Systems for improved social (e-) care provision

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This brief summary of various sub-studies has been written at the prospect of an oral presentation at the AITEC Africa's AfriHealth conference, held in Kenya International Conference Centre (http://www.kicc.co.ke/), Nairobi, 30 November – 1 December.

The conference is described as a way to "bring together researchers, medical practitioners and ICT personnel to share information on the developments in the use of ICT to improve healthcare in Africa"(Aitec Africa, 2011). One of its topics goes "Health management systems for Africa"

We set out these summaries to discuss systems for improved care provision in the Kiberian context.

Theoretical background

Social services as a concept often represents a key area where governments have sought to extend markets to produce 'mixed economies 'of care. Its effectiveness also has to do with the nature of contractual relationships between purchasers and providers. (Kirkpatrick, 2010)

The family has an important role in children's health. Social changes require an active role of the family to promote healthy and responsible values, attitudes and behaviour. Parental skills have an influence on children's emotional state. Families nonetheless do not always receive any specific training to improve their skills and resources (Molina, Pastor, & Violant 2011).

Hence, it is necessary to propose family education as a process that must be started at early infancy and it is relevant to develop parental education in the families of adolescents. "This is an especially vulnerable phase, where risky behaviour for health is most often observed, above all related to sexual and reproductive health." (Molina et al 2011).

> *High risk factors in the family are those related to a low level of education, having multiple maternal responsibilities, difficulty in the learning of basic care routines, an ambivalent perception of pregnancy and drug abuse.*
> *[Molina et al 2011:39]*

Sexually transmitted Infections and diseases and unintended pregnancies are among the major reproductive health problems facing adolescents in Sub-Saharan Africa (Zakayo & Lwelamira 2011:374):

About 60% of all HIV infected people in the world are young people aged 15-24 years in which 63% of them are living in Sub-Saharan Africa.

A survey in Tanzania showed that the numbers can be related to risky sexual behaviours among adolescents in rural community secondary schools. For instance, results indicate more than half of the respondents had ever experienced sex with age at first sex when being 15 years and below. Similar results have been reported from other studies in African countries. Furthermore, a significant number had multiple partners and never used condom. Zakayo & Lwelamira 2011)

Reflections on different systems for improved health care provision

AMREF: E-learning programme for nurses

A visit to AMREF clinic in Laini Saba village in Kibera reveals that in order to reach out the grassroot persons in the slum they do train community health workers (CHWs). These are men and women elected by the community members based on trust; they are then trained in the centre on how to collect data. The majority are illiterate or semi-literate, as such, the mode of their training is done in Swahili mostly using manual papers and markers, slides and play roles to enable them understand.

Figure 1: AMREF e-learning programme for nurses. Photo: Hallberg & Wanjira, Kibera, Kenya 2011

The training entails;- household registration, for example;- number of children immunised, no of children enrolled in schools, number of people with access to clean and treated water, no of people using treated mosquito nets, sensitization on the importance of pre-natal and post-natal health care for pregnant mothers,- identify, escort, referral to health centres' for safe child birth importance of ventilation in houses, importance of voluntary counselling and testing on HIV, follow up on the infected to ensure they are on constant drug –use.

AMREF therefore has embarked on capacity –building strategy for the CHWs.

They are also working with primary public schools in a program dabbed Kibera integrated school programme where they form school health clubs aimed at reproductive health and moulding of peer educators.

On role of ICT training CHWs the AMREF staff argues it would not have much effect since most of them are illiterate or semi illiterate, safe for mobile phones used for communication.

Provision of social care: Carolina for Kibera

Carolina for Kibera has its administration block at Olympics in Kibera, and a clinic in Gatwikera village in Kibera known as Tabitha Clinic; a VCT clinic which offers free and voluntary HIV testing to the community. They also do house to house campaigns creating awareness and educating members of the community on the importance of taking preventive measures to curb the spread of HIV.

The system used for registration is a card given to the patient by the counsellor with a registration number which also reflects in the National Aids and STI Control Program (NASCOP) registration book for statistics this helps determine the prevalence of HIV and AIDS in region and also know the number of people going for testing and their gender number of men verses women.

In Kenya most of people do not have the reading culture. The preference however is in watching. Therefore, information passed on video would have a greater impact than reading materials. Like having a television tagged on the wall, and patients waiting to be treated can watch clips targeted at passing on important information on health.

Figure 2: Carolina for Kibera. From video: Hallberg & Wanjira, Kibera, 2011.

Web-SP: Virtual patient system adapted to the Kiberian context

Virtual patient system could of great impact to the staff who handle patients on a daily basis.

An empower- to- empower approach would yield a great deal fruit given that the staff has a one to one interaction with the patients;- as such, they are in a position to relay information as per the patients need, hence an advantage.
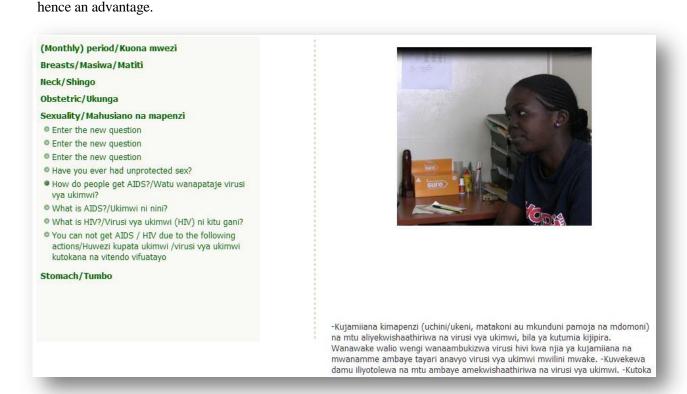

Figure 3: Web-SP. Screen dump: Hallberg & Wanjira 2011

The flip side of the approach would be limitation to the number of people one staff can reach out to. Unless awareness campaigns and other forms of relaying information to a wider population to inform the community are considered, then the knowledge imparted may as well remain in the confines of the recipients.

The emergence of terminal diseases like cancer, which needless to say, does not choose social classes, is an alarm to all stakeholders in health faculty to take initiatives towards curbing the impact on society.

Hence the need for laid down systems and their implementation to cater for social health care.

Final meta-reflections

We face as a nation emerging challenges every now and then as far as health is concerned, we have seen cases highlighted by the media, of people dying with terminal disease in slums with minimal knowledge as to measures they could take to prolong their life. Upgrading of like community nurses would be of great importance in this regard. For instance, cancer has taken root on women of all social classes; we all know that if early diagnosed, cancer is manageable. Unfortunately, a woman, say in Kibera would be eaten up by the disease before diagnosis, owed to poverty, lack of affordable health care.

A trained community nurse, for example, would work so well with a community health worker since the community members and elect them on the criteria of trust.

***Implications* and directives for future research**

- Find out how nurses can integrate with community health workers to improve on the impact health services that streams down to the grass root person.
- Find out also how organizations working on the ground integrate and network in social health care.
- See the possibilities of raising more peer educators among the youth and adolescents with the aim of breaking the cycle and mentalities passed on through generations.
- As an AMREF staff puts it 'slum is mentality, a sub culture, not conditions.' where people invent ways of survival.

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