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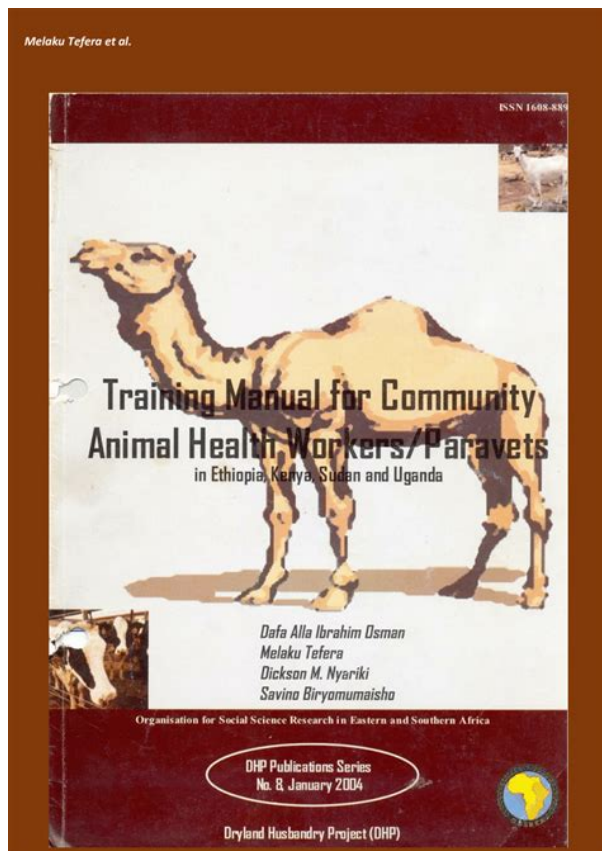
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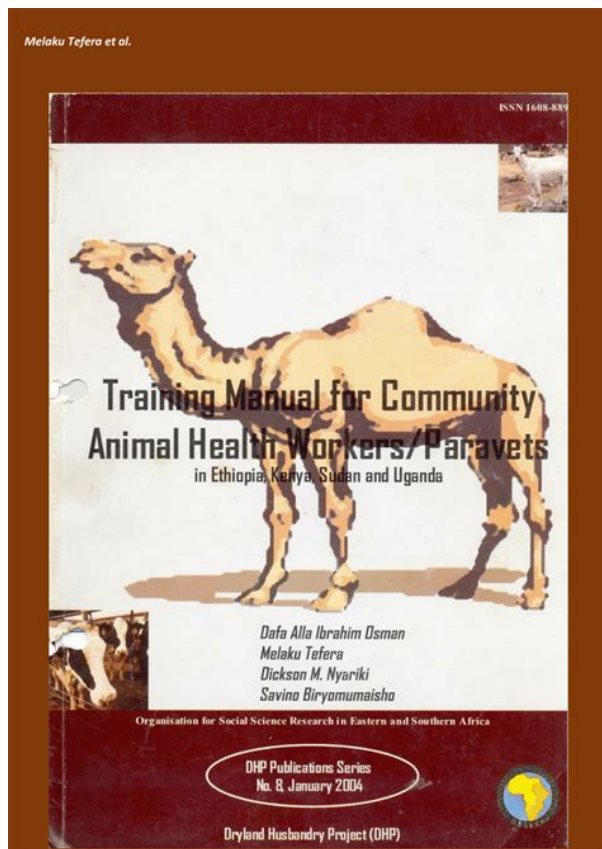


By continuing to navigate this site, you agree to allow us to collect information using cookies. Learn more about how we care for your data in our privacy notice. PATH and our partners are responding. The manual was developed with funding from the US Agency for International Development. It is available as one large file or as 17 smaller files. Upgrade your browser today or install Google Chrome Frame to better experience this site. The guide trains CHWs to identify and interact with women of reproductive age, as well as their families, community and religious leaders, and health care providers at facilities. If you continue to use this site we will assume that you are happy with it. Ok. However, one of the main barriers to proven and affordable health care has been limited access to high impact child survival interventions for pneumonia, diarrhoea and malaria in remote areas and marginalized communities. The deployment of well supervised Community Health Workers CHWs is a strategy that aims to increase access to health care for millions of children across Africa. All 20 countries in the East and Southern Africa Region ESAR surveyed have CHWs serving in some capacity. Policies supportive of CHWs are regularly incorporated into general health policy and strategy documents at a national level, although policy status was not reported for all countries surveyed. CHWs are allowed to provide a wide range of services, as per policy. Indeed, many countries have multiple CHW cadres with differing levels of training, responsibility, and professional status. They provide a spectrum of health related counselling, as well as preventive and curative health services outside of formal health facilities, bringing services closer to families who previously had limited contact with trained health workers. Most of the CHW programs described here have multiple external funders and are at least partially funded by donors. <http://stroytehcentr.ru/images/evenflo-symphony-65-convertible-car-seat-instruction-manual.xml>

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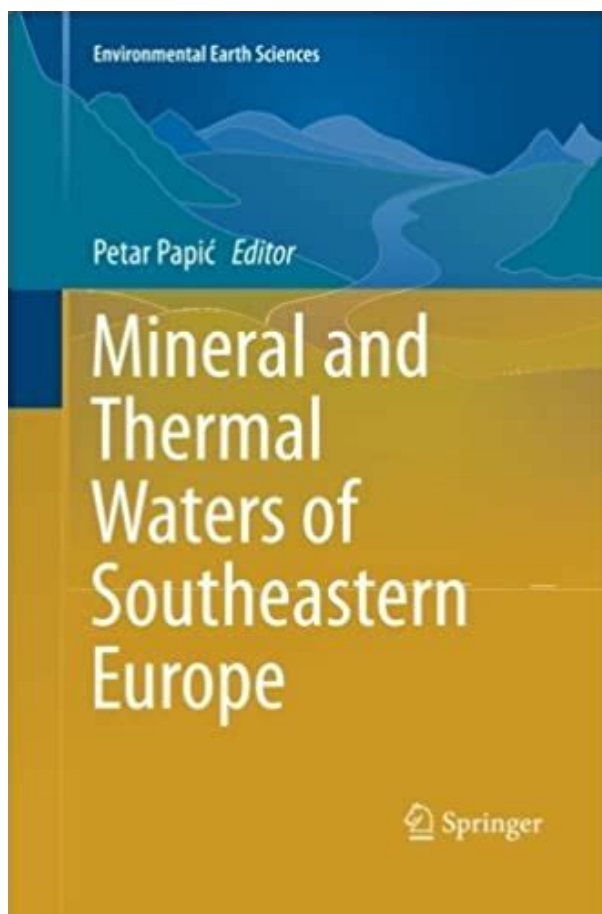
Only two countries, Angola and Lesotho, reported supporting their CHW programs fully through domestic funding. However, about half of the cadres listed were at least partially funded through domestic resources. Most of the donor funding is timebound, which means that there is a need for improved transition planning with respect to implementation. The approach of using CHWs to identify, treat, and refer complicated cases of pneumonia, diarrhoea or malaria the leading causes of under-five mortality is known as integrated community case management iCCM. At policy and implementation levels, iCCM is often a later stage addition to training and responsibilities in existing CHW programs. Since 2010, at least one cadre of CHWs in about half of ESAR countries conduct iCCM in targeted areas, evaluating patients at home or in the community at the onset of symptoms, and providing immediate treatment or referral. The main objective of this report is to elucidate the current state of community provision of health services beyond public facilities, through the vehicle of CHWs. Understanding the role of each CHW cadre in the ESAR countries is intended to clarify the current and potential roles of CHWs in contributing to national healthcare systems. In addition to a comprehensive literature review, the study used a crosssectional survey with close and openended questions administered to UNICEF Country Offices and other key informants to investigate and map CHW characteristics and activities throughout the region. Data on 37 cadres from across the 20 countries made up of nearly 266,000 CHWs form the basis of this report. This report catalogues the types and characteristics of CHWs, their relationship to the broader health system, the health services they provide and geographic coverage of their work. Eligibility for candidacy in CHW programs is an area of significant variability among countries and even among cadres within countries. <http://mim2010.ru/userfiles/evenflo-stroller-owner-s-manual.xml>



The criteria for eligibility can be subdivided into the following categories qualifications academic or skills, age, gender, and geography. The most common qualification-related prerequisites are a minimum level of education 18 cadres or literacy 17. The level of education required varies from completion of primary school to high school diploma; the latter is often for more responsible cadres, such as in Ethiopia, Namibia, Tanzania, Zambia, and Zimbabwe. For the largest number of programs 13, the age requirement is simply having reached 18 years old or the age of maturity; eight require a minimum age of 20 or 21; and four require an age of 25 or more. No cadre has a strict gender requirement, although four programs in Kenya, Mozambique, Ethiopia, and Somalia prefer females. Preservice training regimens vary between cadres and countries based on the availability and skills of trainers, training budgets, and the responsibilities of the CHWs being trained. Beyond preservice training, many countries also provide inservice trainings to extend or refresh the skills of the CHWs. Of the 20 cadres receiving preservice training in iCCM, the iCCM component generally takes place in less than a week only five cadres receive more. Both Ethiopia HEWs and Zambia CHAs provide preservice training for one year on a range of promotive, preventative and curative services, including a component on iCCM. CHWs also receive a wide range of incentives for their work, varying from complete voluntary workers Botswana, South Africa to what are increasingly called Health Extension Workers HEWs or CHAs that are formally employed and paid using domestic funds Ethiopia, Kenya, Zambia. Along this continuum lie a number of different CHW sustainability strategies from “subsidies” Mozambique to performance-based incentives at cooperatives Rwanda. Zambia has a strategy of having both voluntary CHWs and paid CHAs. About two-fifths of CHWs are fulltime and about the same fraction are salaried.

Beyond salaries, few financial incentives are available to CHW program managers. Program managers use some nonfinancial incentives e.g. t-shirts, badges as cost-saving methods to keep CHWs engaged, and also to promote awareness of CHW services in the community. CHWs perform a broad range of activities related to health including preventive counselling, health education, behaviour change communication and health promotion, as well as screening, treatment and referral for a range of diseases malaria, tuberculosis, HIV, among others. In addition, they help mobilize communities for vaccinations and other community health activities. They often even assist in areas

tangentially related to health, such as following up with school dropouts. However, any single CHW cadre only performs a subset of these activities. About half 11 of the countries in the region are utilizing iCCM as a tool to reduce childhood illness and mortality. Because of the communitybased nature of iCCM, it is usually conducted via the lowest level of primary care facilities or through CHW programs. Whether facilitybased care may be considered iCCM depends on the health system design and if facilities are serving one or multiple communities. A single CHW provides health care to a catchment population ranging from 200 to 2,500 people. Populations greater than this are generally seen to fall under a Health Centre. Effective supervision of CHWs by public sector staff in health centres is viewed as an important means of integrating CHWs with the public health system. Despite reportedly detailed supervision strategies, a lack of sufficient, supportive supervision was one of the most mentioned challenges across cadres. It appears that these strategies are not being fully executed as designed.

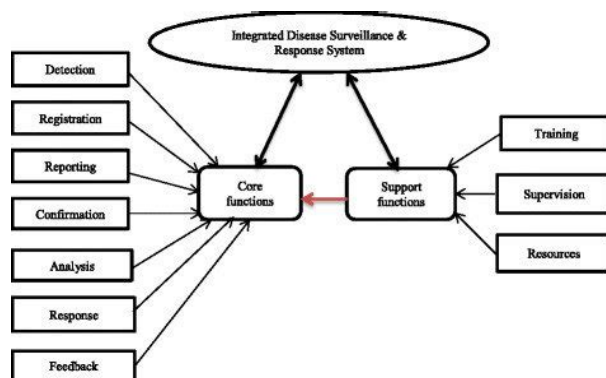


<http://www.raumboerse-luzern.ch/mieten/boss-bv9250-manual>

Although the training, incentives, and activities of the CHW cadres vary greatly among countries, the challenges faced by CHW programs are similar providing incentives for motivating and retaining CHWs, conducting supervision, coordinating CHW activities with the health system, and maintaining the supply chain for services provided by CHWs. Addressing these challenges must be prioritized if efforts to increase the scope and quality of CHW services are to be successful. At the global level, CHWs have largely been considered to be a homogeneous class of healthcare worker. A more nuanced differentiation would be helpful to improve policy coordination, strategic planning and implementation of communitybased health care. Based on results of the present survey, a posthoc classification identified four distinct types of CHWs in ESAR countriesSummary Table CHW classification model. CHW model name Services offered Level of effort Paid. There was only one

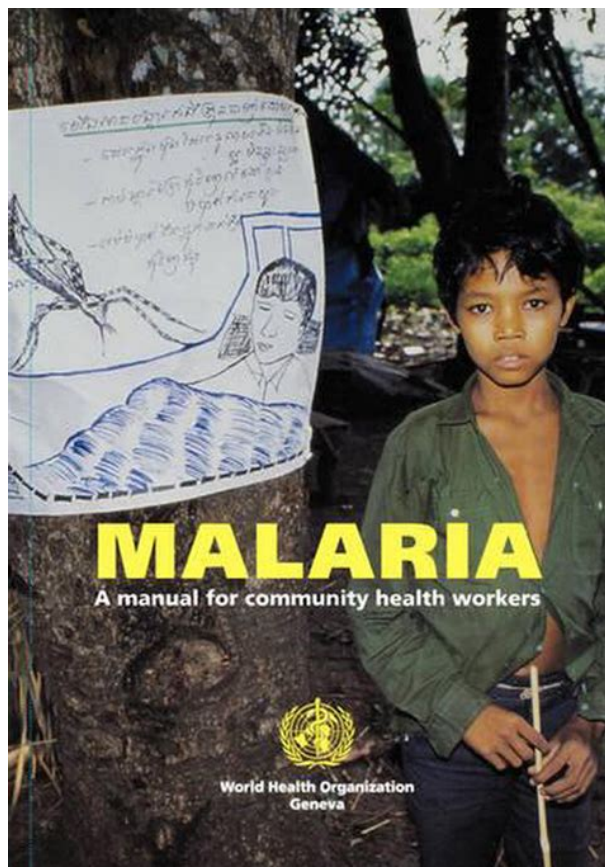
TBAplus CHW cadre reported in this study. However, this may be due to the underreporting of traditional birth attendants, as these are often considered a separate class of healthcare worker rather than a subset of CHWs. Having TBAs engaged in a slightly broader range of reproductive health activities beyond maternal delivery including family planning is likely more widespread and would be a lowcost model for expanding CHW care given the high geographic coverage of TBAs in many countries. In summary, this research documents that CHWs provide a variety of services with a broad range of potential tools. The report presents current training, responsibilities, and the scale of CHW programs in 20 ESAR countries. It also puts forward a potential CHW classification model to improve advocacy for and targeting of appropriate community health interventions see Summary Table, Table 3 and Annex 5.

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They provide a spectrum of health-related counselling, as well as preventive and curative health services outside of formal health facilities, bringing services closer to families who previously had limited contact with trained health workers. However, about half of the cadres listed were at least partially funded through domestic resources. Most of the donor funding is timebound, which means that there is a need for improved transition planning with respect to implementation. At policy and implementation levels, iCCM is often a later stage addition to training and responsibilities in existing CHW programs. Since 2010, at least one cadre of CHWs in about half of ESAR countries conduct iCCM in targeted areas, evaluating patients at home or in the community at the onset of symptoms, and providing immediate treatment or referral. Understanding the role of each CHW cadre in the ESAR countries is intended to clarify the current and potential roles of CHWs in contributing to national healthcare systems. In addition to a comprehensive literature review, the study used a cross-sectional survey with close and open ended questions administered to UNICEF Country Offices and other key informants to investigate and map CHW characteristics and activities throughout the region. Data on 37 cadres from across the 20 countries made up of nearly 266,000 CHWs form the basis of this report. This report catalogues the types and characteristics of CHWs, their relationship to the broader health system, the health services they provide and geographic coverage of their work. Eligibility for candidacy in CHW programs is an area of significant variability among countries and even among cadres within countries. The criteria for eligibility can be subdivided into the following categories: qualifications, academic or skills, age, gender, and geography. The most common qualification-related prerequisites are a minimum level of education 18 cadres or literacy 17.

The level of education required varies from completion of primary school to high school diploma; the latter is often for more responsible cadres, such as in Ethiopia, Namibia, Tanzania, Zambia, and Zimbabwe. For the largest number of programs 13, the age requirement is simply having reached 18 years old or the age of maturity; eight require a minimum age of 20 or 21; and four require an age of 25 or more. No cadre has a strict gender requirement, although four programs in Kenya, Preservice training regimens vary between cadres and countries based on the availability and skills

of trainers, training budgets, and the responsibilities of the CHWs being trained. Both Ethiopia HEWs and Zambia CHAs provide pre service training for one year on a range of promotive, preventative and curative services, including a component on iCCM. CHWs also receive a wide range of incentives for their work, varying from complete voluntary workers Botswana, South Africa to what are increasingly called Health Extension Workers HEWs or CHAs that are formally employed and paid using domestic funds Ethiopia, Kenya, Zambia. Along this continuum lie a number of different CHW sustainability strategies from “subsidies” Mozambique to performance based incentives at co operatives Rwanda. Zambia has a strategy of having both voluntary CHWs and paid CHAs. About two fifths of CHWs are fulltime and about the same fraction are salaried. Program managers use some non financial incentives e.g. tshirts, badges as cost saving methods to keep CHWs engaged, and also to promote awareness of CHW services in the community. CHWs perform a broad range of activities related to health including preventive counselling, health education, behaviour change communication and health promotion, as well as screening, treatment and referral for a range of diseases malaria, tuberculosis, HIV, among others. In addition, they help mobilize communities for vaccinations and other community health activities.

<http://mesotects.com/wp-content/plugins/formcraft/file-upload/server/content/files/1628413c0ac776--Buffalo-tools-generator-manual.pdf>

However, any single CHW cadre only performs a subset of these activities. About half 11 of the countries in the region are utilizing iCCM as a tool to reduce childhood illness and mortality. Because of the community based nature of iCCM, it is usually conducted via the lowest level of primary care facilities or through CHW programs. Whether facility based care may be considered iCCM depends on the health system design and if facilities are serving one or multiple communities. A single CHW provides health care to a catchment population ranging from 200 to 2,500 people. Despite reportedly detailed supervision strategies, a lack of sufficient, supportive supervision was one of the most mentioned challenges across cadres. It appears that these strategies are not being fully executed as designed. At the global level, CHWs have largely been considered to be a homogeneous class of healthcare worker. A more nuanced differentiation would be helpful to improve policy coordination, strategic planning and implementation of community based health care. Based on results of the present survey, a posthoc classification identified four distinct types of CHWs in ESAR countries. However, this may be due to the under reporting of traditional birth attendants, as these are often considered a separate class of healthcare worker rather than a subset of CHWs. Having TBAs engaged in a slightly broader range of reproductive health activities beyond maternal delivery including family planning is likely more widespread and would be a low cost model for expanding CHW care given the high geographic coverage of TBAs in many countries. The report presents current training, responsibilities, and the scale of CHW programs in 20 ESAR countries. It also puts forward a potential CHW classification model to improve advocacy for and targeting of appropriate community health interventions see Summary Table, Table 3 and Annex 5.

However, past and current programs vary dramatically in how CHWs are selected, trained, and tasked to deliver services. The term CHW is used in this report to broadly encompass all individuals providing health services at the community level. This includes, for example, health extension workers HEWs formally employed by the public health system, volunteer nutrition counsellors, and traditional birth attendants TBAs, among others. Based on the definition put forward by Lewin et al 2005, CHW is more explicitly defined as any health worker carrying out functions related to health care delivery for a population under 2,500 people who are trained in some way in the context of the intervention, and who have no formal professional or paraprofessional certificate or tertiary education. Recently, there has been a resurgence of interest in using CHWs to increase access to healthcare across sub Saharan Africa in order to accelerate reductions in child mortality. While most East and Southern African ESAR countries have reduced child mortality during the past two

decades, more than one million children still die each year in this region largely from diseases that could be prevented or treated if healthcare were better accessible. Figure 1 Proportional distribution of child deaths by cause in East and Southern Africa, 2000 and 2010 Source WHO, 2013; World Health Statistics 2013 Report. 19 12 5 8 16 12 8 5 3 14 3 10 10 2 8 16 15 10 6 5 18 5 0 5 10 15 20 25 Percent 2000 2010 Figure 2 Coverage of key maternal and child health interventions in East and Southern Africa, 2005-2011 Proportion of targeted population that received the intervention % Source WHO 2013 World Health Statistics 2013 Report, The practical implementation of iCCM includes diagnosing suspected malaria cases reported fever using rapid diagnostic tests RDTs. Positive cases should promptly receive firstline antimalarial treatment, which is some form of artemisinin-based combination therapy ACT.

Both positive and negative cases should also be screened for pneumonia. Pneumonia classification is based on counting breathing rates using a timer. Children classified with both malaria and pneumonia using the above procedures should receive dual treatment with ACT and amoxicillin. Severe and complicated emergency cases should be immediately referred to health centers for treatment. Some countries also recommend prereferral treatment of severe malaria cases with rectal artesunate suppositories through iCCM. A 2010 supplement of the International Journal of Epidemiology published evidence on iCCM effectiveness and its potential impact on child mortality. Currently the UNICEF regional office for East and Southern Africa ESAR provides technical assistance to 21 countries in a variety of health areas. A key aspect of this work is to support approaches that will significantly reduce mortality in children under 5 in order to achieve Millennium Development Goal MDG 4, notably through interventions targeting diarrhoea, pneumonia, malaria, malnutrition, and general neonatal care. Indeed, more equitable access to care for these conditions can be achieved through iCCM, CHWs and other non facility based approaches. However, the multitude of implementers and funders active in this area has made it difficult to ascertain how far each country has moved in scaling up iCCM provision. Aim This report aims to examine current community level provision of health services through CHWs by describing the intended role of CHW cadres in different ESAR countries, thus clarifying their current and potential contributions to national healthcare systems. Specific objectives For each of the 20 countries in the East and Southern Africa region that responded to the survey, this study profiled CHW cadres reported by government and UNICEF staff according to type, geographic coverage, gender, and qualifications.

Beyond these profiles, the study also assessed CHW roles and responsibilities, including iCCM treatment of malaria, pneumonia, diarrhoea, newborn care, treatment of acute malnutrition, treatment of HIV, and other promotional, preventative or referral tasks e.g. health education, cholera management. Finally, information was collected on implementing and funding partners for CHW programs, as well as the relationship between CHW cadres and the formal health system. In combination with unpublished country level work beyond the scope of this report to map current iCCM resources and to identify iCCM financing gaps in these countries at current levels of implementation, findings presented here will be used to further support plans and ongoing advocacy for iCCM expansion through national scale programs. The first phase included a comprehensive literature review to assess current case studies, best practices, international strategies and country implementation of community level health programs and iCCM. The search was conducted using Google Scholar, Medline, Cochrane Library, as well as websites of key organizations working in this area including. Documents were also supplied by UNICEF ESAR staff providing technical assistance to country programs, which supplemented the website search. These documents included reports, guidelines, peer reviewed publications, and presentations from country stakeholder meetings. The second phase included administering a standardized cross sectional survey with both open and close ended questions to the Chief of Health at each of the UNICEF Country Offices in the region. In many cases, UNICEF Country Offices contacted implementing partners in their countries such as

Population Services International PSI, International Red Cross IRC, Malaria Consortium, Save the Children Save and government ministry officials to obtain the requested information.

In addition, this survey was also sent to implementing partners known to be conducting relevant activities in these countries directly through their regional and global offices. Requests made to these partners were largely used to corroborate information provided by UNICEF Country Offices, and in some cases, to supplement data where it was unavailable. The survey was conducted in May/June 2013. Where there was no response to first contact, up to four attempts were made to reach each UNICEF Country Office by email and phone by 30 June 2013 when datasets were closed. The questionnaire included two tools, which were piloted with the UNICEF Country Office in Kenya, and revised prior to survey implementation during the first week of May 2013. The first tool collected quantitative data through closed-ended questions on each CHW program operating in each country on the following topics. CHW program design and implementation status. CHW participant prerequisites. CHW training time and personnel. CHW incentives CHW activities including but not limited to iCCM. Community Health strategic planning Training content Supervision and linkages to the public health system. Community engagement and feedback. Program challenges Responses to each of these tools, along with any implementing partner data, were compared to corroborate responses and analysed both at a country level Annex 1 Country and aggregated to the regional level. Country summaries were prepared based on these inputs, and respondents were given the opportunity to review them and clarify or supplement previous contributions. All respondents were requested to support their responses with relevant research reports, policy documents, training materials, case studies etc. A list of these documents, document type, and the language of issue can be found in Annex 6.

Responses were also received from the UNICEF regional team, PSI and Save the Children about their country-level community health projects and donor activities within this region. Based on these responses, ESAR countries are home to 37 distinct CHW cadres, which are analysed in this report. The level of detail on these CHW cadres known by respondents varied highly between countries. Also, in some countries e.g. Somalia, only a subset of community health programs is discussed due to a lack of information or other circumstances, although respondents were asked to report on all CHW cadres present in their country. This section of the report presents results at a regional level on key aspects of iCCM policy and implementation. Country-specific findings are included in Annex 1. Policy Community health policies supportive of CHWs are regularly incorporated into general health policy and strategy documents at the national level. The most common path to national implementation of CHW programs follows this route 1 develop a comprehensive health policy 2 translate policy into a strategy and implementation plan and 3 train and deploy CHWs. Most countries have policies that support some form of community healthcare provision whether preventive, promotional, or curative. At policy and implementation levels, iCCM is often a later stage addition to training and responsibilities in existing CHW programs. About half of ESAR countries have some form of health policy supportive of full or partial iCCM activities as an aspect of community-based care Table 1. Policy-level iCCM support by the government takes the following forms 1 comprehensive CHW strategic plan 2 Ministry of Health MoH letter allowing CHW provision of antibiotics 3 overall health sector strategy that includes CHW activities 4 guidelines for the referral pathway that includes CHWs, or authorization for operational research into impact of iCCM provision.

A further six countries Burundi, Madagascar, Malawi, Rwanda, Uganda, Zambia have community health or child survival policies and plans that include elements of community-level healthcare provision, which may or may not include iCCM. Angola, Comoros, and South Sudan are reportedly in the process of developing such plans as of June 2013. No policy-related information was available for the remaining countries. Data are as of 30 June 2013. Funding and implementation Most CHW

programs described here have multiple external funders and are at least partially funded by donors. Only two countries, Angola and Lesotho, are reported to support their CHW program fully through domestic funding. Most of this funding is time bound, which means that there is a need for transition planning with respect to implementation. In contrast to CHW funding, implementation of CHW programs shows greater country involvement. Eight CHW cadres are being implemented solely by domestic institutions, although most countries implement programs in partnership with external organizations. Nearly three quarters of programs are implemented partially by the national MoH. Large funders UNICEF, USAID, WHO are also major implementing partners, and are often joined by NGOs that work specifically on the implementation side e.g. PSI, Save the Children, Malaria Consortium.

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