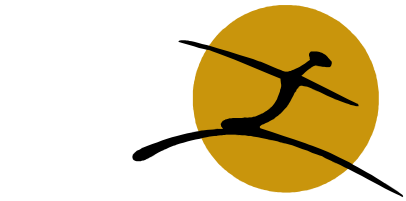

Final Country Report on Community-based Worker Systems in Kenya

Khanya-African Institute for Community-Driven Development

18 August 2007

Khanya-African institute for Community-Driven Development

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The Community-based Worker Project (CBW) is a 4-country action-research project involving Kenya, Lesotho, South Africa and Uganda. The project is funded by the Department for International Development (DFID) in London. The goal is to learn from best practice and to explore how best services can be broadened using community-based worker systems in countries where there is an active interest in implementing such a system.

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Kenya Partners and Members of the National Steering Committee

- Community-Based Animal Health and Participatory Epidemiology (CAPE) Unit of AU-IBAR;
- Community-Based Livestock Initiatives Project (CLIP);
- Department of Livestock Production (DLP);
- Department of Veterinary Services (DVS);
- FARM -Africa;
- Heifer Project International (HPI);
- Intermediate Technology Development Group – East Africa (ITDG-EA), now Practical Action-East Africa (PA-EA);
- Kenya AIDS NGOs Consortium (KANCO);
- Kenyatta University;
- Kibera Community Self Help Programme (KICOSHEP-K);
- National Council for Population and Development (NCPD);
- Society for Women and AIDS in Kenya (SWAK);
- Wajir South Development Agency (WASDA).

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The report is available from www.khanya-aicdd.org

Contents

Glossary

ABC	Advocacy, Behaviour Change and Communication
ACU	AIDS Co-ordinating Unit
AHITI	Animal Health Industry and Technical Institute
AHTs	Animal Health Technicians
AI	Artificial Insemination
AIDS	Acquired Immune Deficiency Syndrome
ALRMP	Arid Lands Resource Management Programme
AMREF	African Medical Research Foundation
ART	Anti-retroviral Treatment
ARVs	Anti-retrovirals
ASALs	Arid and Semi Arid Lands
AU/IBAR	African Union Inter-African Bureau of Animal Resources
BCC	Behaviour Change and Communication
BMU	Beach management unit
CAH	Community Animal Health
CAHW	Community Animal Health Worker
CAPE	Community-Based Animal Health and Participatory Epidemiology
CBD	Community-based Distributors
CBW	Community-based Worker
CCPP	Contagious Caprine Pleuro Pneumonia
CDC	Constituency Development Committees
CDD	Community-Driven Development
CDF	Constituency Development Fund
CHW	Community Health Worker
CIFA	Community Initiatives Facilitation and Action
CLIP	Community-based Livestock Initiatives Programme
DDC	District Development Committees
DLMC	District Livestock Marketing Council
DLP	Department of Livestock Production
DVO	District Veterinary Officer
DVS	Department of Veterinary Services
ELCI	Environmental Liaison Centre International
ERS	Economic Recovery Strategy
FA	Facilitating Agent
FBO	Faith-Based Organisation
FFS	Farmer Field Schools
FP	Family Planning
GoK	Government of Kenya
GTZ	German Agency for Technical Co-operation
HBC	Home-based Care
HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
HPI	Heifer Project International
IGAs	Income Generating Activities
ITDG-EA	Intermediate Technology Development Group - Eastern Africa
KANCO	Kenya AIDS NGOs Consortium
KICOSHEP-K	Kibera Community Self-Help Programme
KLMC	Kenya Livestock Marketing Council
KNDAEP	Kenya National Deaf HIV/AIDS Education Programme
K Sh	Kenyan Shilling
KSL	Kenya Sign Language
KVA	Kenya Veterinary Association

KVB	Kenya Veterinary Board
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSEs	Micro and Small Enterprises
NACC	National AIDS Control Council
NAEP	National Agricultural Extension Policy
NARC	National Alliance Rainbow Coalition
NASCOP	National AIDS and STI Control Programme
NBDA	Nairobi Business Development Association
NCPD	National Council for Population and Development
NGOs	Non-governmental Organisations
NR	Natural Resources
NSC	National Steering Committee
PAVES	Pastoral Veterinary Systems
PDP	Pastoral Development Programme
PLWHAs	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategy Paper
SAP	Structural Adjustment Programme
SNV	Netherlands Development Agency
SRA	Strategy for Revitalizing Agriculture
SRH&R	Sexually Reproductive Health Rights
STI	Sexually Transmitted Infections
SWAK	Society for Women and AIDS in Kenya
TBAs	Traditional Birth Attendants
USAID	United States of America International Development
VCT	Voluntary Counselling and Testing
WASDA	Wajir South Development Agency

Executive Summary

1 Introduction

1.1 Khanya-African Institute for Community Driven Development (Khanya-aicdd) has been managing a 4-country action-research project on community-based worker (CBW) systems as a mechanism for pro-poor service delivery. This 3-year project was implemented in four countries, namely South Africa, Lesotho, Uganda and Kenya. The project is focusing on promoting dispersed, active and locally accountable community-based workers across various sectors, advocacy for policy and institutional support for community-based worker systems and strengthening linkages between community, government, facilitating agents and other stakeholders. The **Project Purpose** is that '*Organisations in South Africa, Uganda, Lesotho and Kenya have adapted and implemented a community-based worker system for service provision in the natural resource / HIV sectors, and policy makers and practitioners in the region have increased awareness of and interest in the use of CBW models for pro-poor service delivery'*.

1.2 The overall objective of this report is to document the action-research process in Kenya from the inception of the project in January 2004 to its end in March 2007.

1.3 The main activities undertaken included the review of in-country experiences of CBW systems shared in a workshop held in July 2004, participation in regional exchange workshops, a study tour to Peru, and the implementation and evaluation of the pilot projects.

1.4 The report has four parts. Part A gives the background and explains the project purpose. Part B gives the situational analysis prior to the project. Part C explains what happened during the project. Part D discusses the recommendations and the way forward.

2 Government policies, systems and structures in service delivery

2.1 The public sector has traditionally been the major service provider in Kenya post independence through public institutions (parastatals) and the civil service. By 2004, other market players such as the community, and the private sector had come into play, thus shifting the government's role more towards regulating service delivery.

2.2/3 Through the Economic Recovery Strategy (ERS) for wealth and employment creation (2003-2007), the Strategy for Revitalising Agriculture, launched in 2004, the National Agricultural Extension Policy and the Poverty Reduction Strategy Paper of 2004, sector wide public reforms have been taking place which are in support of the concept of community participation. Policies in animal health have the stated intention of ensuring improved community participation by involving beneficiaries in identifying issues to be addressed by research, strengthening people's participation through training and improved extension services and empowerment through increased access to credit. The government committed itself to improved service delivery in the health sector by setting up special health care programmes for people living with HIV/AIDS (PLWHAs), training communities on HIV/AIDS, incorporating an HIV/AIDS component into school and community training curricula and strengthening the health sector response to HIV/AIDS by forming AIDS Control Committees (ACCs) at constituency levels.

2.4 Due to the highly centralised public service delivery in Kenya, top-down approaches and poor funding, effectiveness of the services was severely compromised. CBW systems are however thought to be popular and efficient especially in servicing poor and marginalised communities.

3 A review of community-based worker systems in Kenya

3.1 Seven case studies were presented in the in-country review report in 2004. These were collected during a national stakeholder workshop together with a desk-top exercise to review current experiences in-country. The seven case studies were the National AIDS and STI Control Programme (NASCOP), the Department of Veterinary Officers Community Animal Health Workers, the Kenya Livestock Marketing Council Community-based Livestock Traders, Heifer Project International/ Kenya, Private Pastoral Veterinary Practice, the National Council for Population and Development community-based contraceptive distribution strategy and Physically Challenged Persons in the HIV/AIDS Sector.

3.2 The in-country review indicated that CBWs are being used to provide services in animal health, human health, agriculture, water and forestry.

3.3 Sustainability of CBW systems depends on proper selection criteria and procedures. The consensus among service providers and facilitating agents (FAs) was that where CBWs were chosen by their communities with as little manipulation as possible by influential lobby groups, there is a greater chance of success, as the CBWS then have a support system which facilitates their work. Factors often considered in the selection criteria of CBWs included age, gender, trust and reputation within their community, keenness to serve and willingness to learn and assist others, degree of self-motivation, management and communication skills, educational achievement and previous experience of volunteering in community activities.

3.4 Some CBWs receive stipends, some do not. Some FAs offer CBWs seed capital to start income-generating projects. Some CBWs in the animal health sector charge fees for their services, as do traditional birth attendants. Animal health workers are often given initial veterinary drug kits at a reduced fee to get them started. The community was found to be willing to pay for private good services but reluctant to pay for public good services. Voluntary CBW programmes are not without cost because even when CBWs are volunteers there is still a need to train them and provide support and supervision. There is an ongoing debate on the importance of stipends as a motivating factor for retaining CBWs. Retention is of course very important to keeping the system cost-effective as training new recruits is a big expense.

3.5 The government, in collaboration with NGOs, has developed curricula to guide trainers on trainee selection, content, methods, duration of training and even choice of trainers. It was recommended that training should take place as much as possible in circumstances comparable to those in which CBWs are expected to work and at a local venue. A training programme which begins with a functional formal training lasting two weeks to one month, followed by refresher courses, was found to be effective. Training of CBWs should be flexible to suit the trainees' learning needs and should centre on the roles they will play. CBWs require sustained support to be able to work effectively and efficiently. The facilitating agent (FA) plays a critical role in providing or arranging for this support. Supervision is also necessary to monitor performance and to record activities. CBWs must be accountable to the communities that they serve but also to the FA which ensures technical oversight and accounts for the use of funds to donors or the government.

3.6 The community was involved in various capacities through the involvement of different structures such as local government representatives, faith-based organisations, local social groups, village elders or opinion leaders, local public institutions and local businesses. Successful CBW systems had links to existing traditional, religious, administrative or other social structures and groupings.

3.7 Community-based worker systems have had an impact in terms of increased access to services, increased awareness especially with regard to HIV and AIDS, creating entry points for other development initiatives, enhanced collaboration, partnership and networking and an increased level of community participation and ownership of programmes. CBW programmes need to improve their monitoring and evaluation systems so that evidence of significant impact can be more easily quantified.

3.8 The sustainability of CBW programmes remains a critical issue in many programmes. Advocacy for increased government financial and technical support is critical. Advocacy with professionals is also needed so that they understand that CBWs will complement their work and not compete with it. CBW programmes which create local ownership and community control are likely to be more sustainable. If properly planned and implemented, CBW systems have the capacity to utilise local resources at the disposal of the community. Incentives to motivate CBWs have to be carefully considered.

3.9 Areas identified for follow-up included integrating the work of CBWs into national delivery systems, developing curriculum and training, developing measures to increase sustainability, standardisation of approaches and methodologies and stepping up advocacy work.

3.10 The latent capacity at the local and community level and in the private sector is huge and, if harnessed, can create a paradigm shift in development. Sub-Saharan countries have engaged in reform programmes which focus on constitutional reviews/reforms, privatisation, decentralisation, and democratisation. These reform agendas provide opportunities for CBW systems. The current decentralisation process is encouraging the participation of all players, including the community, in the development process through strengthening the meso-operational level and encouraging stronger linkages between all partners.

4 The pilot projects - Implementation from January 2005 to March 2007

4.1 Five CBW service delivery models were identified by participants at the first 4-country workshop. They are:

- 4-8 hours a week unpaid volunteers
- 20 (exceptionally up to 40) hours a week unpaid volunteers,
- 20-30 hours a week paid a stipend
- 40 hours a week paid a salary
- Paid by user (private/commercial model)

Three partner organisations in Kenya were selected to pilot one or more of the models. The organisations were: KICOSHEP-K, WASDA and ABC-Kisumu. Guidelines for the implementation of a community-based worker system were developed to support the selected implementing partners. During the piloting phase, experiences were documented and feedback shared through workshops, exchange visits and other mechanisms.

4.2 ABC-Kisumu is a community-based organisation which works with poor fishing communities on the beaches of Lake Victoria carrying out advocacy, behaviour change and communication activities in relation to sexual and reproductive health and rights (SRH&R). ABC-Kisumu piloted the selection and recruitment of CBWs and the FA's role in supporting, training and financing CBWs.

KICOSHEP-K is based in Kibera, a slum of over 500,000. It provides HIV/AIDS testing, counselling and health services, as well as nutrition and schooling for vulnerable children. KICOSHEP-K piloted issues to do with incentives, accountability and referral/linkages.

Wajir South Development Association trains community animal health workers (CAHWs) to deliver animal health and related services in their communities. The WASDA pilot focused on the work of the CAHWs, their selection and recruitment, training, support, supervision and accountability.

4.3 Lessons learnt from the piloting process were wide ranging including recognition that iInvolvement of the community in selecting CBWs is critical. CBWS should be remunerated either through salaries, a stipend or a 'user pays' arrangement. Funding currently comes from government, donors, the community or from users of the service. Donor funding is problematic because it is short-term. CBWS are experimenting with mechanisms such as income generation projects and saving and revolving fund schemes to support themselves. The CBW system is heavily dependent on creating partnerships with existing community structures. The private sector can contribute a great deal to service delivery in terms of funding, providing credit, training or support e.g providing goods or assisting with technology. Government's role is mostly in policy and regulation and maintaining quality and professionalism. Policy regarding the legality of para-professionals needs to be enacted and should include a regulatory and disciplinary framework for CBWs. Training CBWs within their communities or close to their communities has better results and seems more empowering. 'Hands on' experience was found to be effective in developing skills and building up the confidence of CBWs. A minimum level of literacy is needed on the part of trainees. CBWs can act as the voice of the voiceless, representing the community's views. In terms of external linkages, strong stakeholder forums, donor support and partnerships are critical.

5 Impact and cost-effectiveness of CBWs

The pilot projects were evaluated in terms of the impact of the project on the beneficiaries, on the CBWS themselves and on service-providers, their cost effectiveness in service delivery and their impact on policy and systems.

5.1 The ABC-Kisumu project uses a roundtable strategy to raise awareness in relation to the transmission, the spread, prevention and protective measures against HIV/AIDS and related issues such as unwanted pregnancies. Participants in the roundtables also identify strengths and weaknesses in relation to services delivered by government and other service providers and make concrete recommendations. The programme evaluation suggests that the impact of the project has been very high with a higher rate of condom use among the targeted group and important changes in knowledge, attitudes and practices. CBWs felt they had gained status in their communities but had suffered in terms of loss of opportunities to earn money. Using the salary of a social worker as a basis of comparison though recognising that their roles are not identical, it is much more cost-effective to employ a CBW.

5.2 KICOSHEP's work has seen clients' quality of life improve, has drastically reduced stigma and has increased the number of people seeking VCT services. There is a low turn–over rate among CBWs and a waiting list of people wanting to become CBWs. CBWs are motivated by the desire to be of service to their community and pleasure in being part of a team with fellow caregivers. Some felt that patients expected too much of them. Cost comparisons indicate that home-based care is extremely cost-effective compared to treatment in a primary health care facility or hospital. CBWs are recognised by the Ministry of Health and the hospital works with KICOSHEP, However, policy development still lags behind which indicates that more advocacy is needed.

5.3 The WASDA CBW programme has succeeded in empowering communities by involving them in addressing their animal health problems. This has improved and increased the skills base in the communities and increased access to veterinary services besides

contributing to building community structures that address animal health and other problems. Decision-making in the pastoralist associations has become more participatory, livestock rustling has decreased and there has been sensitisation to women's rights. Benefits to CAHWs are increased skills and knowledge, improved social status, drug kits on a cost sharing basis and the ability to earn a fee for their services. The veterinarians have benefited by profit sharing with the CAHWs and increasing their client base. The government has improved its disease surveillance, management and emergency response capacity. It was not possible to carry out a comparative cost-benefit analysis. However, since there are no qualified veterinarians working in these remote arid areas because the distances and difficulties make the costs prohibitive, it is clear that the CAHW approach is proving to be feasible. Veterinarians who are working through CAHWs see the value of the approach while other veterinarians are resistant. There is still work to be done at a policy level.

6 Good practice emerging from the models

6.1 The piloting organisations made changes to their practice based on reflection within their organisations and learnings from the in-country and 4-country meetings and workshops. For example, KICOSHEP-K introduced flexi-time working arrangements and a stipend for CBWs.

6.2 All the organisations worked on their processes for recruiting CBWs and how best to involve communities to create ownership and sustainability.

6.3-6.7 All the organisations paid closer attention to the quality of training and its relevance to the work of the CBWs, the relationship of the agency with other stakeholders, and referral options when community needs were outside CBWs' scope of practice. Important issues concerning financing and sustainability were addressed with projects exploring other financing avenues in recognition of the fragile nature of donor funding.

7 Reflections on the way the action-learning project evolved

7.1 The national steering committee was key to the success of the overall project as it had to manage the process and was important for advocacy at policy level. Challenges facing it were some sectors not seeing the benefits in cross-sectoral sharing and difficulties in communication with projects in remote areas such as WASDA.

7.2/3 Learnings were shared across organizations, across sectors and across the four countries and were continuously fed back into practice. The initial phase of the project was weak but later partners understood more clearly the project concept and the value of the activities to improving their practice. As part of good practice, all the partner organisations have started to consider documentation and knowledge sharing as integral to influencing policy and advocacy. However, fast tracking CBW project activities in their institutions was late.

7.4 The project manager was also integral to ensuring the project outputs were smoothly achieved.

8 Recommendations

8.1 This action-learning study has provided evidence that CBW systems fill crucial gaps in public service delivery and have the potential to enhance local government accountability and make public resource allocation more democratic and efficient.

8.2 Recommendations include building accountability to communities within CBW programmes, providing effective supervision and support, developing and standardising training and accreditation, addressing licensing, registration, commission, incentives, regulation and policy frameworks, the government taking responsibility for financing, bringing CBWs into the mainstream of service delivery, ensuring NGO participation, forging links and referral systems and recognising and enabling the private sector's contribution to making CBW systems work.

8.3 Changes in policy and legislation are needed to bring CBW operations in line with the policy framework in Kenya. CAHWs are fitting well into the present privatisation of veterinary services and CBWs are currently the only way of meeting the need for care that has arisen from the AIDS epidemic.

8.4 The CBW project has created increased understanding of the community–driven development approach. However, the lack of a supportive policy and legal environment, coupled with inadequate funding of community-based service delivery systems, is holding back wide scale delivery. The current national steering committee is a legacy of the project which can be utilized as a working group to lobby for such developments. The task that remains for completion of this three year action-research programme is to develop national Guidelines on CBW systems which can help with mainstreaming the outcomes and scaling up of programmes.

8.5 An action plan for Kenya for 2007 outlines the final stages of the project which includes the development of the guidelines and the regional workshop at which these will be presented.

PART A INTRODUCTION

1 Introduction

1.1 Background to the project

Khanya-African Institute for Community Driven Development (Khanya-aicdd) has been managing a 4-country action-research project on community-based worker (CBW) systems as a mechanism for pro-poor service delivery. The project is funded by the Department for International Development (DFID) in London. This 3-year project was implemented in four countries, namely South Africa, Lesotho, Uganda and Kenya.

The project goal is to learn from good practice in the use of community-based workers as an alternative model of pro-poor service delivery. It is also concerned with how best such systems can be scaled up. The action research project has chosen to focus on the natural resources and HIV and AIDS sectors, building on existing in-country and international experiences. However, it is hoped that the outcomes of the project will have wider implications across all sectors of service delivery.

The project "Action Learning about Community-Based Workers as a Mechanism for Pro-Poor Service Delivery" looks at widening access to services and empowering communities in the process. It is grounded on the premise that the professional personnel currently employed in the public service and NGOs is not sufficient to meet the needs of the population. |t is too expensive to hugely increase the number of health workers, extension officers and other professionals, hence the idea of deploying a cadre of workers at a lower level who are less trained and receive lesser compensation but to whom some of the work of the professionals can be devolved. Such people are called community-based workers. Poor communities and especially rural communities have always relied on such workers e.g. traditional birth attendants. What is new currently is using such workers in a wide range of sectors.

Apart from saving costs and reaching more people in need, the premise was that, as CBWs are drawn from and work close to the grassroots, they would also serve as the voice of their communities communicating their needs and increasing their say in how service delivery should be conceived which should result in a more appropriate and effective service.

Community-based services have the potential to reduce poverty and enhance sustainable livelihoods. However, this potential needs to be activated through policy and institutional support, re-alignment of community structures and strengthening linkages with all supporting institutions and organisations at various levels of operation (micro, meso and macro levels). There is a need to scale up the existing community-based services if there is to be a significant increase in the number of people accessing services.

The project is focusing on:

- Promoting dispersed, active and locally accountable community-based workers across various sectors;
- Advocacy for policy and institutional support for community-based worker systems;
- Strengthening linkages between community, government, facilitating agents and other stakeholders.

The conceptual framework underpinning the CBW model involves some critical players. These include the community, a community-based worker, a facilitating agent (FA) which could be from the government or non-government sector, who supports the community-

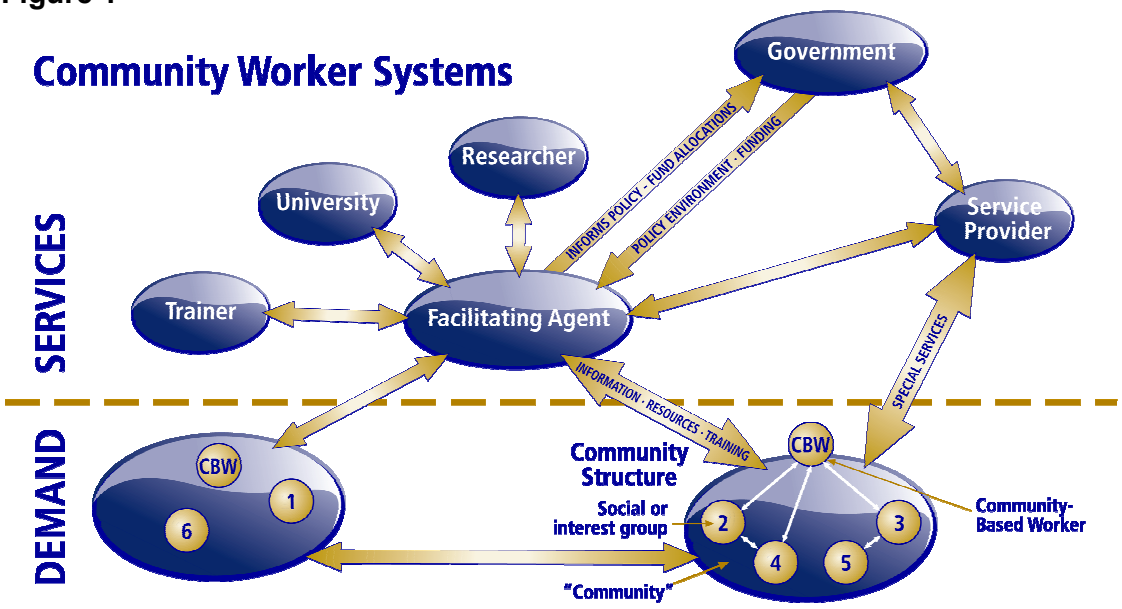
based worker, and other service providers. The community-based worker is a para-professional, based in and drawn from the community they work in, who understands the local context, and is accountable to the community and to a facilitating agent thus maintaining a balance to ensure quality service delivery. Figure 1 below delineates the relationships between the different actors involved to ensure an effective CBW system.

The **Project Purpose** is that '*Organisations in South Africa, Uganda, Lesotho and Kenya have adapted and implemented a community-based worker system for service provision in the natural resource / HIV sectors, and policy makers and practitioners in the region have increased awareness of and interest in the use of CBW models for pro-poor service delivery'*.

Key elements of the project approach included:

- Action–learning: building from existing experience and knowledge;
- A focus on systems and not individuals or sectors;
- Linking government, community, facilitating agents and other players piloting and mainstreaming the lessons learned.

Figure 1



Project Outputs:

1. Good practice in CBW systems **documented and shared.**
2. Common **framework** for CBW models developed, with suggestions for good practice in different sectors.
3. **Pilots** for community-based worker systems designed and implemented or existing practice modified.
4. Results of pilots **mainstreamed** into CBW implementation in at least 2 partner countries.
5. Information on CBW systems and policy implications widely **disseminated** and debated in South and Eastern Africa.

In Kenya, the project was managed by a national steering committee made up of facilitating, implementing and policy making organisations. The Community-based Livestock Initiatives Programme (CLIP), a national NGO, served as the secretariat and coordinated the project

activities for the first two years of the programme. The steering committee members were drawn from the following organisations:

- Community-Based Animal Health and Participatory Epidemiology (CAPE) Unit of AU-IBAR;
- Community-Based Livestock Initiatives Project (CLIP);
- Department of Livestock Production (DLP);
- Department of Veterinary Services (DVS);
- Environmental Liaison Centre International (ELCI)
- FARM Africa;
- Heifer Project International (HPI);
- Intermediate Technology Development Group – East Africa (ITDG-EA) – now Practical Action – East Africa (PA-EA) ;
- Kenya AIDS NGOs Consortium (KANCO);
- Kenyatta University;
- Kibera Community Self Help Programme (KICOSHEP-K);
- National Council for Population and Development (NCPD);
- Society for Women and AIDS in Kenya (SWAK);
- Wajir South Development Agency (WASDA).

In the natural resources sector, partners included community-based water and natural resources management, community-based animal health workers and community trade associations/ workers. In the HIV/AIDS sector, partners included community-based counsellors, traditional health providers and home-based carers.

1.2 Objectives of the Report

The overall objective of this report is to document the action research process in Kenya from the inception of the project in January 2004 to its end in March 2007 and to contribute to knowledge about CBW systems and consequently inform policy and practice in relation to CBW systems in Africa.

1.3 Overall timeline of the project

The implementation of the project in Kenya involved the milestones detailed below. The main activities undertaken included the review of in-country experiences with CBW systems shared in a workshop held in July 2004, participation in regional exchange workshops between the four participating countries, a study tour to Peru, and the implementation and evaluation of the pilot projects.

Timeline of the CBW Project in Kenya

Jan - March 2004

- Establishing the Secretariat with Community- Based Livestock Initiatives Programme (CLIP) and setting up the Steering Committee;
- Launch workshop in January 2004;
- Meetings held with the department of Livestock to get their buy-in.

April - June 2004

- Joint meetings held between the Livestock and HIV sectors with both sectors actively participating in the steering committee meetings – high enthusiasm but concerns around relevance for all sectors;
- Approval of terms of reference for in-country review.

July – September 2004

- 26-27 July 2004: The first Kenya National Workshop was held in Machakos town, with significant representation from natural resource and HIV sectors. The broad aim of this workshop was to share current CBW approaches and explore partner understanding of the present mechanisms and structures of the systems that are in use in Kenya. In essence this event introduced the project and the report produced became the situational analysis of current CBW systems in Kenya.

- 20-23 September 2004: Kenya participated with other partner countries at the 4-country workshop, held in South Africa. Partners shared their findings and identified common frameworks, and models for implementation were designed.

October – December 2004

- Publication of Kenya in-country review report, assessing current status of CBW systems in the country;
- National Steering Committee agrees to pilots at the policy and implementation level: At the policy level, the Community Animal Health Unit (CAHU) is to pilot one model, while the Wajir South Development Association (WASDA) will pilot another model at the implementation level.

April – June 2005

- Steering Committee meetings held to look at representation within models and to firm up partners for pilot schemes and methodology;
- Guidelines were developed to support the documentation of lessons learned during the piloting phase.

July – September 2005

- Secretariat taken over by the Kenya AIDS NGO Consortium (KANCO).
- Approval of the Community Animal Health Workers' Training Manual which is to be rolled out nationally.

October – December 2005

- Three organisations piloting different CBW models i.e. salary based, stipend and unpaid;
- 16-29 Oct. 2005: delegates from the four partner countries participated in a study tour to Peru including 2 participants from the Kenya team
- 01-03 Nov 2005: Second 4-country workshop in South Africa enabled partners to share lessons and findings of current approaches they are implementing.

January – March 2006

- Report commissioned to capture activities and key learnings from pilots;
- Practical Action is also implementing a Community-based Animal Health Workers (CBAHWs) project in Samburu District;
- Practical Action refines the role of CBAHWs by linking them with the Ministry of Livestock in a Drought Emergency Livestock Programme as a model;
- The partners involved in piloting a NR model include the Community-based Animal Health Workers in Samburu district, Northern Kenya and also WASDA in North-Eastern Kenya;
- Within the HIV/AIDS sector pilots are being implemented by KANCO, KICOSHEP-K and ELCI-ABC – Kisumu.

10-13 April 2007 End-of -project 4 country workshop in Uganda.

The 4 country workshop held in Kampala, Uganda in April 2007 was meant to mark the final stage of the project. However, the project has in fact been extended to September 2007 to allow the partners to develop Guidelines for implementing a CBW system and hold a regional workshop to disseminate these Guidelines.

1.4 Structure of the Report

The report has a four part structure:

Part A provides the project background in Kenya and gives the project's purpose, approach, objectives and key milestones.

Part B of the report presents the situational analysis prior to the CBW project, the context, policies and strategies for provision of services, the role of the state in service delivery and evidence of the effectiveness of CBW systems. This section draws heavily on the initial in-country report produced in late 2004.

Part C covers what happened during the CBW project. This section covers the in-country review of a range of case study organisations implementing CBW projects which was presented at the first national and international workshops. It then goes on to address the experiences from the CBW piloting phase and the impact the pilots had on clients, the CBWs themselves and on the service providers. It also looks into possible costs of implementing a CBW system, and the impact the projects could have on policies and systems if the CBW system was effective.

Part D discusses the recommendations and the way forward.

PART B THE SITUATION PRIOR TO THE CBW PROJECT

2 Government policies, systems and structures in service delivery

2.1 The role of the state in service delivery

The public sector has traditionally been the major service provider in Kenya post independence, through public institutions (parastatals) and the civil service. However, the government has faced a problem of inadequate capacity as a result of a poor financial resource base and inadequate budgetary allocations from central government. Poor funding has led to fewer skilled personnel and poor working conditions resulting in low staff morale. Top down centralised approaches have also led to lack of ownership of interventions and therefore lack of effectiveness.

By 2004, other market players such as the community, and the private sector had come into play, thus shifting the government's role more towards regulating service delivery. However, the government still remains the major provider of technology and research capacity. Other services provided by the government included information dissemination through the state media and agricultural extension services. For example, within the Veterinary Department the role of government involves:

- Formulation, implementation and monitoring of veterinary policies;
- Development and co-ordination of programmes in the animal health sector;
- Information management for the animal health sector;
- Veterinary regulatory management and quality control of inputs for livestock production;
- Management and control of animal pests and diseases;
- Provision and facilitation of veterinary extension;
- Research agenda setting, research liaison in co-ordinating animal health;
- Management and conservation of the natural resource base for livestock;
- Monitoring and management of food security;
- Review of veterinary policy and legal framework.[1]

2.2 Policies in support of CBW approaches

Through the Economic Recovery Strategy (ERS) for wealth and employment creation (2003-2007), the Strategy for Revitalising Agriculture, launched in 2004, the National Agricultural Extension Policy and the Poverty Reduction Strategy Paper of 2004, sector wide public reforms have been taking place which are in support of the concept of community participation and it is envisaged they will add value to service provision especially for the poor. The reforms affected the animal health and HIV/AIDS sectors where policies were reviewed.

2.2.1 Animal Health Sector

The Kenyan Government committed itself to strengthening the community-based animal health approach to address development of arid and semi-arid areas (ASALs). The animal health policy was reviewed and the new policy advocated strengthened partnerships in service delivery. Up to 1986, the Department of Veterinary Services (DVS) provided free or highly subsidized services, but policy changes in 1986 brought more private sector

[1] Source: ITDG-EA 2001

participation in the delivery of veterinary services which meant a division in service delivery. The government was to undertake the public good services with the private sector undertaking private good service delivery. Partnership arrangements were identified between the private sector and the community. The policy's stated intention was to ensure improved community participation by involving beneficiaries in identifying issues to be addressed by research, strengthening people's participation through training and improved extension services and empowerment through increased access to credit.

A number of policies were developed including:

- the draft Livestock Development Policy which advocated for improved participation of the community in provision of livestock extension services;
- the Strategy for Revitalising Agriculture and the National Agricultural Extension Policy (NAEP) recommending the use of community animal health workers (CAHW)s in the provision of extension services in ASALs. Despite these positive trends, livestock policy was largely formulated in isolation from national development strategies *(Sones and Catley 2003);*
- the CBW approach was also recognised through key national level strategy papers such as the Poverty Reduction Strategy Paper (PRSP).

2.2.2 HIV/AIDS Sector

Through the ERS, the government committed itself to improved service delivery in the health sector by setting up special health care programmes for people living with HIV/AIDS (PLWHA), training communities on HIV/AIDS, incorporating an HIV/AIDS component into school and community training curricula and strengthening the health sector response to HIV/AIDS by forming AIDS Control Committees (ACCs) at constituency levels.

The government sessional Paper No. 4 of 1997 on HIV/AIDS provided guidance to all organisations and institutions involved in HIV/AIDS work in Kenya. This paper outlined the government's policy on HIV/AIDS and provided broad guidelines on how best to address emerging critical issues in the country over the next 15 years and beyond. In addition, the paper outlines the strategic interventions and an appropriate organisational structure required for effective implementation of programme activities. It also identifies the policy issues that are needed in order to operationalise such an ambitious strategic plan.

In this regard, the Ministry of Health, through the National AIDS/STD Control Programme (NASCOP), drafted a number of policy guidelines that reflected the government's concern for and commitment to address HIV/AIDS (Republic of Kenya 2000). A number of publications were produced including:

- National home-based care policy guidelines, whose purpose was to ensure the integration of home-based care into Kenya's existing health care systems;
- National home-based care programme and services guidelines: which spelt out the basic components of the home-care services, the programmatic standards and the requirements for service delivery;
- Home-care handbook: a set of materials developed by the Ministry of Health to guide the provision of HBC services. The materials also included a policy guide and a programme and service guide, as well as a training curriculum for training community health workers and other service providers in home-based care skills;
- Training home-based care-givers to care for people living with HIV/AIDS at home – a curriculum for training community health workers;
- Home-based Care Orientation Module for health service personnel and programme managers;

- National Voluntary Counselling and Testing Guidelines; and Training Curriculum for Voluntary Counselling and Testing;
- National guidelines on prevention of mother to child transmission of HIV (PMTCT);
- National policy guidelines on the use of anti-retrovirals (ARVs);
- National condom policy and strategy 2001-2002;
- Blood safety policy guidelines.

2.3 Community mobilization and empowerment programmes

The government view on CBWs showed a supportive trend. For example, in the livestock sector, the DVS set up a Community Animal Health Unit through the assistance of the African Union Inter-African Bureau of Animal Resources (AU/IBAR). This was an indication of recognition of the importance of the role played by the CAHWs in delivering animal health services in ASALs. The government was also using CAHWs for livestock vaccination campaigns as well as during livestock treatments especially following emergency disease outbreaks. The government appreciated their role in mobilising the community, and in disease surveillance and reporting.

At the District level, the District Veterinary Officers (DVOs) were involved in the process of setting up CAHW systems and also played a crucial role in monitoring, evaluating and providing support through referral systems. Together with other stakeholders they also participated in a process to standardize training by developing a training curriculum for CAHWs and manuals for training trainers of CAHWs. The Pastoralist Parliamentary Group was also supportive of the Community Animal Health (CAH) system and recommended strengthening of disease control initiatives in order to facilitate access to international markets *(CLIP 2003).*

In the HIV/AIDS sector, the Sessional Paper No. 4, 1997 and other policy guidelines as noted in 2.2 above, stressed the government's concern for the need to use CBWs in HIV/AIDS interventions. Of importance was the fact that the Government recognized the role of a range of stakeholders in the struggle against HIV/AIDS including PLWHA, local communities, donors, NGOs, community-based organisations (CBOs), and faith-based organisations (FBOs). The government was also moving towards providing an appropriate policy and legal framework enabling community involvement and enhanced partnership.

2.4 Evidence of effectiveness in current systems

Due to the highly centralised public service delivery in Kenya, top-down approaches and poor funding, effectiveness of services was severely compromised. CBW systems are however thought to be popular and efficient especially in servicing poor and marginalised communities. The community is willing to pay for services rendered to them by CAHWs, especially for services with tangible benefits. Some individuals have no capacity to pay due to poverty constraints but experience has shown that communities are willing to work out innovative ways of remunerating their CBWs.

PART C WHAT HAPPENED DURING THE CBW PROJECT

3 A review of community-based worker systems in Kenya

3.1 Case studies in 2004

The seven case studies presented in the in-country review report in 2004 were collected during a national stakeholder workshop together with a desk-top exercise to review current experiences in-country. The experiences shared included those of participants from the HIV and NR sectors. The selected case studies gathered different perspectives on CBWs including those from policy makers, facilitating agencies and the grassroots. The seven case studies are briefly reviewed here. The following sections summarise findings from the in-country review about CBW systems in terms of selection criteria, financing, training, support, supervision and accountability, relationships, roles and linkages, impact and sustainability.

3.1.1 National AIDS and STI Control Programme

The home-based care (HBC) programme of the National AIDS and STI control programme, (NASCOP), employs community health workers (CHWs) trained to provide effective home nursing care for people living with HIV/AIDS (PLWHA). NASCOP is the technical arm of the Ministry of Health charged with policy development and implementation of HIV/AIDS activity. CHWs are part of the strategy for extending the continuum of care from the hospital or health facility into the home of the patient. For many PLWHAs hospital care is not necessary nor is it affordable. In the healthcare sector, where the magnitude of infected people is increasing, overstretched clinical workers cannot meet the demand. Every year, more and more professional workers are exiting the system due to poor working conditions, combined with loss through HIV/AIDS related deaths.

3.1.2 Department of Veterinary Officers Community Animal Health Workers

Community Animal Health Workers (CAHWs) are a specific type of CBW that support the work of the Department of Veterinary Officers (DVOs) in pastoralist areas where there are no private practitioners and where the Department of Veterinary Services (DVS) staff is unable to reach easily due to logistical difficulties. They provide a useful link between communities and veterinary authorities, and play a major role in disease reporting, surveillance and community mobilisation. However there are concerns about the quality of services sometimes delivered by CAHWs and the DVS views CAHWs as a temporary measure.

3.1.3 Kenya Livestock Marketing Council Community-based Livestock Traders

Within the livestock sector CBWs operating in conjunction with the Kenya Livestock Marketing Council (KLMC) play a significant role in disseminating marketing information, and sensitising and mobilising communities, especially at the district level. CBWs are members of Livestock Marketing Associations (LMAs) that are mainly composed of milk processors, butchers, livestock traders and transporters of livestock and livestock products. Their main objective is to enhance livestock marketing and improving the livelihood of pastoralists.

3.1.4 Heifer Project International / Kenya

Heifer Project International/Kenya (HPI/K) is a US-based organisation whose mission is to reduce hunger and poverty though sustainable livestock and livestock related services. HPI /K provides start-up animals to self-help groups and utilises CBWs, popularly referred to as micro-small entrepreneurs (MSEs), to provide services to farmers. CBWs receive training in

both technical and business skills which they are expected to pass on to the other farmers in their group.

3.1.5 Private Pastoral Veterinary Practice

PAVES is a Private Pastoral Veterinary Practice (PPVP) using a chain of community-based animal health technicians (AHTs) and CAHWs to provide quality products and services to nomadic pastoral livestock owners in the ASAL area of West Pokot District. As with the MSEs in the previous case study, these CBWs are self-motivated individuals who are motivated by the desire to provide quality products and services to their community at a modest fee.

3.1.6 National Council for Population and Development Community-based Contraceptive Distribution

Community-based contraceptive distribution (CBD) is a strategy for complementing the traditional clinic- based system to meet the family planning (FP) needs of the country. CBD agents move from door to door giving services to those who need them including provision of information, education and counselling, referring clients to the health facilities on issues that need clinical attention and distributing pills, condoms and foam tablets. Current statistics indicate that 20% of the population receive their family planning services from CBD agents. There is also evidence that there is a high usage of family planning services in areas where CBD agents operate.

3.1.7 Physically Challenged Persons in the HIV/AIDS Sector

The Kenya National Deaf HIV/AIDS Education Programme (KNDAEP) is a national NGO, run by and for the deaf, which aims to ensure equality of life opportunities for the deaf through health and education programmes. KNDAEP depends on CBWs to work with deaf communities at the grassroots. Whether deaf or hearing, the CBWs are specially trained not only in service areas but also as vital links to government institutions and services for a community that is not particularly recognised or served by community or state health services and whose closed nature creates real challenges around integration.

3.2 The range of projects using CBWs

The in-country review indicated that CBWs are being used to provide services in animal health, human health, agriculture, water and forestry.

In Kenya, the CBW model is most applicable and provides great benefits in the livestock sector in the following areas:

- animal health;
- clinical services;
- artificial insemination (AI);
- extension;
- marketing;
- disease surveillance.

In human health, CBW systems are being used to provide services in:

- HIV/AIDS;
- reproductive health and family planning;
- distribution of drugs;
- nutrition and health education.

In agriculture CBW are involved in:

- Extension through Farmer Field Schools (FFS) and in marketing.

In natural resource management there are examples of CBWs in:

- Forestry management and conservation.

3.3 Selection criteria and procedures for CBWs

Sustainability of CBW systems depends on proper selection criteria and procedures. The consensus among service providers and facilitating agents (FA)s was that where CBWs were chosen by their communities, with as little manipulation as possible by influential lobby groups, there is a greater chance of success as the CBWS then have a support system which facilitates their work. Different criteria were used in different sectors, geographical regions and organisations. The criteria varied with the prescribed roles of the community workers, the socio-cultural setting of the communities and the anticipated community support and reward system. For standardisation purposes, uniform criteria for the training manuals were developed across different sectors. Factors often considered in the selection criteria of CBWs included age, gender, trust and reputation within their community, keenness to serve and willingness to learn and assist others, degree of self-motivation, management and communication skills, educational achievement and previous experience of volunteering in community activities.

3.4 Financing of CBWs

Different FAs support CBWs in different ways. All contribute to the cost of establishing and maintaining the CBW system and some also provide CBWs with stipends. Some are trying to help CBWs to become self-supporting through offering the initial seed capital for income generating activities. The government contributes both financially and in kind, i.e. personnel, drugs and referral facilities. It also provides technical input through training, monitoring, supervision, co-ordination and research. However, the government does not have adequate capacity to provide these services efficiently and consistently. Sometimes communities contribute to the costs through providing meeting places, food, cash, labour, money and other materials. Communities occasionally pay user-fees for services delivered to them or they organise community fundraising events (harambees) to generate money to pay the CBWs. Sometimes they also operate insurance or solidarity funds, or use micro-finance schemes such as merry-go-rounds or income generation activities to raise cash to pay CBWs. Some NGOs provide retainers or stipends to the CBW but not all. Some CBOs charge subscription fees to their members to generate income.

In the livestock sector, start-up financing of CBWs is normally provided by FAs or through linking CBWs to credit facilities. Most organisations supporting CAH programmes trained CAHWs and equipped them with initial veterinary drug kits. CAHWs were sometimes provided with kits on a cost-sharing basis. In Kajiado District, for instance, the ASAL programme contributed 50% towards the acquisition of the initial drug kit while the CAHWs contributed the rest. In the Pastoralist Development Project (PDP) supported by FARM-

Africa, the CAHWs acquired the basic starter kit at a 25% cost sharing basis. CAHWs in a GTZ programme in Mwingi District were charged only 20% of the cost of the kit and were given a 12-month bicycle loan to facilitate their mobility. In some cases NGOs assisted with seed money for starting community managed drug stores so that CAHWs were able to access drugs. Other organisations, such as Community Initiatives Facilitation and Action (CIFA), linked the CAHWs to credit facilities through guaranteeing individual loans.

During periods of drought, when the community no longer paid for services, some NGOs made arrangements to refinance the CAHWs through providing them with free drug kits to restart their businesses. During vaccination campaigns, the CAHWs were trained and provided with allowances as motivation to mobilise their communities and participate in the campaign. For example during emergency work conducted in Marsabit in 2000 by Intermediate Technology Development Group (ITDG), the CAHWs were paid an allowance of Ksh. 500 per day for the period they worked in their areas. Some ASAL areas did not have a developed cash economy, especially the very remote areas. Under such circumstances, the CBWs were paid using a barter system where livestock was exchanged as a form of currency. The CAHW then made arrangements to sell the livestock and convert it into cash. This was not without risk for the CAHW as the animal could be stolen or die.

The community was found to be willing to pay for private good services but reluctant to pay for public good services. It is accepted, for instance, that traditional birth attendants charge fees ranging from Kshs. 500 to KShs. 2,000 for services rendered. Livestock keepers paid CAHWs for clinical services but were unwilling to pay for long-term disease control programmes such as tsetse fly trapping (public good). As a result, CAHW activities focussed more on curative functions (private good). However, where the community was not involved in selecting CBWs or contributing to decisions as to how much the CBWs are to be paid, they were unwilling to support the CBWs. In cases where communities were expected to pay for public goods, the programmes tended to be less sustainable.

Many organisations working in the HIV/AIDS sector have remained vibrant in part due to the increased involvement of volunteers (Delong 2001). However, experience has shown that even the most active and most motivated CBWs reached a point when they felt someone ought to reward them for their work. Service delivery by volunteer CBWs therefore depends largely on how much they feel valued. Incentives ranged from annual tokens, occasional gifts, parties and outings, certification, child education sponsorship and free clinic treatment for family members as recognition for the role played. Some programmes within the HIV/AIDS sector provided CBWs with a monthly allowance ranging from KShs. 200 to KShs. 800. This was provided by the FA.

It is important to note however that voluntary CBW programmes are not without cost. Governments often fail to realise that even when CBWs are volunteers there is still a need to train them and provide support and supervision. Maintaining a voluntary programme therefore requires an investment of funds. The review argued that due to the high attrition rate amongst volunteers there were obvious increased costs involved in training new recruits (Horizon 2000). There is therefore an important debate about whether it is in fact cost effective to provide to provide a small stipend/allowance to CBWs in order to retain them for longer rather than continuously having to train new ones.

3.5 Training, support, supervision and accountability

3.5.1 Training

The government, in collaboration with NGOs, has developed curricula to guide trainers on trainee selection, content, methods, duration of training and even choice of trainers. For

example, in the livestock sector, a harmonised training curriculum for CAHWs was developed as an attempt to improve the standard of the training for CAHWs (KVB 2003). Many training organisations have since adopted the curriculum, and modified the contents of their own training manuals to reflect the guiding principles in the government manual.

The choice of the training location and venue is at the discretion of the community, the trainers, the trainees and the institution funding the training. Experience showed that taking trainees away from their own locality was a good learning incentive, but it was also recognised as a more expensive option and not always suitable, especially for women. It was recommended that training should take place as much as possible in circumstances comparable to those in which CBWs are expected to work and at a venue that is local enough so that they can sleep at home and be able to attend to their other obligations. Even a boarding arrangement should be as local as possible to help CBWs adapt and practice the expected tasks in a realistic and culturally acceptable and comparable context.

A training programme which begins with a functional formal training lasting two weeks to one month, followed by refresher courses (fortnightly or monthly) that go on for a year or more, was found to be effective. It was more effective when combined with other forms of adult learning such as home visits, group meetings and exchange programmes. According to the minimum standards curriculum for training of CAHWs, the initial training should last a minimum of three weeks. The course content should be covered during this period, and can be staggered depending on the situation on the ground. When training was delivered in phases it allowed participants to internalise their experience more easily.

Most programmes use their staff to train CBWs whilst some use consultants or staff of partnering agencies e.g. government medical personnel, district veterinary or livestock production officers. The minimum standards training curriculum for CAHWs stipulates that one of the trainers of CAHWs must be a qualified veterinary surgeon.

The training of senior competent CBWs as trainers of trainers was also identified as important. This approach has a multiplier effect since more CAHWs were trained and closely supervised by their peers within the village. It decentralised the training process by taking it from the hands of the experts to the villages as key stakeholders.

It was established that training must be as flexible as possible in terms of content, method of presentation, location and duration to accommodate the CBWs' social, cultural and learning needs. For example many volunteers are part-time, and women could participate more actively in non-residential workshops and during school holidays *(KANCO 2000*). When training pastoralist women in animal health, it is important that training opportunities be designed with women's needs and workload in mind *(AU/IBAR Policy Briefing no. 6).*

Training of CBWs should centre on the roles they will play. The knowledge, attitude and practical skills required should inform the training content. While the government provides guidelines and training curricula[2], it is evident that many organisations, especially in the HIV/AIDS sector, are using their own self-developed manuals without consulting the prescribed guidelines.

CBWs were trained on technical issues depending on the sector. Inconsistencies in training were found even within the sectors. For example, in the HIV/AIDS sector, some programmes trained their CBWs in curative care, others in health education (prevention) and others in

2 The government has prescribed curricula for training in VCT, HBC for house service personnel and community health workers (Republic of Kenya, 2002, Ministry of Health, NASCOP Publications). Minimum Standards for training CAHWs and Community-based TB prevention (Kenya Veterinary Board 2003; Minimum Standards and guidelines for training of community-based animal health workers in Kenya, Nairobi).

support care activities. Some did not get training in support care because their FA believed the role of the CBWs was preventive. In some programmes, CHWs were trained in everything; from treatment of minor ailments to programme management. In the livestock sector, CAHWs are only trained in animal health.

As CBWs assume new roles and responsibilities, there is a need to introduce training in other areas such as resource mobilisation, communication and networking, community organisation and action, data collection and reporting, entrepreneurship and advocacy. Within the livestock sector, there are specific training needs in livestock marketing, conflict resolution and natural resource management. Within the HIV/AIDS sector there are specific training needs amongst CBWs in counselling and HBC.

3.5.2 Support

CBWs require sustained support to be able to work effectively and efficiently. This can be a combination of financial, institutional or technical support that would enable the workers to acquire the necessary skills to carry out their tasks and responsibilities, access the community and discharge their duties confidently, network and link with others to enhance service delivery.

The facilitating agent (FA) plays a critical role in providing or arranging for this support. The CBWs are motivated when they function in an enabling environment. Support is also required in the area of remuneration and incentives, e.g. being equipped with kits. The government can motivate the CBWs by recognising the work they do and providing an enabling policy environment. The community can provide social incentives and payment for services where appropriate. Further support in the form of provision of seed capital to start income generating activities (IGAs) is also important. This was shown to be important in making the CBW self-reliant.

CBWs were also encouraged to start their own initiatives to enable them to share information and experiences, lobby for government recognition and certification. Establishing resource information centres is another option aimed at ensuring a continuous flow of information to the community and strengthening the potential impact of the CBW.

3.5.3 Supervision

Follow-up support and supervision is necessary to remind and assure the CBWs that they are not working in isolation, to monitor performance and to record activities. It is also an excellent opportunity for supervisors to determine CBWs' training gaps. This function is normally carried out by the FAs during the active implementation of the projects but it is a big challenge once donor funding ceases. Follow-up can be done by professionals e.g. the veterinarians or the project staff or others.

3.5.4 Accountability

CBWs have multiple accountability to different bodies based on the links required. As members of a community, they have a social obligation to the community that selected them. This can be monitored by the quality of the services delivered and the manner in which they deliver the service. But as far as technical aspects are concerned, accountability has to be to a person with the appropriate technical qualifications. This could be a private entrepreneur (individual), the FA, the government representative e.g. the DVO, or even a micro-credit financial organisation especially when regular reports on performance are required. For example, the DVO needs information on diseases treated, type of drugs administered, and whether the animal recovered or not. The micro-finance body needs information on loan

repayment status and that of the business. Such technical matters could not be left solely under the supervision of the community due to lack of adequate capacity. The FA must also report on CBW activity when accounting for use of funds whether from donors or government.

As a result of these multiple levels of accountability, many CBWs were unsure about who they were really answerable to. In many instances they tended to associate themselves with the FA, as this was the major source of resources.

3.6 Relationship of community structures, roles and linkages

The community was involved in various capacities through different structural arrangements as follows:

1. **Local government level**: Administratively, the government has representatives at the local level, including the chief, sub-chief, councillors and extension workers or social development workers. They translate, implement and enforce government policies at that level. They inform the central government on the socio-economic needs and issues within their locality. They co-ordinate development efforts, guide resource and community mobilisation and lobby for further central government support. They provide the necessary links between the citizens and other development actors.

2. **Faith-based or religious structures** are involved through their funding of institutions such as schools, hospitals and community development programmes. They provide community services through their members or community projects. Through their institutions, FBOs provide a forum for information dissemination as well as ground for CBW recruitment. Using their members to give professional expertise in community-based programmes, they also extend financial support to these programmes. Their facilities are used as meeting points and as training venues. As facilitators of development processes, they can also restrict the growth of interventions e.g. those that contravene their teachings – for example the conventional Catholic Church restriction on the use of condoms as a form of contraception and protection against HIV/AIDS.

3. **Local social groups**: Other interest groups linking with CBWs were youth and women's organisations, CBW associations, drug-store committees, and anti-AIDS clubs. These groups either existed in the community or were established during the project implementation phase. Their main functions included their role as a collective point for community and resource mobilisation, implementing specific programme activity, providing channels for disseminating information, lobbying and advocacy. These groups often provide a forum where CBWs could be selected for training and subsequently provide support for the CBW system. They are effective links between the FAs and the community.

4. There are also **traditional structures** such as village elders or opinion leaders who act as 'gate keepers' and indigenous institutions whose main role is to propagate and sustain cultural values and norms in the community. They uphold powers that shape community development. These traditional institutions are also the opinion setters and they largely influence the way in which new ideas are received in the community. They serve as a key entry point in development initiatives and can offer much needed support to the system. They have the capacity to determine the local resource use

and community mobilisation or hinder development initiatives that go against the community's socio-cultural values.

5. **Local public institutions** such as schools, research institutions and hospitals provide modern services. They complement and supplement services being delivered by informal institutions – for example hospitals serve as a referral facility for HIV/AIDS infected people or for TBAs' clientele. The hospital staff supervise and monitor the work of CBWs. These institutions' technical capacity is useful in supporting the CBW systems – for example, teachers link infected and affected children and their families to other resource systems for further support and help. They also support the ARV therapy for infected children. Hospitals provide diagnostic and clinical services including provision of drugs and ARVs for CBWs. The institutions also support information dissemination in the community. The schools disseminate information through children and parents' associations as well as organising parents' meetings. The hospitals disseminate information through outreach programmes.

6. The **private sector,** which could be an individual or a corporate entity, provides services that are similar to the public service providers but on a smaller scale and for a fee. Some of their support to CBWs is carried out as a social obligation and to promote themselves.

Successful CBW systems had links to existing traditional, religious, administrative or other social structures and groupings. It was important that an inventory of existing structures and groupings was developed and made available to CBW system implementers so that they were better able to find the best entry point for the targeted community. Furthermore, it was important to note that some structures were more powerful than others and facilitated faster entry into the community. The role of FBOs, for example, in community-based HIV/AIDS programmes was well recognized and religious organisations served well as entry points.

The FAs gained credibility when they used existing community structures to support and implement CBW processes. The local structures are well known and are organised around the lives of the people. Utilising the existing structures encouraged the maximum use of local resources. However, it was recognised that some of these structures needed strengthening in aspects like project management, monitoring and evaluation and more participatory approaches.

3.7 Impact and sustainability of CBW systems

Community-based worker systems have had an impact in various sectors in the country. CAHWs have contributed to poverty reduction by improving the livelihoods of communities. A study by the IDL Group (2003) showed that households in villages with CAHWs were more willing to rear livestock because the risk of loss of animals from disease was perceived to be lower. In villages without CAHWs, none of the poorest quartile of the village engaged in cattle, sheep or goat production, while in villages with CAHWs, approximately 64% of the poorest quartile owned or reared at least one ruminant.

CBWs had the greater impact in small towns, in informal settlements in urban areas and in rural areas where professional services were least accessible and local government structures were strong. CBW impact was more evident when local awareness was raised and proper guidance and technical support was provided.

The impact of CBW systems was affected by low levels of sustainability. It was evident that the financing of the programmes was only one factor determining sustainability. Sustainability of CBW systems largely depends on the level of community participation, support,

accountability and ownership of the initiatives by the communities, accessibility of initial start-up equipment, development of appropriate support and linkages from relevant sectors to assist with supervision, continuous training and supply of equipment or resources, and the integration of CBW systems into overall development plans *(Schapink 2001).*

The case studies presented in this review were able to demonstrate impact in the following areas.

3.7.1 Access to services

The information gathered from the in-country review suggests that CBW systems ensured that services were not only more affordable but were of good quality and easily accessible. There was also evidence of increased geographical coverage in service delivery. For example, in the HIV/AIDS sector, it was found that more patients have easier access to ARVs and much needed psycho-social support through the established community-based home care programmes. In the livestock sector, pastoralists in ASALs were found to have greater access to services such as drug supplies, extension and clinical services. An ITDG study indicated that rinderpest vaccination using CAHWs achieved coverage of 38,000 out of 110,000 cattle vaccinated in 1988 (ITDG 2001). CBWs' response to community needs was timely, partly because they were within the same vicinity as the affected communities. This built a sense of ownership and trust in the community and had a direct impact on satisfaction with services rendered.

3.7.2 Increased awareness

CBWs are good agents for social change in that they raise awareness in the community, change attitudes and increase community action in response to HIV/AIDS. Community-based home care programmes have developed new components of behavioural change interventions such as life skills training, peer education, and provision of condoms. This complemented the Information, Education and Communication (IEC) campaigns on abstinence, faithfulness and condom use, advocated by government and other service providers.

3.7.3 Entry point for other development initiatives

Since CBW systems involve setting up or strengthening appropriate community structures, they also serve as good entry points for other development interventions as communities become more receptive to new ideas. For example, the community-based animal health pilot project in Turkana and West Pokot was used as an entry point for conflict mitigation, livestock marketing, grazing rights, human health (HIV/AIDS awareness), biodiversity, natural resource management and water resources improvement.

These developmental interventions are essential for creating a positive environment for behavioural change. This led to developing links between HIV/AIDS interventions and broader development and income-generating opportunities for women, men and youth in the case studies reviewed.

3.7.4 Enhanced collaboration, partnership and networking

The entry of other actors into the development arena led to enhanced collaboration, partnership and networking. This was motivated by a need to improve the quality of CBW systems through a harmonisation of approaches by standardising training and through the sharing of experiences and resources. In addition, there was increased demand for collective lobbying and advocacy for policy. In the HIV sector, through KANCO, an HIV policy was

adopted in 1997. In the livestock sector, an Animal Health Policy was drafted by stakeholders and developed into a national level policy framework. However, a key contention in the latter policy was the recognition of CAHWs as animal health service providers.

3.7.5 Increased level of community participation and ownership of programmes

CBW systems provided opportunities for communities to participate actively in development including decision-making, programme design, implementation, monitoring and evaluation. The community also participated in sharing benefits that accrued from these development efforts. They were also involved in local resource mobilisation utilising their indigenous knowledge and other local capacities.

It is important to note, however, that evidence of significant impacts has emerged from cross -sectional studies rather than from longitudinal studies of individual projects using their data and records. This is due to the poor monitoring and evaluation systems of many CBW projects. There weren't any established monitoring and evaluation systems agreed across different sectors. Impact assessment was also hindered by a lack of baseline information and clearly defined performance indicators.

3.8 Summary of lessons and areas for immediate follow-up

The sustainability of CBW programmes remains a critical issue in many programmes. CBW systems require sustained support for effective and efficient service delivery. Advocacy for increased government financial and technical support is critical. Donors should employ more long-term thinking in their strategies for the implementation of CBW systems, as short-term measures are not sustainable. FAs have to adopt creative and innovative ways to enhance programme sustainability, looking at increased community participation, appropriate support and linkages, and integration into overall government planning processes.

CBW programmes which create local ownership and community control are likely to be more sustainable. Community participation and adoption of new concepts entails a change of attitude and behaviour and flexibility in the implementation process. It is therefore important that the FAs and donors are involved in the project monitoring process to increase the flexibility of CBW programmes.

CBWs provide services that are complementary to rather than in competition with those provided by professionals. However, professionals such as veterinarians, have not always seen it that way. More sensitisation of professionals is required in order to foster acceptance and support of CBW systems. Professional standards of CBWs have to be maintained and there is a need for constant support through capacity building and monitoring. This includes their natural resources, indigenous knowledge and local capacities.

Whereas it has been generally agreed that CBW systems are the most effective means of providing services, innovative models that reduce establishment costs will need to be developed. This will reduce the level of donor dependency, facilitate the mobilisation of local resources and harness local capacities.

For CBWs to provide much-needed services to communities, incentives have to be considered. The type of incentive has to be carefully thought through during the planning stages. It is difficult to switch to a 'user pays for the service' model if the community was first presented with the concept of a CBW as a volunteer providing a social service. It is also difficult for CBWs to be paid a stipend initially and then to be expected to work without a stipend when donor funding dries up.

It has always been intended that CBWs be accountable to the community that they serve as a means of maintaining accountability and sustainability. This has however been elusive and the only way to ensure full accountability is for the community to take central control of CBW management. In most projects, communities only play a peripheral role but then are handed the controls towards the end of projects in a hurried, haphazard manner as part of a poorly developed exit strategy by the FA.

Government should open up the development space in order to allow more actors to provide needed services. This can be done by developing appropriate policies that will enhance mainstreaming of CBW work across all government departments via opportunities emerging from privatisation, democratisation and decentralisation processes. The government must also increase budget allocations to support CBW systems especially for public good concerns.

3.9 Areas for follow-up identified by the situational analysis

- Integrating the work of CBWs into national service delivery systems;
- Strengthening collaboration between FAs, government, communities and other stakeholders to enhance sustainability;
- Commercialising, where feasible, community-based services, as a strategic measure for sustainability;
- Harmonising and co-ordinating CBW approaches to avoid confusion and conflicts of interest between stakeholders including the community;
- Developing curriculum and training manuals for CBWs in different sectors to improve training provision;
- Further research on needs of CBWs as agents of change in service delivery, specifically focusing on standardisation of methodologies and approaches and operationalising the CBW concept;
- Stepping up advocacy work
- Formation of a support network for CBWs.

3.10 Legislative and policy environment - implications for policy change

Increasing poverty levels and dwindling government funding to address poverty's adverse effects is an enabling factor for the CBW system to thrive in Africa. Global policies influence and shape African approaches to service delivery. The World Bank and IMF, the UN agencies and other bilateral and multilateral agencies acknowledge the role of community participation in addressing developmental challenges.

Furthermore, African governments are not only signatories to but have adopted many international conventions, charters and declarations that emphasise policy reform in favour of poverty reduction through addressing key governance issues in development. As a response to these international pressures, Sub-Saharan countries have engaged in reform programmes which focus on constitutional reviews/reforms, privatisation, decentralisation, and democratisation. These reform agendas provide opportunities for CBW systems. For example, privatisation and public sector reform in Kenya has provided a good opportunity for CBW systems as a mechanism for service delivery. The current decentralisation process is encouraging the participation of all players, including the community, in the development process through strengthening the meso operational level and encouraging stronger linkages between all partners.

4 The pilot projects - Implementation from January 2005 to March 2007

4.1 The models

Following the national workshop held in Machakos in July 2004, pilot schemes were identified to test different models of CBW systems. 'Guidelines for the implementation of a community-based worker system' were developed to support the selected implementing partners in their process of project implementation and lesson learning. The guidelines were based on partners' experiences in the implementation of CBW models in their specific sectors and focused on identifying improved approaches so as to make CBW systems more effective and efficient. They also aimed at developing tools to actively document and share information about the impact of the work of CBWs. Five models for implementing a community-based worker system emerged from the first national and 4-country workshop as follows:

- 4-8 hours a week unpaid volunteers;
- 20 (exceptionally up to 40) hours a week unpaid volunteers;
- 20-30 hours a week paid a stipend;
- 40 hours a week paid a salary;
- Paid by user (private/commercial model).

The partners involved in piloting one or more of the models were KICOSHEP-K, WASDA and ABC-Kisumu. The learnings from these pilots were modelled around an agreed framework to strengthen the work of CBWs in the partner organisation. During the piloting phase, experiences were documented and feedback shared at national workshops. Further, pilot peer reviews, partner meetings and mechanisms for sharing were established – for example a regional newsletter providing updates and information about the whole CBW project. An internal review exercise deepened understanding of the CBW action-learning project.

4.2 Implementation of the pilot schemes

This section summarises information on the pilot projects that were implemented in Kenya.

4.2.1 Advocacy, Behaviour Change and Communication (ABC) Kisumu

Facilitating Agent: Environmental Liaison Centre International (ELCI)
Implementing Organisation: ABC – Kisumu (a community- based organisation)
Pilot Model: Combination (8-15 Hrs – unpaid; 20-30 Hrs paid)

What is ABC-Kisumu?
ABC-Kisumu is a community-based organisation. It consists of one volunteer coordinator and nine community facilitators. The aim of the organisation is to carry out advocacy, behaviour change and communication activities in relation to sexual and reproductive health and rights (SRH&R). The organisation works with poor fishing communities on the beaches of Lake Victoria.

What was piloted?
ABC-Kisumu piloted the selection and recruitment of CBWs and the FA's role in supporting, training and financing CBWs.

In terms of enhancing the selection and recruitment criteria, ABC-Kisumu

- worked to strengthen the group's constitution ;
- worked with the community members and CBWs to improve the selection criteria and make the selection process more transparent;
- carried out regular round table discussions at the beaches as a way of engaging with the local population on policy issues.

The project also focused on regular exchanges between the beach management unit (BMU) leaders from the five beaches in the project operation site, to learn, reflect and to share with each other. The intention was to strengthen local linkages and improve the recording and reporting of information from the CBWs to the facilitating agent. Emerging learnings and experiences were then used to influence policy makers about the plight of the fishing communities in the lake basin. The FA worked with the ABC-Kisumu coordinator to develop a fundraising strategy to support sexual and reproductive health and rights (SRH&R) activities in the lake region. The FA also provided strategic linkages between BMU leadership and government processes.

4.2.2 Reproductive Health (Home-based care model)

Facilitating Organization: KICOSHEP-Kenya in collaboration with other organisations
Implementing Organisation: KICOSHEP in Kibera
Model Piloted: Combination (8-15 Hrs – unpaid; 20 Hrs paid)

What is KICOSHEP-K?
KICOSHEP – Kenya is a charity working in four towns in Kenya. It started in Kibera in the early 1990s and at that time was known as Kibera community self-help project. It is based in Kibera, a slum of over 500,000 people. It provides HIV/AIDS testing, counselling and health services, as well as nutrition and schooling for vulnerable children.

What was piloted?
KICOSHEP-K piloted issues to do with incentives, accountability and referral/linkages. The caregivers were paid on a monthly basis Ksh. 1000 (US$ 14) as a modification to theirsystem and that KICOSHEP-K adopted for the piloting. Provision of some travel allowances to the volunteers whenever they did outreach work outside their own communities was also tested. Giving CBWs clothes and food as incentives, training caregivers on IGAs and giving start-up funds to start small micro businesses was also tested.

Concerning accountability, the caregivers were required to report directly to KICOSHEP-K and the community. A monthly meeting in each village where all caregivers gathered to report and share information was initiated. KICOSHEP-K formed a weekly support group meeting where PLWHAs came together and received information on HIV/AIDS. Partnerships and collaboration with government, local NGOs and the community were also strengthened.

4.2.3 Community- Based Animal Health Workers (CAHWs)

Facilitating Organisation: Wajir South Development Association (WASDA)
Implementing Organisation: Members of Pastoralist Associations (PAs)
Pilot Model: Combination (40 paid and paid by user)

What is WASDA?
Wajir South Development Association is in Kenya's north-east province which is very underdeveloped, marginalised and poor. The province has historically been pastoral and has grazed camels, cattle, sheep and goats as a principal source of livelihood. The majority of the population is formerly nomadic. The area is very arid with unreliable, erratic and

insufficient rainfall which means that people cannot grow enough cereal crops to meet their requirements. The CBW system within WASDA works mainly with Community Animal Health Workers (CAHWs), who are members of the pastoral communities motivated to deliver animal health and related services in their respective communities. The focus is primarily on the livestock sector with an emphasis on animal health, environmental conservation, drought management, water development and conflict management. Pastoral Associations (PAs) have been formed and WASDA assists these with veterinary drugs and equipment on a cost-sharing basis.

What was piloted?
The WASDA pilot focused on the work of the CAHWs, their selection and recruitment, training, support, supervision and accountability. During this period WASDA also looked at issues of financing and linkages required by the CAHWs.

4.3 Lessons emerging from the evaluation of the pilot schemes

The pilot projects aimed to achieve a better understanding of best practice in implementing CBW systems in terms of the following:

- the criteria and procedures for selecting CBWs;
- financing of CBW systems;
- the nature of supporting social structures (traditional, religious, administrative) that are necessary in order for CBW systems to thrive;
- the roles played by other stakeholders who contribute to the work of CBWs;
- effective training;
- the policy context required for CBW systems to succeed.

The following sections discuss the learnings that came out of the experiences of the pilot projects.

4.3.1 Recruitment and Selection of CBWs

Facilitating agencies request communities to identify the essential qualities or characteristics of a community- based worker (CBW). Selection criteria are then drawn up jointly. These would normally include:

- Willingness to give service;
- A responsible and respected member of the community;
- Physical fitness and ability to work especially in areas where they may need to lift someone or have to walk quite a distance to reach the clients;
- 'Settled' member of the community who is prepared to serve for a reasonable period of time and not likely to leave soon after training has been completed;
- Illiteracy not a barrier to recruitment for training.

Lessons Learnt

- Involvement of the community in developing the selection criteria and in the actual selection and decision-making process is critical. This enhances accountability and increases ownership by the community. In addition, CBWs selected by the community have more sense of responsibility and commitment and are more likely to remain active than those individuals who were hand picked by their relatives or the facilitating agent.

4.3.2 Financing of CBWs

Financing and supporting CBW programmes is challenging and organisations are often vulnerable to inconsistent income. CBW programmes must be adequately funded and they need to be cost-effectively run to be financially sustainable. There are different funding mechanisms being used to finance CBW programmes. Some organisations have arranged community funding, whereby the community raises funds or makes contributions to pay CBWs. Others get government funding, often in partnership with bilateral/international agencies or donors. Some pool resources (CBWs themselves) or are involved in savings and revolving fund schemes to sustain the continued care and support of members of their families. Also there are those who charge user fees for a service rendered. In the NR sector, user fees (private sector model) appear to be quite successful.

Lessons learnt

There should be an agreed financial package to remunerate CBWs according to the time spent doing community-based work. This will recognise CBWs' efforts in service delivery and motivate them.

Depending on the working arrangements agreed upon with the FA, various methods to remunerate the CBWs are identifiable:

- For full time workers (40 hrs or more per week), an equivalent salary at the end of the month;
- For part-time workers, an allowance would be sufficient;
- Community workers and workers offering specialised services, such as TBAs, whose services are only required at specific times, can be remunerated through user fees for the services they render.

In the NR sector, user fees (private sector model) appear to be quite successful. Access to credit facilities has emerged as a good practice. In the HIV/AIDS sector for instance, credit facilities have been used to kick start CBW Income Generating Activities (IGAs). Financial support can come from government, NGOs or the international community. There should be reliable funding commitments if programmes are to succeed. Unfortunately, government supply systems are sometimes erratic due to bureaucratic processes as well as limited financial resources. Community support can be in the form of voluntary work or direct payment or in-kind. Facilitating agents should involve their CBO implementing organisations in deciding the areas to include when writing funding proposals. The conditions involved and the capacity to attract international funding tends to make it prohibitive. Project support is usually limited to five years which is not long enough for deep-rooted institutional changes to occur. Also donors are reluctant to commit to long-term recurrent costs such as salaries. There is a need for long term engagement by donors to have real impact.

4.3.3 Relationship of community structures to CBW

The CBW system is heavily dependent on creating partnerships with existing community structures. ABC-Kisumu for example cannot work effectively without the involvement of the Beach Management Units (BMUs). BMUs are presently utilised by the central government in the co-management of Lake Victoria fisheries. They are already established and operational.

Lessons learnt

There is a socio-economic benefit to both CBWs and the communities when the two have a good working relationship. CBW CBOs will be more financially sustainable if financial resources can come from the communities which are being served.

- Setting up good partnerships within communities takes time. KICOSHEP-K-K slum projects have been in place for the last 15 years;
- In the NR sector, project planning and preparation should include plans for community mobilisation in the case of adversities such as drought;
- The success of the 40 hour paid (private CBW model) is largely attributable to individual characteristics. Diversification and a business-oriented approach were found to be the key to success;
- Establishment of an effective health referral mechanism requires total involvement of stakeholders;
- When families and community members are informed and involved there is more 'ownership' of the CBW processes;
- While there is currently no evidence that TBAs have improved maternal health, there has been an increase in health facility deliveries through TBAs referring cases to health clinics and hospitals;
- Without linkages and support from external organisations in the relevant sectors, CBW initiatives cannot function effectively. The most successful programmes flourish in supportive political climates where for example health is viewed as an essential part of human development. However, even in countries where this commitment is lacking at national level, it can still exist at district or provincial level - as evidenced in other countries such as Indonesia, India or Peru - where programmes have succeeded against all the odds.

4.3.4 Involvement of other stakeholders

The private sector can contribute a great deal to service delivery in terms of funding, training or support in terms of goods or assisting with technology. In marginal areas such as where WASDA is operating, the private sector is the predominant service provider in the natural resources sector as very few government services reach these rural areas. For care of livestock there are only the private vet practitioners with CAHWs as outreach service providers.

Government's role is mostly in policy and regulation especially in the health sector. At the local level, village health committees are involved. At a higher level, a number of development agencies collaborate with CBWs especially in the HIV/AIDS sector where there are organisations such as the National AIDS Coordination Council (NACC).

Lessons learnt

- CBWs need support and supervision to keep them up to date and increase their knowledge. This can be achieved in collaboration with the government, where it has the capacity, or with the cooperation of private professionals or NGOs;
- Availability of credit and private sector involvement is crucial for the sustainability of the CBW system;
- Policy regarding the legality of para-professionals needs to be revised to include a regulatory and disciplinary framework for CBWs;
- Collaboration and exchange of ideas and experiences through different forums has led to increased adoption of common practice across sectors. The involvement of the

communities in monitoring the CAHWs has inspired communities to look for initiatives to make the system sustainable because it is responding to their felt needs;
- Using CHWs in the health sector and especially to address the HIV/AIDS pandemic, requires a reorientation and radical change in policy and closer supervisory roles from the central health system management.

4.3.5 Training, support, supervision and accountability

Training courses offered were flexible in terms of content, methodology, location and duration. As far as possible, training was carried out in circumstances similar to those in which CBWs were expected to work. In addition, the duration of the training programme was determined by the aims and objectives of the training and envisaged roles of the CBWs. There were regular, supportive supervisory visits that were essential to effective performance of the CBWs.

Lessons Learnt

- Training CBWs within their communities or close to their communities has better results and seems more empowering. The training is more convenient, especially for women trainees who have ongoing family responsibilities. It is also easier for trainees to relate what they learn to implementation on the ground;
- Non-directive, discursive, active,.learner-centred, problem posing learning methods are suitable for CBWs. The trainer's role is to facilitate the self discovery process;
- In general, a minimum level of literacy is needed for community members to be trained as CBWs.
- 'Hands on' experience was found to be effective in developing skills and building up the confidence of CBWs;
- Training is most effective when provided in phases because it gives time for CBWs to absorb the new knowledge, to practice it in the field and give feedback at the next training session. Refresher courses and close monitoring is necessary to sharpen the skills learnt.

With regard to supervision and accountability, communities do not have the right structures to be effective in firing CBWs. It is the prerogative of the FA at the moment, but empowerment of the community to manage all aspects of the CBW system is encouraged.

4.3.6 Roles and linkages required

CBWs are seen as representing the community's view, extenders of services and at the same time agents of change. The community knows its needs with respect to health etc. Services which are intended to help people will be most effective when the people themselves help in the planning and implementation of projects. Through CBWs the people can realise solutions to their problems. The CBWs are therefore viewed as the voice of the voiceless, filling the gap left by retreating government services especially in marginal areas.

In terms of external linkages, strong stakeholder forums, donor support and partnerships are critical. Also strong multi-sectoral committee system linkages with service providers and FAs with a strong national support base are crucial for the success of the CBW system. In addition, in the health sector, provincial and local links as well as links between the health departments and the CBWs are necessary for efficient medical services being delivered to communities.

Lessons learnt

An enabling policy environment that is supportive of the CBWs' processes in communities is critical:

- There would be faster development if greater recognition was given to the value of community-driven initiatives and if this could influence the conventional development paradigm. Moving resources from the centre to the periphery of the political economy (as happens with the Community Development Fund for example) is thus important;
- Building rural capacity for some of these interventions will remain a challenge to making them effective development vehicles;
- Feasibly, the government's main role is to provide leadership in instituting and maintaining quality controls and disseminating information on CBWs;
- The standardizing of the curricula and relevant accreditation processes and making the system more professional are some of the major contributions that government can make.

5 Impact and cost-effectiveness of CBWs

This section summarises findings for each pilot CBW site that was evaluated. The following broad areas were analysed:

- The impact of the pilots on beneficiaries, CBWs and service providers;
- Cost-effectiveness of the pilots in service delivery;
- Comparative cost-effectiveness of CBW and conventional systems of service delivery;
- Impact of the CBW project on policy and systems.

5.1 Pilot 1: Advocacy, Behaviour Change and Communication (ABC), Kisumu

5.1.1 Impact on beneficiaries and CBWs

ABC-Kisumu's experience provides evidence of how efficient these grassroots organisations can be in carrying out their work, if provided with some simple but appropriate forms of technical assistance.

One of the activities of the ABC-Kisumu project has been community advocacy**,** where ongoing roundtable training sessions have been guided by a curriculum covering: poverty, governance, security and sexual and reproductive health and rights.

The ABC-Kisumu project uses a roundtable strategy where community and the facilitators sit and discuss issues to get community members to generate ideas for advocacy and own the work plans, which is important for sustaining the advocacy work. Capacity building of youth clubs through training workshops and roundtable sessions in the areas of leadership, sexual & reproductive health (SRH) and advocacy has resulted in broadening the thinking and understanding of the young people. Awareness has been raised in relation to the transmission, the spread, prevention and protective measures against HIV/AIDS. As a result of this, there is a high rate of condom use among the targeted group. There has also been a change in some traditions especially attitudes to empowerment of the girl child. This can be attributed to advocacy work around the importance of educating the girl child, as well as on the prevention of unwanted pregnancies.

The gains made so far in galvanizing community input regarding knowledge, attitudes and practices that relate to each of the issues are immense. Participants in the roundtables have continued to identify gaps and strengths which relate to structural arrangements for services delivered by government and other service providers. Concrete recommendations point to a need for a strengthened advocacy approach towards policy change and a change in people's attitudes and practices.

The CBWs were trained in various aspects of service delivery to the community, and ten youth facilitators were selected and trained as peer educators. In terms of benefits to the CBWs themselves, CBWs felt that they had gained the opportunity to become more visible in their communities through services rendered including community networking opportunities.

However, there were some negatives. Some CBWs experienced a negative impact because their work prohibited them from securing formal work (for those who are unemployed) and therefore from obtaining a needed income, CBWs who are employed found that they were unable to attend to their beneficiaries during their working days.

5.1.2 Cost-effectiveness of the pilot

In order to determine whether the ABC project was cost effective or not, it is important to identify a number of relevant factors that include:

- All the costs attributable to the project operations;
- Indicators of significant impact (preferably those indicators which can be quantified);
- Comparison data from similar service providers, as a way of establishing a benchmark for the analysis.

In an attempt to measure the cost-effectiveness of the pilot schemes, all the costs attributable to implementation were calculated. The ABC-Kisumu project is one of the projects currently being run by ELCI Kenya and therefore the project budget and costing is based on the ELCI's funding proposals.

The ABC project comprises a project manager; nine CBW facilitators covering five beaches; ten youth peer educators; 40 cohorts, each with 22 members. This translates to eight hundred and eighty (880) intended beneficiaries to be reached. The ABC project invests Ksh.948 ($14) to reach one person with appropriate HIV/AIDS messages. Although there are differences across the various beaches where the project intervenes, these are not significant.

Table 5.1.2 Cost analysis based on the beaches covered[3]

Cost activity[4]	Dunga beach	Kusa beach	Kaloka beach	Usenge Beach	Nyamwar e beach	Totals (Ksh.)
Refreshments	825	825	825	825	825	4,125
Communication	300	300	300	300	300	1,500
Transport	200	600	600	400	400	2,200
Transport for two*160 sessions	12,800	38,400	38,400	25,600	25,600	140,800
Refreshment for 2*160 sessions	46,080	46,080	46,080	46,080	46,080	230,400
Equipment for 40 video facilitated sessions		4,800	4,800	2,400	3,200	17,600
Stationery for community certificates	7,000	7,000	7,000	7,000	7,000	35,000
Administration Expenses (apportioned)						
Stationery and photocopies	3,040	3,040	3,040	3,040	3,040	15,200
Communication expenses	2,400	2,400	2,400	2,400	2,400	12,000
Rent for 12 months @ 5000	12,000	12,000	12,000	12,000	12,000	60,000
Allowance for 9 facilitators @ 3500 *10 months	63,000	63,000	63,000	63,000	63,000	315,000
Total	150,045	178,445	178,445	163,045	163,845	833,825
Cost of reaching one person	852	1014	1014	926	930	948

The type of work carried out by the project CBWs would otherwise be done by a social worker either in the Ministry of Health or the Ministry of Social Services. Within the Ministry of Social Services, the District Social Development Officer coordinates activities and is located

[3] All figures quoted in Ksh.
[4] A number of assumptions have been made: Administration expenses have been given as single figures and therefore have been apportioned to the beaches equally. On calculating the cost of reaching one person per beach, we have assumed that each beach reached the same number of people [i.e 880 beneficiaries / five beach communities =176 people per beach community

at the district level. At the division level, there are the Community Development Assistants who provide services.

Within the Ministry of Health they are structured as indicated for KICOSHEP-K-K, below.

The social workers are within job group G or H. A group H social worker has a higher salary than a group G, earning between Ksh 11,622-15,588 per month.

Each facilitator (CBW) is paid allowances totalling Ksh 42,000 for 12 months (Table 5.1.3 above). A CBF (as they are called) is expected to reach 88 people per year (this includes the coordinator). If a social worker reached a similar number of people, it would cost the government Ksh 139,464 per year in salary (entry salary for social workers = Ksh 11,622 per month). For that amount, the project can pay allowances for three facilitators and reach more people. The travel expenses have not been considered as it is assumed that they will apply for both service providers. However, it is important to appreciate that the social worker has more responsibilities than the CBF.

5.1.3 Impact of the CBW project on policy and systems

The CBWs can be most effective where the policy environment is conducive, with support from community members, facilitating agents and donors, and where the projects are responsive to the needs of poor and vulnerable households.

Many African countries today have little or no local participation, decentralisation or local funds. Sub-Saharan Africa has the greatest centralization of development administration in the world. Accountability is poor, and very often it is only upward to donors and central governments, not downward to local people. Community development and integrated rural development have been tried in the past with disappointing results. The problem actually lies in the inability of central government agencies and donors to respond to local priorities and take advantage of local skills. Therefore there is an urgent need for African governments to look at these problems and come up with favourable policy changes which will ensure that CBWs contribute to development processes.

Under the prevailing socio-political and economic circumstances in many African countries (e.g endemic corruption and a lack of people -centred policies) CBWs can be a vehicle for the poor and the most vulnerable to organize around in order to gain access to services. As long as there is stagnant economic growth in real terms and service delivery is poor, community-based systems will act as a coping mechanism against socio-economic shocks in the communities. In most circumstances, CBWs are the only option.

Community-driven development (CDD) is a form of poverty reduction in its own right, as the process involves helping people improve their capabilities and functioning by enabling them to take charge of their own affairs. Economists now accept that communities have considerable capacity to plan and implement their own development programmes. Vibrant community structures constitute social capital, a much neglected asset that can yield high economic dividends.

In order for CDD initiatives to work effectively, the following dimensions must be given attention:

- **Empowering communities**: organizing to diagnose local problems, come up with solutions, identify priorities, elaborate action plans and strengthen the organization and accountability;

- **Empowering local governments**: through strengthening decentralisation rules, provision of untied aid, inclusion and representation through participation, and strengthening organisations and capacity;
- **Realigning the centre**: by shifting responsibility, focus on facilitation, standard setting, monitoring outcomes, provision of training, and providing rewards and penalties to improve local government performance;
- **Improving accountability**: to encourage downward accountability to users of services through information sharing and harmonising upward accountability mechanisms through clear rewards and penalties.
- **Building capacity**: to develop community capacity for problem solving, through learning and doing.

An important starting point is to harmonise and strengthen ongoing efforts to create community participation within countries that have weak or no local governments and the need to engage in a dialogue with stakeholders and donors on the merits and feasibility of decentralisation.

5.2 Pilot 2: Reproductive Health (Home-based care model)

The KICOSHEP programme in Kenya provides HBC services to 3000 clients per year. The programme's highest priority is to ensure that clients get the benefits of ARV compliance. KICOSHEP's efforts have seen client quality of life improve and have drastically reduced stigma. There is considerable acceptance of the CBW concept within the community.

According to the beneficiaries interviewed, the services provided by CBWs build the confidence of those who cannot or will not freely reveal their status. This, coupled with open discussion forums, has drastically reduced stigma against those infected by the HIV virus and subsequently increased the number of people seeking VCT services.

The health status of most of the beneficiaries has improved through the efforts of the CBWs. The following comments by some beneficiaries illustrate the impact of the programme on them:

"Our lives have changed extremely for the better …...Some of us were ailing most of the time with no medicine, but now we are no longer sick and our health is very steady... The caregivers mostly go an extra mile to bring drugs to us"

"Due to regular meetings on Thursdays, for group therapy among HIV positive persons, these have made us confident and we can talk freely without fear thus enhancing the quality of life.... In the case of serious illness, the caregiver takes the beneficiary to hospital, using all means available". (Evaluation of CBW systems in Kenya report 2007).

Before the CBW programme, according to the beneficiaries, *"We would just sit in the house and wait for a sympathizer and when sick one would go to a health centre, where you are not told anything concerning your status"*.

There were also some criticisms. According to some beneficiaries, they lack adequate care due to the small number of CBWs:

"*The service providers* (read CBW*) are very few in comparison with the beneficiaries, thus we are not well taken care of*"

Some of the beneficiaries said that their needs were meet by AMREF and Mbagathi District Hospital which also run HBC programmes in Kibera.

The CBW turnover rate is estimated at 10%. The few CBWs who leave the programme usually join other programmes where they continue to utilize the skills and knowledge they have gained for the benefit of local communities.

Many aspects of the system seem to be working well in the CBW project at KICOSHEP-K; for example, the freelance model that has been adopted works well. It provides flexibility with working hours enabling CBWs to offer their services according to their own time schedules. The training being provided is very appropriate to the needs of the CBWs. The income generation activity (IGA) training is a sustainability measure. Community support for the programme is very high as exemplified by the number of people wishing to join as CBWs. Weekly and monthly meetings with CBWs are very helpful to programme monitoring.

Table 5.2.1 below captures the core activities and gives statistics for work undertaken in one year, July 2005 – June 2006.

Table 5.2.1: Impact of KICOSHEP-K Kenya Programme July 2005 to June 2006

CBW numbers (active volunteers & hours worked)	
Number of active CBWs	60
Hours spent on CBW work	78,000
Activities within Households	
Grandmothers supported	25
Women supported with IGAs	708
Youth supported with IGAs	157
Orphaned children sponsored to high school	65
Children receiving education at KICOSHEP-K primary school	450
VCT tested clients	3,108
Child headed families	20
Clients served - PLWAs in Kibera	600
Referrals	
Referrals to AMREF, private (Coptic hospital), district and national hospitals	181
Treatment kits provided and replenished	50
Number of patients treated from treatment kits	407
Community wide activities	
1. Condom distribution	75,277
2. Training local leaders on HBC/stigma/discrimination	32
3. Palliative care training	20
4. Awareness through VCT outreach	43,200
5. Network meetings with other stakeholders	20

As can be seen from the table above, the KICOSHEP-K programme is quite active, However, there are challenges that need to be addressed. Firstly, the current remuneration of CBWs, payments of Ksh.1000,is only sustainable while the Centre for Disease Control (CDC) continues to provide these funds, although this threat of unsustainability is partly mitigated by the income generating activities (IGAs) that CBWs have started. Control of CBWs is a major challenge considering they are not formally employed. The CBW concept needs a lot of support from local administrators. like the administrative chiefs. Unfortunately, the concept is not recognized within the governance structures and therefore fragile. Every new Chief, for example, has to be briefed on the CBW system. Another issue was that the communities may not be able to adequately 'control' the CBWs because of the perception that they are accountable to the facilitating agent (FA).

Some caregivers also felt that they are not empowered or acknowledged. For example, one caregiver said, "*We really do work hard and people can't see that*." In a related complaint, it was argued that patients expect too much from caregivers, or that families rely on caregivers and stop providing care and want caregivers to do their washing and cleaning. A female caregiver noted,"*Once they know you are a volunteer, they think it is your responsibility to come every day to take care of their sick family member, even though you explained and taught them how to take care of the patient*."

Despite these challenges, the volunteer caregivers continue to provide services. When asked what motivates them, respondents spoke about wanting to assist their community, having aspirations to be a nurse, and caring about their patients. Many of the caregivers are HIV-positive or have HIV-positive family members and this has motivated them to care for other HIV-positive people. Caregivers also value the support from fellow caregivers.

5.2.2 Cost-effectiveness of the pilot

The costs of providing health care in Kenya were obtained from World Heath Organisation (WHO) statistics for the year 2000. Table 5.2.2 on hospital costs presents the estimated cost per hospital stay and per outpatient visit by hospital level. Unit costs are specific to public hospitals, with occupancy rate of 80% and representing the 'hotel' component of hospital costs, i.e., excluding drugs and diagnostic tests but including costs such as personnel, capital and food.

The table on health centre costs presents cost per visit for primary care facilities, i.e. health centres, at different levels of population coverage. It includes all cost components including depreciated capital items but excludes drugs and diagnostics. The results were presented in local currency units for the year 2000 by the WHO but have been adjusted to 2006 using the Kenya consumer price index and compounded for annual growth rate.

Table 5.2.2: Hospital costs in Kenya

HOSPITAL COSTS - Cost per bed day by hospital level	
	LCU 2006
Primary	452.63
Secondary	590.51
Tertiary	806.56
Cost per outpatient visit by hospital level	
	LCU 2006
Primary	121.71
Secondary	172.64
Tertiary	255.38

HEALTH CENTRE COSTS - Cost per visit at health centre by population coverage for a 20 minute visit	
	LCU 2006
50%	198.58
80%	198.58
95%	215.88

KEY: LCU - Local Currency Units
Population coverage - the percentage of population with physical access to primary health facilities, defined as living within 5 kms or 1 hour away from the facility

5.2.3 Comparison of cost-effectiveness with conventional models

To calculate cost–effectiveness, data from the Kibera project was used (Table 5.2.2). The Kibera - KICOSHEP project has ten CBWs who provide home-based care to 600 clients. The data shows that it takes KICOSHEP-K USD 9,018 to maintain the ten CBWs for one year. If the amount of maintaining the CBWs is divided by the number of patients attended per year, the cost per patient is **Ksh 85 per year**. In comparison, if the patient was admitted in a primary health care facility the cost would be **Ksh 452.63 per day**. From this comparison

it is evident that the cost of managing the patient at home is much less. If the patients are not admitted, but visit a primary health care facility as outpatients, the cost would be **Ksh 122 per day**[5] compared to the CBW cost of Ksh 85 per year. The government recognises that home-based care is cost-effective as it is advocating home-based care for HIV/AIDS patients as a way of reducing costs.

Since the CBWs work on average 5-6 hours per day, it implies that on average the CBW works for about 30 hrs per week (6 day week, five hours daily). In one year, the 10 CBWs will therefore work for at least 15,600 hours. If these hours are divided by the cost of HBC, a HBC hour will cost Ksh 39. In contrast, a 20 minute consultation in a primary health facility costs Ksh 118[6]. This is 9 times the cost of a HBC consultation for the same length of time.

Table 5.2.3: Costs of sustaining HBC services for 10 CBWs (Kshs)

Type of cost	Monthly costs	Annual cost	One time costs	Total
Salary (PM)	25,000	300,000		325,000
HBC kit			70,000	70,000
Technical training (CBW)			102,000	102,000
IGA training (CBW)			1,800	1,800
Replenishing kits	3,500	42,000		45,500
Stipend (CBW)	1,000	12,000		13,000
Running costs	2,000	24,000		26,000
Communication	500	6,000		6,500
Food allowance	1,000	12,000		13,000
Transport	300	3,600		3,900
Food (clients)	500	6,000		6,500
Total (Kshs)	**33,800**	**405,600**	**173,800**	**613,200**
Total (US$)	**497**	**5,965**	**2,556**	**9,018**

5.2.4 Impact of pilot on policy and systems

Community-Based Workers are recognised by the Ministry of Health as part of a multi-disciplinary home-based care team that can handle the physical, social, psychological, and spiritual needs of care recipients[7]. Health workers from Mbagathi Hospital, which is the closest public facility offering home-based care, often refer clients to KICOSHEP-K, an indication of recognition of the CBW system by government. However, these efforts have not resulted in any policy or system shift presumably because CBW thinking has not been adequately and widely understood and documented. This process has started with the 4-country CBW project and there are indications that in the very near future there will be an impact on policy and even systems.

[5] This does not take account of travel time or transport costs to get to the health centre and other costs eg meals
[6] Not sure how this figure was reached??
[7] National home-based care policy guidelines

5.3 Pilot 3: Community- Based Animal Health Workers (CAHWs)

5.3.1 Impact of pilot

WASDA has so far trained 140 CAHWs, of which 80 are still active and work with the veterinary department. The other 60 relocated with their livestock to other districts within the country and even to Somali and Ethiopia, where it is hoped they continue to use the skills gained.

The WASDA CBW programme has succeeded in empowering communities by involving them in addressing their animal health problems. This has improved and increased the skills base in the communities, besides contributing to building community structures (like committees), that address animal health and other problems. Good linkages to professional services have been created in the process including rapid response in emergency situations. One important success is a gradual change in negative cultural practices like livestock rustling.

The impact of the pilot on beneficiaries is not easily quantifiable. 1050 persons from seven pastoral associations have benefited from the programme in one or several ways.

Benefits to the community include:

- Information and training: CAHWs receive initial training based on their needs and wishes and their existing knowledge of livestock diseases and resource management. They also receive follow- up workshops where they are updated about new drugs and have the opportunity to get queries answered. The knowledge received is passed on to the community;

- Decision making has become participatory: Through WASDA, CAHWs have regular meetings to make various decisions that affect them. Through different community social groups. for example the Camel Forum, the whole community is involved in decision- making;

- Gender sensitization: Gender issues have been incorporated in WASDA programmes to bring on board women's rights and their reproductive health issues;

- Access to services: The decentralized animal health system has improved livestock owners' access to veterinary services and drugs in rural areas where government services have totally broken down or were non-existent; CAHWs even moved with the livestock during migrations of the pastoralist communities;

- Affordability: the services provided by CAHWs are more affordable to livestock keepers than those provided by government veterinarians;

- Linkages to other services; WASDA is offering other health services such as TBAs, and services relating to HIV/AIDS. The CAHWs are now being used to bring these services closer to the community.

Benefits to the CAHWs include:

- The CAHWs were given a three week training based on the guidelines developed by the Kenya Veterinary Board (KVB), and were supplied with drugs kits. WASDA has also constructed drugstores in permanent locations, which act as a source of drugs for the trained CAHWs;

- CAHWs have improved income generation and heightened social status. Proceeds from drug sales and services have improved the living standards of CAHWs and the community regards them as 'well-off'. WASDA does not set a standard fee rate for CAHWs to charge clients, CAHWs revealed that they charge higher fees in more remote areas than in areas closer to urban centres or that are more accessible.

Benefits to service providers include:

- An opportunity for veterinarians in private practice as they can work through a network of CAHWs (as is the case with the Private Pastoral Veterinary Practice at Kapenguria);
- The CBWs have enabled the government to improve its disease surveillance and control and increase coverage of vaccination programmes due to the assistance of the CAHWS whom they use for community mobilisation. Currently the government is putting in place a community-based early warning system which makes use of CAHWs.
- Organisations involved in conflict resolution have also used CAHWs to address the problem and enhance sharing of natural resources among warring communities.

Throughout the pilot project a number of factors were seen to contribute to its success including:

- participation by the community in programme implementation;
- increased awareness of and claiming of rights by beneficiaries;
- improved links to professional services;
- acquisition of skills through training and involvement;
- improved revenue collection and management of facilities;
- improved community decision making and advocacy;
- a defined role for the CBWs;
- change of cultural attitudes that were anti-developmental.

However there were constraints too that included:

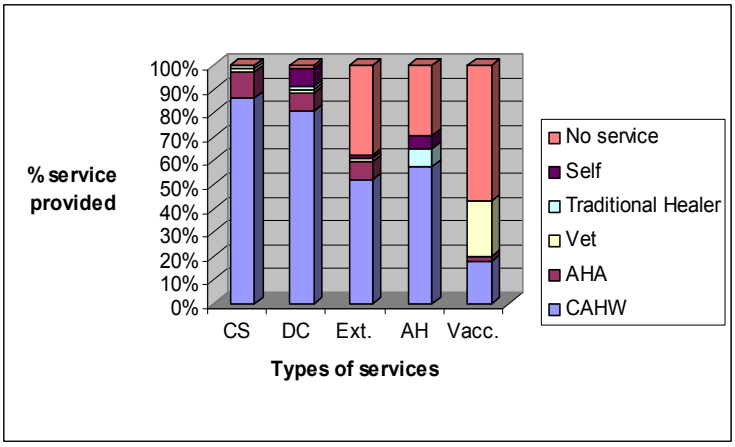
- a poor resource base for the CBWs to thrive;
- loss of CBW personnel affected by periods of drought and a consequent need to change location;
- high expectations from implementing agencies of what a CBW should be able to do;
- vast distances and rough terrain to cover to reach beneficiaries;
- intermittent localised conflicts;
- recurrent drought hampering restocking;
- high illiteracy rates and conservative cultural attitudes.

5.3.2 Cost – effectiveness of the pilot

The conventional animal health service delivery model consists of a veterinarian based at the district headquarters, with a few para-veterinarians (diploma or certificate level) to support him/her. It was not possible to compare the costs of this conventional approach to an approach which used CBWs for a number of reasons. Firstly, the costs of training and managing a CAHW were not available from WASDA. Secondly, the conventional service is not available in ASALs, which is the main reason why the CAHWs operate and have gained such prominence in these areas. This is supported by research data from Njoro JN (2006), showing that CAHWs provided 80% of the clinical services and 75% of the disease control

services in Makueni district, while veterinarians were only visible during vaccination campaigns. The main source of animal health services is therefore CAHWs.

Figure 5.3.2 Types of services provided by Animal Health Service providers



Key: Clinical Services (CS), Disease control (DC), Extension (Ext), Animal Husbandry (AH), Vaccination (Vacc.); Source: Njoro JN (2006)

What is clear is that the government veterinarians located at the district level use the CAHWs to do the field work and report to them. The government officers are therefore playing a regulatory and coordination role and carry out vaccinations while the CAHWs do clinical services and extension work. The cost of services in the high agricultural potential areas where there are enough veterinarians and para-veterinarians is not comparable to ASALs which are vast, with poor infrastructure and where the cost of providing a service is very high. Where private practices exist in the ASALs, the private veterinarian works with a network of CAHWs who buy drugs from the private veterinarian and either administer or sell for a fee. The network provides the veterinarian coverage which would otherwise be too costly and literally impossible.

5.3.3 Impact of the CBW project on policy and systems

The CAHW system has been integrated in the ASALs as the veterinarians in those areas recognize and accept the work that CAHWs perform. Several policy documents also recognize the system as the only way to provide cost-effective services to the ASALs. However, the system is still facing resistance from some veterinary professionals who argue that it is risky to the industry and instead propose employment of more para-professionals or professionals to provide services in the ASALs. However, this may not be feasible owing to the harsh realities of ASALs. The WASDA CBWs leverage on weaknesses of the conventional /specialist system, which include low coverage as a result of inadequate staffing, unavailability and reluctance to work in remote and underserved areas.

PART D GOOD PRACTICE AND WAY FORWARD

6 Good practice emerging from the models

6.1 Revisions to the model

Implementing partners involved in the piloting phase agreed to make modifications to their way of working. Each piloting partner was asked to indicate the elements they will change or incorporate. Table 6.1 is an example and summarises KICOSHEP's work and elements to be modified.

Table 6.1 Elements to be piloted

Area of concern/ research focus	Current practice of implementation	Proposed changes or adaptation in the pilot
Who are the CBWs?	Three types of volunteers: **Caregivers** - trained by KICOSHEP; **TBAs** and **Volunteers** – from the community, assist, identify and support the caregivers	Integrating the work of care givers, volunteers, TBAs, CHWs, CBDs. specialists in family planning matters, grandmothers and teachers to provide a comprehensive approach to care and prevention.
How are they selected e.g. what criteria used and who selects them?	Selected from the community by chiefs/village elders – KICOSHEP requested a certain type of person using specified criteria	Community participation in selection e.g. village elders. Care givers and families involved in programme to recommend who to include. KICOSHEP will assist in developing selection criteria and guidelines – e.g. confidentiality, use of role models i.e. PLWHAs.
What work do the CBWs do?	• Caregivers train families on care and support, assist bedridden clients with bathing and all necessary care. • Volunteers – experiential - give education, sharing of positive living – many PLWHA. They do mobilization in the community. • TBAs give education on HIV/AIDS and health related matters; make referrals to other agencies and health centres and provide care and support to PLWHAs.	• Emphasis on care and support of PLWHAS, - caregivers are assigned 42 households on average; the affected and grandmothers who are caring for OVCs, and may also be infected themselves (IGAs). • TBAs – more specialist in PMTCT. • Include family members as central to service provision and care and support for the patients which is a sustainable approach in the long term.
What hours do they work?	Two hours daily fixed from 10 am-12 noon/day = max. 10 hrs per week.	• Flexi-time based on community needs – linked to wellness of clients This also allows CBWs time for their livelihood activities. • Work closely with family members to ensure sustainability of the process especially for ongoing care. • Issue of specific time not visible to establish – e.g. TBAs cannot determine length of labour (per delivery).
Who is the facilitating agent and what	KICOSHEP coordinates and identifies linkages with other service providers.	• Spot training based on challenges and needs identified. • Increased monitoring of CBW work and

Area of concern/ research focus	Current practice of implementation	Proposed changes or adaptation in the pilot
is their role?	Training – follow up meetings to assist in problem solving unit – specific support agencies e.g. community collect garbage, local municipality takes away.	evaluation at the end of the year to see whether they are still motivated with the work. Also dialogue between KICOSHEP and volunteers on their expectations of the FA, their vision of how the programme can be sustained beyond KICOSHEP engagement. • Diversify scope of training and link CBWs with other agencies and organizations providing training. • Empowerment of communities to establish own CBOs with KICOSHEP as link to them.
What support does the facilitating agent provide?	Meeting and follow up of clients in their homes.Provision of a small stipend or grants to care givers to implement an IGA project.	Meetings with clients' relatives and caregivers and community organisations to support them with the necessary items such as HBC kits. Linking them to government and other service providers. Organise care givers' conferences to exchange ideas. More focus on family training to provide ongoing support. Involve community and clarify roles that the community can play; spiritual support through links with FBOs - there are clergy attached to the project. Home-base care very comprehensive – home-based; palliative and spiritual guidance.
What training do CBWs receive and how frequent is it?	Training on HIV/AIDS and health related matters	• IGA skills and management to be self reliant and as a way to empower volunteers to sustain their livelihoods. • Counselling, psychosocial support, savings and credit, KICOSHEP provides start-up grants for IGAs and sometimes food for bedridden patients – through 'the friends of KICOSHEP'. • Intensify health training and leadership skills to enable CBWs to manage the programme themselves beyond KICOSHEP. • Where more than one FA involved in working with same volunteers explore potential for dialogue to arrive at consensus on shared values
What ongoing support and supervision do CBWs get and from whom?		• Link CBWs through a network of volunteers from Eastern and Nairobi Provinces to share, report and celebrate together. • Six VCT centres, site offices and main office and staff who constantly monitor and support. • Work towards establishing a hospice for the region – training others.
Who are CBWs accountable to?	KICOSHEP	• KICOSHEP – receives weekly and monthly reporting from caregivers about the visits to the households. Also on a daily basis they present data for referral to key hospitals. Implement a waver system

Area of concern/ research focus	Current practice of implementation	Proposed changes or adaptation in the pilot
		for those who cannot pay hospital bills. CBWs write the letter which is approved by the site office staff. • Community – strengthening different interest groups, e.g. grandmothers to work as support to each other. • A community meeting every quarter to report on achievements and challenges etc.
Who has the powers to hire or fire CBWs?	None	• Community through above own interest groups have power to recommend and choose therefore can fire if not satisfied. / KICOSHEP – training in leadership skills Issue: Who has responsibility for these volunteers and how do they perceive themselves in relation to the FA? Are they an extension of KICOSHEP staff and what are the legal liabilities – e.g. if involved in a road accident while on KICOSHEP duty? How long can they continue doing this work for free?
What type of incentives do CBWs receive (monetary/in-kind)?	In kind such as clothes and food – this is not sustainable – Grants to establish IGAs for care givers; kits with surgical gloves and masks for those working with TB patients, etc	• Monetary, 1000/= some care givers – those involved in care and support per month; In kind – materials (Kits, t/shirts, badges, bags, gumboots, rain coats and umbrellas; food parcels once every month as motivation for hard work; end of the year honouring of volunteers by providing them with gifts. • Now strongly believe volunteers should be compensated with monetary incentives and exploring option of income generation activities as a way of motivating volunteers.

KICOSHEP-K initiatives appear to have evolved over time with many of the above elements incorporated into its work. The CBWs for instance now work flexi-time so that they can respond to emergencies which can occur at any time.

In WASDA, one development is that CAHW selection has now been harmonized with the requirements of the minimum standards curriculum and the guidelines for training CAHWs that were developed by stakeholders. The self employment model is also being appreciated and CAHWs are no longer seen as volunteers. The CAHWs are also working in closer collaboration with the government.

6.2 CBWs and selection

In the past, selection was often done without adequate community involvement causing programmes to founder. However, in all three pilot projects studied, community involvement in the selection of the relevant workers was followed. This process ensured that the "*best* person for the job" (from the community's perspective) was selected. This obviously created a sense of ownership from the outset leading to an increased likelihood of sustainability of the system.

6.3 Work of CBWs

Two of the pilot projects focus on health delivery and support for people suffering from or affected by HIV/AIDS, and the third one focuses mainly on animal health. All of them work in previously underserved areas and at grassroots level. They are filling a critical gap in service provision.

6.4 Training, support and supervision

The CBWs within the three projects were provided with the necessary training to enable them to provide services up to a certain level beyond which they had to refer or seek support. This was particularly so for KICOSHEP-K and ABC-Kisumu. They required constant supervision from the facilitating agents as well as occasional refresher courses to maintain a certain level in the quality of care.

6.5 Linkages to other support agencies

Most of the pilots have links with other support agencies, for example KICOSHEP-K is a member of KANCO (Kenya AIDS NGO Consortium), a consortium of several NGOs working in the HIV/AIDS sector. KANCO members refer HIV/AIDS clients to KICOSHEP-K for care and in some instances seek technical support. Besides, KICOSHEP-K has strong links with government through Mbagathi District Hospital, the local hospital, which runs a conventional HIV/AIDS care system. KICOSHEP-K refers clients to the hospital for supplies, care and hospitalisation. WASDA has maintained links with the district government veterinary departments for supplies and technical support as needed.

6.6 Accountability

CBWs are in the difficult position of having multiple accountability - to the facilitating agents, to the communities they work in, and to donors. All CBWs interviewed said they were first and foremost accountable to the facilitating agents. This had worked well as the FAs provided both support and supervision. However, it poses a threat in the event that FAs fold or change their focus, a threat that is currently apparent in ABC-Kisumu project with the project widening its geographical focus to all East African countries. The situation is different in WASDA where CAHWs are paid by the individual farmer to whom he or she provides a service.

6.7 Financing of the CBW system

In KICOSHEP-K the CBWs are provided with a monthly stipend, which is donor supported and therefore unsustainable. However, the workers have been provided with income generation skills and initial monetary support to start income generating projects. So far these seem to be working well but cannot be considered a sustainable mode of financing a CBW system. In WASDA, the scenario is different as the CBWs charge a minimal fee for services rendered which is probably a more sustainable arrangement. Programmes need long term funding if they are to provide appropriate services to their communities. Clients will expect service delivery, especially health care as long as they need it and there needs to be continuity in service provision. Longer term funding will allow HBC programmes to plan for the future and strengthen their programmes. Funding needs to be matched by community contributions. The contribution of HBC to the quality of life/care of clients should be quantified to secure donor and other funding.

6.8 Sustainability

In each of the three pilots, sustainability mechanisms seem to be emerging. This was strongest in WASDA where there is a workable financing mechanism. In KICOSHEP-K, the scenario is different because the facilitating agent is more central to the operations of CBWs. The threat lies in the event the FA decides to pull out or change focus or donor fatigue sets in as a result of which the CBW system will weaken or even collapse.

7 Reflections on the way the action-learning project evolved

7.1 The challenge for the steering committee

This project was an action-learning project. This means that a large component of the process was not formal statistical research but the coming together of role players in workshops to debate issues and learn from each others' experiences. It is therefore appropriate here to reflect on the action-learning process.

The National Steering Committee (NSC) in each country was the overall project management organ driving the country CBW project process. It's membership was drawn from policy makers, implementing agencies and facilitating agencies in the natural resources and HIV/AIDS sectors. It's role was to guide the process and also to make sure that the findings were heard at policy level not just at an organisational level.

Initially, the NSC consisted of 11 partners but at the time of this evaluation, only eight organisations were actively involved in the CBW learning process. Part of the original thinking was that the NSC was to devise a method to expand the stakeholder base to involve many more organisations across many sectors in the whole country. But this did not materialise. The main reason was that organisations from one sector were not easily convinced that they could learn from the concerns affecting CBWs in a different sector. They therefore didn't find common areas in the CBW project process.

The NSC had a chair and was supported by a secretariat. Initially, the secretariat was run by the Community- Based Livestock Programme (CLIP) office. However, concerns started to emerge when the CLIP office wound down and it was handed over to Practical Action – East Africa to host the secretariat. The functioning of the secretariat is critical to ensure that the NSC work together and coordinate in-country activities by various partners. A lot of thinking and work had to be put in to make such a complex programme workable given the involvement of remote projects such as WASDA and multi-country communication and coordination. In such an initiative, the secretariat needs to be a lead agency in the approach being advocated to motivate others and to provide direction.

7.2 Sharing across countries

Experiences were shared through a range a strategies including national workshops and visits to other countries implementing the CBW initiatives. Learning was continuously fed-back into policy and practice in relation to service delivery.

An evaluation of the three pilots to gauge the impact and cost-effectiveness of the CBW system in the two sectors was conducted between October and December 2006. This was shared across in-country partners at a national workshop.

7.3 Cycle of events/learning in the project

Project design should be matched with adequate financial resources, institutional structures and the capacity to support it. Inconsistency in documentation and planning processes involving the CBWs has been a major concern. There were high expectations from the CBWs even though funds allocated were insufficient. It is therefore not surprising that there is a high turnover in these systems due to lack of consistent funding allocation.

The initial phase of this action-learning research was weak, particularly in understanding how the project was conceptualised. There was an improvement later with decentralisation of the

budget allocation from Khanya-aicdd to local partners through the secretariat and after the project manager's review visits, it became clear what pilots were to do.

Piloting organisations then started considering the CBW project as providing them with an opportunity to improve practice and they paid more attention to their internal documentation so that they could share best practices. This enabled some of them to leverage funding from donors, for example ABC-Kisumu (see box below).

As part of developing good practice, all the partner organisations have started to consider documentation and knowledge sharing as integral to influencing policy and advocacy. However, fast tracking CBW project activities in their institutions was late.

7.4 Role of the project manager

The project manager provided a backstopping role. He used various ways to ensure in-country sharing was happening and that the project outputs were smoothly achieved. Regular communication and contact with partners through phone calls, email, teleconferencing and workshops enabled concerns to be expressed regarding the CBW project process in Kenya.The project manager also provided support and assistance with financial management of the project,

8 Recommendations

8.1 Emerging role for CBW systems

This action-research has provided evidence that **t**he CBW system is filling crucial gaps in public service delivery and has the potential to improve development initiatives on a large scale. Some of the emerging roles for a CBW system would include:

- **Enhancing local government accountability:** The CBW system increases local government accountability which is an essential part of the decentralisation process. The use of public disclosure, participatory approaches, sanctions, and transparent and objective criteria has contributed to restoring communities' faith in public institutions, while they appreciate their (communities') role and responsibilities in public investment. This case is illustrated through the devolved constituency development funds (CDF) and local authority transfer funds. (LATF)[8] Improving the CBW system, and aligning it with formal government systems can increase effective supervision, accountability, local capacity building and production efficiency. Once communities and local governments demonstrate their ability to handle funds effectively, resources should be decentralised. This is already happening within the CDF allocation system.

- **Efficiency of public resource allocation:** Local planning through CBW systems can increase efficient allocations by encouraging all communities within a district to express their preferences, as opposed to the few communities whose views are expressed through isolated participatory planning exercises.

8.2 Recommendations

- Build accountability to communities. For example, CBWs must be chosen by their communities, with minimal manipulation by influential lobby groups;
- CBWs must have an effective supervision and support system that facilitates their work;
- Government must promote the development of accreditation and standardised training tools through relevant ministries and agencies which are in line with set national policies;
- Government must address licensing, registration, commission, standardization of incentives, regulation and policy frameworks;
- Government is responsible for ensuring service delivery is available at community level. This means the government should provide the financial resources to support CBW systems;
- Mainstream CBW activities within service delivery, e.g. CAHWs as a cadre of animal health care;
- Regulate, register and license NGOs in order to ensure effective civil society participation and ownership in the long-term;
- Forge links with service providers through referral systems e.g. KICOSHEP-K refers clients to Mbagathi District Hospital;
- Recognise and support the important role of NGOs who are instrumental in sourcing project funds, developing training programmes and providing management for many CBW projects;

[8] CDF funds are accessed from the constituencies through the leadership of the local member of parliament and a local community committee. LATF funds are funds for local development disbursed through the local authorities. The funds are for local development projects.

- Recognise and enable the private sector in providing financial and credit facilities to organisations and private practitioners providing services for a fee.

8.3 Changes in policy and legislation needed

Evidently the operations of CBWs are not completely in tandem with the policy framework in Kenya. Even with the efficacy of CAHWs as a service delivery intervention in the marginal pastoral areas, CAHWs operations are still considered illegal as far as policy and legislation is concerned.

There are false impressions created by professionals that support for CBWs will compete with their operations and will also compromise standards. While there is evidence that CBWs improve access to service delivery, there is none showing that the quality of these services is compromised. A lot of writers have, however, shied away from documenting the efficacies of these systems for rural development. But lack of evidence should not be used to block policy support for the CBWs.

While the government does not make mention of or explicitly support the CAHW system, there is tacit support from the practitioners in the field. A silent 'do nothing about it' policy environment exits. This has enabled the CAHWs and is now having some influence in the policy formulation environment. CAHWs fit well into the present privatisation of veterinary services, which is sustainable as long as the community pays for the services and where the CAHW system has become a mobilisation tool and an entry point for many other initiatives.

With the AIDS epidemic being so severe, the extent of the need for care has made innovative approaches vital. There is a continuing need for the care concept to link contributions and resources from the public health system with other approaches e.g. home-based care. Community-based care is able to boost the quality, scale and sustainability of the care effort.

8.4 Way forward

The CBW project has created the necessary social capital in the country. There is increased understanding of the community–driven development approach. Partner institutions have gained from the action-learning and sharing through meetings, workshops, and documentation of good practice.

However, the lack of a supportive policy and legal environment, coupled with inadequate funding of community- based service delivery systems, is holding back wide scale delivery. Institutionalising the community-driven development paradigm remains the biggest challenge in Kenya. One way to address this is to ensure improved targeted advocacy programmes for CBW systems. The current national steering committee is a legacy of the project which can be utilized as a working group to take this lobbying process forward. There is an urgent need to develop national Guidelines on CBW systems that will help and assist in mainstreaming the outcomes and scaling up CBW programmes. This is the task that remains for completion of this three year long action-research programme. The final steps of the programme are outlined in section 8.5.

8.5 Action plan for Kenya

Activity	Action	Undertaken by…	Completed by (2007)
Reports	New Secretariat	KICOSHEP-K	Current
	Evaluation Report	Stephen	April 20
	Complete Final Country Report	J Njoro & S Mogere	April 26
Meetings	Monthly Meeting	NSC	April 26
	Country Planning Session	J Cornwall	April 26
CBW Guidelines	Development of concepts related to plan	Steve, Joyce and John	April 26
	Develop Country Guidelines	Joyce +	July
	Finalise individuals to assist in writing guidelines – in Animal Health	Joyce	Mid June
	Develop guidelines for implementing CBW models including generic scope of practice and M&E	Specific people led by Patrick	9-13 July
Regional Workshop	Do initial concept and circulate	Patrick	8 June
	Identify venue and get quotes	KICOSHEP-K	31 July
	Finalise who attends (policy makers and practitioners) from Kenya	NSC	15 June
	Conduct the regional workshop	Khanya–aicdd and partners	10-13 Sept
	African Palliative Care – conference in Nairobi	NSC representatives & Khanya	19-21 Sept

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