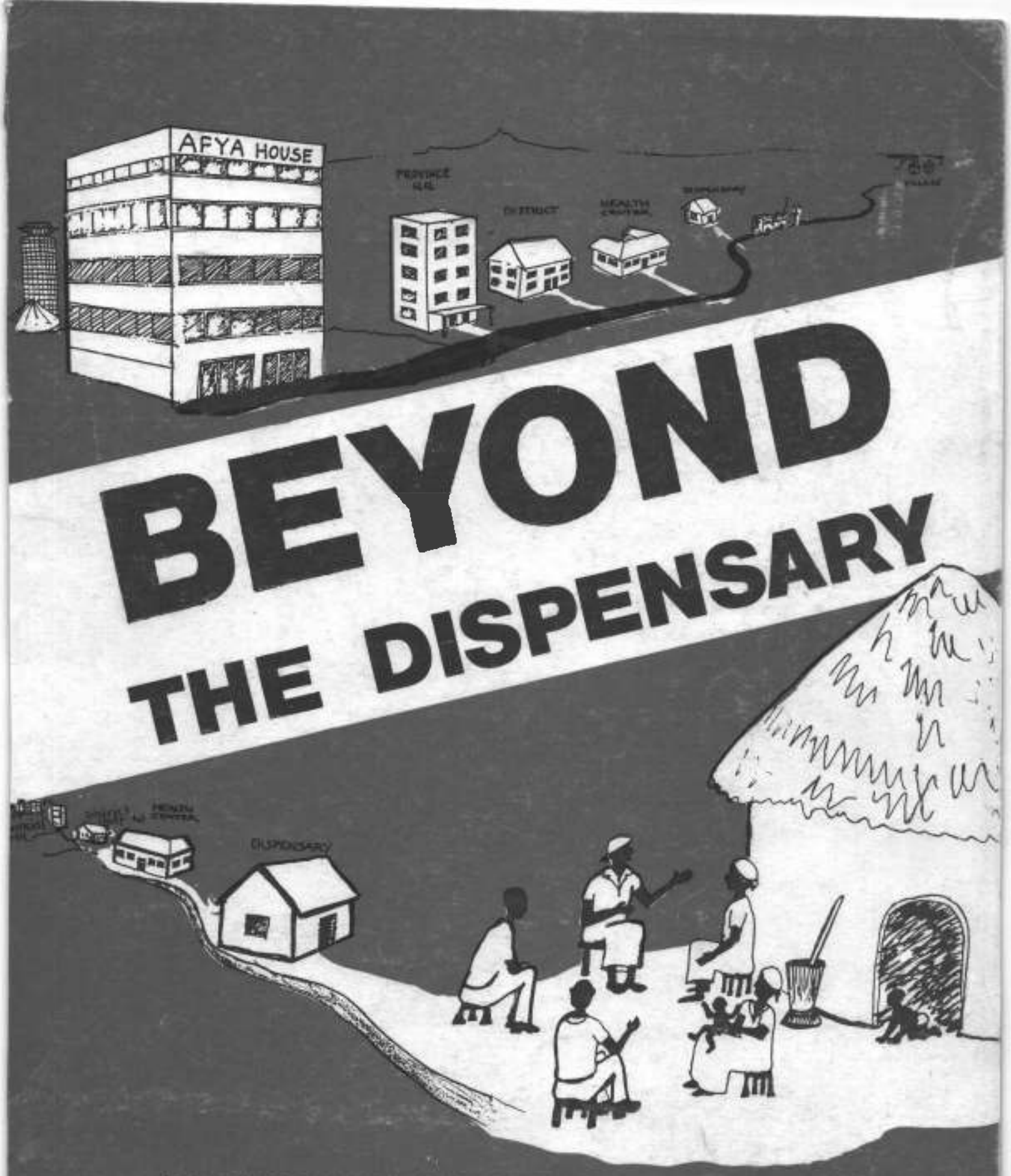

BEYOND THE DISPENSARY

(ON GIVING COMMUNITY BALANCE TO PRIMARY HEALTH CARE)

by ROY SHAFFER

Community Health Worker Support Unit

AMREF

AMREF

The African Medical and Research Foundation (AMREF) is an independent non-profit organisation which has been working for more than 25 years to improve the health of people in Eastern Africa, mostly in Kenya, Tanzania, Southern Sudan and Uganda. AMREF runs a wide variety of innovative projects with an emphasis on appropriate low-cost health care for people in rural areas. Project funds come from government and non-government aid agencies in Africa, Europe and North America as well as from private donors. AMREF is in official relations with the World Health Organisation.

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BEYOND THE DISPENSARY

(ON GIVING COMMUNITY BALANCE TO PRIMARY HEALTH CARE)

Roy Shaffer

Community Health Worker Support Unit
African Medical and Research Foundation

This brief work owes a lot to King, Werner, Morley and Bryan, writers whose personal-experience-based writings ushered in a new era of rationalization and de-mysticization of health service and motivated thousands of other community health workers, myself included.

The writing draws mainly upon the field experiences of many friends, particularly Geraldine, Janet, Gill, David, Penina, Mattie, Dan and Leda; colleagues who pioneered pathways of trust "beyond the dispensary".

Most important of all have been the CHWs themselves. When you consider their position you must agree that in most cases their endeavours are noble. Through their selfless service and example they are ushering in a new era of inspired health service by the people.

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SUMMARY

Public disenchantment and economic constraints related to health services have been approaching the intolerable in all countries of the world. Hence in 1978 WHO and UNICEF convened a conference at Alma Ata in Russia to re-think and rationalize health services. The resulting concensus thinking bore the label "Primary Health Care" (PHC). This paper considers the ramificatons of the PHC approach as it occurs "beyond the dispensary", as a Community-Based Health Care (CBHC) development.

CBHC is seen as a practicable way to narrow the widening gap between health needs and the resources to meet those needs. The key elements are voluntarism, motivation and prevention. The key human resource people are Health Committee members and Community Health Workers (CHWs). The CHW is primarily a catalyst of changed responsibilities, habits and conditions in her (most CHWs are women) neighbourhood. The CHW therefore must be permanent, mature, exemplary and a good communicator. Literacy is not a high priority. Voluntarism and popular selection are of the esssence as is community commitment to moral support of their CHW.

The CHW's primary focus is on her immediate neighbours. But she is also involved in a host of other human interrelationships, both vertical and horizontal. A CHW must be part of a network of reciprocal responsibilities which inter-relate facilities, cadres, philosophies (particularly the cure/prevention balance) and modes of approach to people.

The CBHC approach strives for more delegation of responsibility for health promotion, better balance between cure and prevention, more voluntaristic input into the system, increased awareness/ sensitization and bettèr cross-disciplinary integration.

CBHC, as the title implies, should have been born in the minds and hearts of local people. It should crystalize around a self-help approach to specific preventable problems, not around a dispensary.

Traininig of CHWs generally takes place in the local community and does not last more than a week to start with. The curriculum should be felt by the CHW trainees to have emerged from their community's needs. The most suitable teaching method is the learner-centered-problem-posing method popularized by Paulo Freire.

A key feature of this method is the "starter" or "code" which poses the chosen problem in a sensitizing way.

The well trained CHW will be able to motivate her community towards changes in responsibility, habits and conditions involving motherhood, cleanliness, food and disease control. Evaluation of her impact on the community is still rudimentary. There are about thirty specific CHW-countable changes of habits and condition which are expectable as an outcome of the CHW's motivation of her neighbours. The CHW usually has an intuitive grasp of the state of these developments. The challenge is to devise survey and monitoring instruments which are meaningful and useful to her.

A number of uncertainties still cloud the CBHC scene. Will the CHW's individual reservoir of voluntarism last until she is rewarded by measureable changes in her neighbours' habits? Can communities (and doctors) be weaned off their fixation on a pill for every problem and a needle for every need? Can they be led to believe more confidently in "health without medicine"? Can part-time voluntarism, promoting prevention become a cultural "norm" and an option for closing the needs/resources gap?

Finally the paper points out that CBHC is more complementary to than competitive with formally trained clinicians. CBHC helps them to be EXPERTS rather than "NEXT-PERTS".

BACKGROUND

Throughout the world there has recently been widespread and increasing disenchantment with health care in terms of its accessibility, and affordability. Developing countries in particular are being forced to re-evaluate their health systems in terms of cost and effectiveness.

In this connection, WHO and UNICEF in 1978 at Alma Ata (AA), Russia, launched a campaign to achieve "Health for All by the year 2000" through Primary Health Care (PHC). Prior to AA, "primary care" to most people meant first contact care, a limited use of the expression. The AA declaration broadened the use of the word "primary," putting greater emphasis in principle upon the community and its "participation, self-reliance and self-determination." Based on the phraseology of the declaration, Primary Health Care stands for essential care that is:

- accessible
- acceptable
- affordable
- all-inclusive (integral)
- all-together (participatory)
- at the centre (is the nucleus)and
- amenable to self-reliant initiatives

Furthermore, in the AA terms of reference, PHC renders the following types of service:

- promotive
- preventive
- curative and
- rehabilitative

and covers the following problem areas:

- nutrition
- water
- sanitation
- maternal/child health
- immunization
- endemic diseases
- education
- treatment.

The AA emphasis upon community involvement was not a new idea. Shattuck's Report of the Sanitary Commission of Massachusetts, 1850 emphasized community orientation and personal responsibility. But the personal and community emphasis Shattuck put forth in 1850 did not gain much ground then, for two reasons. First, an era of rapid development of large corporate water works was starting in Massachusetts.

The resulting reduction in prevalence of water-related diseases temporarily took the pressure off local community health services. Then, at the turn of the century great breakthroughs in bacteriology and immunization and, later, chemotherapy put great emphasis on "the men in white coats". There ensued both a popular and professional fixation on the institution-centered "pill for every problem and needle for every need" (PENN) approach to health. This (PPNN) expensive, curative-dominated approach became entrenched in the West, and it spread to the Third World. There its burgeoning costs began to hinder and even reverse progress towards better health in fledgling independent nations. By the mid 1970s it was obvious that something was going to have to change.

So at Alma Ata the former community orientation was revived, re-articulated and re-promoted as PHC, which was to become the nucleus of the health system. See Appendix A for core AA statement.

PHC is not a new system as much as it is a new emphasis and ordering of priorities, with the community becoming more central in the scheme of things. One could say the AA emphasis is upon making that first contact more peripheral, more participatory, more personal and more simple.

But the AA declaration did not define "primary". Neither did it give specific examples of the Where, Who, What, How, etc. of PHC. AA did, however, broaden the use of the word primary to include more than its prior meaning did, i.e. the new use meant more than just a sickness episode, a single point in time/place. Regarding the "Where", AA's geographical use of "primary" went in theory beyond the most peripheral establishment facility. It went right out to the village and the home.

Regarding the "Who", the title "primary worker" was transferred from the lowest and least formally trained establishment worker to the informally trained villager helping her neighbours.

In answering the question "What", AA tended to shift the balance of the emphasis slightly from sickness care to health care, i.e. from getting cured to staying healthier.

As to "How" PHC was to work, the emphasis in theory shifted towards the active (prevention, self-prophylaxis, self-referral) and away from the passive (being helped, being referred, being cured, being told).

A simplification of the above AA inferences might be this: "Primary Health Care refers to the first thing an ordinary villager does for him/herself right in the home to avoid getting sick."

But the official concept is not necessarily the popular concept. Misconceptions and mis-definitions have abounded. Establishment medical workers have often tended to regard PHC as just a strengthened dispensary programme.

Many so-called "Community Based" programmes are more tied up with "pills, preaching and per-diems" than with "people, prevention and problem-solving". On the other hand many villagers think of PHC as a box of medical "goodies" coming down the road to the village from the dispensary. Both these top-down interpretations are wrong and such mis-perceptions are resulting in much confusion and wastage of mental and monetary resources. Of a continental medical conference on PHC it was said, not altogether in jest, that there were 1,000 physicians there and 1,200 different definitions of PHC. One session was actually devoted to "The Role of the Specialist in Primary Health Care".

Three changes are needed:

- the people need to take their own capacities and responsibilities more seriously
- medical workers need to take the people more seriously
- both need to take prevention more seriously.

The word "radical" means root. CBHC should be a radical programme in that the people cut their own problems at the roots (by prevention).

The dispensary is not really primary geographically. Indeed, it is the community beyond the dispensary that is primary. So PHC should by definition have a local, community-based perspective. That perspective should complement and modify the traditional top-down medical establishment-based perspective. This paper attempts to fill in the details of the community-based perspective which will restore balance to PHC.

COMMUNITY-BASED HEALTH CARE

The Community-Based Health Care (CBHC) movement is the "beyond-the-dispensary" part of the spectrum of PHC. It fosters and implements those recommendations of AA that are practicable beyond the dispensary. It addresses itself to encouraging and facilitating the peoples' own efforts to convert AA philosophy into practice right where they live. CBHC represents the geographically peripheral or outer half of PHC. It focuses on community-initiated activism. This activism is catalysed by Community Health Workers (CHWs). This programme of community activism should eventually be viable with or without outside influence or aid, whether from government or non-governmental organizsations. (Note Apx. J - 8 and 9)

This somewhat independent, bottom-up initiative is the heretofore "hidden" half of PHC. It can be considered the most important half of PHC, for if a PHC programme has no bottom-up initiative it is not in the AA sense "primary".

But "bottom-up" is not an altogether apt expression for this situation. If through lack of knowledge the people on the "bottom" do not really know which way is "up" they cannot be expected to initiate movement in the right direction. First they need awareness-raising as a form of orientation. ("Sensitizing" is too presumptuous a word.)

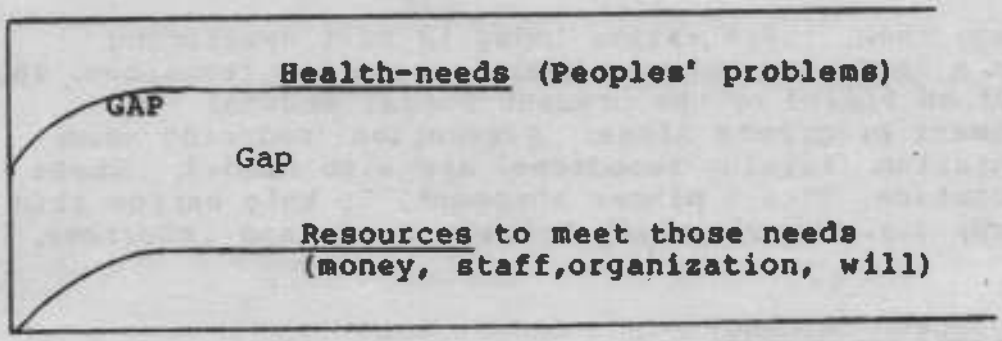
A common African proverb goes "It takes two fingers to kill a louse". And so, for faster progress in the race to attain better health for all by the year 2000, PHC will require a better balance between its two halves. Its traditional curative-centered top-down approach will have to be more evenly complemented by the prevention-centred bottom-up approach that starts beyond the dispensary. Furthermore, the top-down approach will have to involve more delegation of responsibility from formally trained health workers to CHWs. There is scope for such delegation in matters such as nutritional surveillance, immunization surveillance, malaria control, health motivation and TB/leprosy case-finding/holding. Through such delegation, the preventionists in the team can begin to get off the curative workers' "coat-tails".

In East Africa the modern revitalization of the philosophy of CBHC might be said to have first occurred recognizably at Nangina Hospital in the early '70s. In 1979 through the generosity and vision of World Neighbours, a Community Health Worker Support Unit was started at AMREF. This Unit co-ordinates Community-Based Health Care collaborations throughout East Africa between such organizations as Kenya Catholic Secretariat, Protestant Churches Medical Association, World Neighbours, etc. (Note Apx. J - 14)

Writings and discussions on PHC since AA have been preoccupied with the inner (or "top") half, i.e. from the hospital to the dispensary and its mobile extensions. This preoccupation with the establishment has been so strong and, conversly, practical outreach beyond the dispensary so poor that CBHC has remained relatively obscure. So we will attempt to clarify what CBHC is functionally through a series of questions. .

WHY IS CBHC NEEDED?

CBHC is needed to fill the gap between health needs and health resources. The following figure illustrates this.



CBHC can reduce this gap or disparity in two ways: by lowering needs and/or by raising resources.

Needs can be lowered directly by preventing the illness that creates the immediate need. Needs can also be lowered indirectly over the long-term by preventing the birth of an overwhelming number of people (through better child spacing) and thereby minimizing the multiplication of need.

Raising resources is more difficult. Government and Mission institutions are already functioning at the limits of their money, staff and organizational capacity. This affects their philosophical will to make new commitments of staff and other resources, especially to that unknown territory beyond the dispensary walls.

So it may be many years before we begin to see a flow of staff and money that matches the flow of high-level rhetoric about "prevention" and "community". There will probably not be much more than a trickle going down the road beyond the dispensary for some time to come. Certainly, vague talk, at this point, of outside money for salaries for CHWs is unrealistic if not hypocritical or damaging.

So, while awaiting the evolution of philosophic and practical commitment at the centre, let us look at resources already existing peripherally, beyond the dispensary. Here we believe part-time voluntarism can raise the level of local resources and thereby narrow the health gap.

Part time voluntarism does not eliminate uncertainties about money, technical skill, organizational capability and will. But it does put those issues into manageable (local) dimensions. By putting some of the initiative into the hands of the people beyond the dispensary, CBHC voluntarism can produce a biblical "loaves and fishes" effect. A few local human resources blessed with a little training can "feed" (motivate) a multitude of their neighbours.

In summary, then, there exists today in most developing countries a large gap between health needs and resources. That gap cannot be filled by the present formal medical establishment programme alone. Prevention (reducing need) and voluntarism (raising resources) are also needed. These two can combine, like a pincer movement, to help narrow this health gap, i.e. the disparity between needs and resources.

WHO IS INVOLVED IN CBHC?

CBHC may include any or all of the following personnel:

1. A nurse or equivalent medical person who provides technical guidance and, more importantly, moral support

2. Community leaders willing to lead towards commitment

3. Health committee members willing to be regularly, actively responsible for the administrative interests and morale of their CHWs

4. Community Health Workers willing and able to give a few hours a week to motivating their neighbours

5. Villagers willing to try changing their habits and conditions, both individually and as a community.

THE HEALTH COMMITTEE

It is important that the bottom-up approach be a community phenomenon, not just one local individual's enthusiasm fuelled by some zealous outsider. So Health Committees (HCs) are desirable. They may be sub-committees of the District, Locational or Sub-Locational Development Committees. Their selection is usually by the administrative head, hopefully after sounding out the community.

The HC should be a major facilitator of that which CBHC is all about, i.e. community change. The HC's work is active advocacy of the CHW and active prompting of the community to respond to the CHW's motivations towards specific changes in habits and conditions.

The HC needs some preliminary training just as much as the CHW does, though for the HC it will be much briefer. The HC's first responsibility is to ponder questions such as the following:

1. Is there a need for change in people's personal habits and home conditions?

2. What sort of person would be most effective (as a CHW) in demonstrating, popularizing and promoting these simple changes among her/his neighbours?

3. Who could train these CHWs and who could provide them with on-going advocacy and moral support (administrative and medical)?

4. What is the chance of villager improving their personal habits and village conditions in response to the CHWs motivation?

5. Who will keep the CHWs themselves motivated? How?

6. What part, relatively, should chemotherapy (drugs) have in the CHW's role?

7. Approximately how much time per week would the average volunteer CHW be able to spare for this work? Thus, with how many families would she/he be able to keep in touch?

WHAT IS A CHW?

The CHW may be either a man or a woman. However since most CBHC activity concerns Maternal/Child Health there tends to be a preponderance of women serving in the role. TBAs can be excellent CHWs (Note Apx. J-19). The ideal would be one of each sex for each community. The woman covering Maternal/Child Health (MCH) and the man cover environmental affairs.

The main function of the CHW is to be a catalyst of change in personal habits and environmental conditions in his or her immediate social neighbourhood (say 1,000 people or the area within a 2 mile radius or a 1 hour walk). Anything beyond that is not psychologically her community or neighbourhood.

Drugs need not be a pre-requisite to a CHW's acceptance and influence as a motivator. On the contrary, her drug dispensing can and often has weakened her primary message of "prevention". There are "drug-free" success stories and conversely there are cases where drugs have brought disaster to a programme.

The title CHW deserves some scrutiny because it is not altogether apt. Let us analyse the components of the title:

Community. The CHW must not only be in that community, but also "of" it in the sense that her work is a product of communal conception, momentum, management, funding, etc.

Health stands for total health, not just immunizations. It infers acculturated changes of habits and conditions.

Worker. The CHW is not a worker who "does" health for the people. The W should be turned upside down to become an M, standing for "Motivator".

TO BE A GOOD COMMUNITY HEALTH WORKER ONE MUST FIRST OF ALL BE A GOOD COMMUNITY HEALTH MOTIVATOR

She motivates a clean-up of the spring and the men are the workers. She motivates building of a dish rack and her neighbour does the work of building it.

Not listed in the above is the word EXAMPLE. Personal example is one of the CHW's most important influences on her neighbourhood.

PERSONAL EXAMPLE IS THE CHW'S MOST IMPORTANT INFLUENCE

So we could well change the title CHW to "CHEM" standing for Community Health Exemplary Motivator.
(Chemchem is the Swahili word for spring of water. The Swahili word "mchocheo", for incite or arouse is applicable to the role of the CHW).

The CHW is chosen with popular approval after the whole community has clearly understood the terms of reference. CHWs are, ideally, sponsored by a Health Committee and are usually trained by a nurse from a nearby static facility (most often a mission hospital). This trainer might have attended a CHW Support Unit Training of Trainers (TOT) course. Such courses provides special teaching skills designed for the CBHC situation.

The most widely emphasized personal characteristics desired in a CHW include the following (not in order of importance):

- a volunteer (as far as outside remuneration is concerned)
- permanent resident
- parent
- exemplary personal life
- good communicator
- respected activist in community
- has time to spare for this activity
- has approval of partner
- healthy
- fairly "average" person
- education suited to motivational role in that neighbourhood
- knows the community
- mature
- friendly

Literacy is not always a requirement. Some excellent CHWs are illiterate. Furthermore, a literacy requirement has led in some cases to selections which are bad on other counts.

The voluntaristic basis of the CHW's work is a troublesome issue which is discussed at length in a later section (P.35). But experience has shown that:

a. salary from outside may reduce the CHW's motivational role.
b. a gradual transfer of salary responsibility from outside sources to local sources does not work in practice.
c. no programme has yet come up with any consistent lasting local remuneration of CHWs (whether in money or in kind).
d. voluntarism is motivated mainly by religious impulses.

VOLUNTARISM IS MOTIVATED MAINLY BY RELIGIOUS IMPULSES

Communities are sensitive to the issue. Some localities have given one-time rewards such as a goat in Ekarakara or a prize radio in Maua. The Kisii CHWs are full-salaried (from Europe) workers so are not strictly within the terms of reference of this paper. Of far greater importance to the CHW than money or gifts is the remuneration or gratification of receiving moral support from the trainer/leader and response from the community in the form of changed habits.

RECOGNITION/REMUNERATION/TIME

These three factors are inseparably linked. The time CHWs spend should be geared to the realities of what they themselves can spare from their domestic responsibilities.

To a person giving only one or two afternoons a week, salary will not be a big issue. But two or three days a week (i.e. half time) is more time than a typical villager could spare unless there were some remuneration. A full-time paid worker cannot be considered a typical rural community resident.

Because of job security she is less able to empathize with her neighbours and their economic stresses.

Community recognition and esteem can be an important part pf remuneration. It may work in lieu of wages in keeping CHWs happily motivated and on the job. It has been an important part of remuneration of TBAs.

Pay from outside sources is a dangerous tool of development. It is more likely to divide the community than to unite it. Furthermore it may quench local initiative and insight. Instead of asking themselves "why" or "why not?", community leaders may simply get in the habit of asking donors "how much?" It is extremely difficult to "wean" a community from outside aid once started. It is folly to think or pretend that the national health service will ever be able to afford to pay CHWs. (Unless, of course, there is a revolution in thinking and prioritization of funds at highest levels.)

CHW PERSONAL RELATIONSHIPS

The CHW role involves a host of relationships, both vertical and horizontal. First consider the vertical.

A CHW should be the bridge between her neighbourhood and the nearest health-related facility. This facility is usually a dispensary. The bridge should be a two-way bridge, of course. The CHW takes to the dispensary problems which are above her own skill level and training. In exchange, the clinician at that facility should be able to direct or delegate back to the CHW those problems that are below his/her skill level and focus as a clinical expert.

At present, in most dispensaries, a clogging 30-40% of attendances are community-preventable problems brought in for therapeutic re-cycling (the same child with the same infection again, getting the same medicine to go back to the same home environemnt, to practice the same habits to get the same infection again to take back to the dispensary again, for the same medicine...).

The more of these cases there are, the longer will be the queue and the lower will be the clinician's motivation and the less the time he/she will devote to each case. The clinician's most-used word becomes "next", "next", as he/she struggles to get through the de-motivating patient load. The congestion and long queues have converted him/her from an "EXPERT" to a "NEXT-PERT". Hopefully the CHW's preventive work in the village should minimize this deteriorization in the clinician's role.

Because of the complementarity of roles between clinician and CHW, there should be between them the mutual respect of team-mates. But there is a danger here. Some CHWs will be overly attracted by the status of being identified with the dispensary or health centre "daktaris".

They may be tempted to spend more and more of their time there at the dispensary or health centre and eventually they may, in their imaginations, change from being CHWs to being HCWs (Health Centre Workers).

In the strictest sense, horizontal relationships mean a CHW's relationships with her neighbour peers, including traditional birth attendants and traditional healers. She is "one of them" in every way except for her special training as a CHW. The horizontality of these relationships is of the essence in CBHC. It makes more realistic the hope for "health <u>by</u> the people" themselves, i.e. health by the CHW's neighbours.

A CHW's relationships with the local cadres of formally trained extension workers of related disciplines might be termed a 45-degree angle relationship. They are an important resource, supplementing her very limited training. Because they are so local (say within the administrative division), it should be easy for the CHW to contact them and to draw on their expertise. (Note Apx. K-15)

At Mvumi, for example, the agriculturalist has an important input into the CHW's role. This is, thanks in part, to the foundational influence of World Neighbours' integration approach there.

All the CHW relationships (vertical, horizontal and angular) are like strands in an African woven basket. They produce a combination of harmony, utility and durability in the CHW's role on behalf of her neighbours.

RECIPROCAL RESPONSIBILITIES

No man stands alone, so the exercise of reciprocal responsibility between various parties helps determine the health of the CHW's neighbours. For example in the matter of malnutrition, the enrolled nurse has a responsibility not only to treat, but also to educate the parent. That parent has the reciprocal responsibility to change her habits and the community has the reciprocal responsibility to survey itself regarding malnutrition. When it does so, and reports to the nurse, that nurse has the reciprocal responsibility to guide that community towards improvement.

This sense of reciprocal responsibility is the "glue" which holds CBHC together and the CHW is the "catalyst" of that glueing action.

> RESPONSIBILITY IS THE "GLUE" WHICH BINDS CBHC TOGETHER AND THE CHW IS THE "CATALYST"

Here are some instances of a good "glueing" process at work:

a. Sharing income and costs of a mobile clinic - Bukonjo (Kagando)
b. Health Committees assuming responsibility for information-gathering - Maua
c. Community provision of food and accommodation for CHW training - Machakos
d. Community initiative for income generation - Mvumi
e. Outside agency's commitment to on-going moral support in the field - Kisii.

Reciprocal responsibility can have both positive and negative components when it comes to money or materials. An outside agency wishing to be supportive of local CBHC initiatives must be careful. Its response must complement these initiatives, not obliterate them. It is tempting for local leaders to accept "pump priming" assistance in the form of temporary technical staff, vehicles, cement, drugs, etc. And there is a place for such "pump priming" assistance. But there are times when the more responsible response would be "NO" or "NOT YET". A bright looking motor vehicle is not necessarily a "bright" form of reciprocal responsibility.

A BRIGHT LOOKING MOTOR VEHICLE IS NOT NECESSARILY A "BRIGHT" FORM OF RESPONSIBILITY

Appendix B tabulates the various interfaces of reciprocal responsibility between parties within CBHC.

In any area there should be periodic meetings of CBHC leaders from all programmes to find out "WHO is doing WHAT WHERE," etc.

WHAT ARE THE GENERAL OBJECTIVES OF CBHC?

The theoretical general objectives of a CBHC programme are as follows:

1. Delegation of responsibility to the least sophisticated person able to handle that responsibility properly.
2. Better balance between cure and prevention at all levels.
3. Voluntarism to narrow the health-care gap by lowering need and raising resource.
4. Increased self-awareness (quantitatively and qualitatively).
5. Awareness-raising regarding the self-preventability of sickness.
6. Better integration of tasks between related disciplines (this requires better vertical, horizontal and angular relationships).
7. A better life arising out of the above.

HOW PREVALENT IS CBHC? (What is actually happening?)

In East Africa there are over 20 places where the community-based half of Primary Health Care is being promoted in an organized way. Most of these programmes relate to some static medical facility. In the majority of cases so far, that facility is church-related. Here are some examples illustrating the spectrum of medical facilities to which CBHC programmes may relate.

Machakos - Diocesan development office, no medical facility involved.
Kibwezi - Health Centre.
Kapsowar - Hospital, through its mobile unit
Kitovu (town) - Hospital, direct.

The main features of that relationship are the provision by the medical facility of initial training to CHWs, the responsibility for their on-going moral support, and the reception of their referred medical problems. In most other respects, CBHC is a local community affair. Decisions on organization, selection, remuneration, prioritization of desired changes, and initiative toward these changes, should be, and in the majority of cases are, community-based.

The Community Health Worker Support Unit (within AMREF) was formed in 1979 to promote and facilitate the development of CHWs and CBHC in East Africa. Its most important functions are the training of trainers (TOT) of CHWs, development of graphic and radio materials, maintaining a reference bureau and providing consultancies. The Unit collaborates closely and profitably with the NGOs (mostly mission) who are in the forefront of CBHC implementation in the field.

Appendix C lists the programmes in East Africa known to the Unit as being actively involved in CBHC "Beyond the Dispensary".

These programmes are a gratifying start, but a parenthetical note is not so good. In the context of most developing countries, such local initiatives in self-determination are unusual and open to misinterpretation. The word "change" can be threatening to some authorities. So some CHWs face the occupational hazard of being suspected of being "guerrillas".

HOW DOES CBHC START?

There needs to be a "seed crystal" in the form of one or a few individuals who ask some "why?" and "why not?" questions. (Appenddix J-7 has a series of such evocative questions.) These questions should lead the askers to two encounters:

1. with neighbours who will join in the question
2. with someone who can facilitate their finding answers (mainly through clarification of their own thinking about the problem posed).

Without this local seed crystal the programme will be more donor-based than community-based. (Note Apx. J-6,7,12,13)

The evolution of a CBHC programme can be likened to a cascade or a domino effect. The following hypothetical sequence illustrates this.

A mission nurse tires of expending hospital time, staff and drugs in "re-cycling" preventable problems such as intestinal worms, anaemia of pregnancy, malnutrition and diarrhoea. She realizes that outpatient-department-based health education lectures are making little or no headway against the problem. So physically and psychologically she leaves her institution and goes to the community. She spends enough time there interacting with enough ordinary people and their leaders to acquire a community perspective.

She indentifies community interests/needs (subjective and objective) which could be met through self-reliance.

She identifies a few specific problems that could be solved by self-help prevention.

She finds a few residents who believe in themselves and in the preventability of the above problems through changed habits and home conditions.

She comes to believe in the capacities of those residents who believe in themselves.

DONT MOBILIZE PEOPLE
UNTIL YOU BELIEVE IN THEM

These sensitized people provide the leadership to form an ad hoc Health Committee (HC) which, after brief orientation:

> takes initiatives towards awareness-raising in the community, and, if successful, follows up with public community commitment to co-operation for change.

When there is evidence of serious community will and commitment, members of the HC explain how that community could be motivated (catalysed) to change. The motivators would be neighbours, chosen and trained as CHWs. When the CHW idea has been extensively discussed in a series of public and private meetings and is very clearly understood there is:

popularly endorsed selection of CHWs and

training of CHWs. As part of the training the nurse and HC prepare for the necessary sequel to training which is

support (moral, technical and administrative) and leadership of the CHWs on a continuing basis. The purpose of this support is to strengthen each CHW individually in her key role of

motivating individual neighbours and the community corporately towards

changes in habits and conditions in the neighbourhood, which changeswill result in

less sickness and thus more health and happiness for all the neighbourhood.

In the matter of this training leadership, registered or higher- level medical technical training is not a high priority or even necessity. Lower echelon workers are providing splendid leadership at Tigania in Kenya and Mushanga in Uganda.

Some hospital medical directors have "looked over the wall" and sponsored viable, relatively community-based programmes. The best examples are Kagando in Uganda and Ortum in Kenya. On the other hand, the Machakos programme has no connection with any hospital and minimal connection with dispensaries because there are only minimal dispensaries there. The first outside helper/leader in most cases has been an expatriate. But their leadership can be successfully and completely localized, as evidenced by the thriving Machakos programme.

TRAINING/LEADERSHIP CAN BE COMPLETELY AND SUCCESSFULLY LOCALIZED

Of course in this programme the leaders (expatriate and the local successor) have been full time in CBHC. In that diocese CBHC is not just an incidental commitment.

Sponsorship of a CBHC programme can come from one of three levels and each level has a different duration: of commitment.

Sponsor	Probable duration
donor agency.....	very temporary
local health professionals	temporary
community itself	permanent

Schumacher taught us that small is beautiful. His tenet is of the essence in CBHC development and engenders some practical warnings:

1. Do not start where there is not any evidence of specific local genuine community self-help initiative.

2. Do not start a location or division-wide-CBHC-supportive programme until you have had a 6-12 month closely-watched pilot experience in a smaller area. For a doctor to widely promulgate an unfamiliar drug without pilot testing it would be considered unethical medical practice. Doing the same with CBHC is not very different in its implications.

> IF YOU DONT START SMALL
> YOU ARE IN FOR A FALL

3. Do not make your pilot project larger than 5 - 10 contiguous CHWs covering a total of 2,500 - 5,000 population (with no gaps in coverage).

4. Do not let quantity of coverage cause reduced quality of relationships. Remember, motivation is the single most important element of CBHC.

> MOTIVATION IS THE SINGLE MOST IMPORTANT
> ELEMENT OF CBHC

5. Do not try to start broad spectrum. Start with one or two problems only, the ones made evident by a preliminary survey.

Regarding the choice of place, look for the following:

a. Specific health problems which can be addressed by a CHW and which people, given CHW's motivation, can solve themselves.

b. Community will to change their habits and conditions related to those problems.

c. Practicability, i.e. action on those specific problems is possible within existing resources.

Appendix D gives a 20-step suggested starting sequence. Appendix J-16 is a play on how not to start CBHC and K - 3 4 and 28 on how to build CBHC.

TRAINING

ORGANIZATION OF TRAINING

A group of about 15 CHWs are trained by the nurse leader with the help of other resource people. Training is usually right in the community in a school or church, or under a tree. The CHWs mostly sleep at home, thus their family life is minimally disrupted. If a CHW has to spend weeks away from her neighbourhood at a more sophisticated training site, she may become "de-neighbourized". That is, she becomes psychologically less community-based. In Machakos the trainees are away from home but the training context and relationships are kept very home-like. Preliminary (basic) training is, in the majority of cases, full time (6-8 hours a day) for a week or two. Thereafter, it is often one day a week for three months and then one day a month indefinitely.

A longer full-time basic training period is possible where you have a trainer with the institutional support and the personal dedication to live in the field that much. It is not possible yet to quantitate how much difference it makes to CHWs' performance to have had that longer basic training. Machakos has a twelve-weeks basic course within which two weeks are spent in practice at home.

Of course basic training must be scheduled away from planting and harvesting time. Ideally boarding and lodging arrangements and finances are community based. (Note Apx. K-2)

Ideally the curriculum should emerge from the CHW's own personal experience and the community's own priority needs. Thus every single neighbourhood should have its own special curriculum. But regardless of whether or not the local priorities are so elicited, the core content of training usually includes the following:

Communication - the art of motivating people

Food - what to grow, what to feed when, and recognition of malnutrition

Motherhood - antenatal self-care, hygienic delivery, childspacing, good weaning, and accident prevention

Cleanliness - washing, waste disposal, food care

Control and Cure of Common Community Diseases - immunizations, malaria, diarrhoea, TB/leprosy, worms

Beyond establishing this core content, every programme leader (together with her/his HC) must struggle to balance quantity against quality of CHW learning. The greatest danger is that of producing people who know too little about too many topics, i.e. quantity has triumphed over quality. Another danger is in teaching and raising expectations about problems whose solutions are outside the CHW's area of helpfulness. The result is mutual frustration.

The best learning is by doing. No lesson is complete until students have practised in one way or another. Furthermore, the content should include nothing they will not have a chance to be using.

> TEACHING IS HELPING PEOPLE TO LEARN TO DO

The main "textbook" for a CHW course is the CHW's own personal experience and CHW group discussion. This is supplemented, where appropriate, by technical input from the trainer or from books such as David Werner's Nobel Prize-worthy classic Where There is No Doctor or Elizabeth Wood's Community Health Workers Manual. The trainer herself will have had guidance from Werner's encyclopaedic Helping Health Workers Learn and WHO's The Primary Health Worker. Her best guide into the psycho-social method is the Delta Handbook from the Kenya Catholic Secretariat.

METHODS OF TRAINING

The training methods appropriate for CBHC are determined by the participants' abilities and aptitudes. Most CHWs have little or no formal education, but most are above average in their aptness for inter-personal communication and in their initiative towards practical problem-solving.

So the non-directive, discussive, active (vs. passive), learner-centred, problem-posing method is natural for this group. Under Paulo Freire, this method is known as the "Psycho-Social Method". Most CBHC programmess try to follow Freire's principles, if not always his jargon. This learner centred, problem-posing-solving method emphasizes self-discovery which in turn leads to self-confidence which in turn leads to self-reliance in problem-solving. The teacher's main role is to facilitate that self-development process. One of our students labelled it SECODEA - the Self Confidence Development Approach. This method is not altogether a new idea. Most of its best features, such as respect, review, repetition, reinforcement, reminder and reward have always been part of good teaching.

But, though this method is not altogether a new idea, it does represent a new pattern of relative emphasis in which:

interaction is more important than lecture
self is more important than syllabus
motivation is more important than fear
fulfilment is more important than learning
exchanging is more important than accumulating
what you know is more important than what you don't know
self image is more important than teacher's image
group iniative is more important than individual initiative
using a graphic aid for problem-posing is more important than
using a graphic aid for answer-giving

The reader's understanding of the method may be helped by the use of two metaphors. Firstly, we can think of the method as a mirror. In this method the trainer first elicits the trainees' confused ideas about the problem at hand and their personal experiences with the problem. She/he mirrors their ideas back to them in the form of clarifying questions about these ideas and experiences. These mirror questions stimulate and help trainees to reflect (think) for themselves in a more clear way about the problem. This process of growth in the student's awareness should finally lead to their exclaiming "ahah!", This "ahah!" reaction is the first "fruit of the spirit" of CBHC.

THE "FRUIT OF THE SPIRIT" OF CBHC IS "AHAH!"

But a warning is in order here about teaching by questioning. It is easy for the session to degenerate into "shopping-listing", i.e. the endless recitation and newsprinting of every single idea that every student might have on the subject. There are no prioritizations or collations and once again quantity triumphs over quality of learning. The resulting learning is like Lake Magadi - very broad and very shallow.

DONT LET QUANTITY TRIUMPH OVER QUALITY

In the second metaphor, the trainer's questions are likened to ajembe (Swahili for digging tool). The starting questions should dig up or stir up the trainee's mind like soil. The questions should make it good ground for the seed of new thinking about self-help solutions to their problems. With cultivation like this, most people's ideas and self-confidence can grow. They can grow in several ways:

- understanding the problem better
- understanding better the solvability of the problem
- understanding better their own personal capacity to solve the problem
- developing enthusiasm to get on actively with the solution.

Sometimes the trainer must "fertilize" the soil of her/his students' understanding with some of her/his own factual inputs. For example she/he may need to give some scientific input regarding the microscopic aspects of the malaria cycle, without which the trainee would be confused. If "seeing is believing" how can CHWs learn about malaria or worms without a microscope? The answer is that with good teaching, "believing can be 'seeing'". CHWs can "see" sporozoites in the mosquito bite and ascaris ova under their finger nails. And it is important that they do "see" these before they get onto the subject of grass cutting and latrine digging. Solving must arise out of "seeing".

SEEING IS BELIEVING
and
BELIEVING CAN BE "SEEING"

But technical input is not an important part of CHW training. For the most part, villagers already know most of the facts they need to know on the matter. They and their neighbours do not need more facts; they need more clarification, more simplification and more motivation. (Note Apx. K 10 and 11)

Ninety per cent of enrolled-level nurses know ninety per cent of the practical information which CHWs need. The crucial training question then is "who can clarify, simplify and motivate?". It is obvious from the above that the traditional Western doctor is not the key person in this training situation.

There are a few practical features of the learner centred format which can be remembered initially by the letters "EE":

- The first "EE" principle is that "everyone should be able to see and talk with everyone else". So the group sits in a circle (Jesus taught in this format in Bible times.)

- The second "EE" principle is that we should be level with each other or "eyeball-to-eyeball". So no one stands over the group talking down at them except when writing on newsprint.

- A further "EE" is that every participant should be encouraged to make some contribution to every discussion.

The 6-A check list for the learner-centred-emphasis

The emphasis upon learner centredness can be said to rest upon six foundation stones. A learning experience built upon these stones makes for more pleasant and more profitable teaching. (The alliteration is only a temporary aid to memory.)

1. AT — Start building the lesson where trainees are "at", circumstantially or situationally or emotionally (rich or poor, happy or sad, etc).

2. AWARENESS — Build the lesson upon trainees' already existing awareness (knowledge, experience and sensitivity about the problem).

3. ATTITUDE — Build up during the lesson a good attitude in the trainee towards her/himself, other trainees, and the problem. To this end the teacher will:
   - always start with friendly personal introductions
   - frequently use the student's name
   - quote the student's observations to the whole group
   - pay attention to all students, whether they be bright, dull, helpful or unhelpful
   - accept any student ideas without putting them down.

   Furthermore, a good attitude is fostered by reward, reinforcement and reminder.

4. AGREEMENT — Build using as "mortar" whatever ideas, opinions or interests the trainees or community have in common.

5. AIDS — Communicate with the help of audio visual aids which are relevant to the student. In particular build with "codes" or "starters" (see below).

6. ACTION — Build into every session some specific problem-solving action that the student will apply in the neighbourhood. The final phase of every lesson must be detailed participatoryt planning on how to take the specific action of that lesson to the neighbourhood (who, when, where, etc.). Remember that

> TEACHING IS HELPING PEOPLE TO LEARN TO DO

Other "As" could be Aim (objective); Achievement (evaluation) and All participating.

"STARTERS" or "CODES"

We have noted that this method induces learning through problem-solving. But first the problem itself must be posed in a stimulating way. Freire's name for this stimulatory presentation of a problem is "code". It may be that he had in mind the student's struggle to unlock the problem as in unlocking a secret code. Freire also used the expression "starter" as something which starts the students thinking personally about the problem posed. For simplicity we will use only the label "starter" for a stimulatory posing of the problem at hand.

The starter can be in the form of a picture, play, demonstration, song, story, etc. But to be classed as a starter, it must fit certain qualifications:

- It is not the same as a poster, i.e. its purpose is not to remind the observer of what is already known
- Its purpose is not to transmit new knowledge
- It must portray only a single, simple, specific problem
- It must be clear and thus easily understood
- It must be relevant and close to the hearts and experiences of students (Freire's "generative theme")
- It must pose a problem
- It must not pose solutions to that problem
- It should sensitize students to the problem and its relevance to their own lives
- It must be coupled with a series of specific evocative (helpfully provocative) questions

- Its questions will concern what students have seen, heard and thought about the problem posed
- It, with its coupled questions, should generate in the students an emotional/intellectual/volitional response that leads them into action for change.

A warning is in order about the use of plays as a medium for the starter/code. Plays are so easy and so much fun that it is easy for "the medium to become the message", or to smother the message, i.e. the problem itself.

Sometimes the problem gets lost in a mass of detail of contributory factors/problems. The leader must help the group focus on one specific part of a problem at a time.

During training when using role plays it sometimes gets confusing as to which role one is assuming. A student can get so immersed in the role-in-a-role that the starter/code ceases to be a tool of learning.

A starter can be in the form of a demonstration. But demonstration of preparation of ORS often suffers when its main objective is hidden by an excess of incidental detail. The complicated hand-washing ritual, boiling of water, etc. sometimes bores the viewer before the presenter gets to the actual ingredients and their proportions. The message has been drowned in the medium.

DONT LET THE MESSAGE DROWN IN THE MEDIUM

What about teacher-student relationships? A welcome sign is when students spontaneously begin to involve the teacher as a participant in starters and their following questions. Also when the teacher and her methods are humorously satired in end-of-course fun night skits.

"SHOWED"

The type of questions which follow and exploit the starter can be remembered with the temporary help of the mnemonic word S H O W e D. This word indicates the first letter of the key word for each question.

Questions to be asked about the starter which has just been seen		Explanation of purpose of that question
1. What things did you	S ee ?	Have the people and physical objects portrayed by the starter been properly recognized by students? This is mainly a clarification question.
2. What was	H appening?	Did students recognize the problem-posed as being a problem? In their minds was it an issue? This is a key question.
3. Does this (problem) happen in	O ur community?	Is it relevant to and does it reflect students' personal experience? The question is intended to personalize or internalize the problem, to "plant" it in the soil of their own thinking and experience and sensitivity.
4.	W hy does this problem happen?	This question is to evoke causation of the problems. (Also what are the complications arising from this problem)
5.	e	(this letter does not represent a question)
6. What are we, here, now going to	D o about this problem?	What solutions are there either by cure or prevention? This is an action question leading to subsequent questions such as Who? Where? When? How? etc. These subsidiary questions take them to the community where the real problem is waiting to be acted upon.

When these questions follow a good starter, they will produce many profitable hours promoting students' self-awareness, sensitivity and self-reliance in problem-solving.

One could say after the training that the Starter had "SHOWeD" the way to the solution of the problem, through the questions, See? Happening? Our? Why? and Do?

THE LECTURE METHOD?

This method is unsuitable for CBHC because it usually involves:

- no exchange of experience
- no practice
- no stimulation of thinking
- no use of student's knowledge
- no use of student's attitudes/beliefs
- no use of student's experience
- no feedback
- no long-term retention
- no common feeling
- no follow-through

OBJECTIVES OF TRAINING OF CHWS

Training is intended to make the CHW an effective motivator of her neighbours to the end that they change their habits and conditions. If she has been effectively trained, her community will, after a time, reflect the following changes:

Cleanliness i.e. compounds more swept
face-and-hand-washing by children more encouraged Apx. K-9
dish racks more prevalent
water made more available
more water used for hygiene

Motherhood i.e. better mutual understanding and teamwork between CHWs and TBAs
more hygienic home deliveries Apx. K-7
less tetanus, polio and measles* Apx. K-13
return to "breast is best" value* Apx. K-2

Food i.e. less anaemia of pregancy
less infant toddler malnutrition*
more "colourful" (balanced) diets Apx. K-11
less dominance of "cash cropism"

Disease Control i.e. latrines better understood, then built and used Apx. K-6 & 8
home compounds more mosquito resistant
more pregnant women on malaria chemoprophylaxis and under-5s on treatment
water supplies more protected Apx. K-22
mobile immunization clinics more attracted to that community and given better patronage
more acculturation of home-made oral rehydration solution* Apx. K-12.

The asterisks indicate UNICEF's "GOBI" targets.
i.e. Growth monitoring
Oral rehydration
Breast is best
Immunization

Appendix G - lists more possible changes

TRAINING OF TRAINERS (TOT)

In 1979, under the aegis of the Christian Development Education Service (CEDES) of the Kenya Catholic Secretariat, a course was set up with AMREF collaboration to train trainers of CHWs in Paulo Freire's "Psycho-Social Method" or at least its East African derivation. The increase in popularity of the CHW idea led to an increase in demand for more such training. The CHWSU subsequently assumed an increasing share of responsibility for organizing these courses, which came to be known as TOT (Training of Trainers). These TOTs are continuing as a collaborative initiative of a team with representatives from AMREF, Kenya Catholic Secretariat, Protestant Churches Medical Assocation, World Neighbours, Uganda Protestant Medical Bureau and Nairobi University.

The TOT courses are designed for people who are already in a practical way facilitating the development of CBHC in their area. In particular they are expected to be training CHWs. The courses are composed of three one week sessions interspersed with a month or more "homework". The main objective of a TOT course is to habituate the trainer to concentrating on the student as an individual. Further to that she facilitates that student's progress through a problem-posing-solving exercise using a starter/code.

TOT graduates are visited later in their home settings by their facilitators to see how training has been turned into practice.

Appendix E lists the TOT courses thus far held in connection with the Support Unit. (Note also Apx. J-2,3,4,5,15,16 and K 3 and 17).

HOW TO EVALUATE CBHC PROGRESS

KNOWLEDGE, ATTITUDE, PRACTICE

CBHC has short and long term objectives. Short-term objectives include changed or improved knowlege about and attitudes toward local self-preventable problems.

Longer term objectives include changed or improved patterns of practice relative to those same self-preventable problems. Changed practice means changes in behaviour or habits and changes in such environmental conditions as waste, water supply, and food. Just as with a set of falling dominoes, improvement of knowlege generally leads to improvement of attitude which in turn leads to improvement of practices. When all three - knowledge, attitude and practice - are improved, health will be improved. (Note Apx. K-14).

But how can we evaluate progress towards these changes in knowledge, attitude and practice? This is difficult. The average CHW is not very literate and few CHWs ever use numbers other than when counting change from small purchases. But they do have phenomenal memories for the details of their health "domain". Slowly, carefully they are being encouraged and helped to transfer their data from their mental memory bank to paper information-gathering systems.

INSTRUMENTS

The trainer, the Health Committee and the CHWs co-operate in designing what are for them appropriate information-gathering instruments. Such instruments are still in the early stages of development so there is as yet no systematically collected "body" of data from CHWs. But it is reasonable to expect that when the instruments are devised, the data is all in and improvements are documented, everyone will be motivated by the documentation.

A warning must be sounded here against inadvertent academic abuse and exploitation of this potential CBHC information-gathering system. The primary purpose (and perhaps limitation) of any CBHC information system should be the motivation of and benefit to the CHW herself and the local programme. That purpose must not be suborned to the interests of degree hunters who pose confusing and marginally useful and possibly disturbing questions. One large CBHC programme had inflicted upon it by the donors a professionally designed information-gathering "system" with 34 separate information forms. But that programme was unable after several years to document even the increase in prevalence of latrines!

This was "top-downism" at its worst. In contrast in another place the local Health Committees are in full charge of information gathering. Their information system is truly a tool of local self-development.

That surveys can have a very important motivating place in CBHC programmes is evidenced by the following:

> In Tanzania an annual national event of major importance is the carrying through all the 21 regions of the country of an Olympic-like torch called "MWENGE". "MWENGE" stands for the healthy revelation and illumination of all shortcomings in nationhood. It is a very stiring experience for every community through which it passes. So one CBHC programme was pleased when the chief likened that CBHC programme's just-completed survey to a form of "MWENGE". Through their survey they had illuminated or sensitized themselves to the need for health development.

INFORMATION SYSTEM MUST BE PRIMARILY A PRACTICAL TOOL OF LOCAL SELF DEVELOPMENT

Baseline and recurring community-wide diagnosis or survey information instruments should be designed with the CHWs and be, to them, tangibly useful. The survey or monitoring system can be two-tiered, i.e. a CHW-designed instrument paired with a more sophisticated outside instrument. But an upper-tier-only approach is just "informational feudalism". Appendix F is a simple prevalence survey instrument which is within the capability of most CHWs. Even the illiterates can use it with the help of a Standard Five student. Facilitating such surveys should be a major responsibility of the local Health Committee or its equivalent.

"HEALTH HAPPENINGS" Appendix G is an instrument for continuous incidence information-gathering. It has proven to be suitable for both literate and illiterate CHWs. It is being used in a number of programmes (with local artistic modifications). Periodically the CHW and her leader collate, analyse and discuss the implications of the information she has gathered. It gives them a simple picture of those changes which are the purpose of CHWs and CBHC.

There is finally the matter of inter-program comparisons. Appendix H, is a questionnaire for active CBHC programmes with respect to common programme elements. In this as-yet-evolutionary phase of CBHC, such comparisons can be helpful to the new starters. The questionnaire brings out the very important point that every locality is unique and requires its own formulation of what constitutes CBHC. At the same time the questionnaire contributes to the development of esprit de corps among CBHC programs despite their local differences. It reveals to what extent people are doing similar things in a similar way.

Many CHWs keep diaries of day-by-day activities. Some have also some sort of family registration system to which the daily information is related. But the yield from these diaries has been disappointing. The entries often seem to be just a recitation of learned lingo with little insight provided on the family visited. When the diaries contain contradictory or impossible information one is not sure if the problem is illiteracy or indolence.

Some CHWs are given Nairobi-designed Health Centre-like registration books with multiple columns and categories of information. It is doubtful that these will prove any more useful to the CHW herself than the diary format. It is easy to forget that the CHW is a fairly average rural villager and that her great social aptitude is not necessarily accompanied with academic aptitude.

The following are some of the common changes hoped for in CBHC. These changes will often be a direct result of the CHW's motivating influence on individuals. These changes are all countable and monitorable by CHWs, even the illiterate ones.

CHW-COUNTABLE COMMUNITY CHANGES

Diarrhoea: Decrease in incidence (Note Apx.K-19)
BCG scar rate increased(Note Apx. K 13 & 16)
Antenatal care attendance rate increased(Note Apx.K 16)
Protected water sources in more locations
Latrine prevalence increased (Note Apx. K-6,8,21)
Kitchen gardens prevalence increased
Oral rehydration (1-1-1 mixture) more known
and used (Note Apx. K 12-19)
Case/defaulter finding (TB/Leprosy) improved
Safer fuel-saving stoves used by more homes(Note Apx.K-20)
Dish-drying racks usage increased
Water storage improved
Weaning process started earlier
Weaning process ended later
"Mix colours" diet idea more prevalent (Note Apx. K-11)
Child-spacing more prevalent
Sleeping rooms cleared of animals in more homes
Knitting of warm clothing more common
Malnutrition more closely monitored (Note Apx.K 1 &16)

Bottle feeding less prevalent (Note Apx. K-2)
Delivery hygiene using "Kibiriti Kit" more common (Note Apx. K-7)
Water purification in homes increased
Food protection cupboards more prevalent
Grain storage provision improved
Poultry, fish, rabbits, etc. production increased
Handcrafts for income increased
Trees and terraces found in more compounds
Leaky tin hygiene ("Sukuma Maji") practised in more homes (Note Apx. K-9)
First Aid knowledge more prevalent (Note Apx. K-5)
Malaria more managed (Note Apx. K-10)

Each community has its own most pertinent set of desired changes or issues. In Chogoria it is family planning (perhaps mainly because of donor influence); in Kisii nutrition rehabilitation; in Litein and Nangina the feeling is strong that the most important change is spiritual and that that change will trigger off a host of other changes. (The majority of programmes actually share this latter view.)

Wishful thinking (by outside helpers or community) can of course influence perceptions of change. Some changes may turn out to be more anecdotal than actual. Hence the importance of baseline and recurrent surveys and continuous monitoring of countable changes. (Note Apx. J1,12,13,18)

UNCERTAINTIES

CBHC is a new phenomenon and so there are still many uncertainties about it. The uncertainties concern such matters as:

- timing
- medicine
- voluntarism
- government
- politics

TIMING

The CBHC premise depends heavily upon two inter-related factors. The first factor concerns the durability of the CHW's spirit of voluntarism on behalf of her neighbours. The question is, how long will her voluntarism last? Will it stay alive and keep her actively motivating her neighbours for a year or two? Will it be so even without either material reward or the psychologic reward of neighbours showing positive behavioural responses? The second time factor concerns the rate of growth of the neighbours' responsiveness. How soon or how fast will they understand and respond in spirit, word and practice, to the CHW's motivation? How long will it take for them to start changing their habits and conditions? Or, how soon will they begin to feel like rewarding the CHW in a material way?

The CHW and her community of course affect each other's performance. They are interactive. For example:

- If a CHW is known to receive a salary from outside, then her motivating influence on her neighbours is greatly reduced. They see her as being "paid to preach". That concept interferes with her influence in raising their response.

- If the neighbours are progressive and respond behaviourally to the CHW's motivations, that psychological reward (their responsiveness) will change the picture. It will, in the CHW's mind, be a significant substitute for the material reward that the CHW might otherwise begin to expect from them (or from donors).

- If on the other hand the neighbours are reactionary or slow to respond, the CHW's own reservoir of voluntarism will soon run dry.

- If the CHW is a keen communicator and good example setter the whole timing will be speeded up. The neighbours will not have to await the results of their own personal trial of health changes. They will see results already at hand in the home and life of their CHW neighbour. This is a "head start" on motivation.

So in summary, CBHC depends mainly upon the interaction between CHW voluntarism and neighbour responsiveness. Compared to voluntarism, drugs, transport, funds and referral are of secondary importance in CBHC. Appendix I is a graphic portrayal of six hypothetical interactions. The perseverance of CHWs in serving their communities has been very good. Most programmes have less than 15% drop-out at the two year point.

HEALTH WITHOUT MEDICINE?

Another important consideration in the rationale for CBHC is the concept of "health without medicine", i.e. the preventability of disease. This concept is weak at all levels - from directors and doctors down to villagers. Directors, doctors and villagers all tend to be "PP-NN" focused. That is, their health focus tends to be on a "pill for every problem and a needle for every need". If this preoccupation is not reduced at every level (especially at the clinical), then CBHC will not be able to work at the village level.

But what is the prospect for changing the present dis-balance, in peoples' minds, between prevention and cure?

- can the clinician change his own perspective and habits?
- can he in turn change the nature of his influence on the community?
- can the preventionist get off the clinician's coat tails and influence people without having to use medicine as bait?
- can ordinary people be weaned off the "PP-NN" habit engendered by medical and commercial influences?
- can a clearer line be drawn between peoples' "felt" (subjective) need for drugs and their real need for drugs?
- can there develop an objective an aculturation of such preventive practices as the leaky tin, kibiriti kit, safe stoves, BCG scarrecognition, dishracks, 1-1-1 diarrhoea mix, mixed-colours diet, etc?

The CBHC movementis based primarily upon the hypothesis that people can be induced to start thinking and acting preventively on their own. The single most important challenge in the health field today is the attainment of a more rational balance between cure and prevention: CBHC is not against curative medicine. There is a place for curative medicine in CBHC. But CBHC is against the currently irrational and dependence-creating disbalance towards PPNN. CBHC favours the release of health care from the grip of drugs and drug pushers. This release is nowhere more important than in the field of CBHC. CBHC leaders believe that this release of peoples' minds and imaginations from drugs will bear fruit.

The fruit will be in the form of improved knowledge, attitudes and practices, enabling that community to have less morbidity while using fewer drugs.

VOLUNTARISM

a. Why it does not work

The idea of CBHC voluntarism is viewed with scepticism by most health workers. Their scepticism is based on one or more of the following interpretations of the situation:

- Where CBHC is most needed the people are least able to spare the time. It is felt that they are so busy meeting their own basic survival needs that they have no time to spare for their neighbours' health needs.

- There is not enough altruism or generosity of spirit to form a voluntary base for a CBHC structure. This view in effect says, "One-day exhibitionistic or extortive harambees? - Yes. But day-by-day private personal harambee? - No".

- The spirit or flame of voluntarism is likely to be dampened or extinguished by the river of outside aid. After all, what person is going to be an unpaid volunteer when they see lorry loads of free food, clusters of salaried assistants surrounding the donor agent, money for pumps and allowances for seminar excursions, etc?

- Health care is ultimately a government responsibility, and "no one will do anything for the government for nothing."

These negative perspectives are real and reasonable. But they are not the only reality, they are not the whole picture. The fact is that voluntarism is working. People are giving of their personal spare time to help and motivate their neighbours in matters of health. The very existence of such voluntarism is quite remarkable, given the hindrances mentioned above. What is the explanation for this survival of voluntarism?

There are two main explanations.

b. Why it does work

Voluntarism was probably at one time long ago a strong element in these cultures. (TBAs are a surviving reminder of that past indigenous voluntarism.) Then for a time voluntarism was crowded out by government or mission paternalism. Today that indigenous cultural "root" of voluntarism is being revived within CBHC.

Also the Christian ethic and motivation combine to produce voluntarism. CHWs represent a response to the biblical admonition that "faith without works is dead". For the most part, in East Africa at least, CBHC voluntarism has emerged from religious social associations.

However, you cannot build a CBHC programme only on the generous spirit of a few CHWs. Their spirit is vital to starting a programme, but if their spirit does not become "epidemic" among their neighbours, the programme will die. Apropos of this, the CHWs are not the real health workers. The CHWs are just motivators. The real health workers are the CHW's neighbours. In response to the CHWs motivations they work to change their own habits and conditions. That is the single most important fact about the CBHC movement. Part-time individual CHW voluntarism, vision and dedication must be facilitated and guided in such a way that it will produce communal commitment and work towards changed habits and conditions. CBHC must become, as has been mentioned, a "loaves and fishes" type of replication. This is important in view of the likelihood that for economic and organizational reasons CBHC is likely to be the only new local health development for many communities for many years yet to come.

GOVERNMENT

Voluntarism and government control do not go hand in hand very well. Nowhere in the world do people work for the government "for nothing". Furthermore a given group of volunteers would be less motivated by a local (paid) leader who represents a "government programme" than by a leader who is not tied administratively to central government. So a central government-structured "programme" would face handicaps.

But the hand of bureaucracy and the hand of blessing are two very different phenomena. If central government could trust their Health Centre level staff enough to "bless" their local individual initiatives, the effect might be greater than that of a nationally structured "Top-down" programme. Of course those local Health Centre initiatives would at first have to be within the limitations of existing Health Centre resources.

CENTRAL GOVERNMENT CAN EXTEND THE HELPING HAND OF "BLESSING" OR THE HEAVY HAND OF BUREAUCRACY

But where there is a will there will be a way - whereby the Health Centre staff can amalgamate intra-mural and extra-mural (CHBC) interests. For example the Mobile Immunization Clinic could be structured to help and be helped by CHWs. The benefit of this mutual moral support would be enormous, and without any added cost or bureaucracy.

What about government "supervision"? Practical perspectives are needed on this issue. The average CHW is not practising medicine any more than is the local shopkeeper. She is more advisor than clinician. She is not endangering people through introduced chemotherapy. Rather she is, by her advice, reducing the danger of ignorant selection of the duka medicine which her neighbours are going to buy anyhow.

As long as the CHW's basic training is sound there is very little need for regular supervision of her barely-existent "medical practice". The same applies to her possible role as partner to the local TBA.

THE AVERAGE CHW IS NOT PRACTISING MEDICINE ANY MORE THAN IS THE LOCAL SHOPKEEPER

So technical clinical supervision is minimally needed. Furthermore if the supervisor came in the classic askari (police inspector) role it would do more harm than good.

Of course technical supervision is not the same as moral support. Every CHW must have some sort of regular moral support from her trainer/leader, preferably in the form of shared days on the paths and in the homes.

In summary then, one could make three observations about (central) government's role:

1. Administrative structure? Full of difficulties.
2. "Blessing"? Important and necessary.
3. Supervision? Only practicable in a modified limited form.

In East Africa relationships between Ministries of Health and NGOs on the matter of CBHC have been rather indefinite. At times the relationship has resembled the classic situation where two ladies find themselves together in public wearing the identical new fashion of dress. They act as though they are embarrassed by each other.

In one country sponsors of a one-week all-parties-invited NGO workshop on CBHC had to use considerable pressure to get a representative of the Ministry to attend for even one session.

In another country the ministry started planning a CBHC programme in the same location where an NGO had one already underway. The CHWSU, reference centre at AMREF had made a consultation visit to the NGO site, but had received no queries or information about the ministerial plans for the same place.

In contrast, it is good to report that in yet a third country, in one district health ministry people are humbly but happily profiting from attending an NGO's workshops on CBHC. There there is emerging a fine spirit of collaboration in the interests of health beyond the dispensary.

Inter-NGO relationships are for the most part congenial and constructive. The TOT courses have brought out the more truly Christian elements of ecumenicism and those relationships have "sprouted" back in the communities, where different CBHC programmes adjoin or even overlap. There has been only one instance known to us of one group of CBHC sponsors "intruding" on a pre-existing CBHC-type local initiative. Even that might have been an inadvertent result of careless planning.

POLITICS

Things are not made easier by politics. The programmes at Bushenyi and Saradidi have learned that church and clan politics can be almost as troublesome as measles. Busuyi and Mityana have been innocent victims of civil disorder and at Mbarara a programme's birth is being delayed by politics with an international cast. In East Pokot inter-tribal animosities have destroyed the communal sense of security and trust with which CBHC must start.

IMPLICATIONS FOR FORMAL HEALTH WORKERS

What are the implications for the medical establishment of this beyond-the-dispensary CBHC? Is it competitive or is complementary? To the clinician whose livelihood is the treatment of diseases, CBHC might at first seem to be threateningly competitive. But in fact CBHC should be seen by clinicians as helpfully complementary.

Why is this so? Clinicians, whether they be doctors, clinical officers or nurses with clinical expertise, are at their best when performing as experts. Experts do not do well when forced to spend 50-75% of their time re-cycling common and, to them dull diseases. They tire of being re-cyclers, which is, as mentioned earlier, treating the SAME child for the SAME preventable condition, with the SAME medicine, so the SAME children can return to the SAME environment, to get the SAME condition again and again and again.

But modern man's preoccupation with a "pill for every problem and a needle for every need" brings these demotivating diseases, along with serious diseases, to the clinician in long queues for re-cycling. How can the queue be culled out, leaving only a manageable number of cases which really need expert care? In places where CBHC is working well as a true community enterprise, the occurrence of these de-motivating, dull preventable diseases will decline. Where they do not occur, they do not clog up the clinician's queue. In that case the clinician "NEXT-PERT" becomes free to revert to what he/she was trained to be and is happiest at being - an "EXPERT". Conversly, the villagers' own self-reliant initiative towards reducing the occurrence of common preventable diseases has another benefit. It results in their families' receiving from the clinician more expert attention to their fewer but more serious unpreventable diseases. Thus clinical practice and CBHC are truly complementary and mutually beneficial.

CONCLUSION

The central philosophy and practice of CBHC has existed in one form or another for many years. But it has been overshadowed by the popular and professional fixation on clinical institutions and chemotherapy (pill for every problem and needle for every need, the PPNN syndrome). This approach, however, is leading to relative bankruptcy in service as well as finance. WHO/UNICEF, in response to that situation, organised Alma Ata and a renewed world-wide primary health care campaign. The most peripheral half of PHC is CBHC. CBHC has revived and re-articulated some long dormant ideas about community participation in health maintenance and is promoting these ideas in a communication mode which borrows much from Paulo Freire. CBHC is health by the people, catalysed by their own CHW in their own neighbourhood BEYOND THE DISPENSARY. CBHC gives balance to PHC.

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:

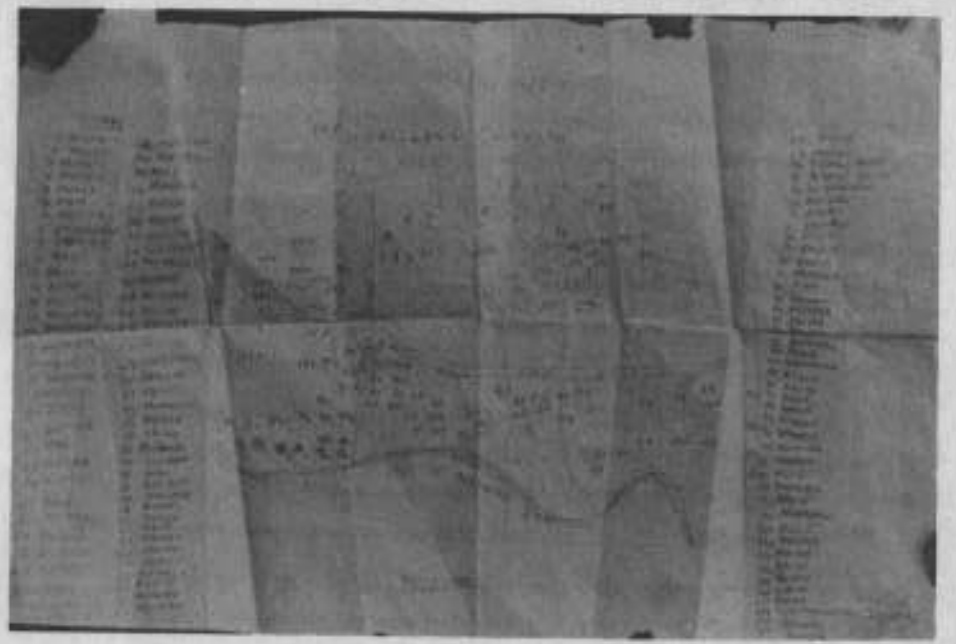
1. reflects and evolves from the economic and socio-cultural characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experiences;
2. addresses the main health problems in the community, 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
Bukungu	✓		
Bubonjo	✓		
Busabaga	✓		
Bushenyi	✓		
Busuyi	✓		
Chagoria		✓	
Enkorika			
Gulu	✓		
Hanang			✓
Kabras		✓	
Kololeni		✓	
Kamweleni		✓	
Kappedo		✓	
Kapsowar		✓	
Kasanga	✓		
Kibwezi		✓	
Kiparaman		✓	
Kisii		✓	
Kisumu (Cath)		✓	
Kisumu (AKF)		✓	
Kingum	✓		
Kinovu	✓		
Kiyinda	✓		
Litein		✓	
Lokichar		✓	
Lwak		✓	
Machakos		✓	
Manyata		✓	✓
Marigat		✓	

PLACE	COUNTRY U	K	T
Maseno (S)		✓	
Maua		✓	
Mbale	✓		
Mbarara	✓		
Mityana C of U)	✓		
Mt. Kenya E		✓	
Mushanga			
Mukumu		✓	
Mvumi			✓
Nangina		✓	
Ortum		✓	
Rhamu		✓	
Rombo		✓	
Ruiinga		✓	
Soroldi		✓	
Tiganio		✓	
T-4 (Ngoara)	✓		
Tiriki		✓	
Undugu - Urban		✓	
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 these 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 "Mis-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.

AGES	SEXES: Male	Female	Total
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 5yrs. (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 barazas spoken to	○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○		
7  Special group health discussion	○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○		
8  Group project completed	○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○		

What you have seen new	Cases ●	Total	date
9  Personal first home visit	○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○		
10  Newly improved cooking Place	○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○		●
11  New dishrack	○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○		
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	○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○ ○○○○○		

What you have seen new	Cases ●	Total	date
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	ANSWERS
A1. What specific person in the community mainly helped "plant the seed of CHW?	Church-related, School - related, Chief Medical student, other.
2. What specific outside person (nurse, doctor etc.) mainly helped to "plant the seed?"	Medical 10, Nearby CHW 1, Church 1
3. What specific institution (if only) was mainly involved in sponsorship?	Mission 10, CHW 2 non-CR-NGO 1
4. Is a local Health Committee non-existant, of little help, helpful?	Helpful 8, little help 3, non-existant 3.
5. Has the community generated any money for helping CHWs through local projects? Yes, No.	Yes 6, No 8
6. What are three most important criteria for selection of CHWs? I), II), III)?	Respect 9, permanent resident 7, interested/ motivated/community/likes people/"heart"/ understanding 7, have skills 4, others 3 or less.
7. Who makes the final selection of individual CHWs?	Health Committee 8; parish/community 5 chief 1; baraza 1;
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.	Very clear 7; clear 6; unclear 1.
9. Was written survey done of the CHWs community? If so, when was it done? Before training, during Training, after training.	During training 7; Before 5; after 1 no resp. 1
10. In what year did this groups start training?	

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

QUESTIONS	Zero	little	important
11. Outside aid in the form of money or materials was /is	2	6	6
12. Outside aid in the few of human motivators was/is	1	6	7
13. Today local leadership in running the the programme is?	2	2	10

QUESTIONS	ANSWERS
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	Registered Level nurse 6; Enrolled Nurse 5; Teacher 2; Doctor 1
2. What % of training (excluding field work) is by LECTURE?	24% (0-5)
3. What % of training (excluding field work is by PSYCO-SOCIAL	63% (25 - 100)
4. What % of training (excluding field work) is by other method.	13% (0-40)
5. Regarding CHW. Within her first six months, how many days in total of training in a group does she get?	1 - 2 weeks 4 average 24 days 3- 6 " 7 range 6 - 24 days Over 6 2 No response 1
7. Is the main trainer also the main field supervisor after training?	Yes 11; No 3.
8. What % of her total time is CBHC/CHW work?	Aug. 81% (range 33 - 100)
9. How many CHWs have been trained so far in this location?	Range: Places 0 - 49: 5 50 - 99: 3 100 - 149: 1 50 - : 4 No response: 1
12. What are two most important textual materials used in basic training (say first 20 training days?)	Warner 9; Wood 3; Others 6 No response 4;
C. REGARDING CHWs work	
1 Estimate the average individual CHWs coverage in terms of homes	Homes 15;15; 20;20; 40; 50; 80; 100; 128; 200; 300; NR 3
2. What about nearest medical facility?	Km ½;½; 4;4; 6; 7; 10; 15; 16; 20; 48; NR 3
3. What is CHWs acceptance by the staff of the facility	Lukewarm 7; Team-mates 5; No recognition 1; NR 1.
4. What moral support does CHW get from the community in general?	Satisfactory 6; little 5; good 3;
5. Number these activities in order according to the time you estimate the average CHW spends on them	Home > Women Groups > Clinic > Public Meetings

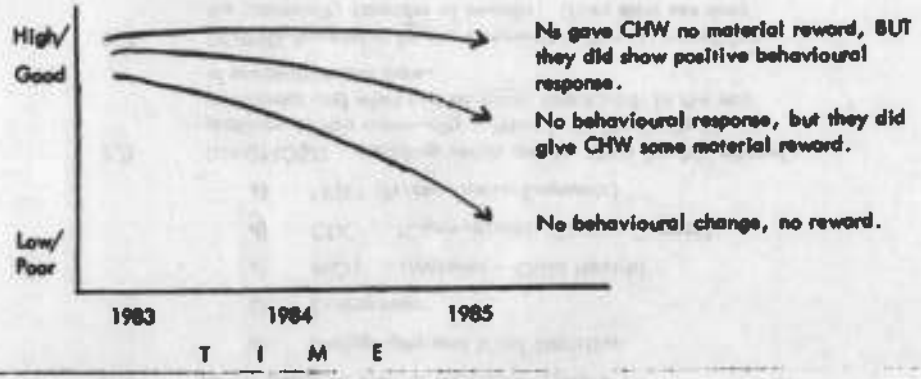
QUESTIONS	ANSWERS
6. What <u>drugs</u> does CHW dispense? Chloroquine, eye antibiotic, aspirin other, other.	Chloroquine 9; eye medicine 7; worm 3; no drugs 5.
7 What is the <u>financial</u> arrangement for these drugs? Free, sold out, sold for profit?	Sold at cost 4; profit 3, free 2 not applicable 5.
8. How <u>important</u> 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 <u>Psycho-social method</u> 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 <u>systematic questions</u> which draw solutions from the peoples' own discussions?	Little 8; much 4; very little 2
11 Name these <u>problems</u> in order (no 1 = most time) according to CHWs estimated total time spent on each of them	Waste problems Malaria Water equal to diarrhoea Pregnancy
12 On which health problems does she keep an up-to-date <u>record of named cases</u>?	Diarrhoea 8; eye 7; malnutrition 6; birth 5; death 4; TB 4
13 Does she keep <u>prevalence figures</u> on:	Latrines 11; Water 6; Stoves 3; No response 3
14. What are the two most <u>technical inputs</u> 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)

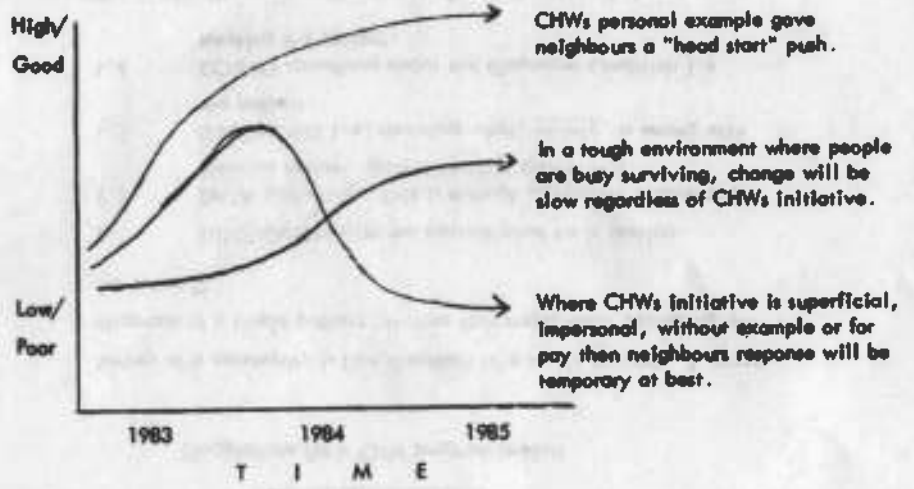


Ns gave CHW no material reward, BUT they did show positive behavioural response.

No behavioural response, but they did give CHW some material reward.

No behavioural change, no reward.

B. Neighbours' Response → CHW's Initiative
(changed habits and conditions) in motivating neighbours
as influenced by



CHWs personal example gave neighbours a "head start" push.

In a tough environment where people are busy surviving, change will be slow regardless of CHWs initiative.

Where CHWs initiative is superficial, impersonal, without example or for pay then neighbours response will be temporary at best.

From The Community Health Worker Support Unit or AMREF

PRACTICAL NOTES FROM THE SUPPORT UNIT

(J-1)

COMMUNITY SURVEY

(Suggestions for a CHW program leader)

1. Survey of a community is like diagnosis of a single patient. A proper diagnosis of a single patient involves four steps, each beginning with the letter D.

   1.1 DISCUSSION with the patient what he is feeling.

   1.2 DATA gathering. This is through systematic examination (nervous system, gastrointestinal system etc).

   1.3 DIAGNOSIS i.e. deciding what, mainly, is wrong with the patient.

   1.4 DOING something about the diagnosed condition i.e. treating the patient.

2. Community Diagnosis or Community Survey involves the same steps:

   2.1 DISCUSSION with many ordinary people in the community about their "felt needs", concerning family and community.

   2.2 DATA gathered from at least five "systems":

   a) Demography and Vital Statistics

   b) Environment

   c) MCH (Matenal - Child Health)

   d) CDC (Communicable Disease Control)

   e) "PSE" (Psycho-Socio-Economic)

   2.3 DIAGNOSIS - deciding which are the Main health-related problems of this community. What is their priority of seriousness and what can be done about each in the way of prevention and cure.

   2.4. DOING Something for the community, that is, something the community consider of benefit. (They dont see data as a benefit.)

3. Some notes on details:

   3.1 DISCUSSION: Make sure that the group of people interviewed are truly representative of the community as a whole. (the sample)

   3.2 DATA: For any community you should be able to produce most of the following data from your visits to randomly sampled households:

   a) DEMOGRAPHY and Vital Statistics

   1) % of population under 15. $\frac{15s}{\text{Total Pop}} \div = \square$

   2) Birth Rate (Per 1,000) $\frac{\text{born in past year X1,000}}{\text{Total population in sample}} \div = \square$

   3) Death Rate (Per 1,000) $\frac{\text{Died in past year X1,000}}{\text{Total population}} \div = \square$

   4) Infant Mortality Rate (Per 1,000) $\frac{\text{Died under 1 year X1,000}}{\text{Total born in year in sample}} \div = \square$

   b) ENVIRONMENT

   1) Water consumption (Litres per person per day) $\frac{\text{Total litres used per day in home}}{\text{People living there}} \div = \square$

   2) % of homes with latrines $\frac{\text{Total latrines}}{\text{Total homes}} \div = \square$

   3) % of main dwelling houses built mainly of permanent materials (metal, brick, cement). $\frac{\text{Houses "Yes"}}{\text{Total houses counted}} \div = \square$

   *"Concerning roof, walls and floor; are 2 of these 3 made of permanent materials?"

   c) M.C.H.

   1) % of pregnancies being seen at ANC

   $$\frac{\text{Total pregnancies seen at ANC}}{\frac{1}{20}\text{th of total Pop}} \div = \square$$

   2) % of $<$5s under weight $\frac{<5\text{s under 80\%}}{\text{Total } <5\text{s}} \div = \square$

   3) % of $<\frac{18}{12}$ not on breast $\frac{<\frac{18}{12} \text{ off breast}}{\text{Total } <\frac{18}{12}} \div = \square$

   4) Average spacing between $<$5s. = ___

   d) C.D.C.

   1) Spleen rate (%) $\frac{\text{Kids 1} < 9 \text{ with palpable spleen}}{\text{Total kids 1} < 9} \div = \square$

...../3

2) Haematuea rate
(Where applicable) $\frac{\text{dip-stick pos. for blood}}{\text{Total Tested}} \div = \square$

3) Scar Rate (%) $\frac{\leq 5s \text{ showing BCG scar}}{\text{Total} < 5s} \div \square$

4) % of registered T.B. patients attending regularly $\frac{\text{Up to date attenders}}{\text{Total registered for attendance}} \div = \square$

5) Chronic ($>$1 month) cough rate $\frac{\text{Coughers}}{\text{Total}} \div = \square$

e) PSE (Psycho-Socio-Economic)

1) 5 Main sources of livelihood

2) 5 Main things for which cash is paid

3) Priority ranking (worst first) of these 7:
Alchaholism ( ); School-girl pregnancies ( )
Divorce ( ); Crime ( ); unemployment ( );
Leaderlessness ( ); Poor schools ( ).

4) % of 5 $<$15 years olds in school

$\frac{\text{Total regularly attending}}{\text{Total living}} \div = \square$

3.3. "Diagnosis" should also consider two things.

a) How each main problem is contributed to or worsened by other community conditions i.e. "contributory factors".

b) What is the community's knowledge attitude and practice with regard to the main problem.

3.4 "Doing" should be in two ways.

a) "feed-back" of information, telling the community what you have found from the survey and discussing it with them.

b) "Action" i.e. doing something of practical benefit with them This can be an immunization program, protecting a spring or demonstrating how to make a latrine slab etc.

...../4

4. CONTACTS People you should have contact with regarding the Community Diagnosis or Survey.

4.1 Medical

(a) Hospital	(b) Health Centre (nearest)
1. MOH	1. R.C.O.
2. D.P.H.N.	2. E.N.
3. D.P.H.O.	3. P.H.T.
4. Lab Head	

4.2 Administration etc.

(1)	D.C.	(4)	Asst. chief (sub-location)
(2)	D.O. (Division)	(5)	If possible, DAO, DEO, DDO, etc.
(3)	Chief (Location)		

4.3 Community

(1)	Teacher	(3)	Maendeleo Leader
(2)	Business Leader	(4)	Pastor

5. MATERIALS

5.1 Questionnaire drafting, field testing, printing, collating, punching analysis forms, blinder, pencil, eraser.

5.2 Anthropometrics - Scales, pants, tapes, wt/age graph.

5.3 Miscellaneous - walking shoes, map, lunch, carrying bag.

6. DATA (already existing data on this community)

6.1 Hospital source

(a) TB (admissions, registrees, delinquents)

(b) PCM cases

(c) OB problems

(d) Immunization coverage

6.2 Other Sources

(a) Crops

(b) Transport

(c) Water

ORGANIZATION OF A WORKSHOP

1st Meeting of Care Planning Group

1. Topic, Objectives (Purpose, Aim, Goal etc)
2. Sponsor. Who will pay?
3. Possible dates and duration. (Check for conflicting holidays etc)
4. Possible places, Scout for several possibilities.
   a) Amenities: Eating and other recreation, sleeping, sanitation, electricity, water Meeting Rooms, phone contact, shops, secretarial/duplicating help
   b) Costs (board, lodging, other)
5. Participants and number (limit)
   a) Names, addresses and cadre
   b) Invitation letter (specific criteria and commitments, map, dates, transport), response slip Yes —— No ——
6. Facilitators
   a) "Pool" of possible facilitators
   b) Recruitment letter (information)
7. Next planning meeting
   a) Date
   b) Place
   c) Check list of Tasks (facilitators' "homework" before next meeting)

2nd Meeting

1. Confirmations of:
   a) Attenders
   b) Place
   c) Facilitators
   d) Tasks
2. Finalize
   a) Staff (Facilitators)
   b) Sponsorship and payment
   c) Dates/Schedule
   d) Booking
   e) Materials
   f) Liaison with local leaders
   g) Expectation (objectives) and method of evaluation of (a) what learned
3. Sharing Responsibility (Check list of specific assignments to facilitators and students).
4. Set time for pre-workshop final planning meeting at site.

At Workshop

1. Confirm completion of assignments
2. Specific arrangements for ensuring participants' practical experience in
   observing
   participating
   evaluating
   planning
3. Re-check shared responsibilities
4. Schedule daily re-planning and evaluation sessions by staff

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Post-Workshop Meeting

1. Review by records and reflections
2. Evaluate (successes, failures etc)
3. On-going plans
4. Pay bills
5. Formal report
   Who will write?
   Printing?
   Distribution?

From The Community Health Worker Support Unit At AMREF

EVALUATION OF WORKSHOP

1) At the start of each session write its topic in the correct time line.

2) At the end of the session tic one rating box for that session.

DAY	TIME	TOPIC	RATING					COMMENT
			Poor	Not OK	OK	Good	Very Good	
MONDAY	Bk-fst-Tea							
"	Tea-Lunch							
"	Lunch-Tea							
"	After Tea							
"	Evening							
TUESDAY	Bk-fst-Tea							
"	Tea-Lunch							
"	Lunch-Tea							
"	After Tea							
"	Evening							
WEDNESDAY	Bk-fst-Tea							
"	Tea-Lunch							
"	Lunch- Tea							
"	After Tea							
"	Evening							
THURSDAY	Bk-fst-Tea							
"	Tea-Lunch							
"	Lunch-Tea							
"	After Tea							
	Evening							
FRIDAY	Bk-fst-Tea							
"	Tea-Lunch							
"	Lunch-Tea							
"	After Tea							
"	Evening							

COMMUNITY HEALTH WORKER SUPPORT UNIT AT AMREF

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12 STEP CHECK-LIST FOR TRAINERS

Steps 1-6 are long term background plans made with the community

PROBLEMS

1. COLLECT all health-related problems. Note which are most serious, most common most "felt".
2. DECIDE which are solvable by the people and suitable for CHWs to tackle
3. CHOOSE to start with the one problem of overcoming (preferred by CHW) which people have best chance

SOLUTIONS

4. COLLECT all parts of all the possible solutions to that chosen problem
5. DECIDE which solutions are relevant to CBHC because they are "discoverable" understandable, performable.
6. CHOOSE to start with the one part of the solution which people are likeliest to succeed in

Steps 7 - 12 are for each lesson session.
This lesson focusses upon _____ as a solution to the problem of _____

			YOUR NOTES
7	KNOWLEDGE facts	- List all the specific facts needed about this Specific part of solution. - Which facts do students already know? Build upon that awareness. Dont confuse them with facts which they do not need for this lesson.	
8	ATTITUDES beliefs	- How might this lesson be affected by attitudes (mine, theirs, community)? - Which attitudes, beliefs etc. help? - Which attitudes, beliefs etc hinder? - What can I do about that?	
9	PRACTICAL needs	- What physical things are needed? - What resource people could help? - Am I practicing practical lessons beforehand - (ORS etc)? - Is the place suitable and ready?	
10	METHOD	- How will I pose the problem? - Will that make students think of their own personal experience? - Will I give students a chance to practice together in class? - Will the lessons include students' plans for practice in community?	
11	ASSESSMENT Measuring	- In what ways can I actually measure how things are progressing with myself as teacher, my students as learners and the community as changers? Try for one measurement for each box.	
12	TEACH Doing it	- Good teaching is helping people to learn to DO things. Will my lesson get people to doing something?	

	TEACHER	LEARNER	COMMUNITY
KNOWLEDGE			
ATTITUDE			
PRACTICE			

From: CHWSU at AMREF

TEACHER'S SELF-EVALUATION EXERCISE

STATEMENT	RATING (Make a tic on the line which applies √) worst lowest least seldom 1 2 3 4 5 best highest most often	COMMENT
1. I give my students opportunity to practice or apply knowledge in practical ways.		
2. In my lectures I stop and draw thoughtful feed-back from my students regarding what I am saying.		
3. I encourage my students to exercise their own initiatives (mental or practical) in mastering a subject.		
4. My daily teaching includes ways of "rewarding" good work.		
5. My assignments are such that the student can objectively measure his success in mastering them.		
6. My emotional relationships with my students are relaxed and friendly and caring.		
7. My teaching includes the connection of my subject with other disciplines.		
8. My teaching includes stimulations or role-playing.		
9. My teaching includes actual case studies.		
10. I give my students a chance to measure their progress half way into a course.		

...../2

Statement	Rating worst lowest least seldom 1 2 3 4 5 best highest most often	Comment
11. I give students a chance to show what they do not know, without shaming themselves.		
12. My teaching includes clear, simple relevant audio-visual aids.		
13. My course content is relevant to the job the student will actually be expected to do in the field.		
14. My course includes relevant interesting presented "on-the-job" visits.		
15. I change my course content to fit changing circumstances.		
16. I take time to explain a student's error to him.		
17. I give practical examples of my points.		
18. I make allowance for individual students' differing aptitudes and pace of work.		
19. My lessons are carefully planned and prepared.		
20. I keep aware of my ex-students' (graduates') performance in their jobs.		

COMMUNITY-BASED HEALTH CARE MISCONCEPTIONS

A prevalent problem in society today is schoolgirl pregnancies. The root causes of these conceptions may be ignorance, rebellion, need to impress, conformity to a fad, impetuousness, excapism or sheer self-centeredness.

These may originate with either or both parties - the un-wed mother or the un-wed father in the case.

But whatever the instigation, the result is the same, an unfortunate "Miss-conception". Temptation has triumped over responsibility. Neither party is really ready for parenthood. Neither party has the knowledge, attitude or experience needed for parenthood. All three lives get off to a handicapped start.

The "Miss-conception" problem can serve as an analogy to warn us against mis-conceived CBHC programmes. Some CBHC programmes are being started ignorantly and impetuously just because "everyone is doing it" and because the opportunity is there.

But "opportunity" in some cases is not far different from rape and among the agressors can be found both donor agents and ministerial bureaucrats. (In some cases it looks like "gang rape").

When we look at the background to "Miss-conceptions" we find that seduction is a two-way street. And so it is also in the mis-conception of a CBHC programme. A local maendeleo leader will say anything or pose any public role that may entice an outside agent to plant in her community that mythical "box of PHC goodies". Likewise any up and coming bureaucrat naturally wants to attract to himself programmes which can confirm his creativity, his "udume".

Parenthood of a CBHC programme is a serious step. The over-ridingly most important consideration must be the local long term concerns of the community which must "gestate" the programme and live with it on and on, long after the outside instigators have left the scene.

In the evolution of CBHC temptation must not triumph over responsibility. Responsibility requires the prior acquisitionol of sound knowledge, a mature attitude and careful small-step-by-small-step practical experience - by both parties.

The Community Health Worker Support Unit at AMREF has the experience, the working contacts and the mandate to facilitate the acquisition of such knowledge, attitudes and practice.

From the Community Health Worker Support Unit at AMREF

"WHY?" And "COULD?"

(The Two Most Important Questions in Health Development)

"WHY?"

1. Why are some people hungry?
2. Why " " " lazy?
3. Why " " children not in school?
4. Why is cholera still with us?
5. Why " diarrhoea still with us?
6. Why " water scarce?
7. Why " water dirty?
8. Why are children having stomach aches?
9. Why " " " scabies/ringworm?
10. Why " some mothers losing pregnancy?
11. Why " " " too tired during pregnancy?
12. Why " " "/newborns dying at time of birth?
13. Why " " people dying of malaria?
14. Why " children dying of measles/tetanus?
15. Why " " suffering polio/kwashiokor/marasmus?
16. Why " people getting T.B.?
17. Why is your dispensary helpful?
18. Why " " " not " ?
19. Why do other areas have better health?
20. Why " " " " worse " ?

"COULD?"

1. Could this community work together to make better water supply?
2. Could school children help sibs to be cleaner?
3. Could schools have a daily wash?
4. Could mothers change infant feeding practices?
5. Could all ordinary village women be listened to?
6. Could face and hand washing be made more convenient and saving of water?
7. Could people try to make kuni-saving stoves?
8. Could TBAs and Nurses come to trust each other and cooperate?
9. Could mosquitos be kept from sleepers?
10. Could the village see that every child is fully vaccinated?
11. Could the village see that all chronic coughers have their sputum tested?
12. Could the village do something to improve relations with dispensary?

(From Community Health Worker Support Unit at AMREF)

GUIDELINES ON COMMUNITY-BASED HEALTH CARE

(From the CHW Support Unit at AMREF)

CONTENTS

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1. STRUCTURE:

1.1 The Ministry of Health and each NGO concerned should have a specific person responsible nationally for keeping in touch with CBHC affairs.

1.2 PMOs and DMOs and COs should keep in up to date contact (directly or by personal delegation) with all CBHC programmes (government or NGO) in their area. The converse is equally important. Each CHW should have linkage with the nearest formal facility.

1.3 Where there are a number of contiguous communities involved with CBHC there should be a mutually agreed-upon co-ordinator of information regarding related activities. In Kenya this person might be the H.U.T. leader.

1.4 At the local level the residers must be involved directly and from the start. Out of barazas and "health awareness" workshops a committee can emerge. This committee (or sub-committee of a Development Committee) should provide a training venue and lodging for trainers. It should also arrange the selection, with popular support of CHWs. The committee should provide strong continuing moral and practical support to the CHWs. The CHWs are responsible to the committee on all administrative matters.

2. GOALS OF CBHC:

To improve the quality of life in general and health in particular in villages/communities by:

2.1 Reduction of disease, suffering and death.

2.2 Improved individual and communal knowledge, attitude and practices related to health.

3. OBJECTIVES OF CBHC:

3.1 Raised awareness by villagers of the preventability of certain disease.

3.2 Individual Action by villagers on personal environmental improvements and changed life styles.

3.4 Improved feeding practices, particularly with children and mothers.

3.5 Community Action - on health benefiting projects. (Also action by special groups as Maendeleo).

3.6 First Aid provided by CHW. (Limits of what is considered "First Aid" must be clearly defined and publicized at the start. It might be helpful to replace the term "First Aid" with something more local).

3.7 Strong steady two-way collaboration between CHW and nearest health facility. (Also with local extention workers of any discipline).

3.8 Objective documentation of the impact on health resulting from this approach.

4. CHWs:

4.1 Qualifications

4.1.1 Permanent, mature, respected, activist, exemplary, communicative parent from that community.

4.1.2 Able and willing regularly to spare some time, after family responsibilities, voluntarily to help and motivate neighbours.

4.1.3 Chosen with popular approval.

4.1.4 Sex and education appropriate to neighbourhood situation.

4.2 Role

The CHW improves health in her/his walking-distance neighbourhood by motivating her/his neighbours to help themselves by personal preventive activities. These activities are mainly concerned with cleanliness, food, motherhood and common diseases. The CHW specific activities can include:

- Home visiting (one of the most important single activities).
- Addressing public gatherings.
- School health: maintaining and promoting.
- collaboration (two-way) with nearest health facility.
- Building a mutually helpful relationship with traditional practitioners and shopkeepers.
- Building integrated relationship with extension workers of other disciplines which have a bearing on health. (Agriculture, Adult Literacy, Water etc.)
- Keeping simple numerical records from which evaluations can be derived.
- Motivating the community - as a community - to undertake health benefiting projects.

5. TRAINING:

5.2 Duration - Basic tuition requires a minimum of 20-30 training days which should be interspersed with home practice periods.

5.3 Content should be tailored to specific problems of that area as expressed by trainees. It usually includes - but is not limited to - child care, hygiene, food, common diseases, women's problems and pregnancy, leadership/communication skills, evaluation skills and First Aid.

5.4 Resources required include trainer's salary, accommodation and transport; graphic aids, possibly books for trainees and lunches.

5.5 The best method is, through a conversational or "psycho-social" approach to build upon trainees' existing knowledge. Technical input must complement "conversation" about their local problems. The conversational approach emphasizes knowledge and thus self reliance and thus self esteem. Everything learned is related to practical solution of local problems.

5.6 Trainers should be medically trained, people assigned full time for the full training period as well as some follow-up field contact.

5.7. The trainers' aptitude for conversational teaching is more important than her/his academic credentials.

5.8 Good training can be self-replicating as graduate CHWs themselves train second generation "Health Helpers" in their home locales.

CONTINUING CONTACT:

6.1 The trainers should be committed after the training to provide regular periodic moral support and on site supervision of the CHWs.

6.2 There should be a yearly gathering of all CHWs in an area (example a District) for interaction.

6.3 CHWs need periodic refresher and new training.

6.4 A co-ordinator at sub-district level should gather CHWs quarterly for administrative and motivational reason.

6.5 There should be periodic co-ordination meetings of programme leaders at each level.

EVALUATION:

7.1 The primary purpose of evaluation is to encourage or motivate the CHW and her/his community.

7.2 A baseline survey done by the CHW is desirable, though difficult. It must be simple enough to be useful and used.

7.3 Evaluate efforts should evolve towards comparability. Ideally everyone should be measuring similar things in similar ways.

8.1 First Aid box. (Contents determined by local policy on what is "First Aid" see 3.6). In some programmes the box is given only at end of a probationary period.

8.2. Text Books, writing instruments, daily journal, graphic aids.

8.3 Any "reward" to CHWs (whether cash or kind; internal or "outside" source) should reflect the following:

a) CHW's time and energy input;

b) CHW's effectiveness - immediate and long-term;

c) long term community considerations;

d) the effect a salary would have on the recipient's role.

COMMUNITY-BASED HEALTH CARE

A Review of 6 Issues From the Advisory Committee to the Community Health Worker Support Unit At AMREF

Issues		Committee Members	
1.	The Community	Mrs. Musandu	- MOH
2.	The Community Health Worker (CHW)	Dr. Nordberg	- AMREF
3.	The Emphasis	Sr. G. Huising	- KCS
4.	The Training	Sr. Bailey	- PCMA
5.	Assistance	Dr. Kaseje	- DCH
6.	Information	Dr. Wood	- AMREF
		D. Cowling	- WN
		Prof. Bennett	- UNICEF

1. Community

1.1 CBHC will have long term viability only in a community which has within itself a good combination of awareness, initiative, leadership and resources. If this "mix" does not exist in the community then outside aid is more likely to engender dependency than development in health. A steadily functioning Local Development or Health Committee is a sighn of viability. But a more important sign is some material project completed mainly by local initiative.

1.2 "Voluntarism" is also important ingredient. The western model is not directly applicable and it should not detract us from Africa precedents of voluntarism. There is need for a survey and study of the phenonenon. There is danger of outside aid contributing to the decline of African voluntarism.

1.3 "Development" event at community level, must, like an African hand-bag be woven of horizontal and vertical relationships. The horizontal relationships are between disciplines (Agriculture; Education; Water etc.). The vertical relationships are neighbourhood, location, division district etc.

1.4 "Material Resources" are among the least important elements of CBHC. But local income-generating projects can be important in galvanizing community spirit and thus boosting the morale - and perhaps the economy of the CHW.

1.5 "CBHC" is built upon a community's sense of need and gratification of that need. The community's first perceived health need is bound to be medicine. A good CBHC programme will make more tangible the health-need-meeting value of such "non-medical" things as water, sanitation and better diet.

1.6 An individual CHW's Community (or Village or Neighbourhood) is defined by a variety of criteria - psychologic, geographic etc. But as a generalization, a CHW should be able to maintain responsible continuous oversight of about 100 families (500-800 pop.) In most cases these would all be within 1 hour walking distance. Any home farther away should no longer be considered her "community". A CHW cannot expect to maintain responsible continuous oversight of more than 150 families.

1.7 Not one CBHC programme has come into being without any outside help. In fact only two or three programmes have shown signigicant local initiative and self-reliance in starting up. The rest were started almost entirely because of outside aid and interest.

1.8 The motivation of religion has been an important factor in almost all programmes. The fact that outside sponsorship has been primarily by religious bodies is only part of the explanation. It seems that religion is a very important cohesive element in these communities. There is minimal denominational rivalry evident in CBHC programmes.

1.9 The CHW's community should be defined by name lists and a map showing locations of homes, boundaries, schools etc. CHWs have shown themselves quite capable of maintaining such maps.

2. CHW

2.1 The personal qualifications of the CHW are one of the most important issues of a CBHC programme. Basically a CHW should be a permanent, mature, respected, activist, exemplary communicative parent from that community. Many programmes have proved that literacy need not be an important factor. Respect and charisma are more important than academic, political or economic success. Experience has shown that "over-education" can cause as many problems as "under-education".

2.2 The CHW's involvement in her community can be measured in several different ways: by total hours put in; by general unscheduled availability when needed; voluntary activities and paid activities.

2.3 The CHWs role is conditioned by the expectations of her sponsors, teachers and neighbours. They must decide if her role is to be that of stimulating or serving. Her main approach can be to the individual or to groups or to a mix of these two. Regardless of the above, the tendency is for the community to regard CHWs as "dakteris" for some time. Perception of their preventive role is painfully slow in developing. Not enough data is in hand yet to enable us to [illegible]

best mix for any programme.

2.4 The CHWs coverage may be defined according to time or distance or population. One programme has set a 1 hour walk as the limit of "community". In a densly populated area, like West Kenya a 15 minute walk may take the CHW beyond the limit of the 150 families she can responsibly oversee.

2.5 Prevention promotion is time-consuming. So there must be an objective appraisal of the balance between a CHW's "spare" time and the role expected of her among "her" families. Her commitment needs clear definition and specification within the general mandate "to help people help themselves to stay healthy".

2.6 Reward is probably the most problematic issue of CBHC.

2.6.1 Ideally the CHW would be someone mature enough and successful enough to be able to spare and volunteer time regularly to this work. This would be her own personal "day by day Harambee" for her community.

2.6.2 Of course an externally sponsored programme could not be based on this approach, for no one would think of working for the government or an outside agency "for nothing".

2.6.3 The majority of CHWs are volunteers more by technicality than by generosity. They are volunteers only because they have not yet managed to get from their community or outside sponsors the pay they feel they should have. (Training and public recognition are only temporary rewards).

2.6.4 The implications of regular salary payment are serious. Whether CHWs would be paid directly by the community or indirectly by the government the cost would be staggering. We have little idea as yet what would be the benefit of that investment.

2.6.5 The ideal situation would be for a volunteer CHW to work initially effectively enough long enough to prove statistically her beneficial impact on the health of her community. Then she would have tangible evidence for "selling" herself to her community. She could convince the community of "profit" if they invested in a gratuity for her. This convincing is of course heavily dependent upon a data system.

If a CHW is contributing only her "spare" time and if she is getting gratifications in the form of training, esprit-de-corps, public recognition and public responsiveness then the problem of monetary payment will be minimized.

Any financial support contemplated must be weighed against the following:

1) CHW's time and energy input;
2) CHW's effectiveness - immediate and longterm - in changing the community;
3) long term considerations of the ability of the community or the country to carry the burden of one CHW for every 100 families;
4) the effect of salary on the CHW's motivation role. A "paid" person is not given as much head as is a volunteer.

3. Emphasis

3.1 Prevention or Cure - For seventy years the over-riding emphasis has been on sickness and or "a pill (or sindano) for every problem". Meanwhile, health has remained a vague concept. So now we face several questions:

1) How do we handle the fact that "community decision" will always opt for drugs as the highest priority for "development"?

2) How necessary is drug dispensing as the "spoonful of sugar that makes the medicine (of self-reliance) go down". In other words, can a CHW get a hearing for prevention if at the same time she does not provide cure?

3) Conversly, if she does provide cure will there be any hearing for prevention?

4) How can the CHW wean her neighbours off of this fixation on drugs?

3.1.1 All the CHW programmes consider their drug programmes to be only "First Aid" or prophylactic and not regular curative care. But in the minds of the people these drugs make them "dakteris" anyway.

3.1.2 There is a constant "tug-of-war". The CHW (the good one) is trying to pull her people off of their preoccupation with drugs while they tend to pull her into a preoccupation with drugs.

3.1.3 There are programmes which have shown that a CHW can be influential for prevention despite having no drugs.

3.1.4 In some programmes the drugs dominate the CHW's role greatly reducing her effectiveness as a changer of behaviour.

3.1.5 The more involved a CHW is with drugs the less chance she has to change behaviour. She tends to become a panacea. Each programme will, according to its emphasis (cure vs prevention), tend to produce either panaceas or changers.

3.2 Stimulation or Service

Another important balance of emphasis concerns the CHW's method of helping her community. The inaugurators of the programme must decide on the balance between her role as stimulator (motivator) and her role as server (doing health for them). The former should bring progress while the latter may bring stagnation on the part of the community.

It takes a much keener person to be a stimulator. Also the risks of unpopularity are greater. So the moral support a CHW gets from her sponsors is important. It can make or break her as a successful stimulator or motivator of her community.

Training

4.1 Ideally training should be in small groups (15) right in the community, where CHWs can sleep at home and keep in touch with affairs.

4.2 There is wide difference of opinion on what is a minimum period of "basic" tution. The practice varies from 20 to 60 days. All agree that the tuition should be interspersed with home practice periods.

4.3 Each programme must struggle with the balance problem shown here:

Quantity	Quality
of time	of knowledge
of content	of practice

Programme designers and trainers should beware of the extremes:

a) a CHW who knows uselessly little about too many topics and

b) the one who knows uselessly much about too few topics.

4.4 The "curriculum" should ideally arise from the expressed sensetivities of the trainees themselves (and their sensetivities should reflect their community). The trainer must "start where they are", with their specific practical problems. This calls for a flexibility which lecture method trainers usually do not have. So "lecturers" have little or no place in a CBHC training programme.

4.5 The idea of the curriculum "arising" from the trainees is good - but also dangerous. Where the trainers are not well prepared you have "the blind leading the blind". The point is that in a trainee-led situation the trainer has to be even better prepared than if she were in a lecture situation. Her trainee's curriculum may prove to be broader and deeper than her own curriculum.

4.6 The best pedagogic mode for CHW training is the traditional African mode i.e. the conversational approach. It starts by building a foundation of shared existing knowledge. This knowledge is then cross-checked against problems. Solutions are sought from within the groups already existing knowledge or resources. The method emphasizes self knowledge which in turn engenders self-reliance which in turn engenders self-esteem.

4.7 Technical input (from outsiders) must not be given until there is a specific "slot" for it, created by the foregoing conversational approach. Technical input must be complementary to the CHW's own primary thinking and questioning.

4.8 All teaching must be kept in the context of solving specific local problems.

4.9 Trainers should ideally be professional ("registered" level) people assigned full time for the full training period.

4.10 Continuing contact may be as important as basic training. So the trainer should be committed to providing her graduates with regular, periodic, personal, on site moral support and supervision.

4.11 Periodic conferences and/or refresher courses are vital.

5. Assistance from Outside

5.1 Any CBHC assistance which does not originate within that local community is "outside aid". The psychologic effect of aid on local self-reliance is little different whether the aid comes from the District Development Committee or from the Agency for International Development.

5.2 The problem is in determining at what point staff/money/materials etc from "outside" are converting local community self-reliance initiative into dependent passivity.

5.3 Almost all programmes are plagued by local perceptions of what outside aid is available. ("You come in a Range Rover, you stay at the Sunset Hotel. So how can you say you are unable to pay the CHWs some pocket money?").

5.4 Outside parties, whether government, mission or aid programmes, should start nothing till they have looked at the implication for five years hence. Premature collapse of any one programme harms all the other programmes. Conversly parasitic prolongation of any one programme harms all the other programmes.

5.5 Outside aid should start as something purely complementary to local initiative and resources. The decline of this aid should be written into the aid agreement. This decline should be adhered to rigidly. Otherwise the CBHC [illegible]

5.6 The key issue is the long term independent viability of the programme.

6. Information

6.1 CHW programmes have been going for a number of years. The public knows that clinicians generate quantities of data yearly. So they assume that CHWs are likewise generating quantities of data. The differences and the constraints are not easily perceived.

6.2 The most important reason for collecting information is its usefulness in strengthening the CHW herself. It motivates her by revealing both her strengths and her weaknesses in her attempt to have a beneficial "impact" upon the health of her community.

6.3 The second reason is for the sake of "selling the CBHC idea to the community. Data collected by CHWs can be "mirror" revealing a community's backwardness or progress. Both are motivating. It can reveal to the community leaders how profitable the CHW is to them.

6.4 Most academicians are far removed psychologically from the average CHW. Therefore all "top-down" data gathering approaches must be treated as potentially dangerous. If they dont obviously and directly bolster the CHW they should be forbidden.

6.5 Great benefits could be had from some commonality between programmes in their information gathering i.e. "everyone reporting the same things in the same way" to the extent convenient and helpful.

6.6 But most programmes are

"VIAZI"

Topics for very Health Talks

1. "WHAT DISEASES COME BY FOOT?"
   Bilharzia and Hookworm. Draw and explain.

2. "THE PATCH IS FATHER OF THE AMPUTATION" (in leprosy)
   A pale patch on the skin will be followed by nerve damage and then finger damage and loss if untreated.

3. "4 Fs"
   Faeces Fingers and flies Food.

4. "HEALTH TALKS SHOULD BE WITH NOT AT THEM
   A health talk without discussion is of little use.

5. "IF YOU ARE FAITHFUL TO YOUR DAWA, YOUR DAWA WILL BE FAITHFUL TO YOU"
   (Provided you take it early enough)
   (" " " " regularly)
   (long)

6. "THE 4 FAIDAS OF A CONDOM"
   (Prevents giving disease
   " getting disease
   " giving pregnancy
   " getting pregnancy

7. "FEELING BETTER FAILURES"
   When T.B. and Leprosy patients start feeling better they failing to take their dawa. (See no. 5 above)

8. "WHAT DO YOU FEED YOUR RATS?"
   Anyone who leaves food open or spilled around feeds rats. Rats dont come into your house for anything but food.

9. "THE LATRINE IS A JAIL FOR GERMS"
   They cant get out to harm you.

10. "WATER IS THE BEST DAWA FOR SCABIES"

Water will shorten the infection and prevent renewed infection. It is more effective than dawa.

11. "UNWED FATHERS"

Even though not married, and not pregnant, they are 50% responsible for the pregnancy.

12. "ONE WORD NUTRITION LESSON: MIX"

Simple advice to mothers:

Mix colours - green, red, white

" types - fruits, vegetables, meat

" above/below ground - cereals, roots

" animal/plant - meat, maize

13. "IMMUNIZE 5 X 5"

Child should have been protected against 5 diseases by his 5 month of age. Dip. Pert., Polio, T.B. (BCG).

14. "ANTE-ANTIS" or "THE TWO ANTIES"

Ante-natal Care should include two Anti disease measures

Anti-tetanus shots

Anti-malarial pills

15. "WHO WASTES SEED?"

Too close planting of maize seeds is wasteful.

" " " " children " "

16. "THERE IS NO SUCH THING AS A CASE OF KISONONO"

It takes two to make a pregnancy and likewise

" " " for there to be kisonono

17. "THE TWO MOST IMPORTANT QUESTIONS ABOUT S.T.D."

1. From whom might you have gotten it?
2. To " " " " givent it?

18. "WHAT DO YOU FEED YOUR FLIES?"

Flies come to you only for food. If they are with you, it means you are feeding them

19 "CURE IS SURE" for Leprosy and T.B. if dawa is taken early enough and long enough (see 5)

20. "IS A "Leaky Tin" A SUBSTITUTE FOR A LATRINE?"

Yes. If it provides handwashing after every choo and before every meal.

21. "DOES MY DAWA PROTECT OTHERS?" (T.B. or LEPROSY)

Yes, it makes your germs unable to infect other people within a short time of starting the dawa. T.B. within a few weeks
Lep. " " " months

22. "TWO PART PROGRAMME FOR LEPROSY AND T.B."

1. Case finding - sputa, survey etc.
2. Case holding - medicine and motivation.

"MORE VIAZI"

Ideas for Short Health Talks on Lepros
from CHWSU at AMREF

1. The "patch is the father of the amputation"
2. Loss of sensation and the loss of strength are warnings
3. The earlier started the easier to manage.
4. Regularity is the secret of success (in time; on time; everytime)
5. Keep on dawa till ordered to stop by doctor.
6. Treatment should be: (Early enough
   (Regular enough;
   (Long enough
7. Dawa benefits the family too. Dawa makes the germs non-infective to them (after patient has been a few months)
8. "Cure is sure" even though slow. Slowness is not the same as failure.
9. If you are faithful to your dawa, your dawa will be faithful to you.
10. Leprosy germ doesn't "eat" fingers. The eating is done by other germs which follow the damage done because of loss of sensation.
11. So note 1 should be changed to read "the patch is the father of loss of sensation which is the father of damage which is the father of super-infection which is the father of amputation which is the father of poverty/dependency."
12. Crippling is not inevitable. It does not need to happen.
13. Which is more of a problem?
    (a) Taking dawa once a day for years.
    (b) Being increasingly crippled and poor for years.
    If you have leprosy, you must choose.
14. Children are not born with leprosy, even if parents have it.
15. When you choose to delay you are choosing "to be cut" (deformity) "Kuchelewa ni kukatwa."
16. "Feeling better Failures
    When T.B. /Leprosy patients start feeling better they start failing to take their dawa.
17. "DOES MY DAWA PROTECT OTHERS?" TB/Leprosy)
    Yes, it makes your germs unable to infect other people, within a short time of starting the dawa. (TB in weeks, Leprosy in months)
18. "TWO PART PROGRAMME FOR TB AND LEPROSY"
    1. Case finding (sputa, survey etc.)
    2. Case holding mainly medicinal and motivation.

(J-12)

MAJOR QUESTIONS

Is it Community or just an outside aid program?

1) What individuals first talked about your project?
2) What was first meeting about?
3) " " " action (money, materials, people chosen etc.)?
4) Is there a Health Committee which meets at least monthly?
5) How much has the community contributed of - Money?
   - Materials?
   - Facilities?
6) Has the community given CHWs "zawadi" of any sort?
7) In what way do CHWs have 'heshima' in community?
8) If all outside money and people were stopped, what would happen?
9) What differences do you expect 2 years from now?
10) What will make these differences possible?

Does it Change Health?

1) Have there been fewer measles cases recorded at your nearest health facility?
2) Fewer infant deaths record at dispensary?
3) Fewer stillborn?
4) How many new latrines built by your neighbours last year?
5) How many water sources protected by community self-help last year?

Who does the Work?

1) Which village health work can only be done by CHW?
2) Which health work can CHWs teach their neighbours to do?
3) Which self-help work are your neighbours failing to do because of lack of knowledge?
4) Which self-help " " " " " " " " " poor attitude?
5) Which self-help " " " " " " " " " lack of skill?

(J-13)

MINOR QUESTIONS

1) If chloroquin and aspirine are available in dukas, does CHW need to carry them?

   Yes - because 1) .....
   2) .....
   3) .....

   No - because 1) .....
   2) .....
   3) .....

We recognize a trained nurse by her uniform and badge and where she works. How can we show that a CHW is someone special?

1) What about uniform? .....
2) " " badge? .....
3) " " other recognition? .....

3) What visual aids are most seriously lacking?
   1) Which types: posters; f graph; model etc.
   2) Which topics: malnutrition; T.B.; flies etc.
4) When you use a Visual Aid, who talks most, you or the students?
5) Do you teach "at" people or teach "with" them?
   1) "at" them because .....
   2) "With" them because .....
6) What about extension workers, those from agriculture; education etc.
7) Which ones are most helpful to your work? Why?
8) About how many families can you keep in touch with?
9) Do you get any "heshima" (respect) because of your activity as CHW?
10) What were the best parts of your training?
11) Which of your activities as a CHW bring the most change in people?

THE COMMUNITY HEALTH WORKER SUPPORT UNIT AT AMREF

exists to promote and facilitate local communities' efforts to develop more self-reliance in preservation of health. This development is catalyzed by the local Community Health Worker (CHW). The CHW receives brief informal training mainly in prevention and communication. Her/his main responsibility is to motivate and help neighbours to help themselves to stay healthy.

Specific Activities of the Unit:

1) Information exchange
2) Training assistance
3) Development of aids
4) Development of evaluation
5) Workshops
6) Newsletter
7) Consultations
8) Broadcast talks

The Unit operates no CHW programme of its own. It maintains touch with local programmes in Sudan, Uganda, Kenya and Tanzania. It works in close collaboration with other parts of AMREF, particularly the Training Department.

Funding organizations include World Neighbours, S.I.D.A., OXFAM and O.D.A.
The Director is Dr. Roy Shaffer who is assisted by Ms Penina Ochola K.R.N. M.P.H., D.A.N., Elkana Absalom B.S., M.P.H., and Josephine Ooko, Secretary.

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NATIONAL SEMINAR

the helper

No.1 July 1980

Compiled and produced by
Community Health Workers Support
AMREF P O Box 30125 Nairobi

A newsletter between people working with village health programmes.

Around the world there are many programmes in which community or village people are given simple training so that they can go back and help their neighbours in matters of health. These programmes have many differences - such as different names, different kinds of training etc.
But in one way they are the same - they all exist mainly to help people to help themselves. That is why we have named their newsletter The Helper. We hope it will help you to help people to help themselves.

THE STORY OF A PROGRAMME – SARADIDI

In Western Kenya on the hills which overlook Asembo Bay, there is a community known as Saradidi. The people of this community are working very hard to improve their own health through their own efforts, united in the Saradidi Community Health Project.

The Saradidi Project grew out of the imagination, the cooperation and the hard work of many Saradidi people. Some of these people were a church elder, a medical student home on leave, a teacher, a retired medical worker, the chief etc. These people and others formed a committee to lead the community forward in matters of health. This committee won the confidence of the community in two important ways:

1. The community believed the committee's message that the people of Saradidi could do much to improve their own health.
2. The community believed that the committee could be trusted in their use of money and materials received for the project.

The Saradidi project has two main activities – curing disease and preventing disease. The curing will be done mainly at the dispensary which has been built by the community itself. The preventing activities have already started. They are a cooperative affair between villagers and their local village "Health Helper" (Jakony). These Helpers are encouraging the villagers in activities such as digging

latrines, using cleaner water, feeding infants, correctly, resisting mosquitos etc. The helpers spend most of their time visiting homes. They talk personally with their neighbours, especially the backward ones, about how to improve things. They also show them how to do it whenever possible.

The Helpers were chosen by their neighbours. They were chosen mainly because they had enough respect to be accepted as teachers in matters of health. The Helpers are ordinary villagers. They have families to raise and fields to dig, just like their neighbours. Therefore they can only work part time as Helpers.

Dr. Roy Shaffer,
Community Health Worker Support Unit,
AMREF,
P.O.Box 30125, NAIROBI.

"IF ONLY"

A Play

2 Nurses 2 Mothers Children

1 Nurse standing at "clinic"

2 Mothers walking to clinic.

Mother A: - "I am worried about my child. I hope that mzungu lady daktari can help him".

Mother B: - "Well I dont know about these hospital people. You know that thing she puts on her ears to listen to our children's chest. Do you think that thing hears in our language? I am not sure if she can speak our language. From her I hear some of our words, but mostly it just sounds like 'wolowolo wolowolo'."

They arrive at clinic.

Nurse examines baby and speaks fast and strongly to mother about medical problems.
Mother tries to answer with her side of the story, but nurse doesnt hear.

Nurse: - "Worms - you must dig a choo etc' "

Mother: - "My husband works in Nairobi."

Nurse: - "Scabies - must wash' etc"

Mother: - "Our river is 3 km. away"

Nurse: - "Vaccination - must be vaccinated' "

Mother: - "I came twice but their advice was so confusong."

Nurse: - "Mother, this child is anaemic - you must dig a kitchen

Mother: - "What is that?"

Nurse: - (Gives 2 dawas) - "Take 2 stat, 2 6 hourly 2 daily" (many confusing words of instruction)

Mother: - "What? What?" (rolls head/eyes in confusion)

They separate, mamas go home from clinic. Another nurse arrives at clinic.

New Nurse: - "Well, Jean, how was clinic?"

First Nurse: - (Slowly and clearly) "If o-nly These pe-ople would lis-ten"

This is the end of the clinic scene. Now change to Village scene, where mamas are arriving.

Mama A's brother says:- "Hello sister, tell me about your clinic visit."

Mama A: - "Ah, the only words that daktari knows are 'Must do this,' 'you must do that'. Or 'you cannot do this you cannot do that'."

A's brother: - "It is just as I have always said, these mzungu ways are no good for us."

Mrs. B's husband has arrived. He tries to be more helpful and says:

- "If she says we must, maybe she knows how we can be helped to do things to be healthy."

Mrs. B says: - "Yes, she does seem like a kind person. But maybe she just doesnt understand how much we want to improve."

Mrs. A says: - "Yes, maybe if we could get her to leave her clinic and come visit us here in our homes she might learn how to "hear" us."

Mrs. A, Mrs. B and both men all say together slowly and clearly:

- "If o-nly these pe-ople would lis-ten"

MIDWIVES "EXCHANGE"

(Traditional Midwives (TM) and Modern Midwives (MM)

Traditional Midwives are important women with high status in their communities. They are providing an important health service not yet adequately provided by the modern medical establishments - government or non-government. Full coverage of this service by the establishment remains a far distant hope. It is important, therefore, that there now be a clarity and harmony of understanding between the TM and their nearest MMs.

1 Specific objectives of the encounter should include:

1.1. For MMs to have a better understanding and be more adoptive to:

a) Helpful aspects of the TM, knowledge and attitudes

b) MMs ability to adapt that knowledge to modern concepts

c) TMs attitudes towards modern services

d) the importance of TMs influence on community natality patterns

1.2. For TMs to better understand

a) Which part of their art is, in the eyes of MMs, undesirable

b) Which part is desirable and important to the sucess of the MCH-FP program in their community

c) Helpful modifications of or additions to their traditional way of doing things

d) The importance of their role in screening for "risk" mothers

e) The broader role they could play in promoting and personally exemplifying other aspects of the total MCH program, particularly antenatal attention and child health

f) That they can be regarded as colleagues with MMs, striving towards the common goal of a healthy child

g) That they can be proud of themselves

2. The following is a summary of the points MMs can try to get across to the TMs.

2.1. Ante Natal

2.1.1. Things to <u>see</u> with the eyes and refer to hospital

anaemia

swelling

malnitrition

gonorhea

2.1.2 Things to tell the mother

- about the ANC clinic when problems can be anticipated (familiarity through antenatal visits, when things are OK, will reduce mothers fear of coming in when problems arise)
- about greens in diet
- about personal hygiene

2.2. Delivery

2.2.1. What things to have ready

- Soap and water
- sheeting or newspaper
- razor and string (Kibiriti Kit)

2.2.2. <u>When</u> to push (only <u>with</u> contraction, but not before head is pushing on "floor")

2.2.3. What TMs can do with their hands

- Wash perineum
- prevent sudden expulsion of head
- clear infant's airway
- massage uterus to keep it contracting
- tie and cut the cord hygienically

2.3. What we MMs fear of TMs activity

2.3.1. Fingers in vagina

2.3.2. Pounding the abdomen (like pounding maize in pestle)

2.3.3. Cord and contermination by accident or by "dressings"

2.3.4. Herbs which cause contraction

2.3.5. Bathing of newborn with dust

2.3.6. Delay in referring:

- arrested labour
- premature rapture of waters
- prolapsed cord
- ruptured uterus
- post partum haemorrhage
- exhausted dehydrated mother - infected uterus

2.3.7. Asphyxia neonatum.

2.3.8. Tetanus

2.4. Which cases the MMs hope the TMs will refer to hospital

Swelling of limbs)
malnutrition) ante-natal
anaemia)

2.4.1. Any of the following:

- Breech or transverse lie or malpresentation)
- inactive or inaudible (heart) foetus)
- history of C. section, hypertension, seizure) birth labour
- hydramnios or large child)
- lost clinic card)
- still birth, prolonged labour, prolapsed cord, haemorrhage (anytime) twins

2.4.2. Mothers having first pregnancy

2.4.3. " " fifth " or more

2.4.4. " " history of obstetric problems such as:

arrest)
premature rapture)
prolapse) delivery
p.p. infection)
p.p. haemorrhage)

blue colour)
diarroea)
rapid.breathing) child
fever)
neonatal death)

2.5 We share a common goal - a healthy living baby and mother. If there is a delivery death in the home the MMs should share in a sense of responsibility. If a delayed referral patient dies in a hospital T.Ms should feel some personal concern. The purpose of the exchange is to promote "kazi bora" on both sides.

3. Micellaneous recommendations for TM - MM exchanges

3.1. Make sure the invitation can not be interpreted as a job offer

3.2. Try to show films showing childbirth

3.3. No talk should exceed half an hour

3.4. Every talk should have some sort of visual aid and feed back and discussion

3.5. There should never be two talks in a row, some other activity should intervene

3.6. Most talk should include opportunity for some students to have some practice of what is being taught.

3.7. MBAs must be reminded that the TMs have never seen a uterus and most have never knowingly palpated a dilating cervix

3.8. Those giving talks must be reminded that "echoing" is not the same as discussion

3.9. High priority should be given to small group discussions of specific problem - posing questions.

Examples:

What sign tells you is it time for the mother to start pushing?

What is the best thing to do with your hands to encourage expulsion of the placenta?

What "dawa" should be put on the cord end?

Collection of visual aids (flannelograph, models, pictures) is necessary part of precourse preparation before students are recruited. If you dont have any aids, dont recruit students.

10. Time should be taken for a discussion of the specific techniques employed by TMs at each stage of labour. Then these techniques should be analysed by the whole group for their merits or danger.
11. Family planning should only come up in response to TBAs raising it.
12. Attempt should be made to send TBAs home with a clear simple remembrable set of conditions which call for referral.
13. Exchange staff should preferably be persons with tribal and /or hospital affinity to the TBAs attending.
14. Local women who are or have been obstetric patients in the hospital should be present and used as references.
15. Every district hospital should have an MM- TM encounter at least every two years.
16. A graphycally imaginative remembrance of attendance should be prepared. A group photo, with course details superimposed in print is attractive without being official.
17. The Ministry of Health should give medico-legal guidance on how far TBA can go, legally, in their activities.
18. Attempts should be made by non-written means to determine TBAs personal assessment of the value of each session. For example by putting a seed in a hole to match their judgement immediately after each session.

Session Evaluation (vote) box.

4. Suggested Format For TBA "Exchange"

4.1. Exchange leader introduces the idea. Iti s like a market place. Everyone's ideas have value. Everyone's ideas should have a chance to be heard - compared.

4.2. Explain that there will be three sessions:-

- First session concerns what happens before labour and During Labour.
- Second session concerns what happens (Baby coming out; (Cord and Placenta
- Third session concerns what happens (Bleeding (Newborn baby

4.3. First session:

- Divide into small groups (4-6).
- Each group chooses a writer.
- Make sure everyone understands the two topics they are to discuss in that session (First session is before labour and dur ing labour)
- Discuss what the traditionalists have always considered to be the most important things to know or to do on these two topics.
- Discuss and decide which are the three or four most important of all those traditional ideas or activities mentioned. Have the writer put each idea on a separate small piece of paper.

4.4. Take a break.

- During the break writers give their groups' papers to the exchange leader.
- Leader puts each paper in one of three piles.

Pile 1 - Ideas on activities which modern midwives think are good and helpful and should be encouraged.

Pile 2 - ideas on activities that are neither good or bad

Pile 3 - ideas on activities that may be changed or stopped.

She concentrates the traditional ideas or activities onto newsprint, preferably with pictures.

4.3.3. Re-gather the whole plenary group together. Leader then comments on the topics as seen by the traditionalists.

- For each traditional idea she explains why it is considred "good", "neutral" or "bad" as compared with modern ideas.
- She is like a person making a basket. The basket is made of horizontal pieces and vertical pieces. When woven together they make a good basket.
- The exchange leader is "weaving" together traditiondl and modern ideas. She is a "weaver", not a "preacher".
- For each topic, the leader should present the two most important points which arise from the various group concerns.
- TMs should then be asked to comment on how these points could be fitted into their practice.

4.4. Sessions two and three follow the same format as session one

a) Small discussion groups producing traditional ideas.

b) Leader classifiesthese ideas.

c) Leader discusses these ideas in relation to modern medicine.

d) TMs comment on application of the leader's ideas in their Practice.

4.5. Suggestions on how to lead the exchange:

a) Start with what they know or think
b) Constantly exchange words and ideas with them
c) Do not preach
d) Do use Visual Aids
e) Emphasise teamwork

(How to Evaluate Them)

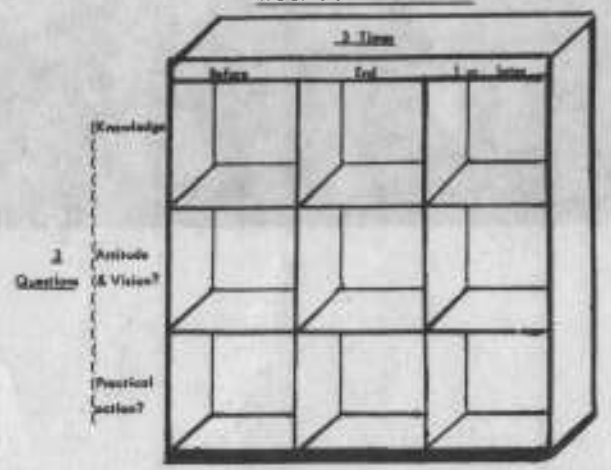
1. Each evaluation exercise should ask 3 questions:
   - 1.1 What is the knowledge, compared to what it should be?
   - 1.2 " " " attitude/vision " " " " " " ?
   - 1.3 " " " practical action " " " " " " ?

2. Each evaluation exercise should be repeated 3 times:
   - 2.1 Before: the activity which is supposed to bring changes
   - At the end of the " " " " " " "
   - About a year after " " " " " " "

3. So each change evaluation exercise can be thought of as a 9 compartment "change cupboard". (See attached)

4. What changes should we expect to be able to evaluate in CBHC?
   - 4.1 Did the TOTcourse change the trainers as much as expected?
   - 4.2 " " Trainers " " CHWs " " " " ?
   - 4.3 " " CHWs " " Community Conditions as much as expected?
   - 4.4 " " " " " people's personal habits " " " "
   - 4.5 Was community nutrition changed?
   - 4.6 " " hygiene " ?
   - 4.7 " " motherhood " ?
   - 4.8 " " communicable disease control " ?

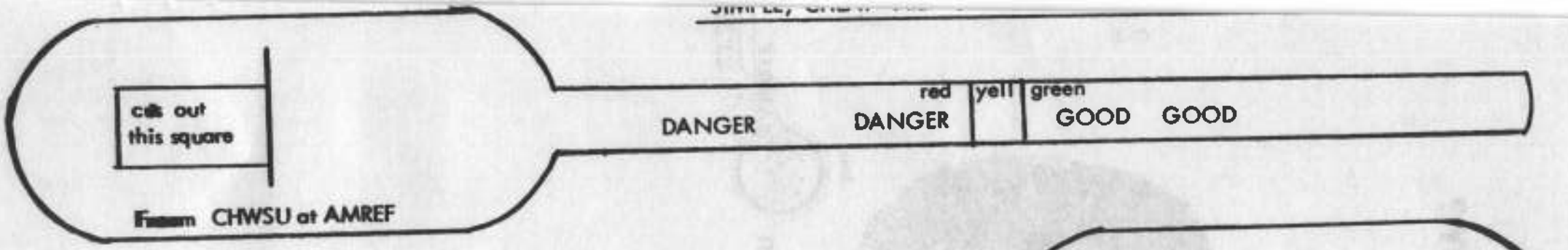
THE CBHC CHANGE CUPBOARD

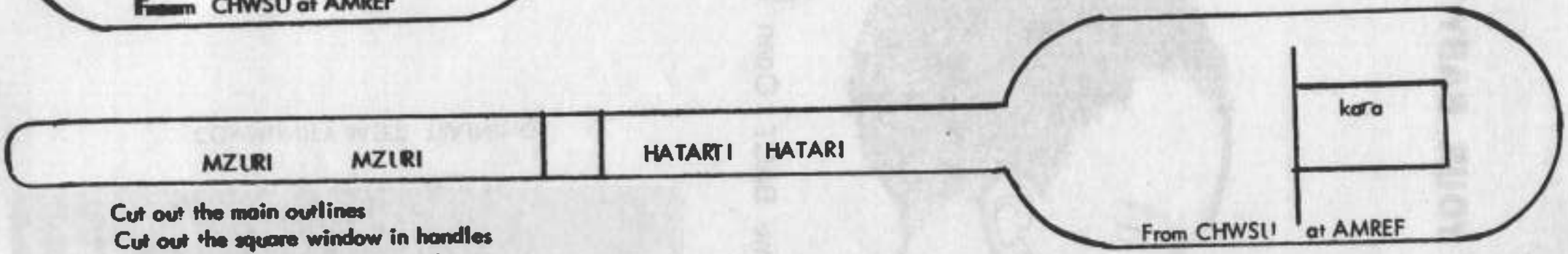


From CHWSU at AMREF

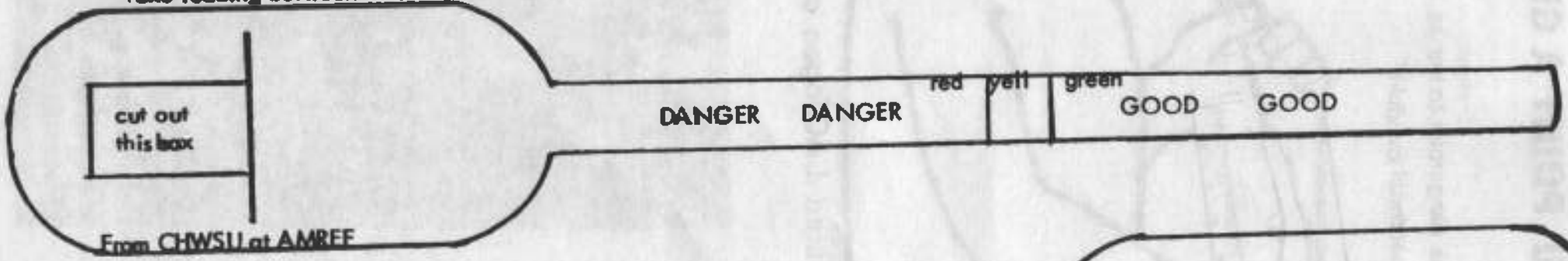
GRAPHICS FROM THE SUPPORT UNIT
(These are not posters)

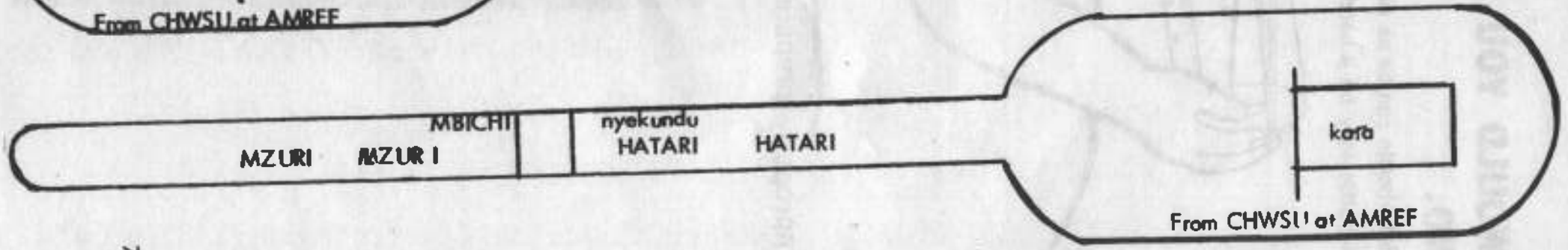
CHW USING VISUAL AIDS (FLANNELGRAPH





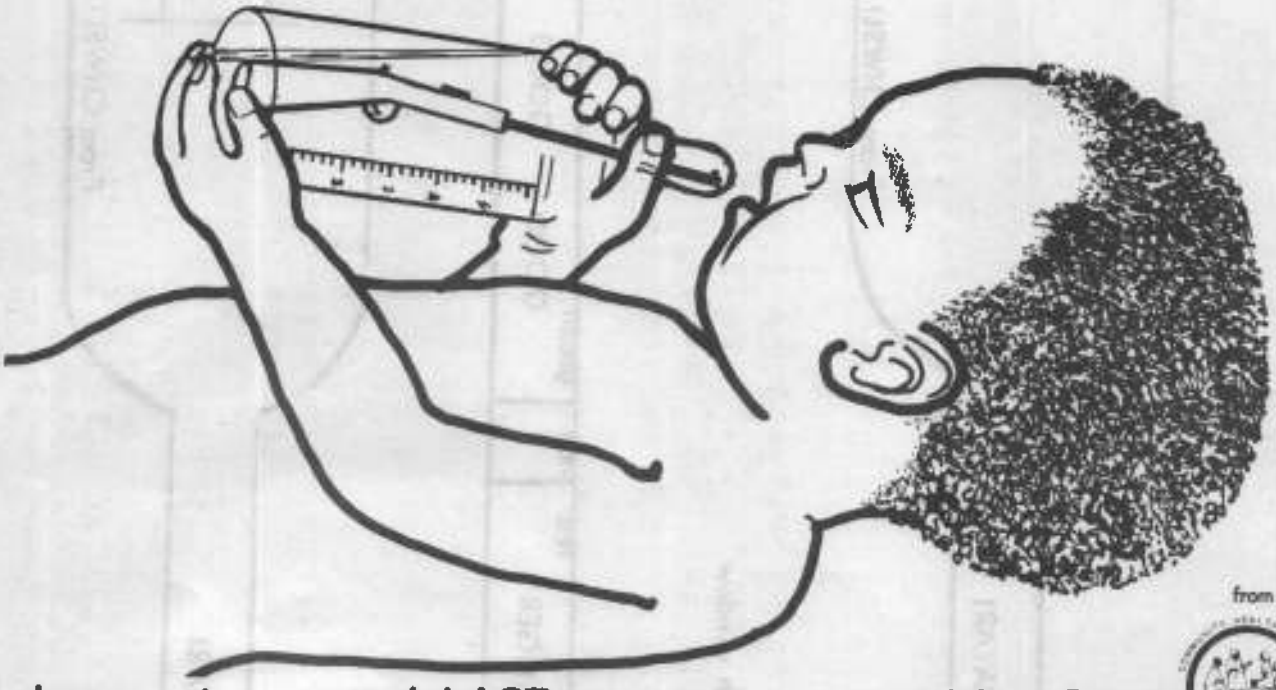
Cut out the main outlines
Cut out the square window in handles
Colour the strip red, yellow and green
From window to first mark should be 12.5 cm
Sellotape will make it last longer
The tail of the strip should go around child's ank and back through window
Take reading between arrows





WOULD YOU POINT A GUN AT YOUR BABY? NO.

But, a bottle can be as dangerous to her as a gun
A bottle may be a "bacterial bunduki"



Improperly prepared LACTogen can become BACT Ogen

from AMREF
Wilson Airport
P.O. Box 30125
Nairobi, Kenya

(K-2)

COMMUNITY BASED TRAINING

NOTES ON CBHC "BUILDING BLOCKS"

A block wall can be strong and can last long. But its strength and durability depend very much upon the mortar or glue which binds the blocks together. There are three ingredients in that mortar: cement, sand and water. If these ingredients are not well mixed the wall will fall.

Likewise the practical "blocks" of the CBHC wall must be bound together by a good "mortar". The three most important ingredients of this mortar are

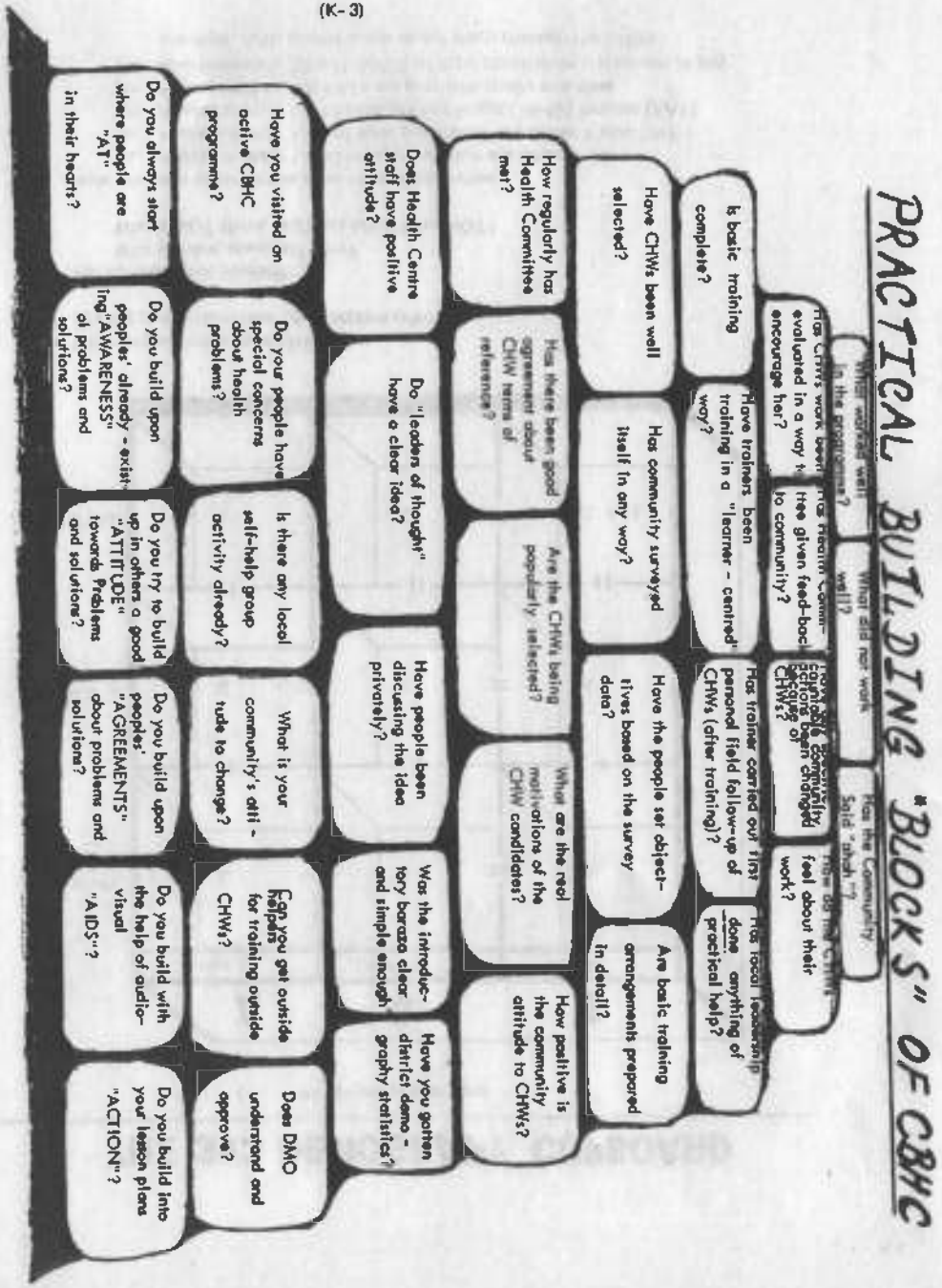
clear knowledge
positive attitude
practical skills

These ingredients must be in good proportion to each other and be thoroughly mixed together. If the mix is poor the wall will fall. CBHC leaders (social, administrative, medical etc.) must constantly be checking on the state of the mix with which they are mortaring together a CBHC structure.

Training is an important part of CBHC and training can be seen as a "wall" of people (students). This wall needs to be bound together with good mortar. Two extra important ingredients of the special training mortar are:

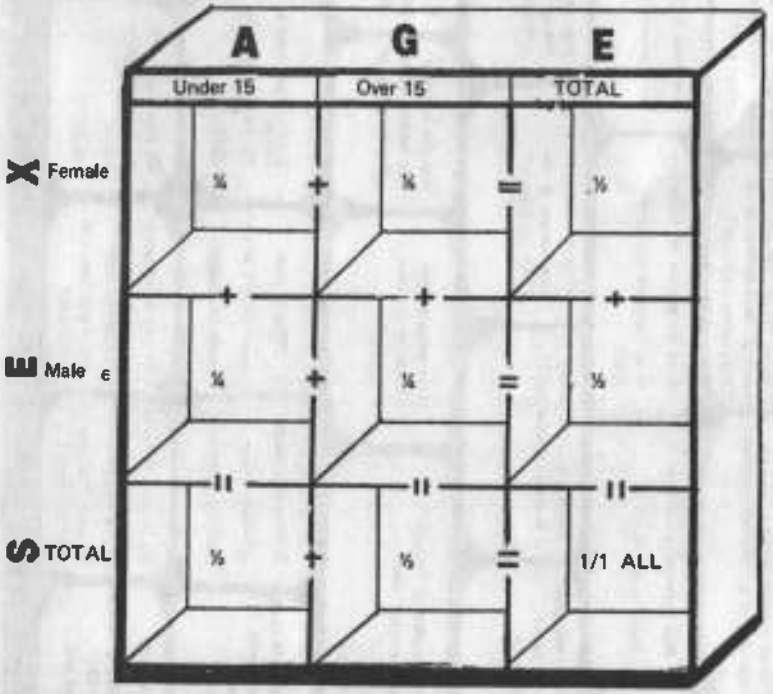
1. Compensation: By this we mean that a good trainer will see that any student's weakness will be compensated for. For example a shy student will be given opportunity to tell about something she is enthusiastic about.

2. Complementarity: Everyone has something to offer which will benefit others and will fill a "gap" in the knowledge, attitude or practical experience of others. A good teacher fits her students' talents together like a jig-saw puzzle or a well-mortared wall, one which has Cohesion.



THE 3x3 DEMOGRAPY CUPBOARD

(of age/sex proportions)



Write in you totals for each box.
Are the proportions near the fractions printed?

For each box ask yourself:
Who is there, counted? Why?
Who is NOT there, NOT counted? Why NOT?

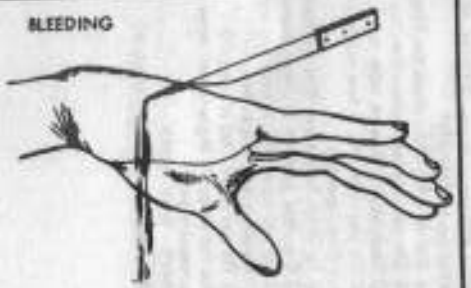
Here are some other simple rules of rememberance:

1a. Approximately 1/5 of total population are under 5 years
1b. Approximately 1/25 of total population are under 1 year (INF.)
2a. Approximately 1/5 of total are fertile age (15-45) females (FAF)
2b. Approximately 1/5 FAFs are pregnant at any one time
2c. Approximately 1/25 (1/50fl/5 of total population is pregnant at any one time. ANC should know about them through the CHWs.

COMMUNITY SELF-ANALYSIS

FIRST AID REMINDERS

BLEEDING

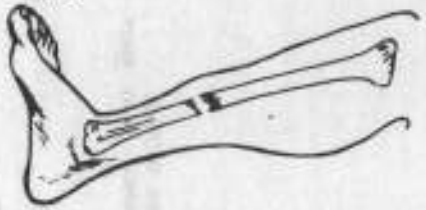


Press; wash; cover

BLEEDING AFTER BIRTH

Nurse; flat hand

BREAK



Prevent movement

BURN

Dip; cover; drink; protein

UNCONSCIOUS

Check cause; coma position

SHOCK

Find cause; flow; talk

From the Community Health Worker Support Unit at AMREF

Bleeding after Birth:

Let baby nurse or else rotate flat hand softly over belly. These will cause uterus to harden.

Bleeding:

Press firmly enough to stop bleeding.
When bleeding has stopped, gently wash out the germs with plenty of water - also soap.
Then cover with clean dry cloth.

Burn:

Dip burn under water (the cooler the better) for ¼ to ½ an hour. Then cover with soft but slightly tight bandage. Drink more than usual fluids. Eat a more than usual protein.

Break:

Prevent movement by tying the part to something solid. (Wood, banana trunk or the good leg).
Stop movement at nearest 2 joints.

Shock: (Cold yet sweaty)

Find cause - burn, break or bleeding.
Help blood flow to brain (feet up, head down).
Talk confidently to patient.

Unconscious:

Check for cause - Broken skull or back, bleeding, breathing etc. Gently roll into coma position. (Left side down, left arm back, right arm forward, right knee bent).

4Fs

(K-8)

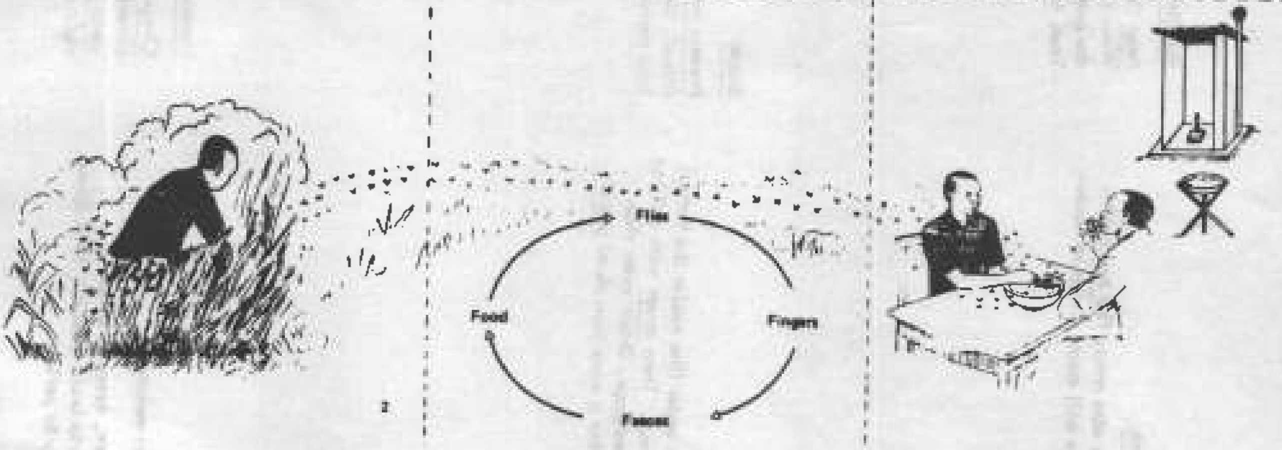
Pix 1 (Table)

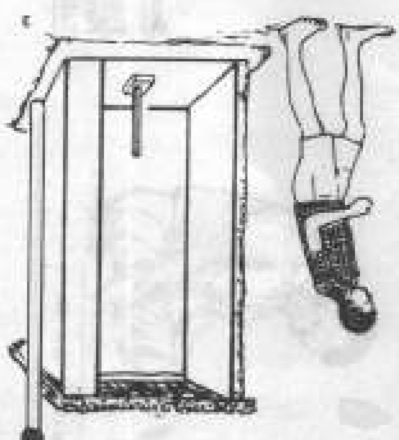
1) What things do you SEE? (Nice Choo with Lid and Vent, Basin, Flies, Fingers, Food).
2) What is HAPPENING?
   a) How are these men getting the food to their mouths?
   b) Do you think Mr. A (local name for man in a white shirt) washed his own hands?
   c) Do you think Mr. B (local name for man in dark shirt) washed his own hands?
   d) Is Mr. A happy?
   e) What worries him?
   f) Where are the flies walking?
   g) Where might they have walked before they came to Mr. A's table?
   h) Do you think the flies are from Mr. A's improved Choo?
   i) Did Mr. A's Choo and his basin prevent other people's flies from reaching his food?

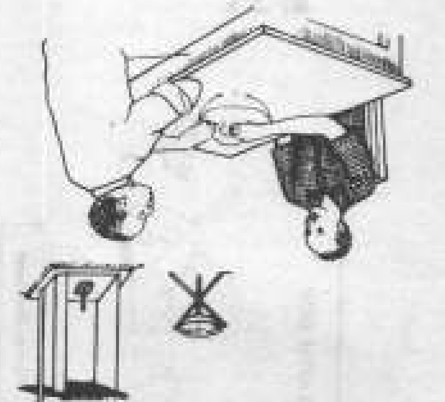
Pix 2 (Bush)

1) What things do you SEE? (Flies, Faeces).
2) What is HAPPENING? (Flies flying from faeces towards food).
   a) To what place might these flies be flying?
   b) Can they even fly to clean homes?
   c) Can one careless person and his flies bring danger to a whole community?
   d) Do you agree that if even one is careless, all are in danger?
   e) Do you agree that "nzi ni umoja"?
3) Does this happen in OUR place?
4) WHY?
5) What can we DO about it?

FOLD







Pix 3 (Choo)

1) What things do you SEE? (Cement slab, lid, vent., i.e., an improved latrine)

Discuss the importance of
a) Cleanable slab (preferably cement)
b) Ventilation to control flies
c) Lid to control flies

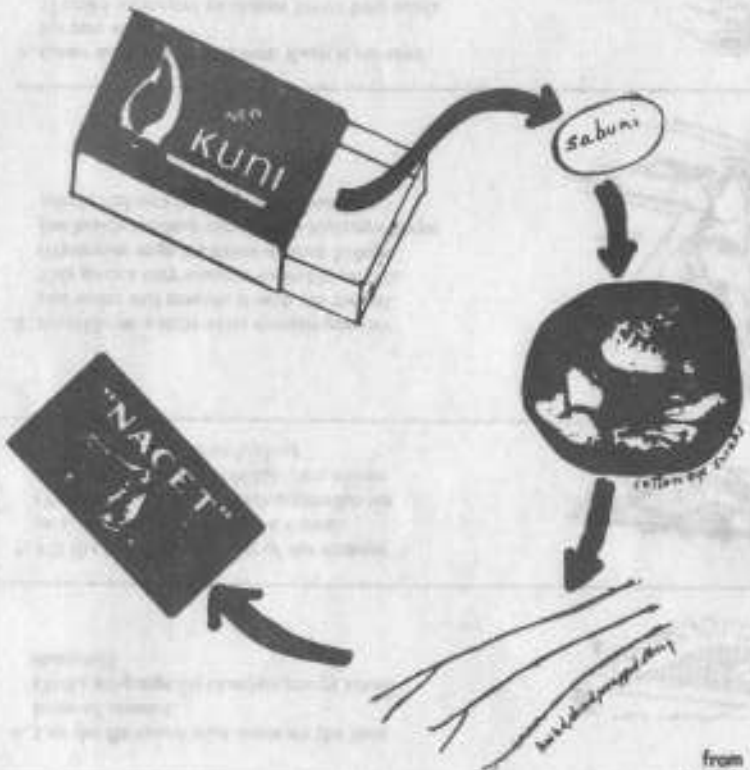
Pix 4 (Table again, revised)

1) What difference do you SEE? (No flies, Smile by A)
2) What has HAPPENED?
   a) Did Mr. A's Choo chase the flies away?
   b) Did Mr. A's basin chase the flies away?
   c) Then why no flies on table now?
   d) Do you think Mr. B now washes his hands?
3) Are flies important?
   a) To which houses can flies fly from faeces?
   b) Can they even fly to clean houses?
   c) Do you agree that if even one person is careless, all are in danger?
   d) Do you agree "nzi ni umoja"?
4) Has this picture's improvement come to OUR community yet?
5) WHY? WHY NOT?
6) What should we now DO about it?

5 Questions which SHOWeD.
SEE? HAPPENING? OUR? WHY? DO?

KIBIRITI KIT

delivery



from

AMREF

WORLD'S SIMPLEST, SMALLEST DELIVERY KIT

81

Materials needed (Vifaa vinavyobitajika)

Twice as much sand as cement
Mchanga (changarawe) mara mbili ya simiti

½ inch chicken wire 1 metre wide, 3 metres long
(Sengenge ya ua la kuku)

Shovel
(Kijiko kikubwa cha mchanga)

Trowel
(Kijiko kidogo cha simiti)

Shears
(Makasi)

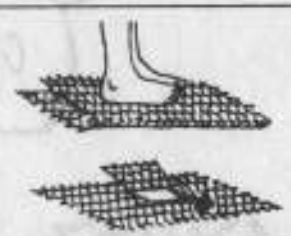
A brick
(Tofali)

Steps (Hatua)

1. Dig a hole in the ground. 1 metre square and 2½ cm deep. Cover the bottom with plastic or paper. Put the brick in the middle. (Chimba shimo halafu weka tofali katikati.)

2. Fold wire twice to make a 3-layer square 1m X 1m.
(Kunja sengenge ya ua la kuku mara mbili.)

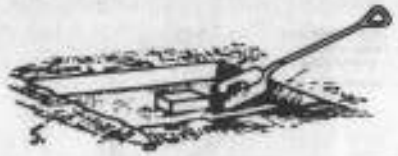
Press wire very flat. Cut a hole in its middle bigger than the brick.
(Kunja sengenge pamoja. Kata shimo katikati itakayotosha ukubwa wa tofali.)



3. Mix dry cement and dry sand together (one third bag cement two thirds bag sand). Mix completely. (Changanya mchanga na simiti sawasawa.)

4. Slowly add water while continuing to mix. Add water till the mixture seems about as thick as cooking ugali. Do *not* make it as thin as uji.
(Ongeza maji polepole huku ukikoroga simiti mpaka iwe na uzito wa ugali unaopikwa. Usifanye maji maji kama uji.)

5. Cover the floor of the hole completely with a thin layer of the cement mix. Make it as thin as a mat.
(Tandaza simiti iliyokorogwa chini ya shimo.)



6. Lay the flattened wire down on the thin layer of cement.
(Weka sengenge iliyokunjwa juu ya simiti shimoni.)

7. Fill the hole with the rest of the cement mix. Smooth the top with a trowel.
(Funika sengenge kwa mchanganyiko wa simiti na mchanga uliobakia. Jaza shimo kabisa na tandaza kwa kijiko.)

8. Sprinkle on a little extra cement powder and water and smooth it with the trowel. This gives a very smooth washable surface.
(Nyunyiza unga wa simiti na maji kidogo juu halafu tandaza vizuri. Kwa kufanya hivyo sakafu itakuwa laini na rahisi kusafisha.)

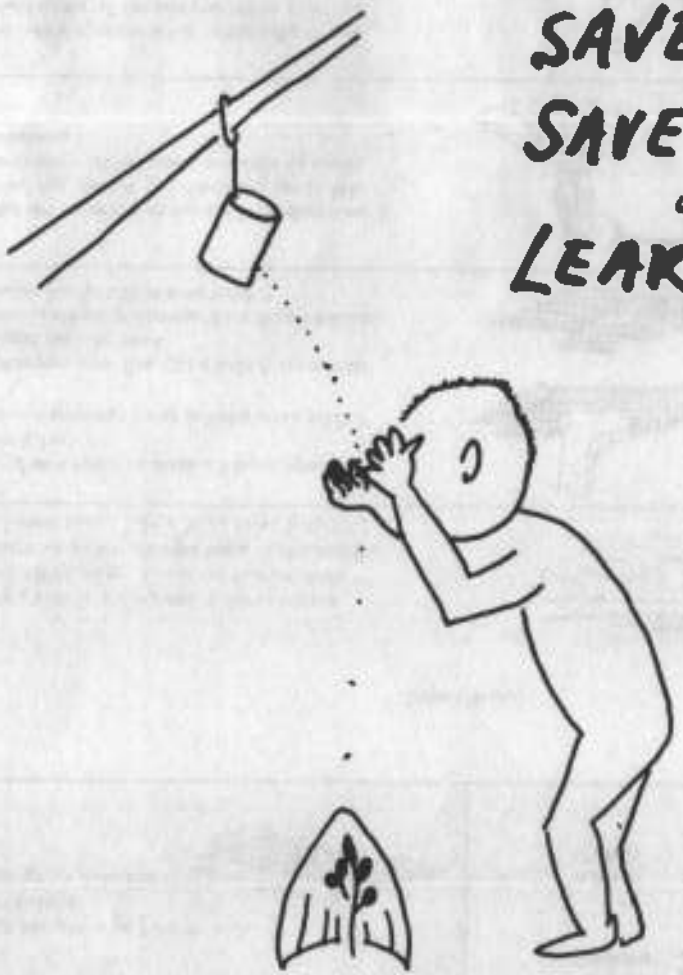
9. Cover with plastic or leaves. Keep it covered for two weeks.
(Funika na majani na iachwe hivyo kwa muda wa wiki mbili.)

Keep it wet the first three days with a sprinkling tin.
(Nyunyizia maji kwa muda wa siku tatu za kwanza.)

10. After 2 weeks remove the covering. Carefully lift the slab out of its hole. Knock the brick out of the centre hole. Take the slab to the latrine pit. (It can be carried on a bicycle.) Make a cover for the hole.
(Baada ya wiki mbili ondoa sakafu na itakua tayari kuwekwa juu ya shimo la choo.)

This slab is strong. It will hold the weight of four people.

SAVE EYES SAVE WATER with a LEAKY TIN



1. Find a small empty tin.
2. Punch a small nail hole near its bottom.
3. Hang the tin from a branch.
4. Once or twice a day mother pours just one cup of water into the tin.
5. Child (1-5 years) washes face in the fine stream of water leaking through the nail-hole.
6. Plant a tree seedling below the tin.
7. If the seedling suffers from drought, the child's eyes may ...

COMMUNITY HEALTH WORKERS SUPPORT UNIT

AMREF

KUTIBU MALARIA

RENOQUIN

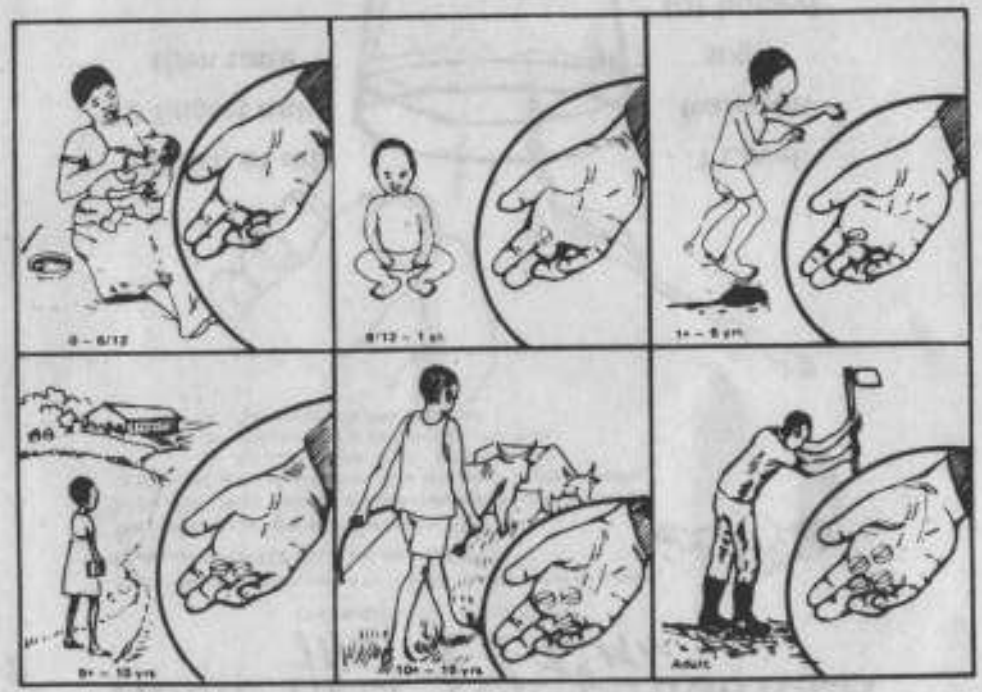
NIVAQUIN

MALAR-AQUIN

RESOCHIN

MALAREX

AVLOCLOR



Single dose Treatment in holoendemic areas

A teaching aid for CHWs and Shopkeepers

From the CHW Support Unit at AMREF

THE WORLD'S SHORTEST, SIMPLEST TALK ON GOOD FEEDING

"MIX COLOURS"

Brown Red Yellow Green White

Every meal should include foods of at least two different colours.

from AMREF

K12

HOME HELP FOR DIARRHOEA

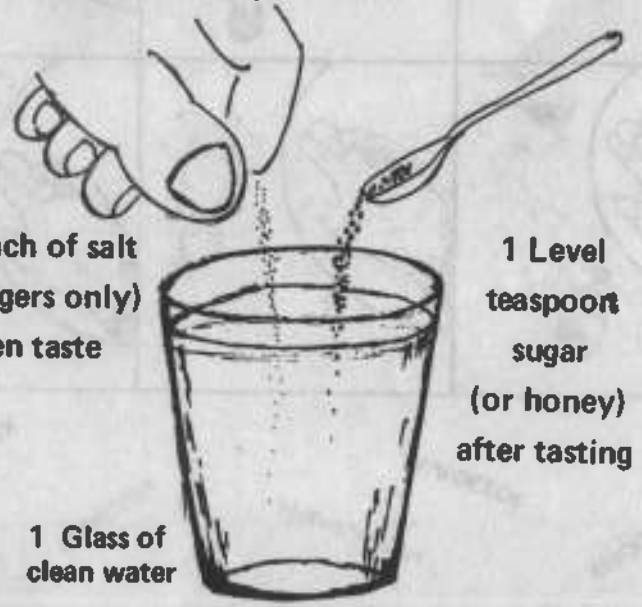
THE "1-1-1" Mix

DIARRHOEA IS SERIOUS!

A diarrhoea patient's first need is for WATER to replace what he is losing.
He also needs a LITTLE SALT, and some SUGAR.

This mixture can be made easily and quickly AT HOME.
So the FIRST HELP should be this home help mixture made in 4 steps
So the FIRST HELP should be this home help mixture made in 4 steps.

1. Put water in glass
2. Put salt in water
3. Taste (should not be more salty than tears)
4. Put in sugar only after tasting salt



1 Pinch of salt (2 fingers only) then taste

1 Level teaspoon sugar (or honey) after tasting

1 Glass of clean water

DRINK AS SOON AS DIARRHOEA STARTS

DRINK FREQUENTLY TILL DIARRHOEA HAS STOPPED

DRINK BY SPOONFUL IF THERE IS VOMITING

DRINK MORE THAN HAS BEEN LOST

FROM THE COMMUNITY HEALTH WORKER SUPPORT UNIT AT AMREF

SUPPORT UNIT TRAINER (Penina) WITH CHW ON HOME VISIT

PREVENTION of DISEASE

Cut

Fold

Fold

Cut

Fold

Cut

Fold

58

DISEASE

Signs

PREVENTION

Protections

TB

Coughing continues a month or more
Tiredness
Thinness
No appetite for food

Fold — Cut

A very small injection
Injection is *in* the skin, not deeper
Best given at birth
Injection must leave a small scar

Polio

Starts with high fever
Pain of head and body
Stiffness
Later weakness and paralysis
Paralysis usually one-sided

Fold — Cut

A few drops of red fluid in mouth
Give at age 2 *and* 4 *and* 5 months

DPT

Diphtheria – severe throat infection
Pertussis – long coughing spell ending in sound of rooster
Tetanus – child stops nursing
mouth tightens till teeth show
neck and back tighten to bend the body wrongly
very much pain
very sensitive

Fold — Cut

Injection deeper than the skin
Give at age 3 *and* 4 *and* 5 months

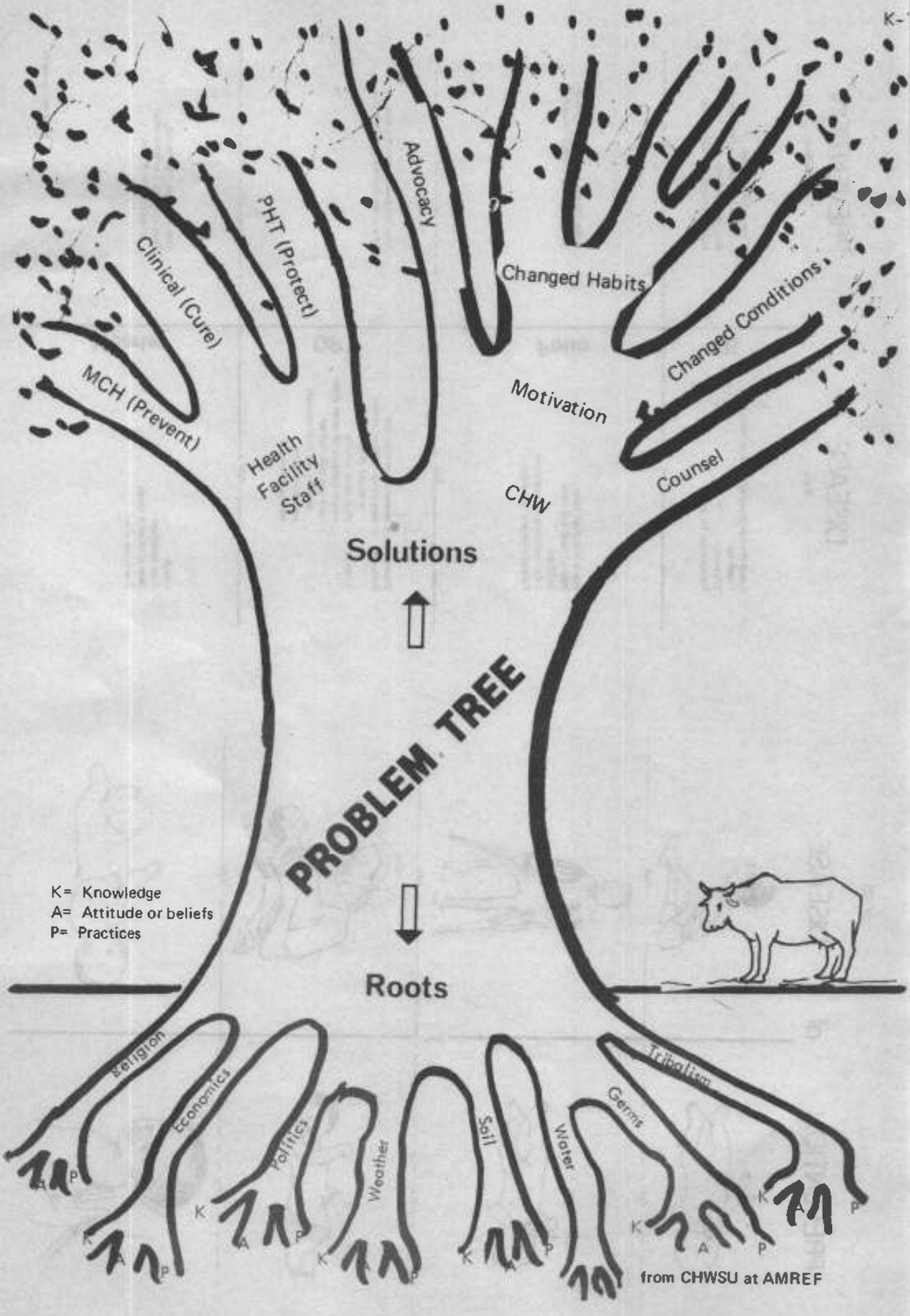
Measles

Cough
Eyes disturbed
Skin of chest is rough
Diarrhoea often

Fold — Cut

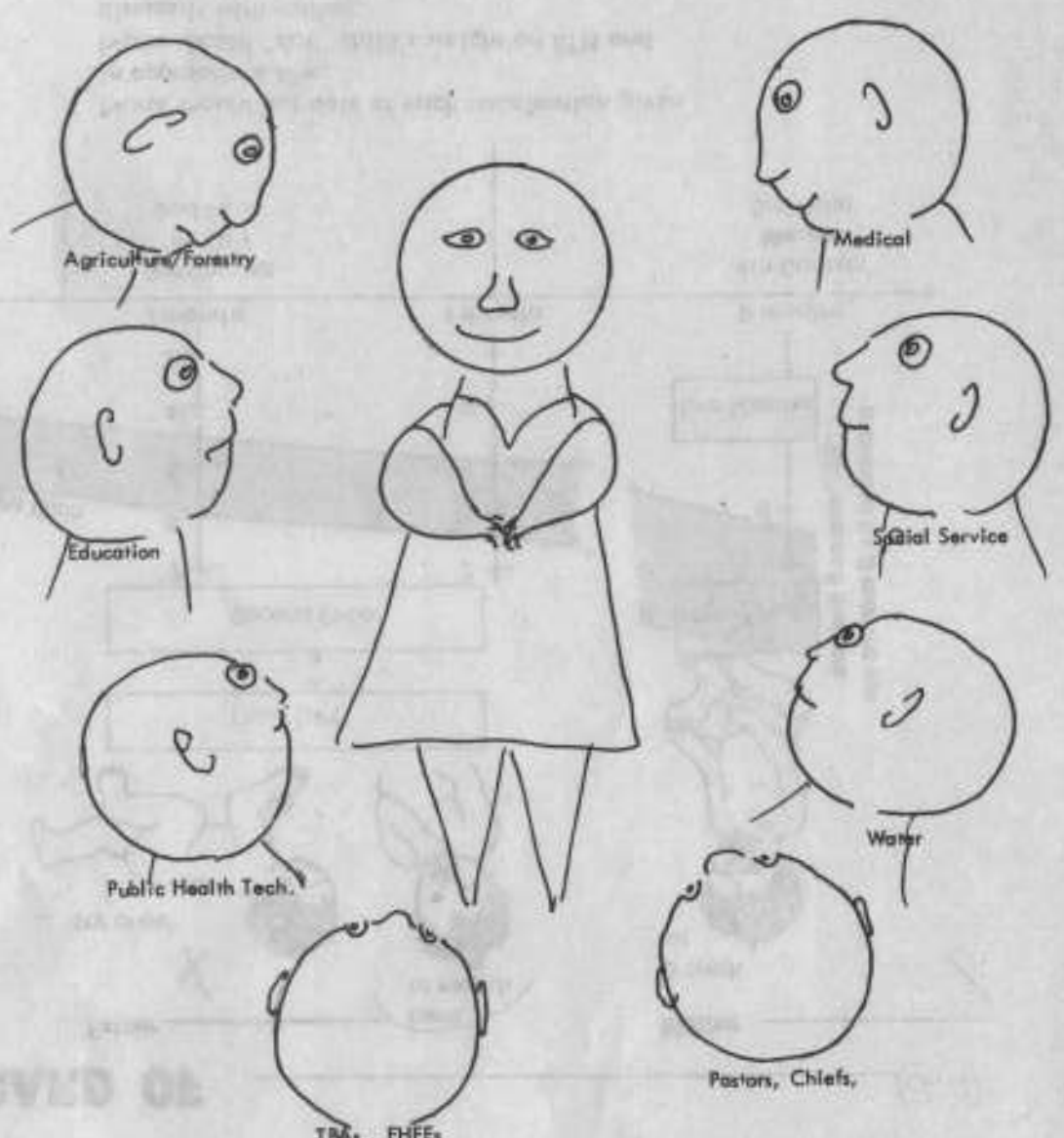
One injection into muscle
Give at about 9 months when child has 2 or 3 teeth

from CHWEU in AMREF


Clinical (Cure)
PHT (Protect)
Advocacy
Changed Habits
Changed Conditions
MCH (Prevent)
Motivation
Health Facility Staff
CHW
Counsel
Solutions
PROBLEM TREE
Roots
K= Knowledge
A= Attitude or beliefs
P= Practices
Religion
Economics
Politics
Weather
Soil
Water
Germs
Tribalism
from CHWSU at AMREF

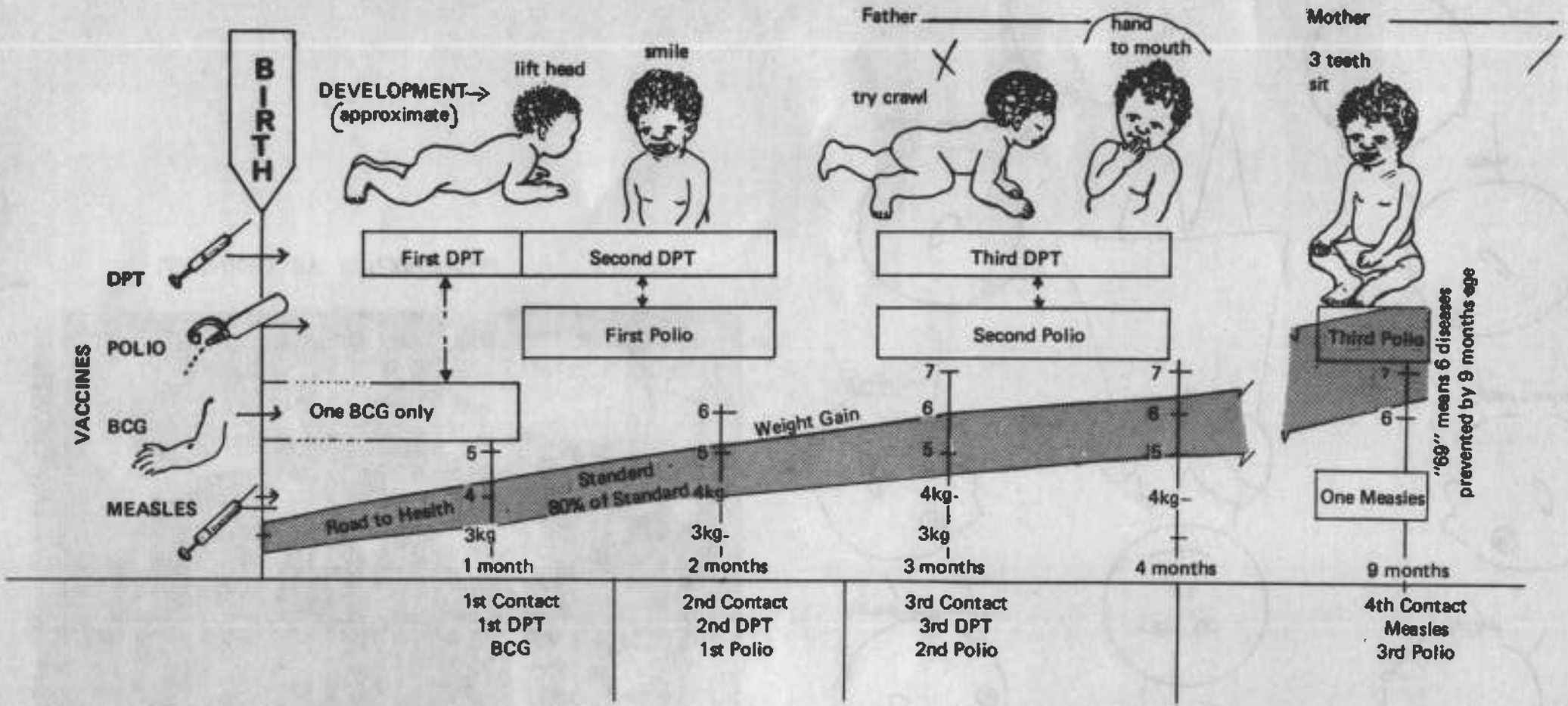
LEARNING BY INTERACTION

THE CHW's "PROFESSIONAL" RELATIONSHIPS



KI6

GROWTH AND PROTECTION CARD OF _____ (child)

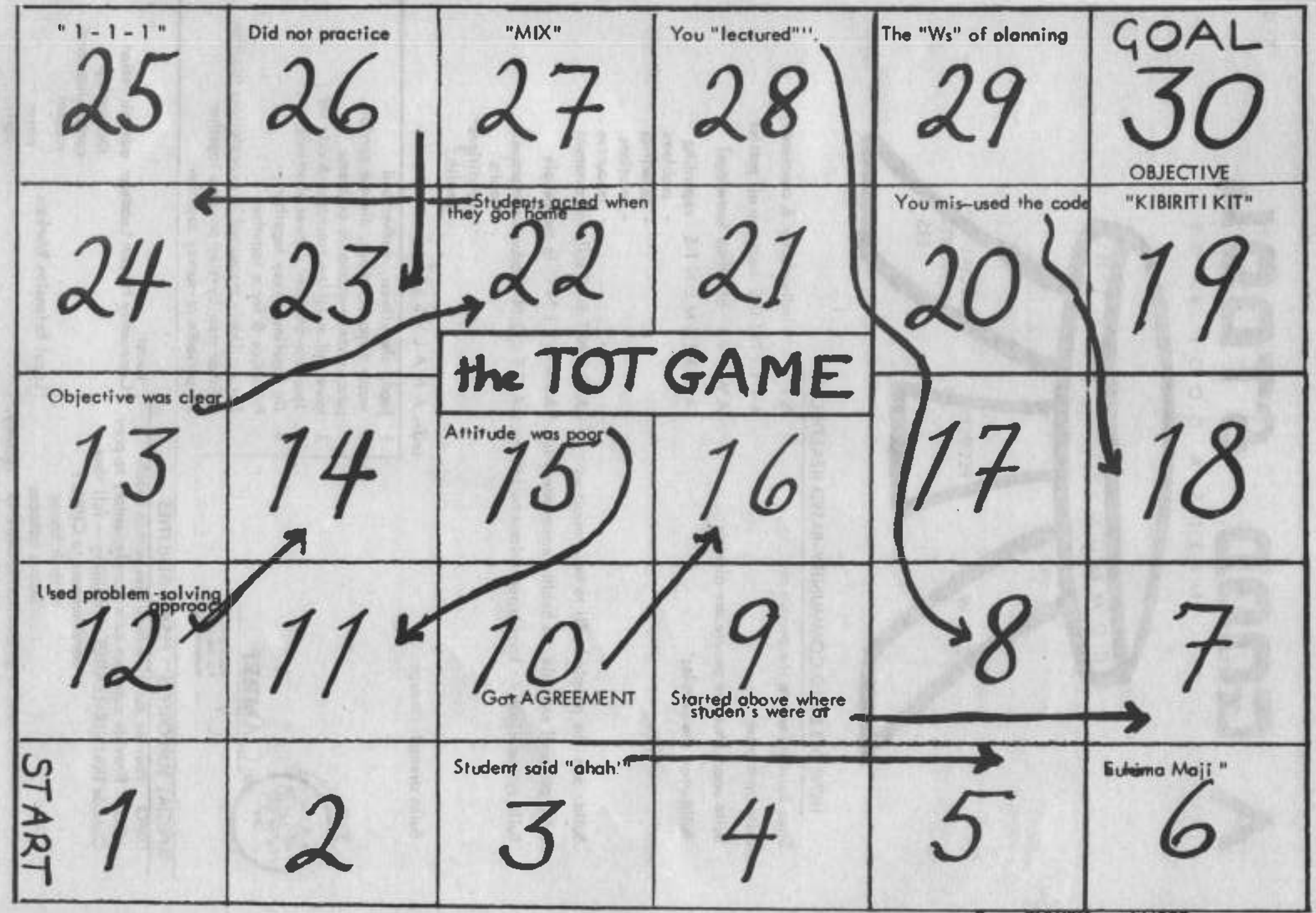


Clinical Notes:

Mother should gradually understand the growth drawings and vaccination boxes and "road to health" weight dots.
Mother should keep this card safely.
Mother should bring this card every visit.

Nurse should put date of each vaccination given in appropriate box.
Nurse should "dot" child's weight on RTH and discuss it with mother.
Nurse should write clinical notes where useful.

From The Community Health Worker Support Unit at AMREF


"1-1-1"
25
Did not practice
26
"MIX"
27
You "lectured"!!
28
The "Ws" of planning
29
GOAL
30
OBJECTIVE
24
Students acted when they got home
23
22
21
You mis-used the code
20
"KIBIRITI KIT"
19
the TOT GAME
Objective was clear
13
14
Attitude was poor
15
16
17
18
Used problem-solving approach
12
11
10
Got AGREEMENT
9
Started above where studen's were at
8
7
START
1
2
Student said "ahah!"
3
4
5
Sukuma Maji"
6
From CHWSU at AMREF

A GOOD STOOL

NEEDS A GOOD BASE

HOW TO BUILD COMMUNITY-BASED HEALTH CARE

Start Building where the people are — AT individually & communaly

Build up a good — ATTITUDE between all parties

Build upon what the people are already — AWARE of (their knowlege)

Build upon the peoples' — AGREEMENTS regarding :
- problems
- priorities
- solutions
- resources

Build upon the peoples' will to be committed — AGENTS of self-improvement

Build personal example, so health improvement is — APPARENT to the people

Build systematically : knowlege → vision → motivation → ACTION producing improved
- habits[1]
- conditions[2]
- health[3]

Build strength through — self- ANALYSIS[4]

1 food, cleanliness, motherhood
2 waste disposal, crops, disease carriers, pshcyo-socio-economic problems
3 lower inf.mort, less trachoma & skin inf.; less dehydration- ; fewer abortions;
4 Do baseline survey together
Prioritize & focus together
Set verifiably measureable expectations together
Monitor step-by-step progress together
Do periodic re-survey together

From
at AMREF
Wilson Airport
P.O. Box 30125
Nairobi, Kenya

"SPECIAL SUPPORTERS'" RESPONSIBILITIES

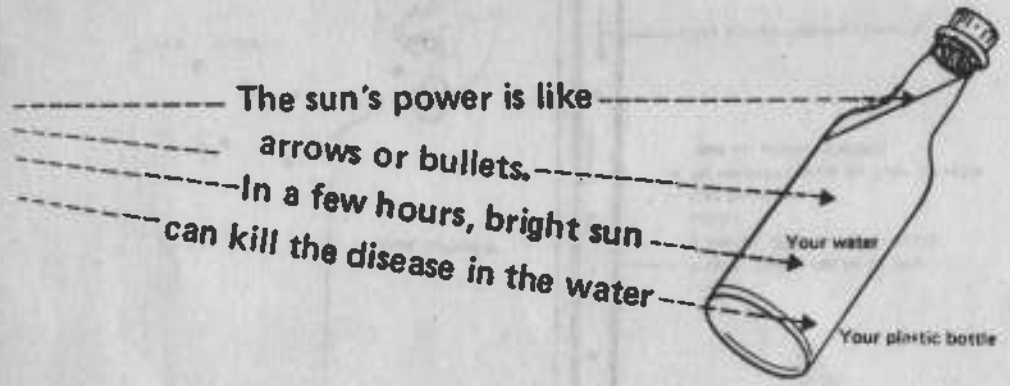
DMO Provide curative facilities within reach
CO Provide curative care complementary to prev.
Outside TRAINER-LEADER : training - full time
moral support to CHWs :
at their homes
before barazas
evaluation leadership (survey, monitor, evaluate)
Local Social Leaders (TBA-;pastors;tchrs) : cultural support

Local Community Health Leaders: administration
sponsorship
continuing moral support

Local Extension Workers :
water
agric.
adult lit.

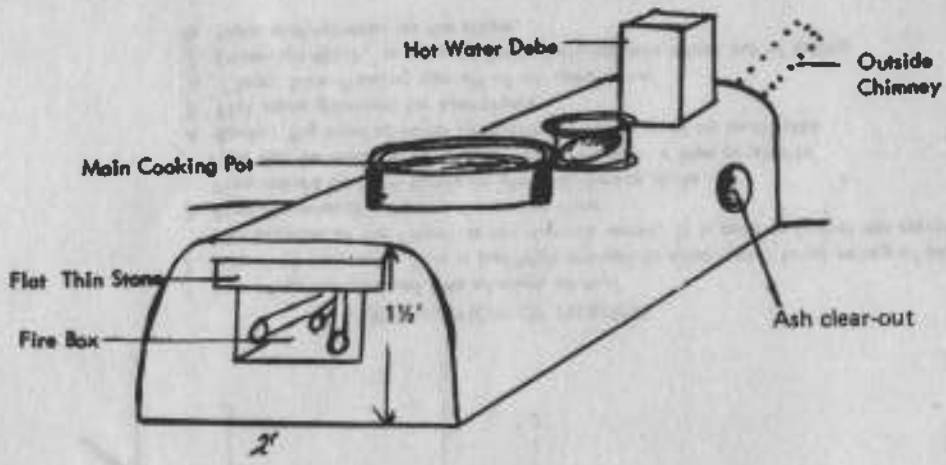
- Is this a common sickness among your children?
- It may come from drinking diseased water.
- But your children do not <u>have</u> to drink diseased water.
- Instead of diseased water you can easily give them

SUN-SAFE WATER

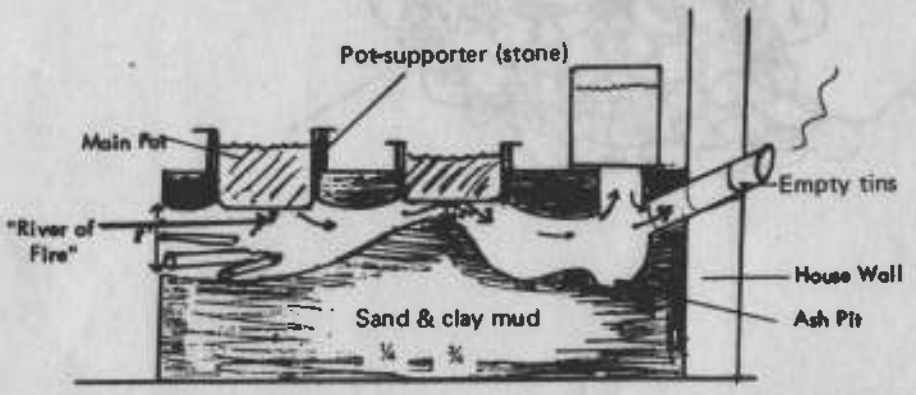


That is how simple it is to get safe water for your child.
Do you have a plastic bottle?
Do you have sunlight?
Why not try this idea?
Just set the bottle or bag of water in the direct sunshine from mid-morning till mid-afternoon. The <u>sun</u> makes the water <u>safe</u>.

SAFE, SAVING MUD STOVE



General View

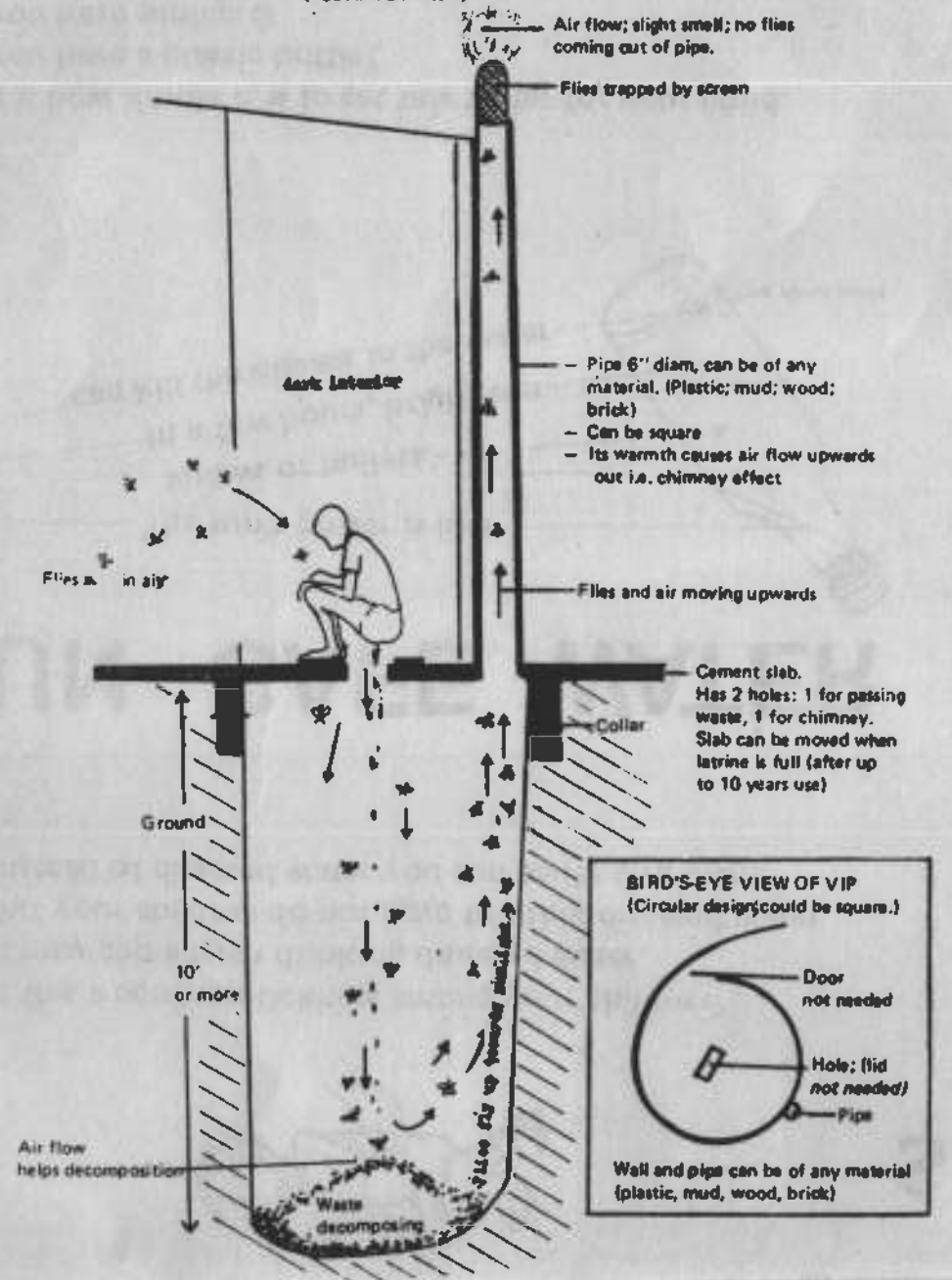


"Cut-in-half" View

BLAIR V.I.P. (VENTILATED IMPROVED PIT) LATRINE

THE "CHIMNEY CHOO"

("Cut-in-half" view)

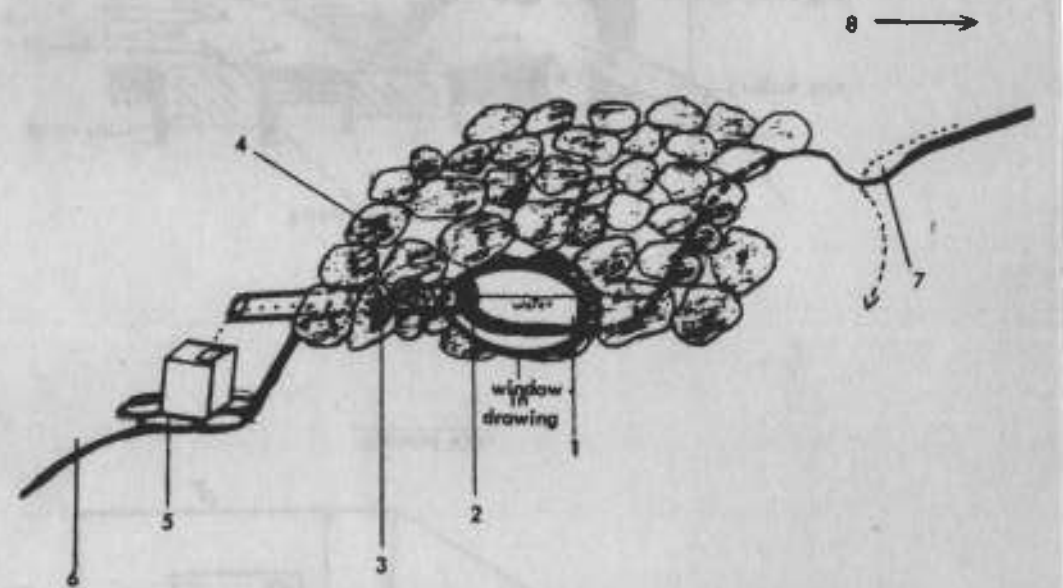


BIRD'S-EYE VIEW OF VIP

(Circular design could be square.)

Wall and pipe can be of any material (plastic, mud, wood, brick)

SIMPLE SPRING PROTECTION



EXPLANATION OF NUMBERS

1. Eye of spring cleaned free of muck or mud
2. "Dam" of clay soil. This is just high enough to raise water level to top of pipe. The purpose of the "dam" is not to store water. It is only to funnel the spring flow
3. Pipe big enough to carry the spring flow. Pipe should be held firmly in place by heavy rocks. Pipe can be made of bamboo or rolled mabati or iron or plastic
4. Rocks. Big ones covered by medium-size covered by small size
5. Flat stone platform for containers
6. Clear, free-flowing run-off of un-used water
7. Diversion ditch, to keep surface polluted rain water out of spring
8. Trees and terraces up the slope

From the CHWSU at AMREF