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The Roles, Activities and Challenges of Community Health Volunteers in Delivering Community–Based Malaria Control Interventions in Migori and Kwale Counties, Kenya

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Abstract: **Community Health Volunteers play a very important role in delivering activities in communities in relation to health and specifically to malaria control interventions. The broad objective of the study was to evaluate the impact on strengthening level one health services on community utilization of malaria control intervention in Migori and Kwale Counties, and specifically to assess the roles, activities and challenges experienced by Community Health Volunteers (CHVs) in delivering the activities. The study design was a qualitative community based comparative analytical intervention that was implemented at baseline and four years post-intervention to measure the impact. The study found out that roles and activities of CHVs were critical in community case management of malaria (CCMM), prevention and control, malaria testing and dispensing of first line anti-malaria drugs, home visits and referrals, conducting community dialogues and participating in health action days, among others. It can be concluded from this study that involving, engaging and training of CHVs greatly contributes to success of malaria control and prevention interventions in community settings where behaviour approaches for change are essential.**

Keywords: **Malaria, Community Health Volunteers, Roles, Interventions, Migori, Kwale.**

I. INTRODUCTION

Community health strategy is the mechanism through which households and communities strengthen their role in health and health-related development issues, by increasing their knowledge and skills in disease control and planning for health interventions [1]. The overall goal of the community health strategy is to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, child and maternal deaths, as well as to improve educational performance [1]. This strategy is driven by Community Health Volunteers (CHVs), individuals chosen by the community and trained to address health issues of individuals, households and communities in their localities, working in

collaboration with community leaders and link healthcare facility staff. The CHVs are catalysts, whose role is to enable individuals take control of their health, and serve as a link to the healthcare facilities when the individuals need it [1].

Control of malaria involves a complex chain of measures that often complement one another. The control of malaria involves control of 3 living beings (man, mosquitoes and parasites) and their environment. For effective malaria control, man has to be targeted first, second is to control mosquitoes, and third is to tackle parasites with development of effective drugs and vaccines. In the recent years, more emphasis has being laid on early diagnosis, treatment, personal protection and on biological vector control [2].

Combating malaria in the long-run requires continued efforts to implement a comprehensive malaria control strategy. The global malaria strategy follows a four-pronged approach namely: access to prompt diagnosis and appropriate treatment, prevention of malaria in pregnancy, vector control through the use of Long Lasting Insecticidal Nets (LLINs), Indoor Residual Spraying (IRS) and other control methods as well as a swift response to emergencies and epidemics [3].

Malaria control in Kenya is guided by the goal of the National Health Sector Strategic Plan (2005-2012) that aims to reduce under-five mortality from 120 to 33 per 1,000 live births and the proportion of inpatient malaria fatality to 3% and the National Strategic Plan (2009-2017) that aims to reduce mortality and morbidity by two thirds of the 2007/2008 baseline level by 2017[4]. The Division of Malaria Control (DOMC) implements a malaria control programme that combines universal coverage of Long Lasting Insecticidal Nets (LLINs), targeted Indoor Residual Spraying (IRS), early diagnosis and timely case management using Artemether-Lumefantrine (AL), Intermittent Preventive Treatment in pregnancy (IPTp) and Information Education and Communication (IEC).

In Migori and Kwale counties, malaria is the leading cause of morbidity and mortality and accounted for 40% [5] and 30% of the outpatient attendance in 2011 respectively. Perhaps, one reason for this high morbidity is the lack of capacity to deliver malaria interventions to all who need them.

II. MATERIALS & METHODS

Study Location

Migori and Kwale counties, with similar malaria endemicity, socio-economic characteristics, geographical features, climate/weather condition and, demographic characteristics were the study areas. Migori County in the former Nyanza Province served as the intervention area while Kwale County in the former Coast Province was the non- intervention area. In Migori County, the study was carried out in four (4) community health units of Nyamagagana and Gosebe in Kuria West Sub County and Itongo and Getongoroma in Kuria East Sub County. In Kwale County, the study was carried out in four (4) community health units' of Eshu and Mafisini in Msambweni Sub County and Mamba and Kikoneni in Lungalunga sub county.

Study Design

A cross sectional study which used a community based comparative analytical intervention study design was carried out in the two counties, collecting both quantitative and qualitative data. Health facility data on malaria morbidity were gathered on monthly basis from four Community Health Units (CHUs) each in both the intervention and non-intervention areas from January 2013 to December 2016. However, the results of this paper are based on qualitative data.

Study Methods

Eight (8) FGDs were conducted with heads of households at each of the study sites (Intervention and Control) with Key Informants such as Community Health Extension Workers (CHEWs), Kenya NGOs Alliance Against Malaria (KeNAAM) Project Officer, Sub county MOH, Public Health Officers (PHOs) as well as Focus Group Discussions (FGDs) with CHVs, Men, Women and Youth groups. At the end of each FGD and in-depth interview, there was debriefing about the salient issues arising out of the process, anomalies that occurred and what the participants overall opinions of the discussion/interview were. Sixteen(16) in- depth individual interviews (IDIs) were carried out with key informants namely (Sub county Medical Officers of Health, Public Health Officers, Community Health Extension Officers, Community Health volunteers (CHVs), KeNAAM Project Officers, Assistant Chiefs, Health Facility managers and Village Elders). The researcher participated in the FGDs and IDIs with heads of households and key informants, and was on site for all interviews /FGDs and was able to address any concerns that the staff raised. The FGDs were used to

explore participants' availability, access and utilization of malaria control interventions Artemisinin-Based Combination Therapies (ACTs), Long Lasting Insecticidal Nets (LLINs), Indoor Residual Spraying (IRS) and Intermittent Presumptive Treatment in Pregnancy (IPTp)). In-depth interviews (IDIs) were used to provide individual accounts of key informants, attitudes and utilization of malaria control interventions (ACTs, LLINS, IRS and IPTp).

Study Materials

Guides on Focus Group Discussion FGDs and In-Depth Interview (IDIs) were used to collect data on the roles, activities and challenges of CHVs in community health services particularly in access and utilization of malaria control interventions (testing, ACTs, LLINS, IRS and IPTp).

Data Management and Analysis

The data were sorted, aggregated from the 8 FGDs and responses of each FGD participants, then entered by the researcher into tables broken down into themes and finally presented in tables and text. Distinctive quotes transcribed from the hand written interviews were noted in all tables and finally presented as quotes and text.

III. RESULTS

This section is a presentation of qualitative of data/results from the study in form of quotes and text in the three (3) themes of roles and support to Community Health Volunteers (CHVs), activities (health education, reporting and referrals) and challenges faced by community health volunteers (CHVs).

Generally, the study established from individual in-depth interviews (IDIs) / key informant interviews (KII) and Focus Group Discussions (FGDs) that community health volunteers (CHVs) equip families with the knowledge and skills to prevent diseases. They promote good nutrition, sanitation, and hygiene, and link families to essential services including referral services to their clients for services they do not offer at the community level and give antimalarial medicine especially artemether-lumefantrine (AL) after testing with malaria rapid diagnostic tests (mRDTs) as well as paracetamol, and albendazole.

Specifically, the study found out that CHVs roles and activities included community case management of malaria, prevention and control, home visits and referrals, drug taking adherence, disease prevention messages, health education, conducting community dialogues and participating in health action days, among other activities.

1. Role of and Support to Community Health Volunteers (CHVs) in malaria reduction

Results from key informant interviews with managers in charge of health facilities, Community Health Extension Officers (CHEWs), Public Health Officers (PHOs), Sub- County Medical Officer of Health (SCMOH), KeNAAM Project Officers in both Migori and Kwale Counties show that since inception, CHVs have been trained on a range of modules covering Community Health Strategy, diagnosis, treatment and prevention of malaria, integration of human immunodeficiency virus (HIV), tuberculosis (TB) and Malaria services. Though not all facility in charges reported being directly involved in the training of CHVs, they were all aware of the capacity building activities and they supported the workers to undertake their work.

"We did the trainings, we trained the CHVs for a whole week. I remember and we also did the malaria testing and all those things and also as a follow up, it was the role of the facility at large to ensure whatever the CHVs have been trained they ...are implementing as it is supposed to be and this of course includes issues to do with the reports they give at the end of the month which of course mostly is through the public health office eeeh and also things like the testing of malaria, we liaised with the facility lab to ensure that each of the CHVs even after the training they pass through the lab and at least the lab person to ensure that they have been properly oriented before they get to the field". (KII Facility manager Mamba Kwale County).

Health Facility Managers, KeNAAM project Officers and Community Health Extension workers (CHEWs) in both counties were involved and supported various CHVs activities. These ranged from coordination of the community health activities through regular monthly meetings, elimination of preventable diseases through immunization, provision of technical support to the CHVs, ensuring regular distribution of CHV medical kits and supplies, record keeping, data analysis of community data and feedback to the community for utilization during community dialogue days, support supervision and quality assurance of CHV work in the community. *"My role is to work with CHVs...., we usually meet for*

monthly meetings when they are bringing their reports, then we look at the reports and I give them feedback according to the reports, Sometimes I teach them on indicators and how to go about them…., and I am involved with them in linking the facility with the community…, so I think my role is to make it collaborative.., to make it… market our facility on what we offer so that they can go down to the clients and talk to them about the services that they can get from our facility…., so I link the facility to the community through the CHVs". (KII Facility in Charge Itongo, Migori County).

Additionally, the facility managers facilitated community services on malaria, HIV and TB and through supervision, monitoring CHVs performance in their jurisdiction, issuance of commodities and record keeping. *"They are under the custody of the facility in charge, he is the one to issue those commodities to the CHVs as per the need," (KII Facility in charge Kikoneni Health Centre Kwale County). "In the beginning the CHVs were issued with full stocked drug kits, the arrangement was to replenish the drugs at the health the facility once issued, I don't think that there was a time they came and maybe lacked the commodities unless the facility itself did not have them." (KII Facility in charge Nyamagagana Health Centre, Migori County).*

Results from key informant interviews with facility managers indicate that they occasionally assign CHVs nontechnical services at the facilities such as record keeping and weighing babies and dispensing drugs. During such occasions, the facility managers provided direct support to the CHVs. *"The non-technical duties including weighing, doing registration and even sometimes cleaning. And sometimes they also do for us malaria RDT testing in the facility when have staff shortage or when the lab tech is not around".* (KII Facility in charge Gosebe, Migori County).

2. Activities (Health Education, Reporting And Referrals)

i. Health Education

CHVs in Kwale County especially in Lungalunga sub county offered integrated HIV, TB, and malaria services. Results from FGDs illustrate various activities undertaken by CHVs in the community. These include: health education; malaria testing and treatment, use of treated mosquito nets, conducting home visits for provision of health services, testing and counselling on human immunodeficiency virus (HIV), tuberculosis (TB) screening and referral for TB & HIV treatment, and hygiene among others. Health education touched on broad health issues including prevention of malaria, vector control, signs and symptoms of malaria, treatment and drug administration, hygiene and sanitation, construction of latrines, treating water, importance of vaccinating children and correcting health related myths and misconceptions.

ii. Reporting and Referrals

Findings from the study show that all CHVs offered referral services to their clients for services they did not offer at the community level such as treatment of severe malaria, HIV testing, TB screening and diagnosis and treatment of other related ailments. The CHVs documented the processes and outcomes of all their activities by making and submitting monthly reports as was expected of them as noted by FGD participants from Kwale County *"CHV role is to fill a report, to ensure that a monthly report is filled and submitted".*

Referral processes were reported to involve filling of triplicate referral forms and two copies issued to the patient while one copy remained with the CHV. The client / patient was expected to seek services referred for, issue the referral form to the doctor/clinician attending to him / her and have the referral form filled by the doctor after the service. A duly filled referral form was to be returned to the referring CHV with indications of services offered and actions for the CHV. However, the referral process was noted to have a few challenges, with some patients seeking services without the accompanying referral forms and some not seeking referrals at all. "*Patients not taking up referrals, so there has been a gap and most of our clients are tough headed, you can write for them referral but he or she fails to go anywhere" (FGD CHV participant from Gosebe – Migori County)."Patients do not return the referral forms; doctors don't understand importance of referral forms and don't fill them" (FGD participant from Nyamagagana health Centre –Migori County)"Most of the time the client forgets the form you issue to him or her. So, when the client goes to the facility he or she does not have the referral form to give to the doctor" (FGD CHV participant from Itongo– Migori County)."Most of the time you find that we give referrals and it is not taken serious. Even if the referrals are seen by the facility or nurse in charge, they just return it as it was with no changes" (FGD CHV participant from Getongoroma– Migori).*

Some of the CHVs noted that referrals increased the patients confidence in accessing services, while in some cases the referrals facilitated direct services (without queuing) especially in emergency cases. *"The referrals help us a lot because*

when they go with the referral form, just at the reception he or she is allowed to see the doctor without queuing if it is an emergency and when it is not emergency, he will be put to queue and he will be told to wait to be treated and he or she will be treated" (FGD participant from Gosebe– Migori).

3. Challenges faced by Community Health Volunteers (CHVs)

In the delivery of integrated health services, CHVs face a number of challenges. Key among them is the inadequacy and sometimes, lack of the monthly stipend offered to them. From the CHVs discussions, it revealed dissatisfaction with the stipend received monthly. They claimed that the stipend is *"very minimal pay, against lots of hours spent in the community" (FGD participant from Kuria West – Migori County).* A delay in paying CHV stipend sometimes demotivates them disrupting their work and referrals. Most CHVs in Kwale mentioned lack of stipend. It was also felt that Ksh. 2000 was not enough remuneration. This affected their motivation to work. When asked what remuneration they would prefer, All CHVs in Migori and Kwale said *"We would wish to get a monthly salary of between Ksh.7,000 -10,000 same as our Support staff colleagues employed by the Ministry of Health in the County. We support services such as immunization; dispensing drugs at the facilities as well do growth monitoring and outreach services in addition to our normal duties".* Further, the additional support given to them in terms of transportation i.e. provision of a bicycle is also thought to be inadequate because they lacked maintenance facilitation especially in Migori county compared to Kwale County who have either or completely lack them. The working tools such as service delivery logbook ministry of health (MOH) 514 are sometimes too complicated for the CHVs level of understanding and are on occasion inadequate in supply. There have been instances where medical supplies are not enough. Some CHVs lack badges causing challenges in their identification. This may be one of the reasons why some are rejected by the communities within which they are stationed. Illiteracy of community members also poses a challenge to the uptake of health messages passed to them by the CHVs.

During focus group discussions (FGDs), respondents were asked about the challenges faced by the CHVs in delivering their work. Most respondents said that rejection from the community is one of the challenges faced by CHVs. Some community members were reported to be hostile towards them and refuse to take the drugs they offer especially in Lungalunga compared to the rest of Kwale County. Perhaps one of the reasons is that community lack confidence in the CHVs as they consider them not well educated to provide medicine. CHVs offer antimalarial medicine especially artemether-lumefantrine (AL) after testing with malaria rapid diagnostic tests (mRDTs) as well as paracetamol and albendazole. This rejection is partly attributed to poor interpersonal skills in some instances. *"Some CHVs are not able to give good explanation on the medicine they are dispensing to us"* (Respondents– FGD, Women Mafisini).

Another challenge is the scarce numbers of CHVs hence some have to travel long distances to cover all community members within their jurisdictions. This is exacerbated by the little or lack of support to them in terms of transport and poor remuneration altogether. Shortage of supplies is another aspect that curtails their work. This challenge came out mostly in Kwale County compared to Migori. In Migori County study site, CHVs were supported with bicycles, monthly stipend, badges, uniforms and drug kits and are therefore much endowed compared to those of Kwale County.

One other common challenge was the erratic supply of commodities for the CHVs. Key informant interviews with health care managers indicated that in both Counties, commodities for testing and treating uncomplicated malaria at the community level was not consistent. *"Sometimes commodities not being available e.g. for malaria there was a time they did not have malaria rapid diagnostic test kit (mRDT) or anti-malarials" (KII Kwale County MOH official).*

Poor documentation and reporting were cited as a challenge. The findings from CHV's FGD's and Health Care Workers (HCWs) key informant interview (KII's) show that there is poor documentation and reporting on the project activities. Some of the issues contributing to this include erratic supply of reporting tools which led to some CHVs using their own money to make copies, inaccuracy and incomplete data due to illegibility of writings when submitting the hand written reports or technical know-how when uploading into the District Health Information System 2 (DHIS2), Key informant interviews with facility managers pointed out challenges on poor documentation of work that has been done in the community by CHVs, incomplete uploading of data to the District Health Information System(DHIS), erroneous data entry, and poor linkages between the field and facility, community health extension workers (CHEWs) and other staff at the health facility, minimal understanding of the data flow, biased reporting by CHVs on specific interventions, inadequate laptops / computers and airtime for bundles to upload data onto the DHIS2, inadequate capacity of CHEWS to enter data into the DHIS2, untimely reporting by CHVs and lack of understanding of reporting by CHCs as cited below.

"A lot of work is done by the CHVs but this is not well captured at the facility because of poor linkages. The CHEWs are not keen with the data coming in from the CHVs hence having data that wasn't adding up e.g. having less positives and more treated." (KII Kwale County MOH official).

"Under reporting also perpetrated because of poor relationship between the field CHEW and the facility as they don't sit and plan together for the community units." (KII Kwale County MOH official). CHVs were also confronted with challenges arising from myths and misconceptions spread in the community.

In Migori findings from key informant interviews with facility managers show that despite the good linkages between the community and facility, some challenges still persist. Top among those identified were inadequate human resources at the facilities. Lean staffing level affected average time patient spend at the facilities. *"Yeah, they are seen like the other patients. How I wish we had enough number of staff so that we could give them first priority.''* (KII Facility in charge Migori County). The other challenge is that of human resources where sometimes the CHVs have already made referrals but sometimes the tests cannot be done due to absence of the health care workers or unwillingness. A particular mention was made by a respondent from Kwale who said that nurses no longer accepted to conduct a HIV test because of a nurse in Diani who was taken to court by a client who was given a positive diagnosis and started on ARVs only to later be given a negative result when she sought a second opinion elsewhere.

Findings from the study clearly showed that some of the patients referred to facilities for services come with different expectations. Most common is the expectation for express treatment at the facility even without going through the triage. The other challenges presented by patients referred for service are those who delay to present themselves to the facility for treatment.

"*Patients not taking up referrals, so there has been a gap and most of our clients are tough headed, you can write for them referral but he or she fails to go anywhere*" (FGD CHV participant from Gosebe – Migori County). *"Patients do not return the referral forms; doctors don't understand importance of referral forms and don't fill them"* (FGD participant from Nyamagagana health Centre –Migori County). "*Most of the time the client forgets the form you issue to him or her. So, when the client goes to the facility he or she does not have the referral form to give to the doctor" (*FGD CHV participant from Itongo– Migori County).

These cases are common among those who are not accompanied for services at the facility by CHVs. This is particularly felt when there are many referrals to the facility who expect to be served without delays. Sometimes referred patients do not submit referral forms to facilities or submit to the wrong health workers at the facility making follow up a challenge.

IV. DISCUSSION

The use of community health workers / volunteers has been identified as one strategy to address the growing shortage of health workers, particularly in low-income countries. Using community members to render certain basic health services to the communities they come from is a concept that has been around for at least 50 years [6]. There have been innumerable experiences throughout the world with programmes ranging from large scale, national programmes to small-scale, community-based initiatives. The roles and activities of community health workers are enormously diverse throughout their history, within and across countries and across programmes. While in some cases CHVs perform a wide range of different tasks that can be preventive, curative and/or developmental, in other cases CHVs are appointed for very specific interventions [6]. CHV programmes have been revered as a panacea and decried as a delusion in the past. A sober view reveals today, as it did in the late 1980s, that "with political will, however, governments can adopt more flexible approaches by planning CHV programmes within the context of overall health sector activities, rather than as a separate activity. Weaknesses in training, task allocation and supervision need to be addressed immediately. CHVs represent an important health resource whose potential in providing and extending a reasonable level of health care to underserved populations must be fully tapped" [7].

From the study, key CHV areas of action in malaria eradiation at community levels include other roles of and support to CHVs, and malaria related activities (health education, reporting and referrals) as well as the challenges they experience in dispensing their duties at community and facility levels.

On the role of and support to Community Health Volunteers (CHVs) the results illustrate various roles played by CHVs in the community. These include: conducting home visits for provision of health services such as malaria testing and treatment, health education and HIV counseling among others. These findings are in agreement with those of [8] in a study in Western Kenya where they established that CHWs (equivalent of CHVs) said they help the community by educating community members on malaria testing, administering malaria tests, enabling quicker treatment, and providing

vouchers for drugs at a subsidized rate. Similar findings conducted in Central Africa on malaria case management by community health workers in the Central African Republic (CAR) from 2009–2014 indicate that CHWs are capable of safely and accurately diagnosing malaria with rapid diagnostic tests (RDTs) if sufficient training and job aids are provided [9].These findings agree with those of [10] who assessed if village health volunteers (VHV) are as good as basic health staffs in providing malaria care in Myanmar and they found out that the VHVs are the key service providers at village / community level in delivering malaria diagnosis and treatment services.

Regarding health education, reporting and referrals, the study established that Community Health Workers (CHVs) undertake health education on malaria mainly on net use, symptoms of malaria infestations, malaria testing, malaria drug taking, sanitation and hygiene human immunodeficiency virus (HIV) and tuberculosis (TB), among other activities. Findings show that all community health volunteers (CHVs) offered referral services to their clients for services they did not offer at the community level. These findings are in tandem with those of a study in western Kenya titled 'motivation and satisfaction among community health workers administering rapid diagnostic tests for malaria' which found out that CHVs play a key role in providing health services, health education, health promotion including testing for malaria and referrals [8]. Also, CHVs undertook record keeping as demonstrated by [9] in a study titled 'malaria case management by community health workers in the Central African Republic (CAR) from 2009–2014' where CHWs (an equivalent of CHVs) were reported to be responsible for keeping daily registers to record each patient consultation, including basic demographic information, symptoms, test results, and treatment given.

On challenges faced by Community Health Volunteers (CHVs) in discharging their duties, the study established that in the delivery of health services especially relating to malaria, CHVs face a number of challenges. Key among them is the inadequacy and sometimes lack of the monthly stipend offered to them. From the CHVs discussions, it revealed dissatisfaction with the stipend received monthly. They claimed that the stipend is very minimal pay, against lots of hours spent in the community as well as delays in its disbursement. These findings are in tandem with those of [8] in a study from Western Kenya where they found out community health workers (CHWs) reported that increased compensation (monetary or otherwise) would help them perform their role better [10]. Further, the CHVs expressed low incentives to work and the importance of monetary and other material incentives in motivation, *"....even that 2000 is little money since it can nowadays be compared with the money that people who go for casual work can get in six days and therefore if they can remunerate us better they should think about it". "....the 'soap'(stipend) should also not come so late and we will be able to work well, like me I have four villages it is a hard work and so if this stipend is maintained at least you have a reason to work."* (CHW from an FGD in Ojolla A, Kisumu County and CHW from FGD in Kisii respectively).

Further, the additional support given to them in terms of transportation i.e. provision of a bicycle is also thought to be inadequate because they lacked maintenance facilitation especially in Migori county compared to Kwale County who have either or completely lack them. The working tools such as service delivery logbook Ministry of Health (MOH) 514 are sometimes too complicated for the CHVs level of understanding and are on occasion inadequate in supply. There have been instances where medical supplies are not enough. Some CHVs lack badges causing challenges in their identification. This may be one of the reasons why some are rejected by the communities within which they are stationed. These findings are similar to those of a study in western Kenya by [8] where participants reported facing a variety of challenges in implementation. The most common challenges included low awareness among the community about malaria testing in general and the role of CHWs in malaria testing, problems with transportation to visit clients, few clients coming for testing (14, 20%), and not being able to dispense drugs directly to the client .

Also, the study found out that some community members are hostile towards CHVs and refuse to take the drugs that are offered by them. Perhaps one of the reasons is that community lack confidence in the CHV as they consider them not well educated to provide medicine. This rejection could be partly attributed to poor interpersonal skills in some instances. In other cases, their inadequate knowledge in some health issues makes community members to look down upon them and their work. This is similar to findings in a similar study in western Keya which [10] found out that the perception of key informants (CHEWs, health facility in-charges and PHOs) on CHWs to for instance dispense drugs in the community was poor.

Lack of commodities is another challenge from the study. One study participant said *"Sometimes commodities not being available e.g. for malaria there was a time they did not have malaria rapid diagnostic test kit (mRDTs) or anti-malarials"* (KII Kwale County MOH official). This corresponds with findings of [10] in a study in Western Kenya where lack of

drugs and basic supplies, including anti-malaria drugs and other supplies such as the rapid diagnostic tests (RDTs) were reported to occasionally to be out-of-stock in the health facilities.

Another key challenge that was established from the study is lack of trust by some community members. Participants from both sites reported mistrust and suspicion among the key reasons for this scenario. These findings are in tandem with those of [11] where in a study in Western Kenya participants reported mistrust and suspicion from community for the reason that they are not adequately trained to handle some health services. These findings are corroborated further by [12] in a study in Kilifi, Kenya where they established that mistrust and lack of faith in the ability of the CHWs /CHVs was a common challenge.

Similarly, another found out is that there are scarce numbers of CHVs compared to the people they serve hence some have to travel long distances to cover all community members within their jurisdictions. This is exacerbated by the little or lack of support to them in terms of transport and poor remuneration altogether. Lusambili *et al* [12] in a study titled ‘community health volunteers challenges and preferred income generating activities for sustainability: a qualitative case study of rural Kilifi’ established that the numbers of CHVs at community and facility level was low.

V. CONCLUSION

In conclusion, involving, engaging and training of CHVs greatly contributes to community access and utilization of malaria control interventions in a community setting where behaviour approaches for change are essential, as well as supportive supervision and provision of adequate medical commodities, supplies and tools. Bearing in mind that health services are not readily available in most developing and third world countries where malaria is endemic, the establishment of community health auxiliaries like the community health volunteers as first line responders to health issues is a sure way of ensuring that community health issues including malaria are taken care off at the community level. Also it ensures management of complicated issues receives due referrals .Further, documentation and reporting of activities improves monitoring and collecting of indicators that give pointers to malaria situations.

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