**File name: 191126\_1059\_IDI\_CHV CHAIRMAN\_NKANDONE**

**I: So thank you very much for coming today; to start could you tell me your roles in Nkandone CU?**

R: My role in Nkandone CU is I am a CHV lead or chairman. So I have led them for a while because previously they had a different leader then I was elected. Nkandone unit has been in existence since two thousand and eight and during that time, there was an NGO called Afya Plus Kamili which we used to work with. They later left.

**I: When did they leave?**

R: I cannot remember very well but they left and Afya Plus II came in.

**I: The first one was Afya Plus Kamili?**

R: Yes, and then Afya Plus II came and they also left. When they left – you know, they used to support us in training and they also paid us some stipends though Afya Plus wasn’t here for long. Also it was a voluntary work but it was called CHW, you can see it is written here community health work. So after some time, they said that if the word work is there instead of voluntary, then we had to be paid, so they removed work and replaced it with volunteer.

**I: So they replaced work with volunteer.**

R: Yes, and that’s how it became voluntary work. So we just hoped to have an NGO come in and support us. At that time we were very many, we had forty CHVs in Nkandone then. Most of them dropped out due to the challenges we faced.

**I: Okay.**

R: What were the challenges? You find that I am an old man and I have to bring reports on my household visits every month, you see…

**I: Daily?**

R: Yes, so you had to visit the households and bring a report. So you find that you didn’t have any means to live, and even at home you needed to carter for your household so that you can be a good example. So during that period, some were not able to continue doing the work and they quit. When they quit, a few of us remained hoping that one day the government would consider our situation. By that time the ministry of health was in the national government not in the county. So we continued until the counties came in. when the counties came in, most NGOs left; we had an NGO called Mchip, we worked together for some time then they left. When they left, as volunteers we continue struggling and straining and working because we had decided to support our communities. So we just hoped that as we supported the community, God would assist us at some point. So we just continued supporting the community to date. In two thousand and seventeen, the county government that was led by peter Munya at that time called some of us and we were given some application forms.

**I: That’s the previous government?**

R: Yes, so they said that we would be paid four thousand per month; some of us still have the forms I just didn’t carry it with me.

**I: Okay.**

R: So we waited for the promise to be fulfilled until Munya left. When he left the current regime took over.

**I: Kiraitu’s regime.**

R: Yes, so when they came in they said that these CHVs are doing a very important job because they are promoting health since the home deliveries had reduced and currently almost ninety percent deliver through facilities. So they said that – also the diseases that could be prevented at the community level had been prevented and currently the community know what to do; so they said the CHVs are very important, so apart from the four thousand, we shall add them one thousand to make it five thousand. We waited for that as well, and we are still waiting for that promise to be fulfilled. Whenever we meet like today, we are always told to wait and that your issues are being looked into. As we are told to wait, more CHVs keep quitting.

**I: So they are quitting their roles?**

R: Yes, they are saying that we don’t want these false promises, so one decides to get engaged with their own business. Subsequently some villages were left without a CHV. You even find that in my village I had five CHVs and all of them quit except me, so I had to cover all the households – a bigger area now.

**I: Even where the other five were covering…were you five or six?**

R: We were five.

**I: So four quit.**

R: Four quit.

**I: So you have all the five villages under your watch?**

R: All the five are under me now, you see. So you find that you strain to visit them but since you know you are serving God, you just believe one day one time God will remember me, so you just keep serving them. And then also as you visit the households, you give them health information and you find that some are so hopeless; in fact when we started there were some community members we would support by even constructing houses for them; you find them at home sleeping and even if you tell them about health, they cannot understand you. So as a leader you have to contribute and buy some iron sheets, we bring some timber and construct a house for them.

**I: Okay.**

R: We would find some people who are really infected by the jiggers, we would wash them and apply some medication together with some CHVs who still volunteered, and especially there is one called Kobia who is now at the county and Kanene Lucy whom we used to move from household to household looking at the issues affecting the community. We were not just giving reports; we were visiting them in person. Especially in Nkandone, we do have action days every month.

**I: Okay.**

R: We do have action days monthly and go to an area and cover the whole of it; the CHV tasked in that area shows us their households and what have you done to the households, what have you taught them. When we go to a household we ask the head who visits and teaches them the health issues, he or she would tell us it’s this one. So we get to know that this CHV is really working and the report he brings is correct information. We would go somewhere and find that the CHV is unknown; when we go to household we do check for a dish rack, compost pit, latrine and hand washing facility and also kitchen garden. Additionally there are clothe lines we check out because in the lessons we were taught about hygiene and we have to check them out. We know that the person tasked in a certain areas has to teach the community about that. So when we find that all that is taught, we move to the next village next month.

**I: Are all those on action days – did you say action day once in a month?**

R: Once in a month.

**I: So who participates on you on action days? You have mentioned that you personally participate and the area CHV…**

R: All the CHVs participate.

**I: All of them?**

R: We all meet as a group of CHVs and walk together.

**I: So what area do you cover; is it a village or specific households in a village?**

R: Not one household, we cover the whole village; say Steven represents Mutuate village, so on the action day in Mutuate, we will move to the whole village covered moving from household to household. So during the visits, if you are found not to be having a latrine, you are warned that next time you will – we want to give you a month to construct it. However there are some people we find that they cannot construct it even if given three months, so we volunteer and dig a latrine. Those who are able are given a week, the following week we will come with the police together with the public health officers. And if they come and not find a latrine, you will be arrested. So we make him dig a latrine, you see.

**I: Okay you had mentioned that sometimes you do volunteer and bring iron sheets and wood to support them; who exactly contributes those materials?**

R: That is us CHVs and other well wishers who maybe like you and feel that since I am a community member, I should contribute and support fellow community members. So we contribute and support them before we leave that is our job. And after some time, we got to a point we couldn’t do it anymore, so whenever we found such people, we would just encourage them and support them in whatever way you can or leave the rest to God. So these are the things we were doing.

**I: Okay.**

R: And also during the action days, we were also walking with the CHWs.

**I: The CHWs?**

R: Yes, we walked together. You know every unit like Nkandone has a CHW, Mwathi the same and Nkaatha the same case also with Buuri. Every unit has a CHW and we walked with them. So we walked together especially when there was something important, we would even go with the focal person as well. And during the visits, we could for example find the Mutuate market very dirty; we would make that a market cleaning day. After that we would leave. So that is something we did as CHVs. And previously I said that CHVs who did that came from far.

**I: Where did they come from?**

R: They come from far. The distance they are coming from is very far and you find that they strain. So you find that when she will be going back, she is tired and doesn’t even know what she and her family would eat because she doesn’t have any money. So the next time you call them they don’t all come. The next time only a few comes and they even come late due to distance. When they come late, you only go to a few households like ten or eleven and then leave, especially I went to some households with them – these are CHVs I was with and these are action days we participated in like on fourteenth of august twenty nineteen we were at Ndonyo and Empitha with some CHVs.

**I: Are the ticks for the CHVs who were present?**

R: No, these are the households we visited, they were nineteen.

**I: Okay.**

R: The ones which didn’t have latrines were three, you see.

**I: Yes, if you tick a latrine it means it’s there?**

R: Yes.

**I: So you visited nineteen households?**

R: Yes.

**I: And I can see almost all of them have compost pits.**

R: They all have.

**I: Dish racks, one two three don’t have.**

R: Four.

**I: Okay.**

R: Hand washing facility is the same case; kitchen garden as well and then there is immunization as well; you have to check the children under five and whether they have all received immunization, you check the booklet and if you find that they haven’t received all the vaccines, you refer them to the area CHV and give her the responsibility of writing a referral form to take to the facility. So that’s what we were doing. For the bedbugs, these are people who had bedbugs. So if you find that this one has…

**I: What does the dash mean?**

R: The dash means that household doesn’t have bedbugs.

**I: What about x?**

R: X means I have bedbugs so I need medicine.

**I: Okay.**

R: And we used to be given some health…

**I: You were given medicine?**

R: They were giving as some bedbugs’ medications and jiggers like the ones we were treating together. They were also giving us water purifies from the health office. So when we had those we would always give them to the household members. So if this one asked for it, we would tell her that so and so will bring so that he gets to know who to look up to on health issues. But currently we have been asked for it but we don’t have them; water purifies, jiggers’ medication – no we have jiggers medications but we don’t have bedbugs medications. So we were told that we would be given all those.

**I: Okay, you said that – I would like to know, how many households do you currently cover?**

R: Right now I cover almost three hundred and twenty.

**I: And that is because you had to cover for your colleagues who quit?**

R: Yes.

**I: But originally, before you started covering for the other four, how many were you covering?**

R: I was covering seventy three – we are now washing jiggers.

**I: Okay, dipping your feet in water with medication?**

R: Yes, that is medication; it’s called manganese…

**I: So you mix it with water?**

R: Yes.

**I: What is the ratio of the solution?**

R: It was five hundred ml, around that because we measured with a spoon.

**I: So you mix it with five hundred ml of water?**

R: Yes.

**I: Okay, so you were telling me, before the three twenty households, how many houses were assigned to you?**

R: Seventy three.

**I: Okay, and are there other CHVs who also cover other villages where the CHVs quit?**

R: Yes.

**I: How many are they?**

R: They are around – we were forty but this time round only eighteen are active.

**I: So around twenty dropped out?**

R: They dropped out.

**I: Okay and when did they drop out?**

R: Some first quit in twenty fourteen.

**I: So it’s been around five years?**

R: Five.

**I: And now that they first quit in twenty fourteen, have you found some replacements in the areas?**

R: We haven’t found any replacements because they all quit because of lack of stipends to support them as we were promised; so how else can you – you know you cannot ask someone to work because she will ask you, what is in it for me? It this person quit and she was trained, how will I join and yet I am untrained. You see, he says – so you have to contend with whoever is there, no one else comes in as a replacement.

**I: Okay, now that you are eighteen; what about your roles as a leader that you do different from the other CHVs?**

R: My roles, I do work a lot because whenever information comes from the CHW, I first get it. When I get the information, I do deliver it to the others. And like now you have to know you are here on Friday and they are not called by the CHW, ii called them and you can sometimes call some of them and find them off air. When you don’t find them, you have to – as their leader, since I don’t want to fail, I have to go to their homes; so I go to the CHVs homes because I know all their homes and inform them about the meeting. If there is any news or any other information, I forward to them.

**I: Okay, where do you find the information from?**

R: From the CHW.

**I: So they communicate to you?**

R: Yes.

**I: And you communicate to the others.**

R: Yes.

**I: Okay.**

R: And you know a CHW – we were trained that the phone should be on…

**I: The phone should be on at all times?**

R: On at all times. sometimes he calls or sends me a text at night telling me that tomorrow at such a time, bring such an information and you know I don’t have the information in my records, I have to pick it from somewhere else. When I call someone from Nkandone and I come from Nathuu up there, if I don’t get them then I have to go there using a bodaboda. So if I don’t have the fare, I will have to go with someone; if I feel that we would have a struggle, then I have to resort to walking. I move from household to household and by that time; I try to bring the information to the office. For example last week but one he asked me for IDs of all the CHVs, he told me that they were needed at nine in the morning. You know what I did, I woke up at six in the morning and went looking for them because we don’t leave close as CHVs, they are from the whole sub location, which makes a unit; there are some up there and others down there. So you have to go there and there and then to Nkandone and Mutuate. So I realized it was tough and one needs to volunteer.

**I: So you were telling me that sometimes you may be forced to go somewhere physically and find that you have to look for a motorbike because it’s a far.**

R: Yes.

**I: What about the – you have said that you haven’t been given stipends.**

R: Yes.

**I: How much was Afya Plus paying you?**

R: Afya plus were paying us twelve thousand.

**I: How about Mchip?**

R: Mchip was also paying us two thousand.

**I: Okay, and do you sometimes involve yourself in other activities like maybe an organization can come with a short project for two or three weeks where they need people to help them mobilize in the community?**

R: They do come, especially for the Marie Stopes, they came and asked us to mobilize the community about family planning. So you have to know all the community members in your area, all your groups in the sub location and when they do meet so that you can forward them the information. During the immunization and tracing of defaulters, you also have to give that information and ask them when they would come. There are also polio campaigns, whenever they come, you have to make sure that the children in that area are all given the polio vaccine.

**I: What I am asking is, whenever you – whenever these campaigns come, Marie Stopes, polio campaign and such like, how much are you paid whenever you are involved?**

R: Our participation, you know because we are many, they do come and select maybe one or two to help them mobilize and they are paid five hundred shillings.

**I: Okay, for the work done.**

R: For the work done; just transport and lunch.

**I: Okay, so you have told me about what you do; hand washing, dish racks, compost most of them are issues to do with hygiene, so could you please tell me about TB; whenever you go to a household, what measures do you take or how will you know that one maybe have TB?**

R: So this is what we used to do; we were doing TB screening, you come and introduce yourself to the family, you know everyone in my area know me. So when I come and tell them that the message I have today is about TB because it is a disease that can be contracted by anyone. So you cannot say that I am so special that I cannot get it. So we want you to understand how it can be contracted; so I say that first, you can now mention how it can be contracted. One can contract it when in a crowded place because when people are crowded, one can infect the others. You know, so when you are in a house – you can tell them of the causes. When you are done with things like being in a non ventilated area or that doesn’t have enough light, at some point you have to tell them that if one coughs – because there was a time we used to report that one coughed for two weeks; so we were told that such a person should be tested. So you tell her that if one has a loss breath, you find that they have trouble breathing, then you should be tested. So if you explain all that to them; at the end of it all she will ask you; after how many days should I be worried? You tell her, if you cough for two consecutive days, then you should go for a test because TB is very prevalent nowadays. One will say that I have coughed for long and you will tell her you may not be having Tb but it is good that you go for the test and that will be better, she will say okay, I will go to Mutuate. So you will tell her, let me give you a referral letter and tell her to go to Mutuate for the test. After the test, you know the following day you will go for follow up.

**I: So you follow up to know…**

R: To know whether she went. After the follow up with her, you will then go to the hospital where you will check the register because the in charge knows you. So she will then tell you. But the challenge we have is that when you go there, you will find that the in charges don’t even recognize you sometimes. The referral is sometimes thrown into the trash bin.

**I: So you referred a patient to the hospital…**

R: With the referral form and was given all the services needed but the referral letter that showed that she was tested by Steven and where Steve also ticked that I attended her and gave her this service; they don’t care about that, you know. They just give them the service and leave. And the in the referral form, she should show that, when filling it, the in charge should fill somewhere and return the form to the CHV to confirm that the patient was served for me to know what step to take.

**I: Okay.**

R: But the hospitals don’t bother.

**I: So someone comes and says I have been referred but you won’t get the form again?**

R: You don’t get it.

**I: And what if the doctor writes all those things, where does the referral note end?**

R: No, he doesn’t return you the whole referral letter, he remains with the part of it at the facility and this other side is returned to you to show you when they are supposed to take the drugs because even your contacts are there, he should show you when the next clinic visits are.

**I: So you have that card to know when she should go back to the clinic and such?**

R: Yes. So you get to know; on that day, since she is in your area, you will go and see her in the evening and tell her that you are needed in the morning. In the morning you will also follow up and tell her that it is her return date to the hospital. If she doesn’t return, the doctor will give you a call.

**I: And ask you why the patient hasn’t returned.**

R: Why she hasn’t returned, so you have to do a follow up and send her back, then the process goes smooth and everyone gets to be attended. But that’s not what is happening here, we are told to give referrals and when you go to follow up you don’t get the forms, that’s a challenge to us. When you come and say that you referred someone, you won’t be regarded as having played a role in improving the health status. And that should be something done between the CHVs, chief and the doctors involved, that makes works easier; but we struggle and sometimes we are even asked, where did you send me to? If you write them a referral, they ask where they should take it. So it makes our work hard because there is no coordination.

**I: Okay, and have you as CHVs got to know why these things happen? Let me begin by what you have just told me, could you know why doctors don’t fill in the referral note and return?**

R: This is an issue we have also follow up during our meetings but we have never known the reason because even the person who is responsible for the MoH, does tell us that the issue will be sorted so that you are people who are recognized by the facility because you are there. We said okay, but when it comes to doing it, nothing happens. After sometime you find that the person we talked with about that is transferred somewhere else and we have a new person. So when the new in charge comes they don’t even know what a CHV is.

**I: That’s a new doctor?**

R: Yes, now they don’t know what your program is because we have never been introduced.

**I: Okay, so someone new comes but they don’t know you?**

R: He doesn’t know us. So we don’t know what to do because the person we talked with has been transferred. And whatever the new doctor tells you, you just feel like you have made a mistake.

**I: Okay.**

R: But the job CHVs do is very important because they even attend to people in the community and if one is to be traced, for example Mwangi [inaudible 00:36:19]

**I: Who was being paid?**

R: The defaulters; the tracer was being paid.

**I: If they traced them?**

R: Yes, so the CHVs were selected from the parents. You find that I am tracing someone but Mwangi tells me to trace such a person and send her to me or show me her home. You tell him, come and you take him to her. When I take her, there are forms she will fill and send to the facility and be paid; but I who took him there, I will not earn anything. Number two, I am the one who travels – you know he will be paid the eight hundred shillings and that means he has airtime and transport; but what will I earn? You see, so it’s for a specific group of people.

**I: So the CHV is the one who fills the form?**

R: Yes.

**I: And he is based at the facility?**

R: Yes.

**I: So you will trace someone and then – he can call you and tell you that there is a patient who…**

R: He tells you that there is someone needed.

**I: So you are to trace that person in the area?**

R: Yes, you tell him you know the person. Will you show me his home? You tell him okay; he comes and I take her or another CHV takes him without knowing anything because our work is voluntary. So he goes and gets all her details, tells her I have been sent by the doctor for this and this; then they leave. Apparently you don’t know that when he goes back to the hospital, he is to be paid but you don’t get anything from that.

**I: And yet you participated in the tracing?**

R: Yes, you see. So that’s a challenge we are facing. So those who participate should be – for example if a defaulter refuses to go for drugs and she comes from my area, as a CHV and a person working in that area, I should be told – a doctor should call the CHV of that area because every clients does write her area. So the CHV will trace her and fill the form and the CHV be paid. But not that he will trace him and the one being paid is someone else.

**I: So it’s like you traced the defaulter but didn’t earn anything.**

R: Nothing.

**I: Okay, have you raised that with your CHWs about that?**

R: We talked to the CHWs but they said the defaulters are not very many. But even if the defaulter is just one person and comes from that area, you know this CHV should also trace and get paid so that they can also feel like a human being. So that’s what it is.

**I: How has it affected your work as CHVs?**

R: It has affected it because you know that even if you trace the defaulter, the payment will be made to someone else, so you find that instead of going through that area and paying for a motorbike or setting aside my chores to do the tracing; it is good to tell them that I am not free to do that. But if you say you are not free, he will not find the defaulter because he wrote my area but the CHV doesn’t know the area.

**I: So the defaulter will not be found.**

R: It won’t be easy for the CHV and he may struggle and even have to do so much work in that.

**I: So it would have been better if…**

R: Yes, but even if it wasn’t so, the CHV who is paid should at least consider you and tell you that we traced the patient together, have this small token; or let me pay for you the bodaboda fare. So when that happens and you ask me to help you trace the next time, I will gladly help trace. But if that doesn’t happen, I will also keep quiet. And if I keep quiet the defaulters will increase in the community. If the number increases then people will suffer because this one doesn’t use the medication anymore and will infect the others, you see.

**I: Okay, so now I want us to look at the other diseases; you have gone to the community and some people have breathing problems or they struggle to breath and their chests are heavy as well, have you ever met such patients during you household visits?**

R: Whenever we visit households, we find such cases and when you get such a case, you know from how we were trained – and some are even through experience, you find that I cannot solve this issue, what is there is, you refer them and tell them that the doctor will have to check you up. What we do cannot make us ascertain whether it is TB or a chest – you know most people here say it’s because of a cold; you will hear them saying, I am so cold because of the rain or something. So whenever they breath, they have that heavy breathing and you know that is dangerous. So you tell her, you should go to the hospital and get tested so that you can have medications, stop using the kiosk medications. So you convince her to go because most people do say that if I buy a drug at the kiosk I will heal. Some even go for traditional herbs and others say that if I drink some soup, I will heal.

**I: What is that?**

R: Some soup.

**I: Okay, so they boil some soup and drink?**

R: Yes, they drink. They think that can help them. So you tell them lets go and have you tested then the doctor will tell us what is really required. So you talk to her and take her to the hospital.

**I: Okay, and have you had any asthma patients in your community?**

R: Yes.

**I: Okay, so how do you know the signs of asthma?**

R: The signs of asthma?

**I: Yes.**

R: You know it is not easy to notice asthma patients because unless the person tells you exactly that whenever I walk a lot I become weak and I have breathing problems – he even tells you that these are the drugs that helps me in such situations. Some are even given an inhaler.

**I: Inhaler?**

R: Yeah, so they inhale before they can get to walk again. You know when one gets to that, you must have been very free with one another and a close friend because that is a confidential matter and we were trained that – you find that some people cannot easily tell the CHVs what they are undergoing. Why is that? Because they know if they tell you, you will tell the other people. So I was also working with the Red Cross some time back and we were working with HIV positive patients. So we were talking and they would tell you that I use these drugs and I do go for them on such a day, some even say I defaulted, I want you to take me to the clinic because if I go alone, I will not be given the drugs. You know by then you have made a friend and he tells you her secrets. So it’s not easy for someone to tell you if you are not fond of one another, it’s not easy. But for the ones we know, one comes and tells me what her problems are and I try to help her solve them and they then realize that I am a close friend.

**I: Okay.**

R: So we were on the signs.

**I: Yeah, so maybe you have someone with such breathing problems and you can hear them breath. What steps are always taken when you send them to the hospital and they come back to the community?**

R: You know when they come back from the hospital they will tell you that I was tested or I was just given medication. So you know that she – and she wasn’t given any report – you know if she tells you that I have a note from the doctor, that’s better; so you can use that to follow up on them and whatever to do to them. So since you don’t have the note, you just let her go to the doctor.

**I: So when she goes to the doctor you don’t have a means to follow up?**

R: No.

**I: Okay…**

R: Because you will go to her the following day and ask did you go to the hospital? Yes I went and I was given these medications I am taking.

**I: Okay, and what about the causes; what do people tell you – you have told me that one may tell you that she was in the cold and that’s why she is having breathing problem, is there anything else that causes these diseases?**

R: For asthma, most people just say it’s due to the cold. If it’s not coldness, one may tell you that I fell down and was injured or I was beaten, such like this. They don’t say anything else. They can say they were beaten, they fell down or it’s due to the cold.

**I: Okay, and as CHVs, have you received training on how to manage the asthma patients?**

R: No.

**I: Okay, and have you received a training on non communicable?**

R: Diseases?

**I: Yes.**

R: Yes, we had TB training.

**I: Okay, you haven’t had any other training on non communicable diseases?**

R: No, we have just received training on hypertension and such like.

**I: What else?**

R: Hypertension and blood pressure.

**I: And who did the training?**

R: And diabetes.

**I: Who did the training?**

R: It wasn’t training; I am saying that we have been trained on TB but on the hypertension and the others, he just touched them like he said the causes are this and this and he stops there. But we have been superficially trained on TB.

**I: Okay, and who trained you?**

R: Tb training?

**I: Yes.**

R: We were trained – it was in the year twenty twelve.

**I: Okay, since twenty twelve you haven’t received any other training?**

R: No.

**I: And who trained you in twenty twelve?**

R: We were trained by a doctor.

**I: From the county?**

R: No, there were no counties then yet so it was organized by an NGO who funded and supported the TB facilitators.

**I: Okay, and do you always communicate with your CHWs – when you refer a patient with breathing problems, how do you communicate with the CHWs?**

R: We just talk about the client’s issues or any other patient that you have referred. So the CHW is never involved in that.

**I: Where is the CHW involved?**

R: The CHW is only involved when we bring the report, during the action days and if there is a community member who has refused to dig a latrine, so we refer them to CHW and they visit them with the police. But issues related to the patient, to my own knowledge and honesty, we have never involved a CHW in the issue of a patient. We have never referred a patient to a CHW.

**I: Okay.**

R: Only defaulters are referred to the CHW. The TB defaulters are referred to the CHW so that the CHW can refer them to the responsible CHV.

**I: Okay, so he refers them to the responsible CHVs?**

R: Yes, and he also certifies that one is a defaulter.

**I: Okay, what about the tests; maybe the patient is coughing or has a certain sign and you advise them to go for a test; let’s just talk about the test for now, what challenges do these patients face when they go for tests?**

R: When they go for tests, when one is asked to bring a sample of the cough, they do bring. But due to the long queues, one would be told to wait and maybe they are very weak and vulnerable so they cannot wait for long because they also come from far. So when they leave, they have to wait for the results. So if he was supposed to bring another sample the following day and the first result is not yet out, who will tell her? So when you go for a follow up with her, she will tell you that I went and waited for long and left; when I asked the doctor to check for me the result, he told me to stop disturbing him or harassing him because of the many patients. When she leaves you know, it will be hard for you to convince her to go back. So you sometimes have to sponsor her and tell her that I will take you on such a day at my expense. So the patient will then feel that these people value me; so I tell her that if he wasn’t polite to you, I want to go and see the doctor and I will take you to the hospital. So I tell her that I will come and pick you up in the morning and I call for a motorbike and we go together. When you go, you know all her responsibilities are yours, she doesn’t realize that you are a volunteer because she wonders how one can volunteer to attend her and yet her husband or wife or children cannot attend to her, so she wonders.

**I: Yes, she has to believe you are getting paid.**

R: But she doesn’t know that it was caused by whatever happened previously that makes you accompany her. And even when you accompany her, the doctor doesn’t act like he doesn’t know you; even if you see how he treats them and talk to you, is the same as anyone else. You know in an environment, if you accompany a patient or if you come with a referral like this one and give it to the doctor, since he knows you; he goes in a room with it and if you came with the patient you will also have to enter with the patient. That will show that he appreciates you; so the following day even if you don’t go with the patient, she will know that if I go I will get the service, even if I may be told to wait, there is still respect. But we do fail to get the respect and when we don’t get the respect, you wouldn’t know where to go to together with the patient.

**I: Okay.**

R: The next time you will not agree to accompany the patient, you will just refer her.

**I: Okay, you will just refer her.**

R: Yes, so as to avoid that embarrassment.

**I: Okay, you’ve talked about the challenge they face on testing; what about on treatment; let’s say you referred someone to the hospital and followed up the following day to check whether she got the service; now we are asking about the other diseases, not TB, diseases like asthma and the rest, what are the patients told?**

R: What?

**I: When you go to ask them about the kind of service they received at the hospital; do you always find out that they received the treatment or not?**

R: You find that most of them – you know, most in my community, they don’t go for medication here.

**I: Why is that?**

R: When they started going for the drugs, there was stigma.

**I: What is causing the stigma?**

R: You know when had breathing problems, people really looked down upon TB patients, so they were saying that they had TB. So in they had to go for medication very far.

**I: Far away?**

R: Yes, they had to go for the drugs in far away clinics. So when you asked them about it, they would tell you, I don’t have any problem, I am fine and I am still okay. So you find that they are really okay because she didn’t go for the medications in the facilities around. And when someone goes for drugs here or in Lari or Maua – if she goes to the hospitals around, we can meet them and then we create friendship; so she will tell me her reasons for coming here. But if she comes from say, Meru or Chogoria, you know they don’t know you unless you meet somewhere else in other health issues then she’ll know who you are and how can you help her in her situation.

**I: Okay, you have said that they associate it with TB, what else have you heard the community say about those with asthma other than comparing it with TB?**

R: The community members mostly say that asthma is caused by genes, and that it is hereditary. They say that if so and so has it then it must have been passed down from generation in that line, you see.

**I: So what is the effect when people say that?**

R: When people say that, the effect is that people – when one falls ill or when one has such like signs, it will not be easy to convince them to go to the hospital because they say that I don’t have a problem because I will talk to people and ask how my father lived with the disease and I will do the same. So they don’t regard it as a disease like the others.

**I: Okay, what about diseases that do have patient support groups; do you have some of those groups in this area?**

R: Diseases with support groups are not many though…

**I: Such as?**

R: HIV.

**I: Is there another like HIV?**

R: No.

**I: And do you have asthma support groups?**

R: No.

**I: And turning back to asthma and other breathing diseases do you as CHVs involve family members in any way in patient supports?**

R: When we find a patient with such disease, you know first we have to tell them that one can recover from the diseases. The diseases like the chronic diseases, you tell them that what the patient needs number one is care, another thing is the patients need love – it doesn’t mean that they might die, no; you should take him like a human being because he has a family, a wife and a husband. So then you will find that like when we were treating jiggers, people who were taking care of the jiggers victims were not close to them, so when they are not close to them we tell them that that is not a good thing to do; we create friendship with them to show them that there is a relationship and we love them. So when we show them love, they are encouraged and hopeful as well. so when you come f=back the following day for a follow up, they will tell you, I am okay, because you are close to them. But initially these diseases such as asthma and TB, you know one would sometimes talk to you from a distance because they feared contracting the same diseases. But now we have been trained to know that it’s good, first to take care of ourselves and to take care of the patient who is affected. So you attend to them with the full knowledge of what you are covering but you don’t act like you don’t have any business with them. So you also teach the family members on how to live with the patient so that if the patients were to die soon, they get to live more until such days. Then the patient will live to see their children grow because they are taking medications as prescribed. But if you stigmatize and discourage them, they will die fast. Even if you ask them to take medication, they may refuse and say that they would rather die because they don’t see any love. But if you show them love, the following day she will ask you to come and sit together with him; they will tell you that whenever I see you I am very happy, come back tomorrow. When you leave, he tells you that if it were not for you, these children wouldn’t have had this kind of life. You know then you have made some friendship that encourages them to live. So that is our role on family members who have such patients.

**I: Okay.**

R: Yes, we encourage them and also we try to talk to the stakeholders together with denominations like churches, we involve them and ask them to show love to the patients and they even get to visit the patient. Say it is December during the Christmas period, you find that a gift is taken to a patient and they get to know that I am really loved; you see now they get to know that even though I am sick and cannot walk, I am still treasured.

**I: Okay.**

R: Such things.

**I: Okay, on your roles, have you ever received any phone call or communication from a different hospital, not this one, telling you that we have received a patient from your area; have you ever received such?**

R: No.

**I: Okay, and on training, you have said that you haven’t had a training on asthma, have you received any other training on chest problems other than TB?**

R: No.

**I: Okay, and what can you say – there are challenges that you face, but what can you say has worked well when it comes to your work as CHVs?**

R: What has worked well in our work is that the people we work with, that is the community members, they have known that we can support them in various issues, so we have created a connection with the community members. The other thing is stakeholders, especially chiefs and assistant chiefs recognize us, so if you tell them that you have a message to tell the community, you find that they cooperate. So the first thing is that we have been recognized and you find that even for the clients, when you talk to them about health issues, they listen to you because they know you.

**I: Okay, apart from the community recognizing you, what else has gone right for you?**

R: Another thing that has gone right is – nothing else has gone well.

**I: Okay, only the community members recognizing you?**

R: Yes.

**I: Okay, and in your opinion…**

R: Sorry I would also like to add that something else that has been good is that as long as we keep being community volunteers, I keep gaining knowledge on how to live with the community even when they are patients. You know earlier on – now I can live with them and even if it’s my family member, I can take good care of them. So I have gained the knowledge.

**I: Okay, and when it comes to challenges, I have heard you mention that you don’t have stipend so covering the communities is very challenging and I have also heard you say that the referral notes that you give to the patients are not given back; I have also heard you say that sometime the doctors can talk to you in a very mean way and that makes you be embarrassed in front of the community members. What other challenge affects you as CHVs that you haven’t mentioned?**

R: Another challenge is that, you know for example the difference between TB and other diseases, you know there is a challenge because if one has this kind of diseases or those other diseases, apart from being trained on TB, it would be better if we were trained on those other diseases so that we can know how to handle patients affected by those diseases. So not getting enough training is a challenge.

**I: Okay, so you have the diseases in the community but you don’t know how to handle them?**

R: Yes, we don’t know how to handle them because we are not trained.

**I: And do you sometimes come together with the CHVs from other areas and train together? Say CHVs from Embu or somewhere else; do you sometimes come together and train…**

R: We have never had that.

**I: Okay, and as we come to the end; what do you think should be done to make improve your roles as CHVs?**

R: The first issue that should be solved is the issue of stipend due to the expenses.

**I: Okay, stipend; what else?**

R: Number two, if we could be trained about these diseases so that we can know how to handle those people.

**I: Okay.**

R: The third issue is that the doctors we refer to should respect us as health workers. So when we refer a patient to them, they should respect the department that referred the patient and that can improve the service.

**I: Okay, you have mentioned stipend and training, respect from the doctors as well; what else do you think can be done to improve the services you offer to the community?**

R: Another thing is, for example the area I cover is too large so if it can be reduced I can get to reach all the households.

**I: Okay, so right now that area covers three twenty households; what measures have you put in place to make sure you attend to all of them?**

R: The mechanisms I have put in place is that I have put them per clusters because even my village I have put aside because I visited households last month so I won’t visit them this month. Next month I will visit the other one, you see, then after that, I will again visit the other community. So you find that by the time I come to give the report on my area, it will be after four months, you see that?

**I: Okay.**

R: So giving the report is after four months but the information required I just provide it. So it’s like the information or report I bring doesn’t seem like mine because I bring reports for areas that should be headed by other CHVs.

**I: Yeah, a different area. So you send the reports monthly but not for your area.**

R: Not for my area.

**I: Okay.**

R: Why is that happening; for my area, let’s say you find this one has his own household numbers, but the household numbers are not in the register I use because I didn’t register them initially, someone else did. You find that I will write one two three four whereas it is not supposed to be this way, you know.

**I: Okay.**

R: so that’s why we are having a challenge.

**I: Okay, do you have any other challenge that you think if addressed can help improve your service apart from the ones you have mentioned?**

R: Apart from these ones, if we can get to have a conference with the others, you know we will get to learn from them as they learn from us. So we will know what we are supposed to improve on and they will also get to learn what they are supposed to improve on so that we can get to improve the health of the community.

**I: Okay, so you learn from them and they learn from you?**

R: Yes.

**I: Okay, so I would like to thank you for taking your time to come today.**

[End of audio]