Millennium Cities Initiative

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in collaboration with

# CITY COUNCIL OF KISUMU

TRAINING OF COMMUNITY HEALTH WORKERS

***"Increasing Access to Healthcare using a Community-based Approach"***

MANYATTA 'B'

By Beldina Opiyo-Omolo

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## INTRODUCTION

Communities are at the foundation of affordable, equitable and effective health care.

The community-based approach is the mechanism through which households and communities take an active role in health and health-related development issues. Community Strategy seeks to enhance community access to health care in order to improve individual productivity and thus reduce poverty, hunger and child and maternal deaths, as well as to improve education performance.

Community Health Workers (CHWs) provide a fundamental level of health care for residents in the community in which they live and have been shown to make a tremendous contribution to public health and community development. The Kenya Ministry of Public Health and Sanitation has developed a comprehensive Community Health Strategy training manual for CHWs that has been rolled out across the nation where the CHWs' impact is being carefully measured.

MCI Kisumu in partnership with the City Council of Kisumu Department of Health and other health partners, has moved forward by piloting training models for how most effectively and efficiently to train and support CHWs living in a downtown informal settlement who can fill the void in their neighbourhood or in similarly underserved urban communities, for so many residents whose conditions might not be recognized in a timely fashion or who otherwise might not have access to any form of healthcare.

In Kisumu, Kenya, residents of Manyatta, an informal settlement with nearly 86,000 people that currently lacks any sort of government-run health facility, has just benefited from an ongoing, wide-ranging CHW training, led by the City Council of Kisumu's Health Department, in collaboration with MCI Kisumu ably led by MCI's Public Health Specialist Beldina Opiyo-Omolo. While other development agencies and non-governmental organizations have organized CHW trainings in Manyatta before, they have always focused on a specific intervention or on disease-specific trainings, such as tuberculosis (TB) home-based care and prevention, HIV/AIDS, child nutrition or maternal care. This far more comprehensive program, which follows the Ministry of Health Community strategy guidelines, is the first of its kind in Manyatta.

## SUMMARY

Thirty eight (38) CHWs, covering part of Manyatta B, have been taken through 11-day training program. These 38 will serve Lower Kanyakwar and Kuoyo units of Manyatta B, adding to the 52 CHWs recently trained by the NGO APHIA Plus to cover the other unit of Upper Kanyakwar in Manyatta B.[1]

The City Council of Kisumu Health Department views this program as valuable and crucial to the existing health system, with the CHWs providing "level 1 care," or basic care, at the household level. The Manyatta CHWs were recruited based on requirements stipulated by the Kenyan Ministry of Public Health and Sanitation; for example, CHWs must be literate, permanent residents of the community they plan to serve and committed to the welfare of their community. As volunteers, the Manyatta CHWs will not receive a stipend – although the ultimate goal would be to have trained, paid CHWs integrated into the national health system, as mentioned above – but will nevertheless be rewarded for performance. Many of the CHWs operate small businesses; as such, other development partners such as Cordaid Urban Matters have expressed the desire to bring in organizations to provide micro-loans to those CHWs involved in health-related businesses, such as soap-making and selling nutritional aids, to enhance their income-earning capacity.

***DPHN (Public Health Nurse of the City Health Department facilitating the training***

The training, which began on 21 January 2013, ended on 4$^{t}$ February 2013 and relied heavily on the Government of Kenya Ministry of Public Health and Sanitation's Community Strategy Manual, building the capacity of CHWs to lead their communities in such health improvement initiatives as disease prevention, health promotion and simple curative care. The CHWs have been trained to serve 100 households each in their community. They have been taught to collect and analyse data at the household level, to prevent and



[1] Manyatta B has three administrative units – Upper Kanyakwar, Lower Kanyakwar and Kuoyo units. APHIA Plus is a US AID-funded project currently working in Kisumu.

monitor for diseases, to perform basic life-saving techniques, to recognize danger signs, to refer patients for further care and to advocate on their patients' behalf. Among their responsibilities: monitoring pregnancies and encouraging expectant mothers to get pre-natal check-ups, ensuring children are getting their immunizations, checking for signs of malnutrition, encouraging families to wash their hands and use toilets, and treating minor wounds and illnesses.

*Manyatta B CHW training participants*

Now that the training is complete, Manyatta's new CHWs in Kuoyo and Lower Kanyakwar's units in Manyatta B will first have a familiarization unit with the other CHWs trained by APHIA Plus, so that they can discuss how best to divide CHW coverage of the entire Manyatta B. They will also do a mapping of the entire community before embarking on the registration of each household under their care by completing the Ministry of Health's CHWs household registration form so that they can be familiar with the members of that household and any existing health conditions or needs.

The Manyatta CHWs will be monitored by a task force, the Community Health Committee (CHC), which will comprise 20 community members who have been taken through the first step of a similar training by the Ministry of Health through other development partners, all of whom will be asked to complete additional training and will then help manage health activities for all of Manyatta B. The CHWs and CHC members will attend monthly meetings led by the Community Health Extension Workers (CHEWs), who are employees of the City Council Health Department and who have been trained to administer these gatherings, during which time household data will be reviewed and the group will discuss how they might address certain issues. The Health Department plans for the CHEWs and CHWs to work together to address health concerns at the community level, setting a standard for "level 1" care.

*One of the CHEWs (Community Health Extension Worker) of the City Health Department facilitating the CHW training*

MCI is highly optimistic about this Urban CHW program, which we believe will build capacity and greatly improve access to health care in one of Kisumu's largest slum areas; ultimately, we hope this will lead to an increase in individual productivity, enhanced education performance and a reduction in poverty, hunger and child and maternal deaths. We are confident that this program will provide great benefits to the people of Manyatta B, while also serving as a model to learn from and to apply across Kisumu and well beyond.

*MCI Public Health Specialist at Manyatta B CHW training*

## Organization of the Training

The CHWs were taken through a basic training course comprised of six modules:

1. Introduction to Community Health and Development
2. Communication and Advocacy
3. Community Health Information Management (CHIM)
4. Governance and Coordination
5. Basic Health Promotion and Disease Prevention
6. Basic Case Management and Life-Saving Skills

## DAY 1

## Concept of Health and Development

Health was defined both locally and according to the WHO definition. Development on the other hand is a process through which there is positive change' in a population's attitudes, knowledge and skills, thus raising the health, economic and political status of the people. It is both a process and state that entails physical, infrastructural, economic, political and social development (knowledge, attitudes and skills).

## Relationship between Health and Development

Health and development are interdependent. Health is an indicator of development; hence the more developed a country is, the better it is able to meet the needs of its people. Better health makes an important contribution to economic progress, as healthy populations live longer, are more productive and save more. The importance of health in people's development, the role of education, poverty in health and development and vice-versa, were discussed: economic status, education, religion, culture, traditions and attitudes, infrastructure, political instability, leadership and policies, corruption, transparency accountability, dependency and insecurity, food and water. Factors both hindering and promoting health and development were also discussed.



## DAY 2

## Community Involvement and Participation

Community participation is a process by which the communities are actively involved in all stages of project or programme implementation. Trainees were taught the steps in community participation, the importance of community

participation, factors hindering community participation, how to promote community participation through partnership and what community participation involves.

**Participation assessment, planning and implementation of community health & development**

Community assessment is an evaluative study that uses objective data to assess the current social conditions of a specified community or targeted area. They were taught the steps of community assessment: to plan and organize, design the data collection, gather review and analyse the data, make decisions and be introduced to community assessment tools, including a survey, asset inventory, community mapping, daily activities schedule, seasonal calendar, focus group and panel discussion.

**Governance structure of community health strategy**

Governance, management and coordination were defined and discussed. The structures of health in relation to level 1 - the CHC, CHWs and CHEWs -- were discussed, detailing the criteria/eligibility for election/selection and the characteristics of each.

**DAY 3**

**Governance & coordination linkage structures at level 1**

The linkage between the community-level health workforce and the link facility was outlined. Moreover, steps and guiding principles in resource mobilization were summarized. Trainees were also taught financial management in relation to community governance.

**Basic principles of Disease prevention**

Disease prevention was defined and the CHWs introduced. Trainees were introduced to the common communicable diseases, their modes of transmission and preventive measures that can be taken to forestall their occurrences. Among the priority diseases for prevention discussed were: high morbidity and mortality diseases - STIs, HIV/AIDS, TB, malaria; under-five childhood illnesses - diarrhoea, pneumonia, malnutrition; outbreak/epidemics and notifiable diseases, e.g., cholera, dysentery, yellow fever, plague, typhoid fever, meningococcal meningitis, measles and viral haemorrhagic fever.



**Introduction to Community health information management**

Data, information and health information were defined. The importance of community health information management, methods/techniques of

information collection, types of information/data to be collected at the household level, sources of information and the tools used were all discussed. The processes of data collation, data analysis techniques, the presentation of information, information dissemination and the use of data for community health planning and action were elaborated.

## DAY 4

### Record-keeping and reporting

The record-keeping process was defined, including the importance of records, characteristics of good record keeping, the types of records needed for level 1 care, the appropriate information to record, the information-gathering process and how to keep records were all looked into.

### Disease surveillance

Disease surveillance was discussed and its importance elaborated. The integrated disease surveillance programme was introduced, its goal and aims discussed.

### Concept of communication

Communication is a process of sharing ideas and information to create a common understanding. To be effective, it must be a two-way process. Trainees discussed the purpose and importance of communication channels, barriers to effective communication and how to overcome them. The consequences of ineffective communication and two types of communication, verbal and nonverbal, were also discussed.

## DAY 5

### Elements of communication programming

The CHWs were taught elements of the communication process and basic counselling skills: interpersonal skills – negotiation, assertiveness, effective listening, conflict resolution and consensus building -- and facilitation skills. They were also taken through adult learning, characteristics of adult learners and those things that can help adults communicate more effectively, such as motivation, recognition, participation, discussion and a sense of responsibility, among others.

## Concepts and approaches in advocacy

Advocacy is speaking up for an issue or action taken to influence a decision, or speaking up for the people who cannot speak for themselves. Examples of advocacy, components/steps in the process and effective advocacy strategies were looked at.

Networking was defined as the act of inter-relating among people or organisations, such as to exchange information and other resources. Among the areas considered were skills for networking, strategies involved and the benefits of networking and partnerships.

## Household registration and mapping

CHWs were taken step by step through how best to approach home visiting. The structure of the register, proper mapping procedure and how to collect information were outlined. The significance of household registration was also discussed.

## Priority diseases for prevention

Among the diseases of public health importance discussed were malaria, tuberculosis, new AIDS cases, childhood pneumonia, childhood diarrhoea, cholera, dysentery, meningitis, typhoid fever, plague, measles and H1N1.

## DAY 6

## Performance-based reward system for CHWs

Performance-based reward was discussed, its purpose being to encourage behaviours that strengthen the community unit and create an environment that can enable CHWs to achieve their targets. The benefits of performance based rewards and the steps to successful performance-based rewards were highlighted, as well.

## Participatory rapid situational assessment



Household registration and mapping: CHWs were shown again the proper approach to home visiting, this time, in the field, in a pilot that included several households. The structure of the register, mapping procedure, how to collect information and the importance of the household registration were all discussed, this time, in the context of a real field trial.

**Field exercise**

CHWs went to their respective ancestral villages. They sampled a few households and collected data that they then presented the next day, for review. The exercise was designed to enable them to develop the practical skills and techniques for data collection at the household level.

**DAY 7**

**Basic principles of health promotion**

Health promotion was defined as the process of enabling people to increase control over their health and its determinants and thereby improve their health. The concepts and principles of health promotion, priority interventions, basic strategies and action areas of health promotion were discussed.

**Monitoring and evaluation**

Monitoring was defined, and the importance of monitoring, key indicators in health monitoring and evaluation and the characteristics of good indicators: (e.g., SMART, examples of other monitoring indicators) were cited.

The CHWs were also introduced to the evaluation process, within which the types and the importance of evaluation were elaborated. Monitoring and evaluation methods and tools and the importance of basic monitoring and evaluation were also discussed.

**DAY 8**

**Case identification, diseases for eradication, disability and rehabilitation**

Among the diseases earmarked for eradication/elimination discussed were polio, neonatal tetanus, guinea worm, and leprosy. Trainees were introduced to disability, types of disability, a few common disabilities and possible causes, and ways of preventing disability. The CHWs were also introduced to rehabilitation -- especially community-based rehabilitation (CBR) -- the purpose of rehabilitation and the role of CHWs in rehabilitation



**Eye healthcare and related conditions**

The eye is a vital sensory organ, and blindness is a severe physical handicap. CHWs were introduced to disease conditions related to eye health, including diabetes and HIV. They were also informed of the importance of counselling and rehabilitation for persons with disabilities due to eye conditions.

**Socio-cultural practices and the associated outcomes**

Social and cultural factors influence health by affecting exposure and vulnerability to disease, risk-taking behaviours, the effectiveness of health promotion efforts and access to, availability of and quality of health care. In addition, such factors contribute to understanding societal and population processes such as current and changing rates of morbidity, survival and mortality. Among the factors discussed were child rights, care for development, child abuse, exploitation and neglect, early marriage, Female Genital Mutilation/Cutting, violence against children, post-rape and defilement care and incest.

**DAY 9**

**Nutrition and health**

The CHWs were introduced to nutrition and malnutrition. They were taught about what constitutes a balanced diet and what factors can lead to malnutrition. Common cases of malnutrition were discussed and ways of curbing the same suggested.

**Antenatal care, breast feeding and care of the baby**

They were introduced to those immunizations required for children and pregnant women. All the immunizations were discussed and their importance stressed. Basic oral hygiene and eye care of the baby and the importance of exclusive breastfeeding were also discussed.

**Gender and reproductive health**

The CHWs were introduced to gender and health and taken through the reproductive system. Sexual and reproductive health was discussed, together with gender role analysis and its implication for health.

**DAY 10**

**Health promotion in schools**

Trainees were introduced to this component and to the importance of having school health programmes. Among the activities looked at were: Vitamin A supplementation, de-worming, hand-washing with soap, safe faecal disposal, peer education and information on growth and development.



**Life saving skills and demonstrations**

The CHWs were introduced to the life-saving skills for infants, children and adults. They were also shown how to conduct cardiopulmonary resuscitation

for infants/child and adults, and first aid procedure for choking. They were shown basic skills of conducting first aid: opening the airway, checking breathing and circulation, counting breaths per minute, taking of pulse and placing the victim in recovery position.

**Referral**

CHWs were shown the importance of directing those from the community with health needs to nearby hospitals for appropriate services. A few cases requiring referral were discussed, to provide an insight into the importance of timely and appropriate referrals.

**DAY 11**

**Community education and awareness creation**

CHWs were shown how to conduct education with the community, for the purposes of promoting proper health standards at the household level.
They were informed of the importance of sharing information with the community on certain issues that may require community participation.

**Preparation of an action plan**

An action plan is a sequence of steps that must be taken, or activities that must be performed well, for a strategy to succeed. The elements of an action plan include specific tasks (what will be done and by whom), the time horizon (when will it be done) and resource allocation (what funds are available for specific activities). An action plan must be S.M.A.R.T: specific, measurable, accurate, reliable and time bound. They were also shown the stepwise process of action planning.

**Way forward/next steps**

The first two weeks after the training, the newly trained CHWs will have a familiarization meeting, when they will all come together with the other CHWs trained in Manyatta to get to know each other and to discuss how best to divide the number of households they will be serving. MCI will play a key role in facilitating these meetings, together with the City Health Department CHEWs and other health partners working in Manyatta. Thereafter, each member of the two units within Manyatta B (Lower Kanyakwar and Kuoyo) who has just been trained will develop a Detailed Implementation Plan (DIP); share the work plan with stakeholders; identify sources of support and proposal development; brainstorm on indicators and timelines; identify likely obstacles/challenges and possible solutions; plan weekly meetings to review progress; and start work on social mobilization to get everyone involved. The CHWs will then embark on a mapping of all the households in Manyatta and

follow with a registration of each household, using the CHW registration form by the Ministry of Health.

**Next steps for the Urban Community Health Workers Project for MCI in Kisumu**

1). To scale up the number of trained CHWs throughout all urban informal settlements within Kisumu.
2) Before implementing the project in other informal settlements, however, there needs to be 100 percent CHW coverage in all of Manyatta. To attain 100 percent coverage, approximately 10 more CHWs (from Manyatta B) need to be trained, along with 20 Community Health Committee members who will supervise the CHWs.
3) There is a need to: a) continue to supervise data collection at the household level; b) support community dialogue days (where the community discusses their health issues); and c) support community action days (such as an immunization day).
4) To further train and build the capacity of CHWs in the use of e-health systems.
5) To register the nearby health facilities with the Ministry of Health and build the capacity of facility management.
6) To support the government malaria prevention program by using the urban CHWs to distribute mosquito nets.
7) To support the trained CHWs in sustaining basic health services by implementing high-impact interventions for maternal, newborn and child survival (e.g., by promoting individualised birth plans, emergency preparedness, newborn temperature management, hand-washing with soap by caregivers, complementary feeding, Vitamin A supplementation, Immunizations, LLITN, giving ORT and Zinc and safe drinking water) by providing mobility aids and health kits to CHWs.

**Challenges**

In recent months, the number of NGOs working in the Manyatta Informal Settlement has rapidly increased. This creates the potential for community confusion and overlaps in service provision. MCI is addressing this risk through the partnership coordination initiatives with organizations such as Cordaid Urban Matters and APHIA Plus, to undertake joint community dialogue sessions; continuous community health actor tracking; and through the continuous facilitation of stakeholder forums to integrate and build cohesion among the CHWs and to enhance coordination. There is also a challenge in the culture where the City Council Health Department staff demands to be paid for what is in fact their responsibility, to the point where they threaten not to train until they are paid by the supporting NGOs.

## Sustainability

In order to encourage project sustainability, MCI is actively engaged in community dialogues and stakeholder consultations. Community participation ensures that project interventions are driven by real-time needs. To ensure community ownership, capable local community members have been/ are being identified, so that they might participate in capacity-building training to maintain the project over time.

## CONCLUSION

The CHWs completed the basic training successfully and are expected to provide meaningful service at the community level. However, it is important that they be trained in the technical modules as well, and in other components of community strategy. There should be regular updates and trainings on areas of special need or particular interest. The CHWs should be trained on home community-based care and should be provided with household registers, bags and customary identification (name tags, T-shirts, hats and backpacks).