting the tracing of non-immunized cases. • Funding constraints to keep the CHU running.

4. FINDINGS

This ethnographic study set out to answer the question of why Isiolo County immunization coverage is high despite the challenges that comes with being a hardship geographical area. The approach to this exercise involved delving into the role of CSOs in contributing towards the uptake of immunization services by documenting the existing programmatic approaches towards this end.

(i) Isiolo CSOs Consultative Forum: One of the important contributors towards the increase in immunization uptake in Isiolo involves the programme integration approach, under the Isiolo Consultative Forum. The assessment team documented the existence of many CSOs running programmes in Isiolo ranging from health, agriculture, peace building, infrastructure, cultural preservation and others. Initially, CSOs running health and health-related programmes would operate haphazardly and, in several cases, duplicate roles that would otherwise be spread out to areas needing them the most, hence the formation of the Forum.

The main role of the monthly forum is to bring together organizations working in Isiolo to share programmatic concerns in their areas of operation, and brainstorm the best way forward. The organizations take a revolving leadership each month in an unwritten arrangement that is adhered to by the CSOs. In terms of immunization, the CSOs meet to tap into the existing child health and nutrition frameworks employed by different organizations working in Isiolo.

Mapping out the Isiolo area is also another strong point for the successful implementation of the immunization programmes. This is done by demarcating Isiolo County based on geographical landscape, health service provision infrastructure, and presence of CSOs running child health and nutrition programmes, and levels of security in those areas.

Box 1: The Isiolo CSOs Consultative Forum

The County government of Isiolo is still laying ground for the absorption and rolling out of the devolved health functions, as per Schedule IV of the Constitution of Kenya 2010. When the Kenya Red Cross Society (KRCS) first set up a base in Isiolo, there was no recognizable pooling of resources, CSOs programme distribution was haphazard, roles were duplicated, stakeholder involvement was amorphous and private-public partnerships was non-existent.

Initially, the KRCS mandate was to respond to disasters (banditry attacks, disease outbreaks, fatal road accidents and other emergencies). However, they soon discovered the need to collaborate with government agencies and CSOs working in the area to; consolidate efforts & maximize on returns – hence the formation of the Isiolo CSOs consultative forum.

The Isiolo CSOs Consultative Forum (ICCF) brings together all CSOs running health and health-related programmes in a bi-monthly consultative workshop to discuss successes, share experiences, challenges and way forward in working together to confront the health challenges in the county in a consolidated manner.

After the mapping of CSOs and evaluating their capacity to implement programmes, the forum then seeks to divide roles based on programmatic strengths. For instance, if the main strength of the Kenya Red Cross is in disaster management, they will be allocated hard-to-reach areas based on their efficiency and timely response to emergencies.

(ii) Public private partnerships: Isiolo CSOs running child health and immunization programs have developed close ties with the County Government of Isiolo and the Isiolo District Hospital. This partnership enhances the sharing of resources available between the two sets of partners. For example, the Vaccines and Immunization department at the Isiolo District Hospital had no functional mobile ambulance when the study team visited. In this case, whenever there is an immunization outreach programme, the District Public Health Nurse always relies on the CSOs to provide the institution with ambulances for such exercises. For the CSOs, this is a win-win situation for the child health programmes they run outside Isiolo town since they will provide an ambulance as the Isiolo DH provides vaccines and other essential immunization and child health services those is their respective CHUs require.

Box 2: Public Private Partnership

Isiolo, being an ASAL region, has lots of hard-to-reach areas, making it difficult for the government to reach with the little resources at their disposal. To enhance competitiveness and change with the times, a health facility capacity and needs assessment is conducted every six months with the help of development partners to map the hard-to-reach-areas after which they share their findings with the CSOs on level of need in curative, preventive, and promotive healthcare services.

The findings from the mapping exercises inform s the CSOs working in their various CHUs when it comes to resource allocation, programmatic approaches and collaborative arrangements. They also help the government identify their strengths, weaknesses, challenges and opportunities going forward which informs the monthly CSOs consultative forums recommendations.

In addition, there was an indication of the use of this approach by the County Government of Isiolo to incorporate in their development plan for healthcare provision and access in the county. The CSOs officials interviewed by the study team indicated that with the devolved health functions to the county level, the new County administration have been engaging them on the best approaches that should be deployed to tackle the health challenges faced by the county, going forward. There have been consultative meetings organized by the county government involving the CSOs to this end, and one of the suggestions that have been floated is using the existing PPP arrangements already existing in the County to achieve this end.

5. LESSONS LEARNT AND CHALLENGES FACED

i. The study team found that immunization outreach programmes are not organized as standalone but instead they are integrated into other maternal and child health programmes e.g. nutrition, growth monitoring, ANC, etc. The holistic MCH package is designed to comprehensively address the needs of the mother and child at all stages of the pregnancy and during the early life cycle. This makes it efficient, economical and cost-effective for organizations conducting the outreach due to the nature of the vast landscape and the nomadic way of life of the people involved.

ii. Participation of CSOs in strengthening the existing community health systems elicited grassroots acceptance, government acknowledgement and strong community support. This resulted in increased uptake of immunization and child health services, and health seeking behaviour thereby improving the health of the target population. In particular, this was evidenced during FGDs with the MTMSGs encouraging other mothers to join in as the groups have helped them to gain knowledge on maternal and child health topics otherwise unknown to them. This, in turn, has helped in eradicating ignorance and improving the health status of the community, mothers and children.

iii. From the government perspective, the study documented the existence of active supervision and linkages between DHMT, CHEWs, CHWs, and CHU, which played a key role in increasing the uptake and sustainability of the immunization programmes in Isiolo County.

iv. Information from IDIs at the MoH and DHMT showed that the facilitation resources were limited and therefore there is a need to mobilize resources from within and without government to help fulfil the immunization needs as espoused in the KEPI protocol. While the effort from government in bridging this funding gap was minimal, at best, the Isiolo DHMT has a formal partnership agreement with CSOs working in the area of child health and immunization to help with key services especially during community outreach missions. Additionally, the coordinated approach adopted by the CSOs running immunization and child health programmes, and the integrated approach adopted by the DHMT to include CSOs in their immunization outreach programmes, both played a key role in registering increased uptake of immunization services in the county.

v. The role of the CHWs in the functioning of the CHU was a key highlight of this study. The current Ministry of Health policy, which involves the non-remuneration of CHWs, was reported not to be favourable. The study found out that some programmes implemented by CSOs working in Isiolo have a structured remuneration package for their CHWs hence the government CHWs who are not remunerated gets disillusioned thereby paralyzing the operations of the CHU. This was reported to be one of the greatest challenges to the increased uptake of immunization services.

6. CONCLUSIONS AND RECOMMENDATIONS

Based on the study results, the following recommendations are made for sustaining the high uptake of immunization services in Isiolo County.

1.1. The Isiolo County health department requires full support from the county government and CSOs to conduct immunization and child health services especially in hard-to-reach areas. Currently, the department of vaccines and immunization at the Isiolo District Hospital has no vehicle for community outreach programmes, making it difficult to implement the community health strategy. The study team, therefore, recommends that each hospital should have a KEPI/DVI vehicle. The MoH Isiolo has been borrowing ambulances and vehicles from the DMoH and mostly from CSOs working in Isiolo whenever they want to carry immunization in hard-to-reach areas.

1.2. The community health policy says CHWs are supposed to be volunteers for five years. They are not remunerated while conducting MoH functions except in few occasions where CSOs hire their services during outreach programmes where they receive a token of appreciation for their efforts. It is our recommendation that the community health strategy be reviewed to include CHWs in the MoH remuneration package and, increasingly, be provided with requisite reporting tools, e.g. referral forms, chalkboards so that they are fully supported to do their job.

1.3. Mother-to-mother support groups should be formed in every village, and strengthened in villages where such groups are already present. It is also our considered recommendation that CSOs pilot the idea of having father-to-father support groups, because family and child health issues cannot be left to the mothers alone due to the cultural decision-making structures which often elevate the voices of fathers above that of their wives. If men were involved in the health affairs of their children, the entire family would be more informed and the community demand for healthcare increased.

1.4. Immunization caravans should be introduced in every sub-county in Isiolo County where communities move seasonally in search of pasture and water for livestock. The team in charge of executing this would first have to map out the migratory patterns of communities in these areas before launching the respective immunization outreach caravans.

1.5. Even though CSOs in Isiolo are organized into CHUs according to individual resource capacity, this arrangement is largely informal, for it lacks a clear formal structure that guides the functions of such a body. Because of this, CSOs representatives we interviewed pointed out on the need to have a CSOs coordinating office akin to the HENNET structure to help safeguard the gains made and strengthen the coordination arm of the existing non-formal arrangement. This approach will ensure that the setup have an official convener whose task is to play the coordinating role with clear roles and functions. The presence of a HENNET model in Isiolo would help advise CSOs on urgent programmatic areas of focus, on a case-by-case basis.

7. REFERENCES

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8. ANNEXES

Annex 1: List of people interviewed & respective organizations.

	Name	Designation	Organization
1.	Lilian Wairimu	Nutritional Officer	Isiolo Catholic Dispensary
2.	Simon Githinji	Nurse	Isiolo Catholic Dispensary
3.	Sr. Lucy Thomas	Sr. in-charge	Isiolo Catholic Dispensary
4.	Selina Aspital	CHW	Tupendane CHU
5.	Beatrice Karuta	CHW	Kiwanja CHU
6.	Yussuf Memo	CHW	Kipsing CHU
7.	Scolastica Namoye	MCH in-charge	Isiolo DH
8.	Rose Kayuyu	Nurse In-Charge	GK Prisons Dispensary
9.	Joseph Gitonga	District Public Health Nurse	Isiolo DH
10.	Nicholas Musembi	Programme Manager	International Medical Corps, Isiolo
11.	Sr. Lucy George	Sister in-charge	Ngaremara Dispensary
12.	Joseph Makanda	BCC Programme Manager	APHIA IMARISHA, Isiolo
13.	Ibrahim Boru Wako	Regional Team Leader	APHIA IMARISHA, Isiolo
14.	Ali Waho	Programme Officer	APHIA IMARISHA, Isiolo
15.	Ibrahim Malow	National Youth Council	Isiolo
16.	Bitacha Mohammed	Regional Team Leader	Kenya Red Cross, Isiolo
17.	Gibson Kimani	County Coordinator	World Vision, Isiolo