Human Resources for Health Program
Clinton Health Access Initiative, Zambia

KAPIRI MPOSHI DISTRICT COMMUNITY HEALTH ASSISTANT MENTORSHIP REPORT

FEBRUARY 2018

OVERVIEW

Clinton Health Access Initiative (CHAI) has been working closely with the Zambia Ministry of Health (MoH) since 2008 to design and implement health systems strengthening interventions through the Human Resources for Health program. A key component of this support is the Community Health Assistants (CHA) Program, which was established through the 2010 National Community Health Worker Strategy[1]. The CHA program is aimed at recruiting, training, and deploying Community Health Assistants to be attached to rural health posts across the country. The CHAs are trained for 12 months at two CHA training schools situated at Mwachisompola Health Demonstration Zone, in Central Province, and Ndola Central Hospital, in the Copperbelt. CHAI committed to support the training of 2,100 CHAs by March 2018 through a DFID-supported Human Resources for Health strengthening grant. To date, 2,124 CHAs have been trained and 1,403 CHAs deployed in over 105 rural districts of Zambia.

Despite the country's gains in recruiting, training, and deploying CHAs, evidence from Zambia[2] in 2015 mirrors the global literature outlining large gaps in CHA effective supervision. To address these performance issues, CHAI worked closely with districts to identify key gaps and develop practical solutions to address them. The results show improved CHA supervision, better facility staffing, increased community case management at household level, and strengthened systems for CHA supply and commodity disbursement.

CHA SUPERVISION AND MENTORSHIP

During monitoring visits conducted to various health facilities around the country, CHAI observed that a number of CHAs were not meeting the 80/20 work ratio which requires that CHAs work is apportioned as 80% working within the community and 20% of their time working at the health facility. This was preventing most of the CHAs from working within their scope. It was identified that lack of effective supportive supervision and mentorship was the underlying cause. Effective supervision is key to the implementation of the *National Community Health Worker Strategy*. Supervision has been identified as a pre-requisite for the success of CHW program implementation globally.[3,4] In Zambia, supervisors should provide supportive supervision and mentorship to assist CHAs in the delivery of quality community health care services.

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[1] Ministry of Health, 2010. National community health worker strategy in Zambia

[2] Phiri, Sydney Chauwa, Margaret Lippitt Prust, Caroline Phiri Chibawe, Ronald Misapa, Jan Willem van den Broek, and Nikhil Wilmink. "An exploration of facilitators and challenges in the scale-up of a national, public

[2] Phiri, Sydney Chauwa, Margaret Lippitt Prust, Caroline Phiri Chibawe, Ronald Misapa, Jan Willem van den Broek, and Nikhil Wilmink. "An exploration of facilitators and challenges in the scale-up of a national, public sector community health worker cadre in Zambia: a qualitative study." *Human resources for health* 15, no. 1 (2017): 40.

[3] Palla S, Minhas D, Pérez-Escamilla R, Taylor L, Curry L, Bradley EH. Community health workers in low- and middle-income countries: what do we know about scaling up and sustainability? Am J Public Health. 2013;103:74–82.

[4] Kane, Sumit S., Barend Gerretsen, Robert Scherpbier, Mario Dal Poz, and Marjolein Dieleman. "A realist synthesis of randomised control trials involving use of community health workers for delivering child health interventions in low and middle income countries." *BMC health services research* 10, no. 1 (2010): 286.

The Ministry of Health (MoH), with support from CHAI and other stakeholders, developed a CHA supervisors' manual in 2012. The manual aimed to mainstream supervision to assist CHAs' efforts to provide quality services, as well as identify and address major bottlenecks in the roll out of the CHA program throughout the country. This was later revised in 2016 to align it to the lessons learnt, experiences and recommendations from the evaluations and monitoring reports. To date, a total of 554 supervisors have been trained in supportive supervision and mentorship of CHAs nationwide.

From June 2017 to January 2018, the Ministry of Health in Zambia, with support from CHAI and financial assistance from DFID, embarked on a capacity-building initiative at 11 health posts in Kapiri Mposhi district to follow up on the implementation of supportive supervision and mentorship of CHAs. In total, 34 visits were conducted, an average of three visits to each of the 11 health posts. During the initiative, gaps in implementation of supportive supervision and mentorship for CHAs were actively addressed and localized solutions were designed in partnership with the MoH to strengthen the district health system and ensure that effective supervision and mentorship of CHAs were being carried out. This was done through one-on-one discussions with CHAs and with supervisors and through group discussions with staff at the facility and community members. A meeting for all the CHAs was held to give them an opportunity to share experiences and learn from one another. This meeting also gave CHAs an opportunity to interact with the Ministry of Health at national, provincial and district levels.

SCOPE OF WORK

Initial monitoring visits identified specific strengths and weaknesses in supervision and mentorship in each of the health posts visited. Visit reports were reviewed and recommendations discussed with the District Health Office (DHO), which committed to providing support to the facilities. This information was used to formulate interventions required for each specific health post, which were then implemented through the District Health Office. MoH and CHAI monitored implementation of the interventions monthly. Lessons drawn from Kapiri Mposhi district were documented and shared with other districts within Central Province and with other provinces to inform future implementation of strengthened supportive supervision and mentorship of CHAs.

OBJECTIVES

The objectives of the support to Central Province (Kapiri Mposhi District) were as follows:

1. To implement interventions to address supportive supervision and mentorship gaps at all levels – provincial, district and facility.
2. To engage and re-orient all staff on management of CHAs.
3. To re-orient CHAs on their scope of work.
4. To advocate for support and resources from the Provincial and District Health Office towards ensuring sustainability of the CHA program.
5. To advocate for more integration of the CHA in district health activities.
6. To provide technical support to ensure that every deployed CHA has a supervisor that is identified and oriented by the district CHA focal point person.
7. To re-orient the CHAs to ensure that they fully understand their role in the community and in coordinating community volunteer groups working in their catchment areas.
8. To work with districts and provinces to ensure that CHAs work within their scope and that they are provided with the necessary support in cases where they are working beyond their scope.
9. To clarify reporting structures at all health posts.

EXPECTED OUTCOMES

The expected outcomes following the support to Central Province (Kapiri Mposhi District) were as follows:

1. An improvement on the overall CHA program implementation.
2. Strengthened district and provincial support towards the CHA program as a step towards integration of the program.
3. Improved CHA community engagement.
4. Improved support from the Province and the District towards implementation of supportive supervision and mentorship of CHAs.
5. CHAs have a clearer understanding of their role in the community and with existing community volunteer groups.
6. Supervisors and CHAs develop monthly supervision plans.
7. The district integrates supervision of CHAs into routine programs.

RESULTS

The intervention focused on improving seven components of the CHA program, which were identified and selected to form the basis for the initial assessment and follow-up interventions in the target facilities. A dashboard was created to monitor and track progress made by the facilities on all seven components (Figures 1 and 2). It also served as a guide to the appropriate interventions required by each facility. The two figures below show the status at the initial assessment and after the final capacity building initiative visit.

Status of facilities at initial mentorship visit in October/November 2017

Figure 1 shows how the 11 facilities performed on each CHA program component during the initial assessment prior to implementation of capacity building initiatives.

Figure1: Status of facilities at initial mentorship visit

Intervention/Facility	Kaswende	Chipepo	Chapusha	Mpunde	Chitaba	Chilumba	Lunkomba	Chishinka	Kafinda	Lunchu B	Chambulumina	Progress %
Engage DHD on staffing of the facility	Poor	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved	Poor	Achieved	Achieved	90%
Orientation of supervisor on CHA supervision	Poor	Achieved	Poor	Achieved	Poor	Achieved	Poor	Poor	Poor	Poor	Poor	27%
Introduction of CHA to the community	Poor	Poor	Poor	Poor	Achieved	Achieved	Achieved	Poor	Poor	Poor	Achieved	36%
Re-orientation of CHA on scope of work	Poor	Poor	Poor	Poor	Achieved	Achieved	Achieved	Poor	Poor	Poor	Poor	81%
Engage supervisor to assist CHA to request for medical supplies for community work	Poor	Achieved	Poor	Poor	Poor	Achieved	Poor	Poor	Poor	Poor	Poor	18%
CHA oriented on how to mobilise communities for health	Poor	Poor	Poor	Poor	Achieved	Achieved	Achieved	Poor	Poor	Poor	Poor	27%
CHAs re-oriented on reporting tools and reporting to the district	Poor	Achieved	Achieved	Achieved	Poor	Achieved	Achieved	Poor	Poor	Poor	Poor	45%

Achieved Partially achieved Poor

Status of facilities during final mentorship visit in January 2018

Figure 2 shows progress made by each facility on each component after implementation of the capacity building intervention over a period of four months based on joint assessments conducted by CHAI and MoH.

Figure 2: Status of facilities during the final mentorship visit

Intervention/Facility	Kaswende	Chipepo	Chapusha	Mpunde	Chitaba	Chilumba	Lunkomba	Chishinka	Kafinda	Lunchu B	Chambulumina	Progress %
Engage DHD on staffing of the facility												100%
Orientation of supervisor on CHA supervision												91%
Introduction of CHA to the community												91%
Re-orientation of CHA on scope of work												100%
Engage supervisor to assist CHA to request for medical supplies for community work												91%
CHA oriented on how to mobilise communities for health												100%
CHAs re-oriented on reporting tools and reporting to the district												91%

The interventions undertaken to achieve these results within the seven component areas are detailed below:

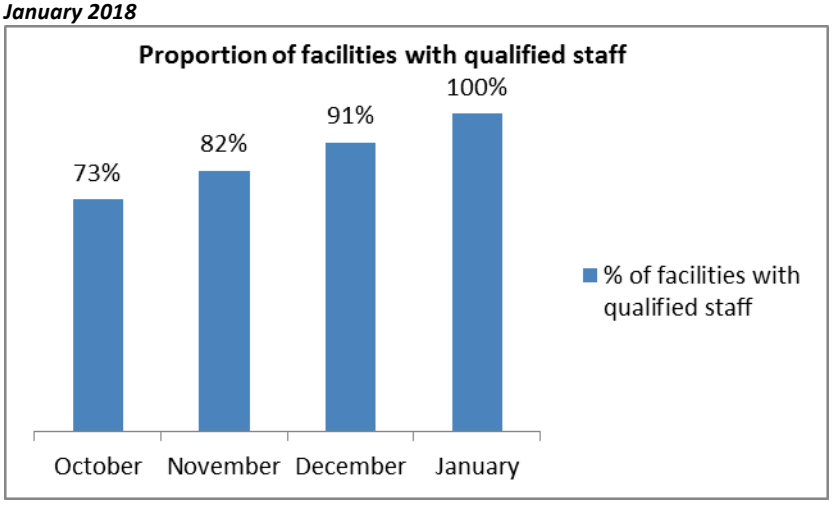
<u>Intervention 1 - Trained staff at facility</u>

In October, three out of eleven targeted health facilities in the district, namely Kaswende, Chapusha and Kafinda Health Posts, were manned by CHAs working without a skilled health care worker due to human resource constraints. This made it difficult for CHAs to operate within their scope. The CHAs from these facilities had no opportunity to mobilize their communities and provide community health education and household visits due to the high patient loads at facilities. They were also unable to report community data. Communities were not mobilized for health and community health structures, such as NHCs, and HCCs were nonfunctional.

Together, CHAI and Provincial and District Health Information Officers presented these findings to the District Health Office. An evidence-based case was made outlining that the absence of a skilled staff not only negatively impacted curative services at the facility but also resulted in CHAs working outside of their scope of work, making them unable to use their training and specific skill-set in performing crucial preventative and promotive health services. The strong relationships created throughout this capacity building partnership meant that the message that district human resources used ineffectively was taken on board, which led the DHO to make use of a Ministry of Health recruitment drive to prioritize the recruitment of and deployment of nurses and midwives to all the 11 health facilities which previously had no skilled staff (Figure 3). These skilled health care workers were deployed with the specific instructions to work in tandem with CHAs and to provide them supervision and mentorship as they set about improving health prevention and health seeking behavior through community case management. The district teams expected this to contribute towards ensuring that all CHAs within the district worked within their scope of work. Following the deployment of qualified health workers at Chapusha and Kaswende in October and November respectively, CHAs made good progress towards achieving the

80/20 work ratio. Before the qualified health workers were posted, the facilities had been unable to maintain the CHA's expected 80/20 work ratio or implement recommendations from monitoring, which included provision of curative services at community level, community action planning, and household listing and mapping.

Figure 3 - Proportion of target facilities with qualified staff (trained health workers) during the period October 2017 to January 2018



Intervention 2 - Orientation of facility staff on the CHA supervision

Good relationships with supervisors improve the frequency and quality of supervision and can also motivate CHAs to improve their performance, as indicated in Uganda.[5] In Zambia, the lack of supervisor orientation on the CHA program and scope of work was observed to be a key reason why facility in-charges were not able to provide adequate mentorship and supervision to the CHAs. During visits to the facilities, CHAI and district staff observed that this resulted in large gaps between the CHA scope of work and the expectations from the supervisors. In most instances where supervisors had not undergone training on supportive supervision and mentorship, CHAs were viewed as clinical assistants. Supervisors did not understand that enabling CHAs to spend the larger proportion of their work time in the community would contribute to lower facility patient loads. This was the case in nine out of eleven facilities where supervisors had not undergone training. This not only affected the performance of CHAs but was also a source of conflict between CHAs and their supervisors. In some cases, this conflict also extended to the community health structures.

Facility in-charges were oriented on the CHA and their supervisory role, which included sharing the CHA scope of work to give the supervisors a better understanding of day-to-day tasks that CHAs are trained to perform as well as a review of the job description to provide guidance to the supervisors on what is expected of the CHAs. Orientation was done through discussions with individual supervisors and a training that was conducted at provincial level.

CHAI shared evidence to show how implementation of the CHA program would have an impact on the facility by reducing the patient load at the facility resulting from intensified preventive measures

[5]Ludwick, T., Turyakira, E., Kyomuhangi, T., Manalili, K., Robinson, S., & Brenner, J. L. (2018). Supportive supervision and constructive relationships with healthcare workers support CHW performance: Use of a qualitative framework to evaluate CHW programming in Uganda. *Human resources for health*, *16*(1), 11.

implemented by the CHAs, as well as management of diseases such as malaria and diarrhea within the household. Supervisors were able to appreciate that CHAs complement the facility.

This evidence has contributed to improved implementation of the CHA program as supervisors are able to provide the much-needed support which creates a favorable work environment for the CHAs. Once oriented, the supervisors are able to initiate awareness on the role of CHAs in the community.

Intervention 3 - Introduction of CHAs to the community

The introduction of CHAs to the community helps both the CHAs and the community to understand one another's roles and expectations. Dialogue between the CHAs and the community contributes to the success of health promotion in the community. CHAs who were introduced to the community by their supervisors had no challenges in engaging communities in health activities. Where this had not been done properly, conflict arose between the CHAs and community health structures such as Neigbourhood Health Committees and Health Centre Committees, and the CHAs faced difficulties in engaging and mobilizing communities. Some of the CHAs had challenges working with communities because they had not been living in the same community before deployment. The communities were not willing to accept them and engage in health programs that the CHAs initiated.

To ensure that communities work well with CHAs and trust them, it is important to engage communities at the time when CHAs are being selected to train as CHAs. This was evident in the Chitaba community where community members demanded CHA services when they had not seen them conducting household visits. The community committed to communicating health issues to the CHAs unlike other facilities where the community members opt to go straight to the facility in-charge. Demand for provision of medical supplies was also made by community members during the HCC meetings. This is an indication of ownership among community members and that they trust CHAs with resources.

Trust between the community and CHAs is essential in fostering accountability in the community health system.[6] When CHAs and communities do not integrate their work, very few health achievements can be realized. During the visits to the facilities, the supervisors were encouraged to formally introduce the CHAs to the community. This took place at all facilities, except at one in which the supervisor had only been deployed to the facility in January 2018 and had not yet had a chance to formally introduce the CHAs when this final visit to the district was undertaken. Where facility in-charges formerly introduced CHAs to the community, Community Based Volunteers were more willing to work with the CHAs in implementation of community health activities.

Intervention 3 - Re-orientation of CHAs on their scope of work

During the initial assessment by CHAI and MoH, evaluators observed that most CHAs had deviated from their roles for two principal reasons:

1. Placement at a facility without qualified staff (health worker).
2. Working at a facility where the supervisor had not been oriented on the CHA program, resulting in the absence of a supportive environment and appropriate supervision.

[6] Schaaf, Marta, Caitlin Warthin, Amy Manning, and Stephanie Topp. 2018. "Report on the 'Think-In' on Community Health Worker Voice, Power, and Citizens' Right to Health." Accountability Research Center, Learning Exchange Report 3. P15

CHAs were found to be performing purely clinical tasks such as dispensing drugs, screening of patients and managing patient records at the facility, while community health activities were not being done. To create a supportive work environment for the CHA , a team comprised of officers from MoH and the Community Health Assistants Training Schools conducted orientation of both the CHAs and the supervisors on the CHA scope of work. Orientation was conducted on a one-on-one basis during health facility visits, through a learning and reflection workshop for the CHAs as well as through training of all CHA supervisors. This led to an increase in the time that CHAs spent in the community; improved community action planning, with seven out of the eleven facilities completing action plans; and supervisors more consistently providing CHAs with medical commodities for community health activities.

Intervention 4 - Provision of medical supplies to the CHAs

The absence of medical supplies is a deterrent to CHAs operating within their scope of work. At two health facilities both the CHAs and community were of the view that it was not necessary for CHAs to conduct household visits if they were not going to treat common ailments such as malaria and diarrhea. In some instances, the lack of medical supplies made it difficult for CHAs to conduct community activities as the community would not welcome them into their homes if they were going to leave patients untreated. This was coupled with the limited understanding of the role of CHAs among community members.

In October 2017, only two health facilities were providing CHAs with medical supplies. CHAs were using the facility internal requisition system to acquire drugs for community work. In the other facilities, CHAs were not provided with medical supplies because facility in-charges were expecting a specific CHA medical supplies kit. The District clarified that CHAs would not receive a specific medical supplies kit, but would depend on the drugs the facilities were receiving from Medical Stores Limited.

As a result of engagement of individual facilities by the DHO, as of January 2018, ten out of eleven facilities had devised a system through which CHAs acquire and account for medical supplies. Using the patient care register and drug dispensing log book, the CHAs account for drugs used in the community. This will contribute to an increase in curative services being provided at household level.

Intervention 5 - Orientation of CHAs on community mobilization

During the visits to Kapiri Mposhi district and through the CHA learning and reflection workshop, staff from the MoH and training schools oriented all CHAs on how to mobilize communities for health. To date, six out of eleven facilities have completed their community action plans and the district will follow up and ensure that the rest complete the process by the end of the first quarter of 2018. Through the process of planning, CHAs and their communities have built working relationships and these have a positive influence on community health. This process has been an opportunity for all players in the community to understand each other's roles in improving the health of the community.

Recommendations and lessons

- To achieve positive health outcomes from the CHA program, there is a need to *build capacity across the whole system*. The program invested in orientation of staff at national, district and facility levels through training in supportive supervision and mentorship of CHAs. During the capacity building initiative, CHAI's technical support to the District Health Office identified weaknesses and

implemented proposed solutions. Some solutions were targeted at the whole community health system while others were for specific individuals.

- *Regular supervision and coaching* from the District Health Office, which helps to advocate for the CHAs, is key. The district should include CHAs during facility performance assessments and reviews.
- The approach of *tailoring capacity-building interventions towards the needs of a specific facility* was effective in enhancing learning. There were varying issues contributing towards weaknesses in the program components across the eleven facilities. Analysis of the contributing factors and development of interventions specific to each health post made it easier for the facilities to relate and come up with sustainable solutions.
- To achieve improved health outcomes, *CHAs need to be provided with medical supplies*. These supplies contribute to CHAs reaching more community members with health education and a reduction in the number of people that have to walk long distances to the facility for treatment of less complicated issues such as malaria and diarrhea.
- Neighbourhood Health Committees and Health Centre Committees should be revitalized and supported to become functional. *CHAs working in communities with functional community health structures experience less difficulty in mobilizing communities for health*.
- Through enabling CHAs to spend more time at the community level, *facilities where CHAs have conducted community action planning processes built up better working relationships with community health agents*. Through the CHAs, all facilities should ensure that communities engage in the community action planning process to build trust and ownership. Community members begin to appreciate that the CHAs are there to promote health in their communities and can be trusted with resources, thus contributing to more sustainable health promotion programs.

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