(A)

THE DECLARATION OF ALMA-ATA

I. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II. The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

III. Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

IV. The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

V. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

VI. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universal accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

VII. Primary health care:

1. reflects and evolves from the economic and socio-cultural characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experiences;

2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of proper nutrition, an adequate supply of safe water and basic sanitation; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works and communication, and demands the coordinated efforts of all those sectors;

5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability to communities to participate;

6. should be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

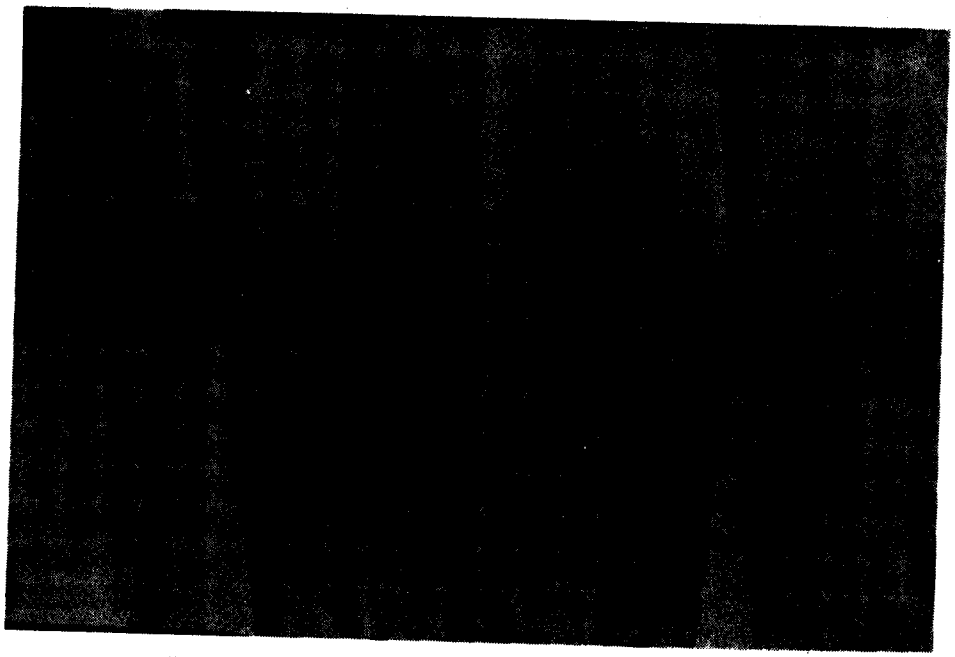
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

VIII. All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

IX. All countries should cooperate in a spirit of partnership to ensure primary health care for all people since the attainment of health by people in any one country directly concerns and benefits every other country. In this context the joint WHO/UNICEF report on primary health care constitites a solid basis for further development and operation of primary health care throughout the world.

X. Any acceptable level of health can be attained for all the people of the world by the year 2000 through a fuller and better use of the world's resources, a considerable part of which are now spent on armaments and military conflicts. The promotion of disarmament and detente could release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care is an essential part.

The International Conference on Primary Health Care calls for urgent and effective international and national action to develop and implement primary health care throughout the world and particularly in developing countries in a spirit of technical cooperation and in keeping with the New International Economic Order. It urges governments, WHO and UNICEF, and other international organizations, as well as multilateral and bilateral agencies, nongovernmental organizations, funding agencies, all health workers and the whole world community to support national and international commitment to primary health care and to channel increased technical and financial support to it, particularly in developing countries. The Conference calls on all the aforementioned to collaborate in introducing, developing and maintaining primary health care in accordance with the spirit and content of this Declaration.



CHWs Map Of Coverage

(C)

CBHC PROGRAMMES IN EAST AFRICA

(With which the SU has some acquintance)

(Some not yet operational)

PLACE	COUNTRY U	K	T
Buhungu	✓		
Bubonjo	✓		
Busabaga	✓		
Bushenyi	✓		
Busuyi	✓		
Chogoria		✓	
Enkorika			
Gulu	✓		
Hanang			✓
Kabras		✓	
Kololeni		✓	
Kamweleni		✓	
Kappedo		✓	
Kapsowar		✓	
Kasanga	✓		
Kibwezi		✓	
Kiparaman		✓	
Kisii		✓	
Kisumu (Cath)		✓	
Kisumu (AKF)		✓	
Kitgum	✓		
Kitovu	✓		
Kiyinda	✓		
Litein		✓	
Lokichar		✓	
Lwak		✓	
Machakos		✓	
Manyata		✓	✓
Marigat		✓	

PLACE	COUNTRY U	K	T
Maseno (S)	✓		
Masa		✓	
Mbale	✓		
Mbarara	✓		
Mityana C of U)	✓		
Mt. Kenya E		✓	
Mushanga			
Mukumu		✓	
Mvumi			✓
Nangina		✓	
Orhum		✓	
Rhamu		✓	
Rombo		✓	
Rusinga		✓	
Saradidi		✓	
Tigania		✓	
T-4 (Ngoara)	✓		
Tiriki		✓	
Undugu - Uhoan		✓	
Totals Sept. '83	U 15	K 31	T 3

In Sudan CBHC is designed to be an intergral part of the function of every government facility. In addition there are a number of special CBHC programmes within the NGO framework there.

(B)

RECIPROCAL RESPONSIBILITIES IN COMMUNITY-BASED HEALTH CARE

A sense of responsibility is the "glue" which holds CBHC together - the CHW is the catalyst of that glue.

TOPIC	RESPONSIBILITIES: LOCAL FORMALLY TRAINED PEOPLE	LAY SOCIETY	THE INDIVIDUAL
FOOD	- educate while treating - emphasize the nutritious food they have	- self-survey of malnutrition - compare with other places - find cases - explain those cases	- attend MCH Clinics - start weaning early enough - stop weaning late enough - don't sell the food children need
WATER	- know practical local facts - give practical suggestions - balance material help with moral pursuasion - don't wait for ministry	- think - listen - look/compare - try something - don't wait for ministry experts	- think - listen - look/compare - try something - don't wait for PHT
WASTE	- explain understandably - demonstrate - try being helpful before starting "askari" action	- discuss a common technology - cooperate on materials - start with schools and markets - discuss common expectations	- smell, look and think at home - ask and look at others - try to copy model - set family expectations - don't just wait for PHT
MOTHERHOOD (+ Fatherhood)	- peripheralize ANC and MCH Clinics - raise priority of mobiles	- see that ANC and MCH Clinics are properly patronized	- be faithful to Clinics - train your children
CCCD (Control of Common Communicable Diseases)	- have a disciplined cold chain - monitor OPD statistics - be heard at barazas - look beyond the dispensary - innovate, expand, use volunteers	- attract and use Clinics - organize people and set rules - facilities - set community objectives - openly discuss un-wed and un-controlled fathering	- be faithful to Clinics - keep good family records - understand " " - discuss " " - report cases and obey rules - don't just wait for "Miss-conceptions" in your family

HOW TO START

Community-Based Health Care

20 Suggestions from the Community Health Worker Support Unit at AMREF

DRAFT

20 FIRST STEPS

DETAILED DISCUSSION

1. **VISION**

It requires only one person to have vision. That person can be anyone. That person should support their vision with some reading and some visiting. The reading may be "Where There is No Doctor", HELPER newsletter or reports about workshops. The visiting may be to an active Community-Based Health Care programme. This may be arranged through the Support Unit at AMREF.

2. **PRIVATE DISCUSSION**

The inspired and informed individual then discusses the idea with neighbours. She/he should discuss it with a variety of people: old/young; male/female; rich/poor; medical/non-medical; official/non-official etc. These people must ask themselves questions like this:

a) Do we feel keenly about any health problem?
b) Is that problem solvable?
c) By villagers?
d) Do villagers have the will to work together?
e) Do villagers have good leadership?
f) Who could we get to help with training?
g) How much voluntary (no pay) help can we expect from villagers?
h) What could the village-together-do for gratuity for health workers?
i) Will people listen to a slightly trained neighbour?
j) Will this neighbour's words produce changed actions?
k) What about money and equipment?

If this small interest group do their "homework" well the Chief or Sub-Chief will be willing to call a baraza.

3. **First BARAZA (Sensetization)**

The Community should hear a brief simple explanation of the main ideas:

a) We have specific problems such as .....
b) These problems can be stopped by the village changing its habits.
c) These changes of habits can be promoted gradually by neighbours who get a little training.
d) The whole thing concerns villagers (CHWs) helping their neighbours to help themselves to stay healthy.
e) There is almost no money or dawa involved.

The question before the baraza is not "What Will We Get?"

No. The question before the baraza is "What Will We Do?"

If the community seems ready in spirit to try the path of self-reliance, the leaders can arrange appointment of a small Committee. Those chosen must be people who get things done.

4. ORGANIZATION

The Committee organizes itself with chairman and secretary. They get in writing what their objectives are and their authority for pursuing these objectives.

5. INVESTIGATION

They share out responsibility for digging out answers to these questions:

a) What are the main self-solvable problems?
b) What people as CHWs would be the best motivators of improved habits?
c) How many needed to cover this village at 1 to 1,000?
d) Are these people available?
e) What about zawadi?
f) What is the best method of training?
g) Who locally has this skill or could be sent to find it?
h) Who, specifically would give them medical back-up?
i) How, specifically would the Committee give them administrative back-up?
j) How Health Committee relates to local health facility.
k) Health Committees part in training.
l) What demographic data is available?

6a. SECOND & THIRD BARAZA (Evaluation-Decision)

The Health Committee reports to baraza, explaining their findings and recommending a plan of action. This plan would specify WHO? WHEN? HOW? WHY? WHY NOT? WITH WHAT? etc. The baraza will then recess for a week. This week is for personal thinking and private group discussion of the plan. In particular villagers must be thinking about WHO should be the CHWs and nominating such people to the Committee.

b. At a re-convened baraza the Community must:

a) agree to the Committee's plan
b) approve Health Committee selection of CHWs
c) make commitment to actively support the plan

Also there must be agreement on the area chosen for the first (pilot) programme - a sub-location.

7. ORIENTATION

The Trainer and local health worker (may be same person) gives trainees orientation to their role. Might even take them to visit an on-going programme somewhere else. Back home the group agrees on which CHW is covering which part of the village.

8. PLAN SURVEY (Baseline)

A very simple survey form is designed by the "team" (CHWs, Health Committeemen, local Medical Worker and Trainer). The survey form must be appropriate to the CHW's abilities. Its purpose is to enable the CHW to start her/his training with a clear understanding of her/his defined area (people, problems, distances, etc.) The Support Unit at AMREF has a model CHW survey to borrow ideas from. One of the most important parts of this exercise is the designing of the tables on which the survey data will be tallied for analysis. The survey should ask only for information which has a place in a table. Dont ask for what you wont use. The form must be field-tested repeatedly before final printing.

9. SURVEY

The survey itself should be run as a Community exercise. Even though only a sample may be interviewed, everyone should feel that the survey concerns them.

10. ANALYSIS etc

The results of the survey are tallied, collated and then analyzed. From this information the team can decide which problems deserve highest priority in CHW training. They should also agree on what specific changes they expect could be achieved by the end of one or two years. These expectations should be written clearly as objectives to try for.

11. 4th BARAZA (Presentation etc)

A baraza reports to the whole Community what "their" survey showed and what the Health Committee hopes the community can do about it in future.

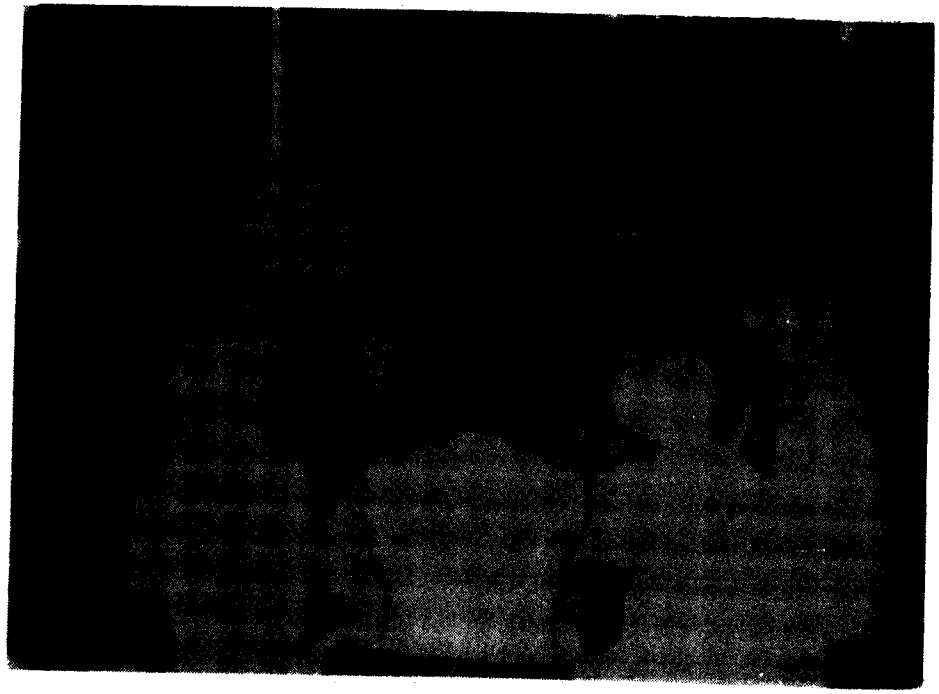
12. TRAINING

With this foundation of facts and hopes the CHWs start their training. Training should be led by someone experienced with CHWs. It should be carried out right in or near the village. Effective communication is the most important skill taught in the training. Next comes evaluation. See Support Unit papers for more detailed discussion of training.

(E)

TOT COURSES

NUMBER		DATE		PLACE	APPROX. NO TRAINED
Kenya 1					
	a	May	1980	Sagana	
	b	Nov	1980	Nairobi	
	c	March	1981	Kitui	31
Kenya 11	a	Aug.	1982	Nakuru	
	b	Nov.	1982	Kakamega	
	c	Feb.	1983	Ahero	25
Kenya 111	a	Sep.	1982	Kakamega	
	b	Dec.	1982	Mosoriot	
	c	March	1983	Mbale	14
Uganda 1					
	a	June	1982	Bushenyi	
	b	Jan.	1983	Kagando	
	c	May	1983	Masaka	25
Tanzania 1					
	a	Sept.	1983	Mvumi	
	b	Dec.	1983	Mvumi	21
Kenya 1V					
	a	Nov.	1983	Tigoni	40
				Total	156



"FACILITATING" A TOT COURSE

(F)

COMMUNITY SURVEY

Name of CBHC programme ..... Date: .....

Name of Surveyor: ..... Location | Sub-location | Household

Name of head of house ..... Son/wife of .....

SEX	Male	Female

RELIGION	Cath.	Prot.	Mus.	Trad.	Other

A. DEMOGRAPHY (the People)

In each of the 9 "boxes" below put a number. (The number may be 0). That number is the total number of people living there who belong in that age/sex box. The totals must agree in bottom right box.

		SEXES Male	Female	Total
AGES	Under 15 yrs.			
	Over 15 yrs.			
	TOTAL			

← Total people living here regularly

B. HOME ENVIRONMENT (Where these people live)

1. Main dwelling house materials: (Tic one box only)
   - Permanent (all permanent materials) ☐
   - Semi-permanent (some " ") ☐
   - Temporary (no " ") ☐

2. Do you think the compound has been swept today? Yes ☐ No ☐

3. Is there a latrine? Yes ☐ No latrine ☐

What is floor made of? (√ one box)		How is it kept? (Yes/No)		Is it used?	
Cement or boards	Dirt & Poles	Hole covered?	Floor clean?	Yes	No

4. Water: (household water for washing, drinking, cooking)

	Source (2 tics)			Use (4 answers)	
	Tap/Borehole	River/ Dam	Well/ Spring/ Rain	Quantity litres/day/ household	Distance time or km.
Main Source in Dry Season					
" " " Wet Season					

5. Fuel: most used for cooking

	Firewood	Charcoal	Paraffin	Other
Kind (tic one) →				
Amount used per week (loads, chupas, Shs. etc)				

6. Cooking stove (√ one box)

3 Stones	Mud box	Metal	Other

This form was developed by World Neighbours and CHWSU at AMREF for use by CHWs.
(Supplies available from CHWSU, P.O. Box 30125, NAIROBI, Kenya)

C. HEALTH of mothers and young children

Complete a separate copy of this page for each resident mother (or foster mother) of a child under 5 yrs. (She does not have to be a wife).

Name of woman: ..... Name of Head of House: .....

	Question C1-C6 apply to each and all of this woman's-live-born children - whatever their age now	1 (last born youngest)	2	3	4	5	6	7
1.	Year of birth and age now							
2.	Sex							
3.	Where born: Hospital/H.Centre/Home							
4.	Level of education completed (years)							
5.	Age at death (write number from list*)							
6.	Cause of death (write number from list*)							
Qs.	C7-C14 about above children who are still under 5 years							
7.	Nutritional status (red/yellow/green							
8.	Have you seen this child's MCH card Yes/No							
9.	Measles vaccination on cards? Yes/No							
10.	Polio completed 1-2-3 write number							
11.	DPT " 1-2-3 " "							
12.	BCG Scar seen on skin? Yes/No							
13.	Has the child been sick and not eating or playing in the last week Yes/No							
14.	What was the cause of sickness? (Number*)							

Use extra copies of this page for extra children 77

Death or sickness left for question 6 and 14 if applicable

1.	Head/consciousness	4.	Abd./Diarr./Vomit	7. Skin	10. Injury
2.	EENT	5.	Urin/sex parts	8. Fever/Malaria	11. Other-specify
3.	Chest/Cough	6.	Joints/Muscles	9. Measles	

Qs. C15-C24 to the mother of a child under 5 years about her activities

15. At what age (months) do you usually start giving other food along with breast milk? ☐
16. At what age (months) do your children usually stop taking the breast completely? ☐
17. What specific solid food should a child get first when he needs more than just liquid food? Name 2 foods: Meat ☐, Milk ☐, Beans ☐, Nuts ☐, Fish ☐, none of these was mentioned ☐, Other protein food ☐
18. On your latest-weaned child, what specific solid food did you first use? .....
19. By the time God has closed your womb, how many children do you guess He will have finally had you bear? ____ Total.
20. What methods do you know which can help a woman give her womb a rest time? Traditional ____. Billings ☐, Condom ☐ Pill ☐, Injection ☐ none of these mentioned ☐, Other .....
21. Have you yourself tried any method? If so which one? .....
22. For how long did you continue it without stopping? ☐ months
23. How does disease come to a home? Name 2 important ways: (√ two)

Flies	Water	Air	Dirt/Faeces	Don't know	Other -

24. What action can people in this place take to prevent disease entering their homes? (Write first 2 answers) .(1).....
(2).....
25. What or who could cause more people to take those preventive actions? (First 2 answers)
(1).....
(2).....

(G)

HEALTH HAPPENINGS

Recorded by: ..... CHW at: ..... Community

This is a record of things which you have seen to happen. The happening may be good or bad. For each happening make a mark like this ● in the proper place. When your leader visits you, together count the ● s and write the total and date of counting. Also you make a line like this —●— through all those you have just counted. Then they will not be counted again. This paper will give your work accOUNTability.

What you have seen new	Cases ●	Total	date
1 Newly Pregnant woman	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
2 Delivery assisted	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
3 Birth in your community	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
4 Death under 1 yr of age	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
5 Death over 1 yr. of age	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
6 General public baraza spoken to	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
7 Special group health discussion	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
8 Group project completed	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
9 Personal first home visit	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
10 Newly improved cooking Place	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
11 New distrack	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
12 New or improved granary	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
13 New water tank	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
14 Improved latrine (vent and/or cement slab)	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
15 New ordinary latrine (no vent, no slab)	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
16 Improved house	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		

What you have seen new	Cases ●	Total	date
17 New Kitchen garden	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
18 New person started F.P. (1 month)	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
19 Too close birth spacing spacing (< 2 yrs)	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
20 New case diarrhoea in child under 5	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
21 Newly malnourished child under 5	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
22 Too soon off breast (before walking)	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
23 New ear problem in child under 5	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
24 New eye problem any age	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
25 New skin problem under 5	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
26 New 1 month cough any age	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
27 New measles case	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
28 New mental problem any age	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
29 New BCG scar	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
30 New accident to child under 5	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
31 New accident to person 5 or older	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
32 Child newly started school (first ever)	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
33 child(5-15) newly stopped school	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		
34 Local item	●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●● ●●●●●		

FROM THE COMMUNITY HEALTH WORKER SUPPORT UNIT AT AMREF

P.O Box 30125, Nairobi, Kenya

CBHC PROGRAMME PROFILES
(Selected answers from 14 programmes)

QUESTIONS

A1. What specific person in the community mainly helped "plant the seed of CHW?

2. What specific outside person (nurse, doctor etc.) mainly helped to "plant the seed?"

3. What specific institution (if only) was mainly involved in sponsorship?

4. Is a local Health Committee non-existant, of little help, helpful?

5. Has the community generated any money for helping CHWs through local projects? Yes, No.

6. What are three most important criteria for selection of CHWs? I), II), III)?

7. Who makes the final selection of indivudual CHWs?

8. How clear was the general understanding that this CHW work was a part time, voluntary, unsalaried contribution to the community? clear, very clear, unclear.

9. Was written survey done of the CHWs community? If so, when was it done? Before training, during Training, after training.

10. In what year did this groups start training?

11. Outside aid in the form of money or materials was /is

12. Outside aid in the few of human motivators was/is

13. Today local leadership in running the the programme is?

ANSWERS

Church-related, School - related, Chief Medical student, other.

Medical 10, Nearby CHW 1, Church 1

Mission 10, CHW 2 non-CR-NGO 1

Helpful 8, little help 3, non-existant 3.

Yes 6, No 8

Respect 9, permanent resident 7, interested/motivated/community/likes people/"heart"/understanding 7, have sides 4, others 3 or less.

Health Committee 8; parish/community 5 chief 1; baraza 1;

Very clear 7; clear 6; unclear 1.

During training 7; Before 5; after 1 no resp. 1

76 - 79	80	81	82	83 "	no res
2	2	1	7	1	1

Zero	little	important
2	6	6
1	6	7
2	2	10

QUESTIONS

B. REGARDING TRAINING OF CHWs

About the one person most involved in training.

1. What is her professional title
What is her position in her organisation

2. What % of training (excluding field work) is by LECTURE?

3. What % of training (excluding field work is by PSYCO-SOCIAL

4. What % of training (excluding field work) is by other method.

5. Regarding CHW. Within her first six months, how many days in total of training in a group does she get?

7. Is the main trainer also the main field supervisor after training?

8. What % of her total time is CBHC/CHW work?

9. How many CHWs have been trained so far in this location?

12. What are two most important textual materials used in basic training (say first 20 training days?)

C. REGARDING CHWs work

1. Estimate the average individual CHWs coverage in terms of homes

2. What about nearest medical facility?

3. What is CHWs acceptance by the staff of the facility

4. What moral support does CHW get from the community in general?

5. Number these activities in order according to the time you estimate the average CHW spends on them

ANSWERS

Registered Level nurse 6; Enrolled Nurse 5; Teacher 2; Doctor 1

24% (0-5)

63% (25 - 100)

13% (0-40)

1 - 2 weeks	4	average 24 days
3- 6 "	7	range 6 - 24 days
Over 6	2	
No response	1	

Yes 11; No 3.

Aug. 81% (range 33 - 100)

Range	Places
0 - 49	5
50 - 99	3
100 - 149	1
50 -	4
No response	1

Warner 9; Wood 3: Others 6
No response 4;

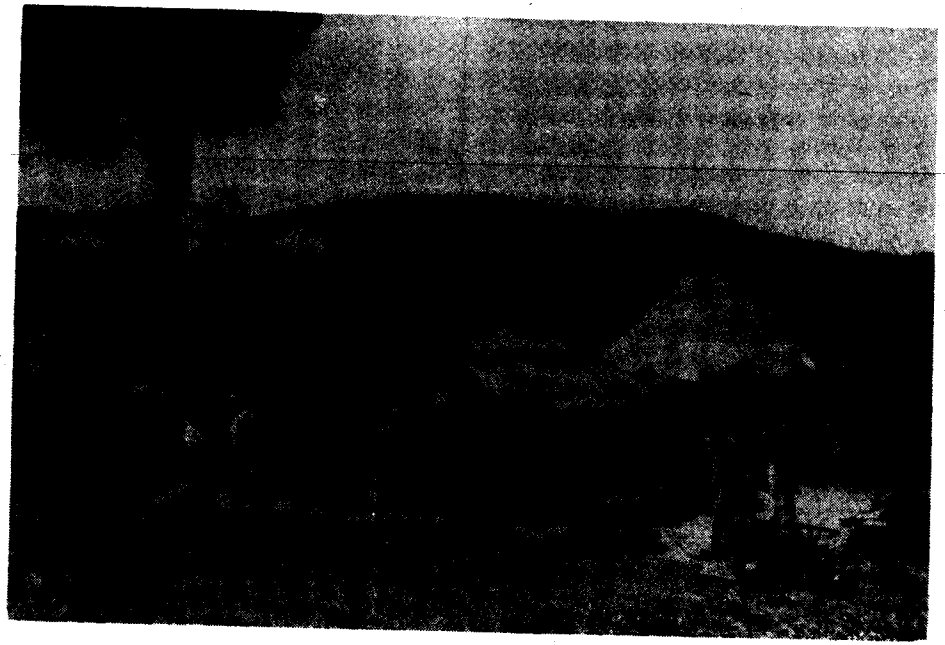
Homes 15;15; 20;20: 40: 50; 80; 100; 128; 200; 300; NR 3

Km ½;½; 4;4; 6; 7; 10: 15: 16; 20; 48; NR 3

Lukeworm 7; Team-mates 5; No recognition 1; NR 1.
Satisfactory 6; little 5; good 3;

Home > Women Groups > Clinic > Public Meetings

QUESTIONS	ANSWERS
6. What drugs does CHW dispense? Chloroquine, eye antibiotic, aspirin other, other.	Chloroquine 9; eye medicine 7; worm 3; no drugs 5.
7. What is the financial arrangement for these drugs? Free, sold out, sold for profit?	Sold at cost 4; profit 3, free 2 not applicable 5.
8. How important are these drugs to her general influence for good on the community?	Important 7; very important 2 not applicable 5.
9. Does the average CHW naturally and spontaneously and regularly use the Psycho-social method or its equivalent in problem solving? Yes, No	Yes 11, No 3.
10. Regarding use of codes (problem-posing aids). To what extent do your CHWs use them in the PSM way, that is with systematic questions which draw solutions from the peoples' own discussions?	Little 8; much 4; very little 2
11 Name these problems in order (no 1 = most time) according to CHWs estimated total time spent on each of them	Waste problems Malaria Water equal Pregnancy to diarrhoea
12 On which health problems does she keep an up-to-date record of named cases?	Diarrhoea 8; eye 7; malnutrition 6; birth 5; death 4; TB 4
13. Does she keep prevalence figures on:	Latrines 11; Water 6; Stoves 3; No response 3
14. What are the two most technical inputs to CBHC from other ministries?	Education agro-forestry literacy No response 3
15. How many hours a month does CHW spend helping the medical team at local HC/Disp/MU?	0 3 4 6 7 8 20 32 70 1 1 2 1 1 2 1 1 1 No response 3.



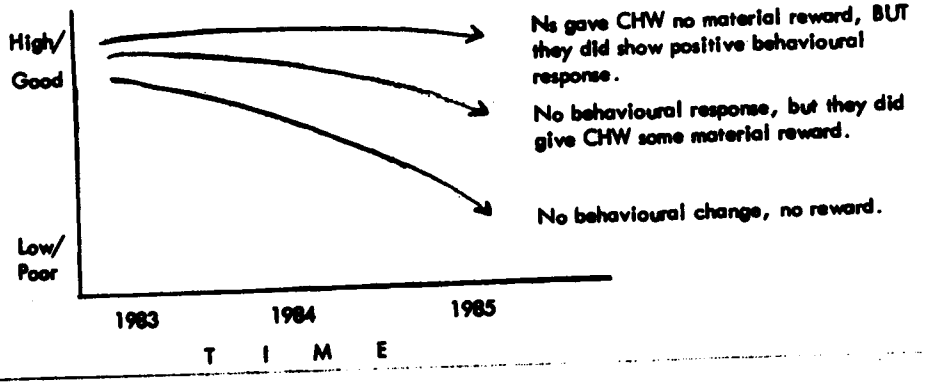
COMMUNITY SURVEY

INTERACTIONS

(CHW Initiative ... Neighbour Response Over Time Period)

A. CHW's Level of Voluntary Initiative → Neighbours' Response

as it is affected by → (Changed habits and conditions)

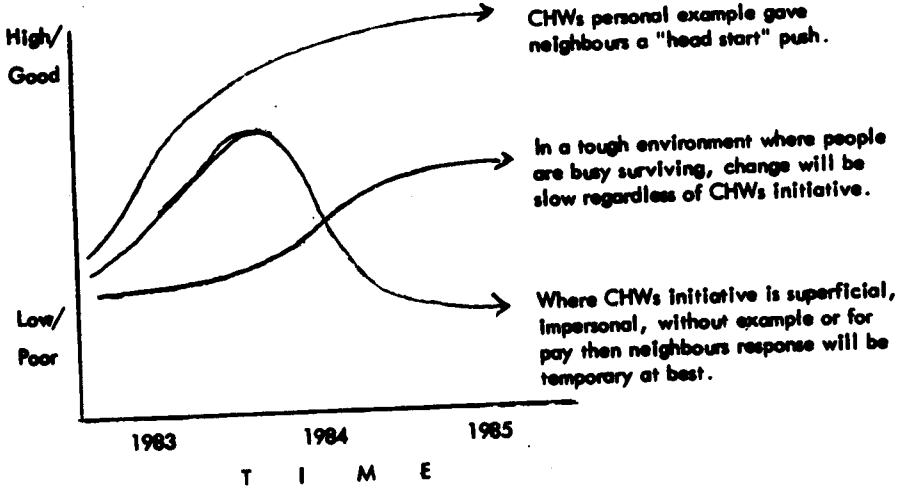


B. Neighbours' Response

(changed habits and conditions)

as influenced by → CHW's Initiative

in motivating neighbours



From The Community Health Worker Support Unit or AMREF

PRACTICAL NOTES FROM THE SUPPORT UNIT