

Building the Capacity of Low Literacy Community-level Providers to Offer Health Services to Nomadic and Semi-Nomadic Communities in Northeast Kenya



Save the Children.



Background

Save the Children, with funding from the Bill & Melinda Gates Foundation, partnered with the London School of Hygiene and Tropical Medicine and the Centre for Behaviour Change Communication on the Nomadic Health Project (NHP). This 4-year (2018- April 2022) project sought to increase use of quality family planning (FP) services among nomadic and semi-nomadic populations in Kenya. Despite making up 60% of the population of Wajir and Mandera counties, nomadic and semi-nomadic communities have low access to health services, and women in these communities have high maternal mortality rates, high fertility rates and low uptake of health services, including use of family planning. Due to limited awareness, social norms that do not support the use of modern contraception, and long distances to health facilities, facility visits for non-emergency services - such as for family planning - are of lower priority.¹ Furthermore, with general population literacy rates of 24% and 30% in Wajir and Mandera counties respectively, there is limited availability of skilled health service providers in areas where nomadic and semi-nomadic populations reside.^{2,3}

This brief describes NHP's approach to provider capacity building for low-literacy level community health volunteers, in order to strengthen access to and provision of health services for mobile populations in Wajir and Mandera counties.

Project Approach

To bring health services closer to communities, the Community Health Policy (2020 – 2030) proposed the establishment of community health units (CHUs) linked to a primary health care facility.⁴ While the primary focus of NHP is on the use of FP, formative research demonstrated the importance of providing integrated

¹ Save the Children (2019). Exploring the social norms and other factors that FP use among nomadic and semi-nomadic communities in North Eastern Kenya: formative assessment. Nairobi: Kenya.

² Save the Children (2019). Assessing barriers, facilitators, and opportunities for inclusion of nomadic and semi-nomadic populations in health policy formulation, implementation and monitoring and evaluation: A case study of Wajir and Mandera Counties in Northern Kenya. Nairobi: Kenya.

³ Ministry of Health, Kenya (2020). Kenya Community Health Policy 2020-2030. Nairobi: Kenya

⁴ Ibid.

health services. Therefore, NHP expanded its scope to increase access to primary reproductive, maternal, newborn and child health (RMNCH) services for nomadic and semi-nomadic pastoralists, including access to contraception, working with the county health departments. NHP worked with the county health departments to introduce a comprehensive package of community-based health services including FP through the CHU. CHUs are comprised of community health volunteers (CHVs), who provide community-based services, community health assistants (CHAs), who are a formal employee of the government and form a link between the community and health facility, and the community health committee (CHC) which governs the CHU and is also linked to a primary healthcare facility. Fifteen mobile CHUs, each covering a population of 2,500 and linked to the nearest primary health facility along their migratory path, were established in six sub-counties in Wajir and Mandera. Nine CHUs were established in Wajir and six in Mandera. NHP selected and trained 179 CHVs from the community to deliver basic health services at community level.

To increase the capacity of the community-level health workers to be able to offer a wider range of services improving for these mobile populations and to strengthen the representativeness of the community actors, Save the Children and the Kenyan Department of Health used the following approaches:

Selection

Working with the county health departments, Save the Children identified the communities where the CHUs would be established. These communities were identified through the support of the sub-county health management team (SCHMT), the area chiefs, and community elders. Nomadic zones, migratory routes during the wet and dry seasons, and all water points in the target sub-counties were mapped. Facilities along the migratory pathway were identified for linkages and referral during migration.

Community meetings were held to select ten CHVs and eleven CHC members per CHU, and the selection criteria in the Community Health Strategy was contextualized to respond to specific challenges faced by nomadic and semi-nomadic CHUs. The criteria for selection included the standing of the individual within the community, willingness to serve and residency within the community where they will serve. SCHMTs encouraged gender balance when selecting members for the CHU, as community members, responding to gender norms, seemed to prefer male CHC members, who they view as being trustworthy decision makers. The selection ensured equitable representation from the different sub clans, which are made up of large extended families.

Initial training of CHVs and CHC members

CHVs received a five-day basic module training in July 2019 that covered their basic roles as a CHV including community health, first aid, communication, problem solving, health promotion and social mobilization. They then underwent additional training on the technical aspects of their work. The technical sessions were focused on nutrition, maternal and newborn health (MNH), FP, immunization and water, sanitation, and hygiene (WASH) and each lasted two days. CHC members were trained on leadership, conflict resolution and community sensitization, as well the basic modules on health. A total of 269 (179 CHVs and 90 CHC members) were trained. Average score for pre-test was 28% while average score for post-test was 83% for the basic training and average score for pre-test was 20% while average score for post-test was 85% for technical training.



The trainings were planned for the most effective participation of all attendees. Trainings were conducted during the rainy season when populations tend to settle for longer periods and are less distracted by their pastoral duties, during morning and evening hours, as the afternoon heat makes it difficult for participants to concentrate and engage in discussions, and private areas and breaks were provided to allow lactating women to nurse their infants. In addition, to accommodate the low literacy of most training participants, the training curriculum was modified to use several participatory approaches, including:

- *Brainstorming and group discussions* were carried out during the training, including on topics such as common childhood illnesses and danger signs that the CHVs should look for to make sure content was understood.
- *Flip charts* were used to record points raised by the participants, as well as key points and topics as they were introduced.
- *Videos and pictorials* were used to show key signs and treatment methods to participants, such as videos on fast breathing, chest in drawing, ORS demonstration, edema etc.
- *Role plays* of household visits and treatments, including ORS preparation.
- *Data forms* were used throughout the training and participants filled during the role play and discussion.
- *Clinical placement* in health facilities for practice on client counselling and assessment of children for common childhood illness.
- An audio version of the CHV training curricula was distributed to CHVs to refresh their knowledge as low literacy levels affected ability to a handbook or other materials.

Data Tool Mapping and Adaptation

A data flow map illustrating sources of data, interaction of data between levels and systems, weak points in the data flow grid and potential pain points was developed. This exercise helped in setting the minimum reporting requirements and solutions to the challenges associated with data, such as parallel data systems and collection of redundant data. The table below shows the adapted tools for the nomadic population:

Tool	Purpose of tool and norm	Changes included
MOH 513 (Household Register)	Collects information from all households within their catchment area. Completed by the CHVs every 6 months.	<ul style="list-style-type: none"> CHV to generate information through mobilization CHA to support CHV in filling out the tool CHV to keep the tool
MOH 515 (CHA Summary)	To document commodity management, was not used by the CHAs especially commodity management section	<ul style="list-style-type: none"> Generated by the CHA To be used for replenishing commodities to the CHV
MOH 516 (Chalkboard)	A community information notice board displayed at link facility. Contains monthly summaries of key service use indicators from the target community	<ul style="list-style-type: none"> To be maintained and updated by the CHA Need to simplify the chalkboard to make it easy to move around – originally designed for a static community.
MOH 514 (Service Delivery Logbook)	A log of all the services provided against key indicators. Completed by the CHVs every month.	<ul style="list-style-type: none"> Develop a sketch image representing indicators to help the low literate CHV to easily understand the indicators Tally each service given, against the image representing the indicator and by gender (also represented by image).

Tailored supervision and mentorship

In collaboration with the MOH, the project developed a supervision plan that included mapping of community health assistants (CHAs) and development of supervision checklists and itineraries. Fifty-three CHAs from linked facilities along the migratory routes in both counties were identified to provide regular supportive supervision to the migrating CHUs. The supervisory team discussed the aim and content of supervision, checked the household recording and pretested the reporting tools, and noted the challenges in reporting. The supervisory team prepared a field report and shared it with the respective SCHMTs for follow-up actions, including simplification of the reporting tools, on-the-job training, redistributing CHAs in rural static facilities along the migratory routes (currently CHAs cluster near urban centers), and FP commodity management.

As a result of reporting challenges due to low literacy levels of CHVs, it was recommended that the project adopt verbal reporting by audio recording CHVs, and that CHAs be tasked with compiling the information using the CHA Summary. Further, the frequency of meetings between CHVs and CHAs was increased to monthly (and where possible bi-weekly) to accelerate the capacity building of CHVs. Routine face to face supervision was sometimes affected by insecurity and floods and droughts, and the project was able to use technology to aid in contact, such as using phones to guide CHVs and WhatsApp use by CHAs.

Training on expanded scope of services

Given the limited access to services for these populations, it was necessary to expand the scope of services offered by CHVs beyond what they traditionally provide based on the community needs as reported by the CHV as well as feedback received from communities during meetings. Traditionally CHVs provide health education and household visits but through NHP, CHV duties also included first aid. Integrated community case management (iCCM) and community-based FP provision were also added to their duties in 2020.

iCCM: CHV training on iCCM enabled them to diagnose and treat basic childhood diseases such as diarrhea, malaria and pneumonia (diseases that become more common with increasing natural disasters). In addition to the training, they received CHV Kits that contained basic medicines for first aid and treatment of minor illnesses at community level. All 179 CHVs received the five-day iCCM training in July 2020.

Community-based provision of FP: The project rolled out the new community-based distribution for family planning (CBD-FP) curriculum for the CHVs in November 2020 (delayed from early 2020 due to COVID-19 restrictions). The overall objective of the CBD-FP strategy was to enable CHVs to provide quality FP services at the household level to improve access to FP. Prior to the roll out of the CBD training, the project began with sensitization of community leaders, CHMTs, SCHMTs and facility in-charges. These meetings provided a platform to endorse the strategy and dispel myths and misconceptions surrounding the new intervention.

A cohort-based training approach (four cohorts in total) was developed to enable the team to respond to COVID-19 safety restrictions limiting the number of participants in in-person training. The cohort-based approach also allowed for improvements to be made to the curriculum for subsequent trainings. Content was translated into the local language to enable the low literate CHVs to understand and the training curriculum had more practical activities. Classroom trainings lasted for one week while the clinical placement took 4 weeks for each cohort (25 participants). After restrictions on travel from Nairobi due to COVID-19 were lifted, national trainers traveled to Wajir and Mandera to lead the CBD training. Starting in November 2020, 179 CHVs in both Mandera and Wajir counties participated in the training.

The average pretest score was 21%, highlighting there was limited or no prior knowledge and/or skills exposure among the participants. After two weeks of clinical placement, the average posttest score was 54%. As this posttest revealed an insufficient increase in knowledge and skills, the clinical placement was extended for another two weeks (four weeks total). This extension resulted in a significant increase in skill level among the CHVs, with an average post test score of 84%. The lessons from this training will influence curriculum changes, especially the clinical placement duration.

The services offered in CBD included counseling on FP, provision of short-acting methods (pills, DMPA-IM, condoms, and counseling on LAM) and referral of client for LARCs. CHVs provided 892 clients with FP counseling and methods and referred 1,145 clients for FP services from 2019 through 2021. Although CHVs were trained to provide DMPA-SC, prioritization of counties for DMPA-SC shifted to include counties with high FP use to test self-administration of DMPA-SC.

Task sharing

Task sharing of mid upper arm circumference (MUAC) screening from CHVs to household caregivers was introduced through the CHV household visit as a measure to reduce the risk of COVID-19 transmission during screening. Household members – mostly parents – were orientated on MUAC screening and provided with



color-coded adult and children MUAC tapes to screen children, pregnant and lactating mothers. As of Nov 2021, 2,570 children and 675 pregnant and lactating mothers were screened through this approach. Interestingly no difference in accuracy was noted between the household led MUAC and MUAC taken by CHVs or health workers. This accuracy was observed during follow up monitoring visits where mothers who referred themselves were rescreened by CHVs.

Conclusions and Recommendations

- CHVs with low literacy require continuous refresher trainings, supportive supervision and mentorship in order to ensure they provide quality services to the community. While the need may be intense during the initial phases, and clinical placement time extended, this high intense support can be reduced gradually once CHVs demonstrate that they can provide quality services.
- With adaptations in training, supervision, and data collection tools, low literacy is not a barrier to selection of and service provision by CHVs. Key adaptations include reviewing the training approach to ensure sufficient time for learning, use methods including role plays, to allow learners opportunity to practice, ensure data collection tools include sketch images and that there is sufficient time to practice their use during the training.
- When providing supportive supervision to nomadic and semi-nomadic CHVs it can be difficult to manage regular in-person supervision visits. While in person supervision is superior, use of WhatsApp can provide more frequent contact. CHC members provided administrative and emotional support to CHVs.
- Advocacy at county and national level is required to address policy gaps in provision of health services, particularly related to scope of services that CHVs can provide and requirements for literacy, to improve access to nomadic and semi-nomadic populations.
- Identifying opportunities for members of the household to be engaged in tasks (like mid-upper arm circumference screening) can alleviate a burden on CHVs while also generating excitement and engagement from caregivers to take on the tasks.

