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Short Communication

Perceptions of volunteers on the effectiveness of Kenya Medical Training College-run free medical camps in enhancing access to healthcare by vulnerable communities

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ABSTRACT

In certain regions of Kenya, such as Nyahururu, Kabarnet, Kasikeu, and Mbooni, inadequate access to healthcare services contributes to avoidable deaths. Organizations like the Kenya Medical Training College (KMTC) address this challenge by organizing free medical camps, involving both local and international volunteer healthcare workers. This study explored the effectiveness of KMTC's free medical camps through interviews with 18 key informants, including faculty, non-faculty members, and community leaders from purposefully sampled hardship areas, namely, Nyahururu, Kabarnet, Kasikeu, and Mbooni. The study found that KMTC's free clinics offered crucial services like curative care, immunization, maternal and child health services, disease sensitization, reproductive health services, and substance abuse education. However, limitations were identified, including a shortage of medications, lack of specialized screening, follow-up care, and referral services. Resources available included community health volunteers, KMTC and hospital staff, socio-structural support, and physical infrastructure. Challenges faced by volunteers included motivation issues, inadequate facilitation, limited stakeholder involvement in planning, and perceived service comprehensiveness issues. Despite these challenges, the community acknowledged the vital role of medical camps in delivering essential services to marginalized groups. Addressing resource shortages, enhancing stakeholder engagement, improving service comprehensiveness, and boosting volunteer motivation were highlighted as crucial steps to maximize community benefits.

Keywords: Volunteerism, Perceptions, Challenges and successes

INTRODUCTION

In Kenya's rural areas, healthcare facilities are often basic, non-existent, or at best, scarce.[1] Government-run hospitals exist, but most residents in rural villages cannot afford the associated fees or the costs of traveling to these facilities, typically located in larger municipalities, towns, and cities.[2] This lack of access to healthcare services is a major reason why treatable diseases continue to claim lives.[2] Diseases like diarrhea, malnutrition, and pneumonia, which are entirely treatable and preventable, still claim thousands of children's lives each year.[3,4] Endemic diseases such as malaria, gastritis, and typhoid also pose a significant threat despite being manageable with proper treatment.

Additionally, non-communicable diseases like hypertension, cancer, and diabetes exacerbate the already

dire healthcare situation.[5] Local organizations in Kenya have been working to address these challenges by facilitating volunteer healthcare workers, both local and international, to serve in local hospitals and clinics, providing treatment for underprivileged individuals.[6,7] These clinics, run by volunteers, are often referred to as free clinics and play a vital role in delivering medical services at little or no cost to uninsured, low-income individuals, primarily relying on the dedication of volunteers to serve vulnerable populations.

Despite efforts from the Government of Kenya (GoK) and various non-governmental organizations (NGOs) to reduce disparities in access to healthcare, persistent health disparities and limited access to quality healthcare remain pressing issues. As part of their corporate social responsibility (CSR) initiatives, campuses under the Kenya Medical Training College (KMTC) have organized medical camps for surrounding communities[8]. Notably, Makindu Campus has experienced a high turnout in these initiatives, highlighting the potential for volunteer involvement and community support. Nevertheless, there is a notable lack of nationwide documented evidence concerning the most frequently sought services, the services lacking in free clinics, and the associated challenges when KMTCs offer these free services. This study therefore, sought to explore the most frequently sought services, identify the services lacking during free clinics, and explore the challenges associated with operating these clinics to enhance healthcare access for the communities' most vulnerable members.

METHODS

Study design and settings

This qualitative case study aimed to investigate the utilization of volunteer-run medical clinics under KMTC in selected areas, with a focus on identifying frequently utilized services, pinpointing missed opportunities, and uncovering challenges in clinic operations. The study centered on three purposefully chosen KMTC campuses and one health facility located in designated hardship areas in Kenya. The selected study areas encompassed Mbooni in Makueni County, Laikipia County, and Baringo County, along with the inclusion of Kasikeu Health Centre in Makueni County.

Sample size and sampling method

The study employed a purposive selection of study sites and 18 key informants. It interviewed individuals who had previously volunteered in KMTC-run free medical clinics, encompassing faculty and non-faculty members from different campuses, community opinion leaders from surrounding facilities, local administrators, and representatives from healthcare facilities as key informants. In total, 18 key informants were interviewed (Table 1).

Table 1: Summary of respondents interviewed.

Cohort	Number interviewed
Opinion leaders	9
KMTC administration officer-2	
Principal's representative-2	
Local administrator-2 chief	
Hospital administrator (4)-NOi; PHO; HMT representative	
Faculty and SRC	9
PHO-1	
Nursing-2	
Clinical medicine-2	
SRC representatives-4	

Data collection

Data was collected between 01 and 31 May 2023. With prior communication and arrangements made with key informants, face-to-face interviews were conducted, and short notes and audio recordings were taken. For those who were initially unavailable, recontact was made at their convenience. The study adhered to an interview schedule with questions aligned with the study objectives. These tools had been pretested on campuses in similar settings, although not in the actual study locations.

Analysis

Face-to-face interviews were conducted, and the recorded audio was transcribed, followed by thematic analysis to identify patterns and themes in the data. The findings are presented through prose, figures, and tables. All ethical considerations were adhered to throughout the study.

RESULTS

Services sought and missed

These services were sought and provided at the free clinics: curative services, immunization services, routine maternal and child health services, sensitization about preventable communicable and non-communicable diseases, reproductive health services, and education on drug and substance abuse.

With regards to services sought and missed, a number of the services were missed: A number of services were missed previously. In the past medical camps, it has been acknowledged that large populations have turned up for services and given necessary prescriptions. However, the medications were either unavailable or inadequate. Though basic screening was done during medical camps, patients who required specialized screening services, e.g., for cervical cancer and other non-communicable diseases like arthritis, did not get those services. Besides, the volunteers

could not do follow-up to know if the clients went for referral services as advised by the initial contact clinician:

So screening of the major cancers especially the cervix and breast cancer and also enhancing our message to the male whatever on prostate cancer male involvement because the current gaps', Respondent 6 said.

Volunteerism challenges

During medical camps, stakeholders, including service providers and consumers, expect accessible, high-quality services with broad coverage and uninterrupted service. Failing to meet these expectations results in dissatisfaction. Table 2 summarizes the successes and failures of previous free healthcare services in meeting these expectations and the challenges stemming from unmet expectations.

Motivating volunteers

The people who volunteered were driven by the desire to meet organizational CSR goals (exigency drives), to give back to the community (charitable desires), and to gain experience and knowledge (personal enhancement goals). These expectations were generally largely met. However, the volunteers were somewhat frustrated that some potential beneficiaries of these services went home without essential drugs and services due to a lack of medicines, specialists, and diagnostic equipment.

Respondent 8, a nursing faculty: "I think you may find that the drugs you carried finished and the people are in the queue, and you are their hope that you have to turn them down. That time, we didn't have the issue of the personnel because it was well organized and the staff was organized (from the nursing department and the clinical medicine department) so that we would go together [and offer services], but the issue was medical supplies."

Respondent 7b, a nursing officer, stated: We also have the issue of specialists in certain areas like gynecological issues; zinahitaji mtu ambaye ni (need a person who is) specialized in that, so that's a big challenge. We also have the issue of screening; if somebody comes for HPV with HVS, we need people who have done that as part of their training to do sample collection. We also need things like the ultrasound machine, so they have to go to Sultan or Emali. Also, X-ray the same, and you see some of these conditions may need some of these investigations to diagnose.'

Table 2: Volunteer expectations: met and failed expectations.

Theme (main expectation)	Sub-themes (subexpec-tations)	Success	Failures
Volunteer motivations	Altruistic values	Helped the needy	Huge turnout, good prescriptions but inadequate supplies, e.g., drugs
	Personal enhancement goals	Students and staff got a chance to practice skills.	
	Exigency drives	Good social interaction with the community; increased KMTC visibility	
Community response and turnout		Mostly positive and appreciative; large turnout; mostly good community leadership-good mobilization	Unrealistic community expectations, e.g., demands for handouts (water, T-shirts); huge turnout, good prescriptions, but no drugs; there was poor mobilization in some areas where poor stakeholders were not involved in time
Planning	Organization	Organized KMTC staff and students	Poor communication and stakeholder involvement; inadequate facilitation: reimbursements and allowances and no time off
	Resources	There was a range of staff; there were some resources	Inadequate drugs/supplies/equipment; lack of funds; inadequate wide range of expertise/personnel
Service delivery		Large populations served; prescriptions given; health-messages shared; nutritional counselling done; and screening and referrals are done	Lack of service continuity (irregular camps); many prescriptions are not serviced due to inadequate/lack of drugs; inaccessibility (camps far from people); non-comprehensive services, e.g., preventive curative, etc., including referrals and regular screenings and checkups for conditions such as cancer; no follow-ups on identified and referred cases

Community response and turnout

There was an excellent mobilization in most areas, resulting in large turnouts for services. The communities are said to have been highly grateful for the services provided. The following excerpts, made in response to previous medical camp successes, capture the preceding.

Respondent 9, a PHO faculty member: "The satisfying part of it is the impact, the outcome from the community, and for them, they yearn for more opportunities. That is satisfying because it shows I am doing the right thing. After all, the beneficiary appreciates and yearns for more, and they own up and continue with the services from where we left off. So, they ask you when you are coming back or, yes, they say we want to come back here and the CHVs."

However, in most cases, some community members were denied services due to a lack of resources such as drugs and equipment. Others had unrealistic expectations, such as demanding handouts and T-shirts. Poor mobilization, as discussed elsewhere under planning, and myths and mistrust of free services were identified as contributing factors to low turnout in certain areas.

Therefore, significant effort must be invested in orienting the community towards realistic expectations and addressing mistrust, which can be rooted in the past hostile relationships between the government and its people. In this regard, community members are utilized to reduce mistrust and gain entry, which is crucial in building trust and facilitating engagement.

Respondent 9, a PHO Faculty member: this is because they are used to these handouts from some NGOs that operate in those areas and give them some lunches and t-shirts.

Respondent 10, a faculty member in nutrition: [The] unsatisfying part was when the community was expecting gifts and tokens we didn't have. [This is] because the chvs are used to being given something to mobilize the community. So, one of the incentives was money, what else; you know, some of the organizations do t-shirts, lesos but the money came out clearly.

And respondent 4, a KMTC administrator, based on her past experiences: 'They [IDP people in Molo] are not so free, and they don't want anything the ministry wants to give them is to kill them, like any food is to kill them and immunization to sterilize them and things like that, and because of language that they can identify with, I was able to use that to bring them out, tell them I know what you have through I know what how you came up here and this is what we are offering which is also made slightly different from what you get there. So I could use those groups, the community resource persons, to enter and talk to them for them to open up. Also, most of them would expect a lot of free items, which was a problem.

Planning

For free healthcare services to succeed, adequate planning (with good organization and adequate resource allocation) is required. In terms of organization, students and KMTC staff were widely acknowledged to be well organized when providing free healthcare services. However, some stakeholders (facility and community leaders) felt a lack of involvement, particularly in delayed communication (leading to a lack of time for good community mobilization). Respondent 11, the CSR Chairperson of one of the hospitals, stated the following regarding what needs to be done to ensure the success of free healthcare activities.

"If we have them[stakeholders] on board and provide them with relevant materials [and budget], they will be able to take up. Also, the impact in the community and proper communication, appreciating their effort n giving them what they require to work."

On introspection, respondent 12, a KMTC administrator, added thus:

We learned that it's good to reach out to the entry points of a community; these are the religious leaders, the assistant chiefs, and the chiefs, [who] will help convince the community to turn out.

Volunteers should be adequately facilitated when organizing free healthcare services (regarding time off and out-of-pocket expenditures). Volunteers frequently mentioned inadequate facilitation as a shortcoming. All volunteers, including community health workers and students, require transportation and lunch reimbursement during mobilizations and free healthcare camps. Aside from rebates, lecturers noted that a lack of staff made balancing community service and teaching responsibilities difficult.

Respondent 7b, a Nursing officer, in response to failures of the previous medical camp organized by KMTC, said: "So I think these CHVs as much as their work is voluntary, but the voluntary has limits. So if you try and see how you can facilitate their movement to the community, I think it would be better."

And respondent 4, a KMTC administrator, on time for lecturers, said: "Then also staff, we won't have enough staff like for the department we are even contracting lecturers, and you may not have contracted lecturers doing some of those activities…."

Respondent 6 added: allowances and even regularizing an income for these people [CHWs/CHVs]. They can get something regular; they will own the project more than only feeling that these people only use us to achieve their objectives. Those are some of the complaints I am getting

from these people that it is important that they may be facilitated regularly if any intervention is to work.

Insufficient resources, e.g., personnel, time, funds, drugs, and equipment, have marred past free healthcare activities. While most respondents agreed that the available human resources were sufficient to provide the most essential services, the same cannot be said for drugs.

Respondent 10, a nursing faculty member, stated resources needed: " Support from the institution mainly will be the provision of transport, equipment/supplies like weighing machines, MUAC tapes and support for students with lunches."

In most cases, healthcare providers could diagnose conditions and prescribe treatment; however, there was an insufficient supply of drugs for beneficiaries. Community leaders complained about a lack of diverse expertise to diagnose and treat conditions during camps. Though this may not be the intention of free medical camps because referrals could solve this problem, as some respondents mentioned, the prohibitively long distance to these referral facilities and a lack of advanced equipment and expertise even in the referral facilities means that referrals are often worthless.

"So you will find that someone will be going to a hospital, e.g., Chemoligot level Four hospital, but only to find that there is no specialist…" said respondent 4, a KMTC administrator.

Service delivery failures

In the past medical camps, it has been acknowledged that large populations have turned up for services and given necessary prescriptions. In addition, they have been given preventive services such as health messages (commonly nutritional counseling) and some screening services (such as breast cancer screening and vital signs). However, some problems were associated with past service deliveries during these camps.

First, because most of these camps were irregular and held far from the community, there was a lack of continuity and patient follow-up. Furthermore, early screening of most villagers who could not reach the screening centers was unlikely. Respondent 7, an assistant chief, averred as follows:

The success [of previous camps] is that there was a high turn-up, which assisted many people in knowing their health status and getting advice and medicines during the camp. The failure was follow-up since when the camp ends, there is no follow-up unless the patient's condition becomes serious.

In mitigation, respondent 1, a PHO, suggested the "medical camp is transferred" nearer the people and be held "frequently."

Some respondents felt that the services were insufficiently comprehensive and thus excluded some preventive services such as cervical cancer screening and tuberculosis services (especially contact tracing and defaulter tracing). Some of these issues can be addressed if CHVs are taken care of.

Respondent 6, an assistant chief, noted: Those people [CHVs] I must confess that they must be facilitated to effectively handle those issues because they are not on a payroll. They could be facilitated to assist the trained personnel in the facility to reach out to more people because, in some areas, we have defaulters of TB drugs and even HIV drugs. They can assist the outreach in reaching the unhealthy person but with facilitation."

DISCUSSION

The study shows that rural communities have a significant demand for services, including immunization, curative, and preventive care, aligning with the findings of Ilinca et al and Otieno, which indicate limited access to care for individuals in rural areas due to financial constraints or lack of insurance.[9,10] There was a high turnout and utilization of immunization services in this study, consistent those of Joseph et al that missed opportunities for immunization are more common in rural areas.[11]

The study findings reveal that free clinics have limitations in the range of services they can provide. Darnell conducted a similar study and also supports the notion of limited-service provision in free clinics.[12] The findings from this study underscore the importance of addressing challenges such as timely stakeholder involvement and volunteer motivation, as well as utilizing existing local resources for the success of volunteer clinics, consistent with previous studies by Rogers et al.[13]

CONCLUSION

In conclusion, the community recognized the significant impact of medical camps in delivering curative and preventive services to marginalized groups. However, the success of these camps faces various challenges, including inadequate resources, insufficient stakeholder involvement, limitations in service provision, and issues related to volunteer motivation. To fully realize the potential benefits of medical camps and effectively address the healthcare needs of the community, it is imperative to address these challenges through coordinated efforts and strategies aimed at enhancing the overall effectiveness of these vital healthcare initiatives.

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REFERENCES

1. Ngugi AK, Agoi F, Mahoney MR, Lakhani A, Mang'ong'o D, Nderitu E, et al. Utilization of health services in a resource-limited rural area in Kenya: Prevalence and associated household-level factors. PLoS One. 2017;12:e0172728.
2. Mwaura JW, Pongpanich S. Access to health care: the role of a community based health insurance in Kenya. Pan Afr Med J. 2012;12:35.
3. World Bank. Global Financing Facility in Support of Every Woman Every Child Launches Replenishment to Save Lives of up to 38 Million Women, Children and Adolescents by 2030. Available at: https://www.worldbank.org/en/news/press-release/2017/09/20/global-financing-facility-launches-replenishment-to-save-lives-of-up-to-38-million-women-children-and-adolescents-by-2030. Accessed on 12 January 2024.
4. Wanjau MN, Aminde LN, Veerman JL. The avoidable disease burden associated with overweight and obesity in Kenya: A modelling study. EClinicalMedicine. 2022;50:101522.
5. Onyango EM, Onyango BM. The Rise of Noncommunicable Diseases in Kenya: An Examination of the Time Trends and Contribution of the Changes in Diet and Physical Inactivity. J Epidemiol Glob Health. 2018;8(1-2):1-7.
6. Lusambili AM, Nyanja N, Chabeda SV, Temmerman M, Nyaga L, Obure J, et al. Community health volunteers challenges and preferred income generating activities for sustainability: a qualitative case study of rural Kilifi, Kenya. BMC Health Serv Res. 2021;21:642.
7. Ngugi AK, Nyaga LW, Lakhani A, Agoi F, Hanselman M, Lugogo G, et al. Prevalence, incidence and predictors of volunteer community health worker attrition in Kwale County, Kenya. BMJ Glob Health. 2018;3(4):e000750.
8. KMTC. Kenya Medical Training College. Available at: https://kmtc.ac.ke/?s=CSR. Accessed on 12 January 2024.
9. Ilinca S, Di Giorgio L, Salari P, Chuma J. Socio-economic inequality and inequity in use of health care services in Kenya: evidence from the fourth Kenya household health expenditure and utilization survey. Int J Equity Health. 2019;18(1):196.
10. Otieno PO, Wambiya EOA, Mohamed SM, Mutua MK, Kibe PM, Mwangi B, et al. Access to primary healthcare services and associated factors in urban slums in Nairobi-Kenya. BMC Public Health. 2020;20(1):981.
11. Joseph NK, Macharia PM, Ouma PO, Mumo J, Jalang'o R, Wagacha PW, et al. Spatial access inequities and childhood immunisation uptake in Kenya. BMC Public Health. 2020;20(1):1407.
12. Darnell JS. Free clinics in the United States: a nationwide survey. Arch Int Med. 2010;170:946-53.
13. Rogers SE, Rogers CM, Boyd KD. Challenges and opportunities in healthcare volunteer management: insights from volunteer administrators. Hosp Top. 2013;91(2):43-51.

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