Final Report

Building the Capacity of Community Health Workers

For the

Charles and Rita Field-Marsham Foundation

September 2014

amref health africa

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LIST OF ACRONYMS

ANC	Antenatal Care
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CIDA	Canadian International Development Agency
C-IMCI	Community-Integrated Management of Childhood Illness
CHU	Community Health Units
CHW	Community Health Workers
DFATD	Department of Foreign Affairs, Trade and Development
HCW	Health Care Workers
HMIS	Health Management Information System
HSSF	Health Sector Services Fund
ITN	Insecticide-Treated Bed Nets
MNCH	Maternal, Newborn and Child Health
MOH	Ministry/Ministries of Health
MTE	Mid-Term Evaluation
WASH	Water, Sanitation, and Hygiene

EXECUTIVE SUMMARY

The Building the Capacity of Community Health Workers (CHWs) Program has been a 3-year initiative designed to respond to the specific health challenges faced by marginalized communities in Kenya, South Africa, Tanzania and Uganda. It was designed to more optimally leverage the human resources of community-level health actors as parts of robust and sustainable health systems that better reach communities that are currently underserved. At the program's core has been a series of mutually reinforcing activity areas that simultaneously aimed to build the capacity of these community workers and better integrate them into the spectrum of community-based and institutional health care, with the anticipated result of a reduction in disease incidence and ill-health. The program aimed to entrench improved skills and health service delivery approaches at the most accessible levels possible, permanently increasing access for populations that most often lie outside the formal health system's reach.

The increased recognition that CHWs have realized over the course of the program has contributed towards the development of positive relationships between CHWs and formal health care worker (HCWs). In turn, this has improved the quality of health service delivery and increased health seeking behaviour, as greater numbers of households became better informed of the significance of seeking out health service support from facilities. In many cases where formal HCWs cannot reach patients, the gap is now covered by CHWs who provide referrals and important advice to communities and households. This has led to changes in health-related behaviours, which in turn has contributed towards improvements in the prevention and control of the spread of communicable diseases.

Parallel to African-based activities, Amref Health Africa in Canada engaged the public, providing information on the CHWs, and providing discussion opportunities on the need for sustainability and innovation in international health programming.

While the program was implemented across four countries, the contribution of the Charles and Rita Field-Marsham Foundation was specifically applied towards the Kenya component of the program. As such, this final report focuses specifically on the results achieved in Kenya. This final report outlines activities and achievements that were completed over the program's three year implementation period, as well as lessons learned, program sustainability, and a financial summary.

PROGRAM SUMMARY

Broadly, the CHW program's key activities included the training of CHWs (using existing Ministry of Health (MOH) curriculum where applicable, developing new curriculum where required) in current best practices for treatment and referrals for priority illness appropriate to specific community contexts. The program also worked to systematically improve the integration of CHWs into the formal health care system (improving efficiency and capitalizing on opportunities for better health information management). Through these improvements to the operation of health services, the program achieved an observable change in disease incidence levels within the targeted communities.

In addition to its aims of affecting positive health system change where it is implemented in the program countries, Amref Health Africa also sought to utilize the program for further evidence generation as to the efficacy of this approach. Amref Health Africa will be able to seamlessly integrate the lessons learned through this program into its own organization-wide learning processes as well as offering details as case study examples within the African and International forums to which it is invited to participate as a health sector expert. Operational experience and lessons generated will also be valuable resources to be shared with various MOH to support any efforts at replication.

The program set out to achieve this by implementing a set of activities centered on four key Results Areas:

- 1 – Increased recognition and integration of CHWs by Ministries of Health in the target communities;
- 2 – Improved quality of health services provided by CHWs, especially for women and children;
- 3 – Reduction in the incidence of preventable and treatable diseases among male and female adults and children within the targeted communities; and
- 4 – Improved knowledge, interest and engagement among the Canadian public on maternal and child health and international health development issues in sub-Saharan Africa.

CONTEXT OF REPORTING PERIOD - KENYA

In Kenya, the program realized tangible results in integrating CHWs into the formal health care system resulting in a reduction in the health centre personnel work load and subsequent improved service delivery in Kibwezi and Makindu districts (total population of 248,704; 51% female). The program worked with CHWs via the four Community Health Units (CHU) in AthiKamunyuni, Ilatu, Ivingoni and Mangelete to build CHW skills and capacities and integrate CHWs within the formal health system.

The improved capacity of CHUs to heighten recognition of CHWs as significant actors in the formal health system has been considerable. The CHU in Ilatu, for example, successfully lobbied district officials for the construction of a new link health facility in Ilatu which serves 10,091 people. Previously the nearest health facility to which CHWs could refer clients was a district hospital 30 km distance from Ilatu. In December 2013 the country witnessed a 12-day health care worker strike to protest the devolution of health services in Kenya from the auspices of central government to the county administrations. Similar HCWs' protests which occurred in 2012 and 2011 also called for higher wages for the country's HCWs. The protests paralyzed health services in program targeted areas, forcing those in need to seek services from private and/or faith-based service providers at extra cost for a short amount of time.

Demonstration garden by Community Health Workers in Ilatu

PROGRAM ACTIVITIES AND OUTCOMES FROM REPORTING PERIOD

Activities implemented over the course of the program contributed to the goal of a more integrated, efficient and community-based health delivery system, ultimately improving the health of program-targeted communities.

Impact:

The program exceeded the target set for client satisfaction with 75.8% of clients reporting satisfactory services from CHWs.

- ✓ Over 60,000 people are estimated to have attended health promotion activities.

- ✓ Results from a survey conducted to assess the usage of ITNs by children and women showed a sharp increase in usage.
    - o 71.6% of children aged 0-59 months were reported as having slept under an ITN the previous night (up from 10.3% at the baseline)
    - o 79.8% of women were reported as having slept under an ITN the previous night (up from 74.3% at the baseline)
- ✓ Alongside the increase in ITN usage, field staff have observed improvements in knowledge regarding prevention, detection and treatment of both malaria and acute diarrhea.
- ✓ The proportion of mothers with children under five who opted to seek treatment from a health facility when their child had diarrhea rose significantly from 3.5% at the mid-term evaluation (MTE) to 23.2% at the end of the program. This improved health seeking behaviour is attributed in part to the consistent efforts of CHWs to promote such services in order to reduce the number of diarrhea cases escalating to acute status.
- ✓ Low diarrhea prevalence in the targeted area is attributed not only to increased household and community health education efforts of CHWs, but also to usage of improved sources of drinking water and use of improved sanitation facilities at household and community levels.

Training:

Over the course of the program, 200 CHWs (147 female) participated in training using curriculum developed by the MOH, ensuring that services carried out by CHWs align with national guidelines and standards. Most importantly, CHWs gained a clear understanding regarding at which point it is appropriate to provide referral to higher level health service providers. Connected to this, CHW training clearly outlined the scope of services CHWs are expected to deliver. Topics covered during training included antenatal care (ANC); immunization; Community Integrated Management of Childhood Illness (C-IMCI); prevention, detection and treatment of priority communicable diseases; and referrals.

As well, Amref Health Africa was able to leverage program resources by supporting two program-targeted nurses (from Athi Kamunyuni dispensary and Mangelete CHU) to participate in training on Basic Emergency Obstetric and Neonatal Care via a separate program supported by Amref Health Africa in Spain.

Service Delivery:

After completing their initial training, CHWs continued actively delivering and promoting health care in their communities. 100% of CHWs trained are now providing care services according to national standards.

Services delivered over the program implementation period include:

- ✓ Over 38,000 household visits conducted by CHWs (to 10,200 different households) to deliver health information to families.
- ✓ 4,200 cases referred to health centres by CHWs for treatment of complicated cases.

- ✓ CHWs are actively contributing towards the collection of health data using the national Health Management Information System (HMIS), via household visits for analysis at CHUs. All of the program targeted health facilities are using the data generated to inform decision making on priority services and campaigns.
- ✓ A total of 1,825 insecticide-treated bed nets (ITNs) were distributed (865 to pregnant women, and 960 to children under 5.)
- ✓ CHWs delivered 80 public health information sessions.

A Community Health Worker assisting pupils on proper hand washing during Global Hand Washing Day

Supervision/support:

The result sought at this outcome level was to see CHWs fully benefitting from a systematized supervision mechanism as well as receiving consistent and objective recognition for their role within health service provision.

- ✓ All 200 CHWs participating in training via the program have received MOH certification and are receiving routine support and supervision provided by Community Health Extension Workers (CHEWs).
- ✓ CHEWs continue providing the technical support and supervision to CHWs both at the community and health facility level to ensure that the set standards are adhered to

- ✓ Community Health Committee (CHC) members, elected from among the CHWs, have been trained to assist the CHEWs in the supervision of CHWs.

Integration:

One of the program's central strategies to improve accessibility and quality of community-level care is increasing the integration of CHWs into the formal health system, leading to better access to and use of resources available to the community. CHWs act as an important bridge between the formal health care sector and individual families, since they themselves are trusted members and understand the needs, concerns and culture of each community. The more integrated the CHWs are into the formal health care systems, the stronger the ties to the community it hopes to serve.

- ✓ CHWs have taken on unprecedented support roles at health facilities, easing the resource burden placed on overstretched health facility staff with resultant improvements in the experience of those attending facilities for health services.
- ✓ CHWs are assisting with child growth monitoring; identification and management of mild and moderate malnutrition; referral of severe cases of malnutrition; registration of clients and vitamin A supplementation.
- ✓ CHWs are also supporting action during clinical outreach activities during events such as: Global Hand Washing Day, Malezi Bora, World AIDS Day, etc.

ADDITIONAL RESULTS

CHWs reporting to Ilatu Community Health Unit successfully lobbied district officials for the construction of a link health facility in Ilatu that now serves 10,091 people (51.1% female) who previously had to travel 30 km to access a health facility. The CHWs petitioned the Ilatu Chief, who then with CHW representatives began discussions with the District Commissioner. In turn, all parties were involved in discussions with the Kenya Pipeline Company, whose ultimate decision to fund the program was strongly influenced by the cohesion that existed among CHWs.

CHALLENGES AND LESSONS LEARNED

It is an indication of the strength of the program's success that challenges encountered produced lessons and best practices that can be pursued in the future. The high degree of enthusiasm for the themes of this intervention inspired a wide-range of future possibilities for developing a wide-array of health system issues while developing local resources.

- A multi-dimensional approach that takes into consideration the social and physical determinants of health is most likely to positively impact maternal, newborn and child health (MNCH) outcomes. To

varying degrees, and always in response to the needs and assets of communities and stakeholders, the program took advantage of community assets to incorporate elements of food security (e.g. establishing demonstration gardens, poultry keeping), microfinance (e.g. establishing village savings and loans associations) and water, sanitation and hygiene (WASH) (e.g. advocating for adoption of improved sanitation facilities at household level).

- As CHWs become increasingly integrated within the formal health system, the need exists for CHWs to be adequately compensated to avoid burnout, attrition and reduced motivation. The program provided compensation mainly in terms of material goods (e.g. bicycles), facilitated the formation of partnerships that would complement or benefit CHWs (i.e. encouraging savings and loans groups comprised of CHWs), and advocated for increased recognition of CHWs at district, regional and national levels to some success.

SUSTAINABILITY: BEYOND THE "BUILDING THE CAPACTITY OF CHWS"

Measures to secure the sustainability of program efforts were incorporated into the program from the planning stage through to the final evaluation. Most notably, the program worked in close partnership with appropriate ministries (i.e. Ministries of Health, Education, Water, etc.) to ensure that program objectives aligned with and complemented ministry objectives. Linking CHWs to health facilities worked to ensure that CHWs receive continued support and mentorship from health facility peers well beyond the life of the program.

Scale-up of government support for some form of remuneration for CHWs is a regularly identified solution to challenges inherent in sustaining the efforts of CHWs in an integrated health system model. CHW remuneration has been an advocacy point throughout the program, with varying results between countries. Amref Health Africa helped integrate CHWs into community based organizations and associations to assist in their future dialogue with the various ministries, in addition to providing trainers for ongoing training to new and old CHWs.

In Kenya, the program worked with CHWs to identify viable income generating activities and outside partners to engage with in order to contribute towards sustained CHW service. CHUs successfully advocated for the mobilization of financial support via the Health Sector Services Fund (HSSF); a Government of Kenya direct funding mechanism for health facilities that supports capacity building in the management of health facilities, community involvement and participation in facility management and governance. This support will contribute towards the ongoing delivery of CHW services by supporting stipends to some degree, as well as the procurement of supplies.

Case Study: Community Health Worker Josephine Makai

Above: Josephine Makai makes a summary of the day's work at Nthongoni Health Centre

Josephine Makai started as a volunteer Community Health Worker at the Nthongoni Health Centre in Kibwezi, Kenya. Her days are packed. She works five days a week at the Health Centre, now as a paid Community Health Worker and clinic support staff:

"My work starts as early as 8:00am. I clean the waiting bay that I use as my consultation room for the mothers and children…. As soon as the first client arrives, I am always ready to give my services to avoid having a long queue. In a very busy day, I sometimes see as many as one hundred clients."

Through her training in Amref Health Africa's workshops, Josephine recently identified a young mother patient with a dangerous post-delivery condition, a recto-vaginal fistula. The local health centre nurse reviewed Josephine's case, and trusted her diagnosis, knowing that she had undergone training. This diagnosis led to corrective surgery at a major hospital, and a series of further diagnoses. The patient is now in Nairobi, under specialized care.

Discussing her work, she glows: "I am happy to be a Community Health Worker because I am making a difference in the lives of women and children in my community."

FINANCIAL SUMMARY

A financial summary of the Kenya program's expenditures is presented below. The variance between expected and actual expenditures observed in the Kenya component of the CHW program was very low ($76). There was however variance for specific line items.

- Direct Labour (overseas personnel) – Increased cost of maintaining staff during the no-cost extension period brought about a 20% over-expenditure in this area.
- Equipment and Materials –The program experienced savings on purchasing of inputs due to bulk purchasing and currency fluctuations over the course of the program, resulting in 14% under-expenditure.
- Travel & Accommodation –One planned international trip to participate in a health conference did not occur, resulting in 16% savings.
- Building Capacity of CHWs – The cost of delivering training to CHWs was reduced due to the ability of the program to conduct trainings in-house, thus saving on the cost of venue hire.
- M&E –The cost of executing the End of Term Evaluation was greater than expected, resulting in $9,300 over-expenditure.

Please note that the figures presented below include contributions from the Charles & Rita Field-Marsham Foundation and DFATD (formerly CIDA).

Project Expenses - Kenya	Total Approved Budget	Total Expenditure	Variance
Direct Labour (Overseas Personnel)	$175,289	$209,706	$- 34,417
Equipment and Materials	$74,700	$64,054	$10,646
Travel and Accommodation	$21,000	$17,692	$3,308
Building Capacity of CHWs	$164,129	$139,012	$25,117
M&E	$28,303	$37,603	$- 9,300
Office Costs	$73,323	$68,601	$4,722
Total:	**$536,744**	**$536,668**	**$76**