Maximizing Human Resources by Involving Lay Health Care Workers in HIV Service Delivery in Kenya

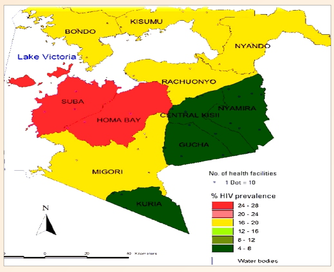
Agengo G[1,2], Lewis-Kulzer J[1,3], Nyabiage L[4], Penner J[1,5], Cohen CR[1,3], Bukusi EA[1,2]

1. Family AIDS Care and Education Services, 2. Kenya Medical Research Institute,
3. University of California San Francisco, 4. Kenya Ministry of Health,
5. University of British Columbia

Description of the Problem

- Nyanza Province – highest HIV prevalence in Kenya at 15%
- Large number of people seeking HIV services
- Shortage of health care workers
- Novel approaches required to meet demand for quality HIV services

Map of Nyanza



Objective

- Involvement of Lay Health Care Workers (LHCW) in patient care to increase access to quality HIV services

Approach

- Task shifting
  - LHCW take on non-medical duties
  - Medical staff focus on patient care
- Expanding scope of services
  - Take on additional responsibilities to fill service gaps (support group organization, etc)

Task shifting

- Patient registration
- Taking weight, height, temperature, pulse, and respirations
- Managing Food By Prescription (FBP)

- Conducting HIV education, adherence counseling and health talks
- Pill counting
- Managing supplies

Other Responsibilites

- Form and lead support groups
- Recruit and supervise peer educators
- Initiate and maintain patient advisory groups

- Lead children's club activities
- Facilitate parent and guardian meetings
- Conduct home visits and tracing
- Conduct hospital visits
- Link with CBOs and FBOs for other support services

Recruitment of LHCWs

- Model patients (open about status and living positively): "Expert Patients"
  OR
- Active members of a Community-Based Organisation (CBOs)
  AND
- Must be literate and fluent in local languages

Staffing Levels

- 5-7 per high volume site
- 1-3 per lower volume site

Training

- Internship training (12-weeks)
  - Seminars and practicum
- Weekly Continuing Medical Education
- Child counseling training
- On-job-training and mentorship

Internship Training

- Training curriculum is tailored to LHCW activities
- Divided into 11 modules each with a number of units

Modules

- **Module 1 – Orientation into the system**
  - Units curriculum over view, client flow, human resource issues, LHCW concepts, Terms Of Reference
- **Module 2 – HIV Knowledge**
  - Epidemiology and natural progression of HIV, BCC, condoms, dispensing, HIV, myths and misconception, the germ theory
- **Module 3 – HIV Management**
  - OIs, TB, malaria, HAART, paediatric management, CTX multivitamin
- **Module 4 – Counseling**
  - General counseling, stigma and discrimination all model of counseling
- **Module 5 – ARVs, Adherence, Dispensing**
- **Module 6 – HBC – Collaboration, OVC, Referrals, Community Mobilization, Defaulter Tracing, HBC**
- **Module 7 – Nutrition – ART & Nutrition, Safe Water Systems, FBP**
- **Module 8 – Support – Support groups, Legal empowerment, Children's club, Group dynamic and Effective communication**
- **Module 9 – Reproductive**
  - Sex and sexuality, pre conception counseling, family planning, condoms
- **Module 10 – Basic Clinical Care**
  - Vital signs, infection control
- **Module 11 – Clinic Organization**
  - Commodity management, monitoring and evaluation, data collection

Compensation

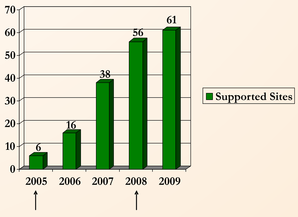
Progression based on performance and available resources:

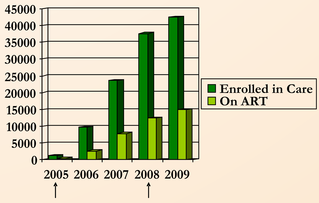
- Volunteers with no reimbursements
- Volunteers with a small stipend
- Salaried staff: Clinic and Community Health Assistants (CCHA)
  - 52% of volunteers have been hired as staff by FACES or other partners

Evaluation Methods

- Aggregated data from FACES-supported sites
- Compared differences in site volume and patient enrolment prior to task-shifting implementation (Dec. 2005) to post implementation (Sep. 2008)

Results





Conclusion

- LHCW approach grew substantially in less than 2 years
- During that time, there was also a dramatic increase in the number of FACES-supported sites and patient enrolment
- Ongoing mentorship, learning opportunities, motivational rewards may have helped with LHCW enrolment and retention
- LHCWs able to assist with patient flow and successful decentralization efforts
- More evaluation of LHCW approach needed to assess impact and effectiveness

Recommendations

- Strong MOH involvement to inspire team work and local program ownership
- Build LHCW skill capacity through trainings such as Provider Initiated Counseling and Testing and Community Integrated Management of Adult Illnesses
- Ongoing training and mentorship is essential

Ministry of Health

Gagengo@kemri-ucsf.org • gchiambe@yahoo.com • tel: +254 720 640 632 • www.faces-kenya.org