2. The Essential Elements of the Community Strategy

This chapter defines and outlines the structures and mechanisms that link the community with the health system at all levels needed to support level 1 services. The specific committees and forums are described in terms of their composition, formation, roles and responsibilities.

2.1 The Linkage Mechanisms and Structures

Community linkages are important points of emphasis in NHSSP II. The strategic plan recognizes that the health facilities at levels 2 and 3 will improve the effectiveness of their service delivery if they work closely with their catchment communities through various committees in the community strategy framework that link to service delivery at the household level. The structures provide opportunity to generate informed dialogue between the health system and the community, to create demand for quality services on the part of the community, and to enhance their responsibility for action for health at level 1. For this to happen, the committee structures must be inclusive in terms of administrative areas as well as interest groups. The structures defined in the sections below and illustrated schematically in Figure 2.1 are key to the Community Strategy framework.

It is the members of households and families who are both the primary targets and the primary implementers of level 1 services.

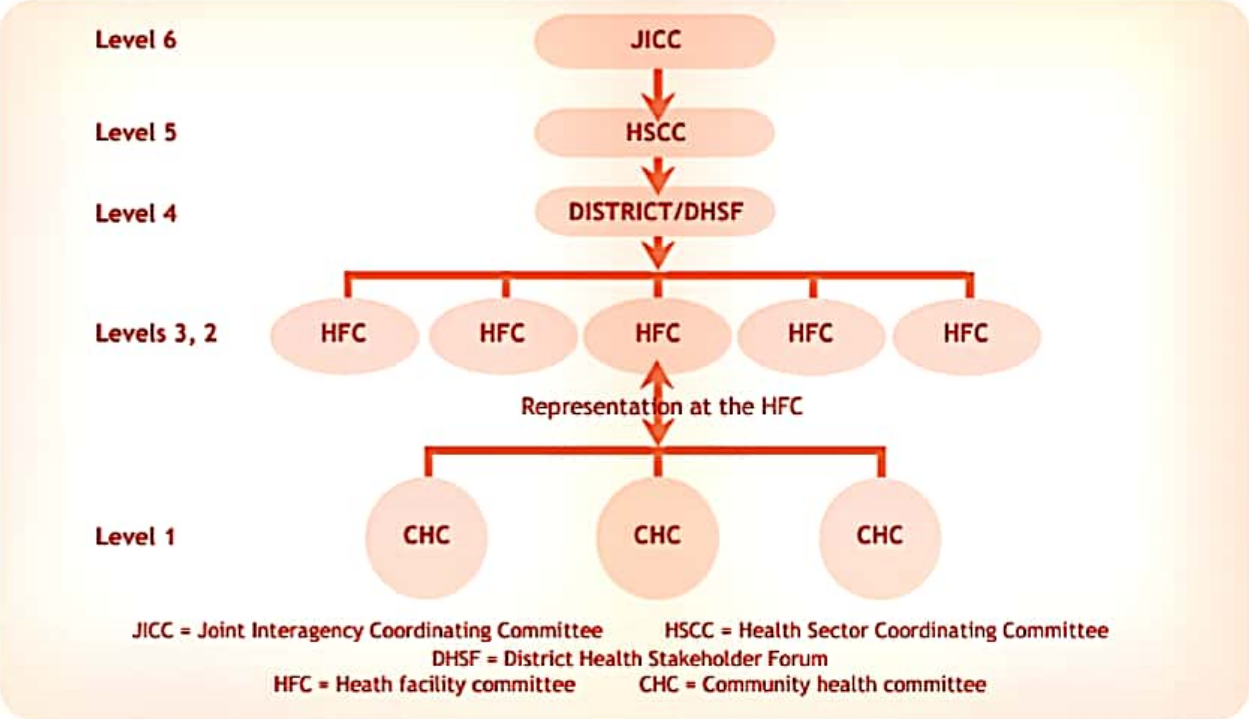
2.1.1 Community Units

The "community unit" as defined in this context comprises approximately 1,000 households or 5,000 people who live in the same geographical area, sharing resources and challenges. In most rural areas such a unit would be a sub-location, the lowest administrative unit. The number of households in a community unit will determine the number of community health workers to be selected, so that 1 CHW serves approximately 20 households.

The household level consists of individuals associated with and usually headed by the household head or caregiver. It is the members of households and families who are both the primary targets and the primary implementers of level 1 services. They are responsible for the day-to-day upkeep of the household affairs as well as for participating in community-organized health activities. They have contacts with the CHWs and the formal health system where they seek and utilize health services. The household forms the first level of care that is universally available.

The community units are organized in villages and other interest groups that are responsible for identifying and supporting the CHW. The CHWs report to the community health committee (CHC) through the community health extension worker (CHEW), who is the secretary to the committee. All the villages within the community unit should be represented on the CHC. Since health status depends on factors beyond the health sector, coordinated action across sectors at the community level will increase efficiency in improving health outcomes. This includes nurturing economic empowerment and transformation, enhancing access to the means of production and marketing, and paying

Figure 2.1: Community Strategy linkage structure



attention to the social determinants of health. All these sectors and actors should be represented on the CHC to the extent possible.

2.1.2 Community Health Committee (CHC)

The health governance structure closest to the community is the CHC, elected in such a way that all the villages in the community unit are represented. The CHC should be elected at the Assistant Chief's *baraza* under the chair of the Assistant Chief. The committee is chaired by a respectable member of the community. It is recommended that a CHW should be elected treasurer and that the CHEW should be the secretary. There should be nine additional members, to include representatives of: youth, faith groups, women's groups, NGOs, people living with HIV and AIDS (PLWHAs), people with disability (PWDs), and relevant others. At least one-third of the committee members should be women.

Role and Functions

The role and functions of the CHC will include:

- Identifying community health priorities through regular dialogue.
- Planning community health actions.
- Participating in community health actions.
- Monitoring and reporting on planned health actions.
- Mobilizing resources for health action.
- Coordinating CHW activities.
- Organizing and implementing community health days.
- Reporting to level 2 on priority diseases and other health conditions.
- Leading community outreach and campaign initiatives.
- Advocating for good health in the community.

Meetings and Agenda

The committee should meet at least monthly to receive reports from the villages to enable the CHEW to compile monthly reports for level 2 or 3 management committees. The standing agenda should include:

- Review of actions agreed on in the previous meeting and progress made in their implementation.
- Review of the chalkboard records of key indicators by village (immunizations, deliveries, cases of fever and diarrhoea in children, the chronically ill, use of insecticide treated nets [ITNs], maternal and child mortality).
- Identification of and dialogue on areas needing improvement and planning action to improve.

- Encouraging them to take up paid jobs when such opportunities are available and accepting them back when such assignments end (it may be necessary to train an alternate counterpart CHW per village when the first one has been serving for more than two years).
- Logistical support, regularly providing working materials (transport, basic kit)
- Evidence-based output linked to rewards at regular celebrations.
- Organizing them into savings and credit associations to enhance their own income earning capacity as well as linking them to other CHWs through exchange visits and meetings.
- Training them in productive skills according to their own interests and capacities, beyond health issues.
- Attending relevant conferences.

4.1.2 The CHEW

Community health extension workers (CHEWs) are trained health personnel with certification in nursing or public health. They will supervise CHWs and will be Ministry of Health employees.

The Roles and Functions of CHEWs

As provided for in the Community Strategy implementation framework, CHEWs constitute a new cadre of health worker. Their function is to facilitate the provision of quality services by CHWs and to ensure a smooth referral mechanism linking the community to level 2 and 3 facilities. The CHEWs' main functions therefore include:

- Overseeing the selection of CHWs.
- Organizing and facilitating CHW training.
- Monitoring the management of the CHWs' kit.
- Supporting the CHWs in assigned tasks and coaching them to ensure achievement of desired outputs and outcomes.
- Collating information gathered by the CHWs to display summaries at strategic sites to provide relevant feedback as well as material for dialogue at household and community levels.
- Compiling reports from CHWs and forwarding to level 2 and 3 management committees.
- Receiving feedback from level 2 and 3 facilities and passing it on the CHCs and CHWs through dialogue and planning that leads to actions to improve identified issues.
- Following up and monitoring actions emerging from dialogue and planning sessions to ensure implementation.

How a CHEW Is Selected

The DHMT will take the lead in the recruitment of the CHEWs with the support of level 3 management committees. Community health committee (CHC) members will be informed about the roles and functions of CHEWs by the DHMT to enable them to make informed decisions on the type of persons they elect as CHEWs for their community, as described in Chapter 3. The CHEW should be received by the community at a community unit meeting that is open to all members. Selection criteria should include:

- Having suitable qualification in nursing or public health.
- Being a mature and responsible person.
- Being acceptable to and respected by the whole community.
- Being a good communicator.
- Being able to work with people of diverse backgrounds.
- Being willing to teach and mentor others.
- Being able to be available to the service consumers according to demand.

4.1.1 Community Health Workers

Community health workers are expected to be mature, responsible and respected members of the community, men or women chosen by the community to provide basic health care. They should be good communicators and leaders who have shown signs of healthy practices as a parent or caregiver in their own household. In many communities there are community-based resource persons such as community-based distributors (CBDs), TB ambassadors and others. All these resource persons at the community level should be incorporated into the strategy as CHWs, if

Implementation Guidelines

they have the characteristics described in this section.

The Roles and Functions of CHWs

CHWs have several functions in the community that are influenced by community priorities and the availability of health services to the community. Their main role is to promote good health by:

- Teaching the community how to improve health and prevent illness by adopting healthy practices.
- Treating common ailments and minor injuries, as first aid, with the support and guidance of the CHEW.
- Tending the CHW kit with supplies provided through a revolving fund generated from users.
- Referring cases to the nearest health facilities.
- Promoting care seeking and compliance with treatment and advice.
- Visiting homes to determine the health situation and dialogue with household members to undertake the necessary action for improvement.
- Promoting appropriate home care for the sick with the support of the CHEWs and level 2 and 3 facilities.
- Participating in monthly community unit health dialogue and action days organized by CHEWs and CHCs.

Community health workers (CHWs), who work on a volunteer basis, and community health extension workers (CHEWs), who are MOH employees, are the front line of the Community Strategy. The community health committees manage the two.

- Being available to the community to respond to questions and provide advice.
- Being an example and model of good health behaviour.
- Motivating members of the community to adopt health promoting practices.
- Organizing, mobilizing and leading village health activities.
- Maintaining village registers and keeping records of community health related events.
- Reporting to the CHEW on the activities they have been involved in and any specific health problems they have encountered that need to be brought to the attention of higher levels.

How a CHW Is Selected

To the extent possible CHWs should be accepted by the whole community as they are the link-pin between the household system and the health system. It is therefore critical that the community be briefed on the functions of the CHW to enable them to select persons who can work effectively with them in promotion of good health among households. Village leaders will organize meetings to inform the people about the CHWs' functions in the community, linked to the launching workshops described in Chapter 3.

At a village meeting convened by the elders, consenting nominees are presented for consideration by the villagers. In this forum the villagers select the individual of their choice on the basis of on the following criteria:

- A permanent resident in the area.
- Able to read and write, and enthusiastic to learn more.
- Concerned about the welfare of the people.
- Willing to volunteer.
- Physically fit.
- Willing to visit all village members.
- Respected by villagers as an example of healthy behaviour.
- Having demonstrated attitudes valued by the community.
- Backed by immediate family members (particularly the spouse).

How a CHW Is Motivated

Because they are volunteers, CHWs may require specific incentives to remain motivated to serve their communities. Years of experience working with CHWs has revealed the following motivating mechanisms:

- Continuous lifelong training based on the needs expressed by CHWs.
- Religious commitment, giving meaning to service to others.
- Having responsibility over households to which they belong and cultural, religious or economic ties permitting permanent loyalty and reciprocal giving and receiving from members.
- Organizing their work into fixed number of days in a quarter/year, beyond which they must be financially compensated (e.g., one household visit for two hours for 20 households per quarter and one dialogue meeting/*baraza* or health day per month).
- Supportive supervision and coaching as individuals or groups based on need, giving them regular feedback on performance and improvement being made.
- Giving them priority when there are paid jobs for health campaigns and mass treatments, for example, or distribution of communities (if they have served the community for two years after initial training).

Table 4.1: Summary of functions of the Community Strategy workforce

Function	Level 1 CHW	Level 1 CHEW	Level 2 In-charge	Level 3 PHO	Divisional PHO	District DHMT
Registers and record keeping	✓					
Report writing	✓	✓	✓	✓	✓	✓
Facilitating HH and comm. dialogue	✓	✓	✓	✓	✓	
Facilitating evidence-based planning		✓	✓	✓	✓	✓
Action monitoring and follow up	✓	✓	✓	✓	✓	✓
Coordinate CHWs activities		✓				
Distribute CHW kits		✓	✓			
Training of CHWs		✓	✓	✓		
Training of CHCs		✓	✓	✓		
Training of level 2 and 3 committees				✓	✓	✓
Supervision and follow up		✓	✓	✓	✓	✓
Training of CHEWs and PHOs					✓	✓

4.1.3 The CHC

A community health committee (CHC) is a group of people who are charged with the responsibility of leading community health action at the community unit level. The committee is composed of 8-12 people selected from the community. Membership must be sensitive to gender balance and equal representation of villages and all interest groups in the community. The CHC elects officials from among the members: Chair (a respected community member), secretary (the CHEW) and treasurer (a CHW). The CHC has regular meetings that relate to the 100-day improvement cycle as well as community dialogue and action days. When they meet they discuss health-related community issues and review progress of households, CHWs and CHEWs on the basis of planned action for health guided by available data. Village and activity specific data are presented for dialogue and planning to ensure adequate targeting of areas and specific interventions.

The Roles and Functions of CHCs

- Leading monthly dialogue sessions at community unit level on the basis of data presented by villages and activities, leading to planning action.

CHEWs are a new cadre of health worker whose function is to facilitate the provision of quality services by CHWs and ensure a smooth referral mechanism linking the community to level 2 and 3 facilities.

- Providing structures for community action for health, emphasizing key household health practices.
- Providing a channel for external assistance to be continued where necessary.
- Providing a channel of communication with the levels 2 and 3 management committees, divisional health forum and the district health stakeholder forum.
- Facilitating community change by actively advocating the CHWs' work, backing them up in their tasks.
- Monitoring trends of key community health data and reporting to level 2 and 3 management committees for quarterly dialogue, planning and action.
- Overseeing CHW activities and appraising CHWs in preparation for recognition during community health days or forums at various levels.
- Seeking and mobilizing local human and financial resources for health action, on the basis of priorities identified by available data.

How a CHC Is Selected

The selection of members to the CHC is led out by the administrative head of the community unit, an Assistant Chief. The respective level 3 management committee facilitates the process by sending representatives to attend meetings organized by the administrator for the purpose of selecting CHC members. The characteristics of people to be identified are explained and then consenting nominees are identified for consideration by the *baraza*, with attention to inclusive representation as described in Chapter 3. The following characteristics are considered in the selection:

- Residency in the area.
- Ability to read and write.
- Demonstrated leadership qualities.
- Demonstrated role model in positive health practices.
- Representative of a constituency in the community (village, faith communities, youth, disabled, women, etc.).