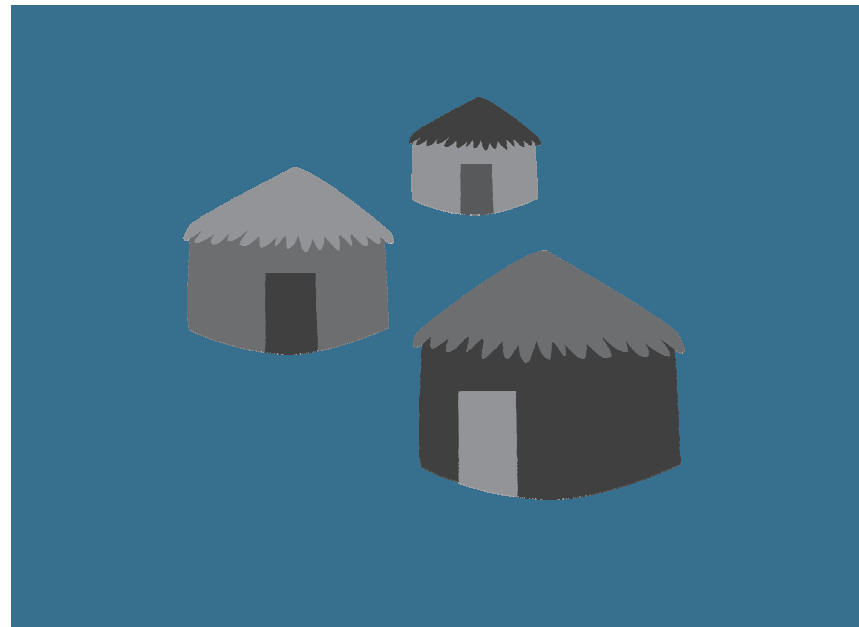# Institutionalizing Community Health Conference

27-30 March 2017 | Johannesburg, South Africa

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Mentoring Community Health Volunteers (CHVs) to improve Quality of integrated Community Case Management (iCCM) Successes, Challenges & Lessons Learned

Siaya County to Migori County
Dan Otieno, MCSP Kenya

(Presented by Dyness Kasungami)
March 2017

Presentation Outline

- Definition and rationale for CHV mentorship
- Bondo mentorship model
- Adapting Bondo Model to Migori county
- Successes and Challenges
- Lessons learned
- Conclusions

Definition of CHV mentorship and Scope of iCCM

Definition

- Support a CHV to build skills to assess, classify, treat, and provide follow up care for a sick child and counsel a caregiver through regular observation and coaching by a qualified clinician (the mentor)

Scope of iCCM in Kenya

- Assessment, classification and treatment of uncomplicated malaria and diarrhea in children under 5 years of age

- Referral of severely sick children, malnourished children, suspected pneumonia, sick newborn and all newborns delivered at home

Rationale for CHV mentorship

- Many CHVs have not completed high school ('O' levels) hence the need to increase instruction after standard training

- Individualized coaching increase skills retention/building

- Easier to identify gaps and act on them immediately

- Pace is set by needs not a set number of days to complete the curriculum

- Setting is the best suited for CHVs to practice what they have learned

- CHVs able to learn from one another

Photo Credit: Mark Kabue, MCSP

Bondo iCCM CHV mentorship model (1)

- CHVs trained using MOH iCCM curriculum (6 days)
- Key competencies defined based on scope of iCCM in Kenya
- Tools for mentorship developed
- CHVs clustered in small groups of 3-5 by Community Health Assistants (CHAs) depending on number of clinicians at the facility
- CHVs invited to facility on set days
- Clinicians at facility select children with iCCM conditions (e.g. diarrhea, fever.)
- CHVs observed over a period of time by ToTs & CHAs on each case managed
- Scores aggregated (pass mark is the 80%) & successful CHVs start implementing

Bondo iCCM CHV mentorship model (2)
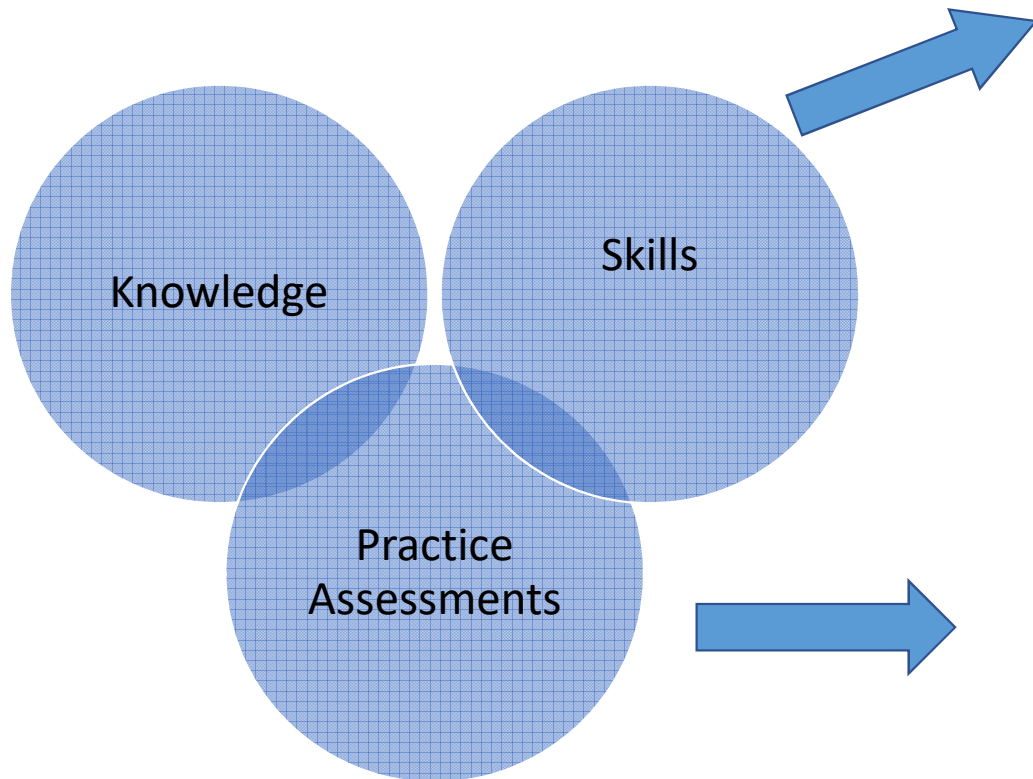
Skills

1	Count breaths in one minute in a child with cough
2	Identify chest in drawing
3	Assess nutrition status with MUAC: if above 6 mths.
4	Identify edema in sick children with malnutrition
5	Conduct RDT for fever cases to confirm malaria
6	Use sick child recording form correctly
7	Identify child in need of referral

RDT steps

1	Preparation of client and finger done
2	Pricking done correctly
3	Blood drawn correctly
4	Correct timing of test
5	Correct interpretation of results
6	Correct disposal of wastes

Knowledge

Skills

Practice Assessments

Ongoing mentorship and skills enforced

Photo Credit: Mark Kabue, MCSP

- During supportive supervision visits in the community by CHAs
- At monthly group or individual sessions, at the health facility when they submit reports
  - Review reports and identify strengths and gaps
  - Review cases managed and disease trends
  - Identify individual and common mistakes among CHVs
  - Coaching by clinician, CHA and by peers (other CHVs)

Adapting Bondo model to Migori CHV mentorship

Components of the Bondo Model	Adaptations from Bondo to Migori Mentorship Model
CHVs trained by ToTs using MOH iCCM curriculum (6 days)	Yes
Key competencies defined based on scope of iCCM in Kenya	Yes
Tools for mentorship developed	Yes
CHVs clustered in small groups of 3-5 by CHAs	Yes
CHVs members invited to facility	Yes
Clinicians at facility select iCCM cases	Yes
CHVs observed over a period of time by ToTs & CHAs on each case managed	Period shortened to 2 weeks
Scores aggregated (pass mark is the 80%) & successful CHVs are commissioned to start implementing	Yes

Successes and Challenges (1)

Successes

- Fewer mis-classifications and incorrect treatment observed over time
- Improved adherence to referral by caregivers over time
- Registers/records correctly completed and submitted
- Strengthened relationship between clinic staff and CHVs, a motivating factor for both
- CHVs able to request support from a CHA or clinician because of the established relationship
- Clinical training for CHEW/CHA makes ongoing support possible

Successes and Challenges (2)

Challenges

- More support (monetary and staff) in Bondo than in Migori
- CHVs in Siaya had monthly stipends paid, not so in Migori
- Weak capacity from MOH staff in Migori resulted in frequent stock out of medicine and delay in making M&E tools available
- Building on existing malaria CCM by a different organization and support system required more time to negotiate
  - Weaker skills esp. doing RDTs

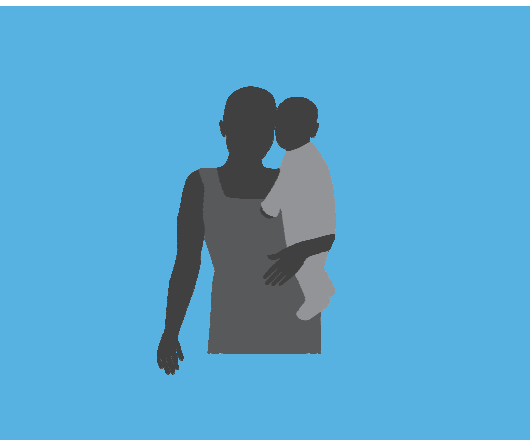# Lessons Learned and Conclusion

Lessons

- The National iCCM implementation framework has to be contextualized to county capacity and needs

- Dissemination of Bondo results to Migori county allowed for practical adaption of approaches

- Availability of tools and commodities play a key role in success of CHV mentorship thus plan for these before any trainings

- Adaptations of CHV mentorship models should consider county MOH leadership dynamics

- Investing in sharing of results and human stories among staff and community increases support

Conclusion

- The Bondo mentorship model can be scaled-up but has to be adapted to align with available human and financial resources
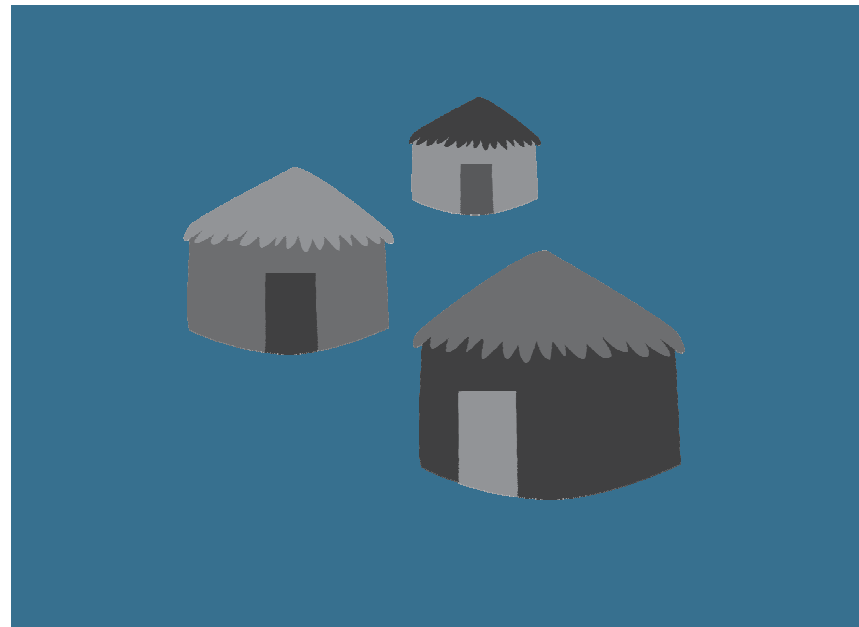
Photo Credit: Allan Gichigi/MCSP

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