MINISTRY OF PUBLIC HEALTH
AND SANITATION

TRAINING COMMUNITY HEALTH COMMITTEES IN KENYA

THE HANDBOOK
FOR COMMUNITY HEALTH COMMITTEES

Division of Community
Health Services
"Afya Yetu, Jukumu Letu"

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AND SANITATION

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Division of Community
Health Services
"Afya Yetu, Jukumu Letu"

MASAAI SAYING

"WHEN YOU WALK ALONE,
YOU MAY WALK VERY FAST BUT YOU DON'T GET VERY FAR.
WHEN YOU WALK WITH OTHERS,
YOU MAY NOT WALK VERY FAST BUT YOU CAN GO VERY FAR"

USAID
FROM THE AMERICAN PEOPLE

Funding for the development and printing of this document was provided by the United States Agency for International Development (USAID) through the Management Sciences for Health (MSH) Leadership, Management and Sustainability (LMS) program under the Kenya Cooperative Agreement No. AID-623-LA-10-0003.

AFYA YETU JUKUMU LETU: OUR HEALTH, OUR RESPONSIBILITY

This song, in both languages, is sung to the popular tune of "IF YOU'RE HAPPY AND YOU KNOW IT, CLAP YOUR HANDS". Verses 1 & 4 are the same deliberately!

KISWAHILI

1. Afya yetu, afya yetu jukumu letu!
Ndio! Ndio!
Afya yetu, afya yetu jukumu letu!
Ndio! Ndio!
Afya yetu, Afya yetu;
Afya yetu, afya yetu;
Afya yetu, afya yetu jukumu letu!
Ndio! Ndio!

2. Tukiwa na afya vijijini tuna afya!
Ndio! Ndio!
Tukiwa na afya vijijini tuna afya!
Ndio! Ndio!
Tukiwa na afya vijijini;
Tukiwa na afya vijijini;
Tukiwa na afya vijijini tuna afya!
Ndio! Ndio!

3. Mawazo yetu ya kiafya yaleta afya!
Ndio! Ndio!
Mawazo yetu ya kiafya yaleta afya;!
Ndio! Ndio!
Mawazo yetu ya kiafya;
Mawazo yetu ya kiafya;
Mawazo yetu ya kiafya yaleta afya;!
Ndio! Ndio!

4. Afya yetu, afya yetu jukumu letu!
Ndio! Ndio!
Afya yetu, afya yetu jukumu letu!
Ndio! Ndio!
Afya yetu, Afya yetu;
Afya yetu, afya yetu;
Afya yetu, afya yetu jukumu letu!
Ndio! Ndio!

MWISHO

ENGLISH

1. We, indeed, are responsible for our health!
Yes, indeed!
We, indeed, are responsible for our health!
Yes, indeed!
We, indeed, are responsible;
We, indeed, are responsible;
We, indeed, are responsible for our health!
Yes, indeed!

2. When there's health in the community there is health!
Yes, indeed!
When there's health in the community there is health!
Yes, indeed!
When there's health in the community;
When there's health in the community;
When there's health in the community there is health!
Yes, indeed!

3. When our focus is on health we'll be healthy!
Yes, indeed!
When our focus is on health we'll be healthy!
Yes, indeed!
When our focus is on health;
When our focus is on health;
When our focus is on health we'll be healthy!
Yes, indeed!

4. We, indeed, are responsible for our health!
Yes, indeed!
We, indeed, are responsible for our health!
Yes, indeed!
We, indeed, are responsible;
We, indeed, are responsible;
We, indeed, are responsible for our health!
Yes, indeed!

END

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FOREWORD

In 2006, the Ministry of Public Health & Sanitation embarked on launching the Community Health Strategy, province by province. This was in line with Kenya's stated commitment to good health for all Kenyans. Indeed, health is not only a right but also a responsibility for all. Promotion of good health at different levels of society is the responsibility of all individuals, families, households, and communities. The purpose of the Community Health Strategy is to enable communities to improve and maintain a level of health that will enable them to participate fully in national development towards the realization of Vision 2030. Community Health Committees have an important governance role in the processes that take place to improve health at the community level.

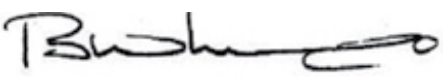
A one day consultation took place at which stakeholders deliberated on the Community Health Strategy and what roles and responsibilities Community Health Committees (CHCs) would play. Deliberations also included presentations on Principles of Curriculum with respect to what needs to be taken into account in preparing a curriculum for Community Health Committees. This was followed by a week's retreat attended by a wide spectrum of stakeholders to develop the Curriculum for Community Health Committees. The product was harmonised through a number of processes and I am happy to present the final product.

This document will assist the Ministry of Public Health and Sanitation and the Division of Community Health Services along with other stakeholders who work at the community level to achieve the Ministry's strategic objectives as outlined in the National Health Sector Strategic Plan (NHSSP-II) 2008-2012, with particular reference to the Community Health Strategy. Successful undertaking of these activities will significantly contribute towards the attainment of health-related MDG targets. The modular format of the Curriculum has facilitated the development of the Trainers' Manual for Community Health Committees and this take-home Handbook for Community Health Committees. These documents have been pilot-tested and refined and will greatly facilitate the successful undertaking of training Community Health Committees to carry out their leadership, governance oversight and coordination roles at the community level.

Therefore, on behalf of the Ministry of Public Health and Sanitation, I wish to thank all stakeholders who work at the community level for their interest and involvement in the development of this handbook and the other two documents for Community Health Committees.

In particular, my Ministry expresses our thanks to USAID which, through Management Sciences for Health (MSH), provided financial and technical support that made the preparation of the documents possible. I thank MSH for tirelessly supporting and following up on this work which included the provision of the consultant who has facilitated the preparation these documents.

I am confident that the implementation of this handbook will help us address the issue of equitable access to primary health services and by so doing, bring about a much improved health status for all Kenyans that will be reflected in robust positive health indices.



Hon. Beth Mugo, EGH, MP
Minister for Public Health and Sanitation

PREFACE

One of the dominant themes in health policy and planning today is the need for interventions based on sound evidence of effectiveness. The responsibility of ensuring programmes are consistent with the best available evidence must be shared between providers, policy makers and consumers of services.

Community Health Committees (CHCs) are key for providing an appropriate and supportive social environment for the work of Community Health Workers (CHWs) and Community Health Extension Workers (CHEWs). Community Health Committees do this by taking responsibility for leadership, governance oversight and coordination at the community level. They also have the responsibility of mobilising communities for involvement in health-promotive and disease-prevention activities. To enable Community Health Committees (CHCs) to be effective and efficient, the need for appropriate training was clear.

Community Health Committees need to ensure smooth working relationships with CHWs at level one and also at the link health facility. To bolster the evidence base, Community Health Committees need to have the required skills in record keeping and report writing and to be familiar with the information gathering tools used by CHWs under the supervision of CHEWs. In order for CHCs to carry out these functions, they need training guided by an appropriately developed curriculum. This Curriculum has been the basis of developing the Trainers' Manual and the take-home Handbook for Community Health Committees.

The Government of Kenya is committed to supporting community health initiatives and in so doing accelerating the achievement of the current National Health Sector Strategic Plan II (NHSSP II) goals, and the MDGs, while providing the support to the achievement of Vision 2030.

This curriculum is organised in 7 modules and the proposed time-frame for the training is 7 days spread over two weeks so that in the first week the training is for three days and four days in the second week, thus leaving time for CHC team members to look after personal concerns in their lives including their livelihood.

These documents have been pilot-tested and appropriately adjusted to provide a solid base for the training of CHC team members. It is my expectation that all stakeholders engaged in community health activities will utilise this Curriculum, the Trainers' Manual and the take-home Handbook for Community Health Committees so as to have a standardized approach in training CHCs and to institutionalize procedures on governance at the community level.

Mark K. Bor, CBS
Permanent Secretary,
Ministry for Public Health and Sanitation

IMPLEMENTATION OF THE CURRICULUM FOR COMMUNITY HEALTH COMMITTEES

This Curriculum was developed by key stakeholders who work at the community level and who are aware that Community Health Committees (CHCs) are of crucial importance for the success of both CHWs and CHEWs. This Curriculum formed the basis for developing the Trainers' Manual, out which was derived the take-home Handbook for Community Health Committees. Development of the curriculum was guided by the roles and responsibilities of CHCs. These roles and responsibilities for CHCs hinge on their core functions of providing leadership and governance oversight in the community. These are:

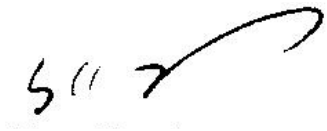
1. Provide leadership and governance oversight in the implementation of health and related matters in community health services at level 1
2. Prepare and present to the Link Health Facility Committee (and to others as may be needed) the community Annual Operational Plan (AOP) on health related issues at level 1
3. Network with other sectors and developmental stakeholders towards improving the health status of people in the Community Unit, e.g. Ministries of Water, Agriculture, Education, etc.
4. Facilitate resource mobilisation for implementing the community work plan and ensure accountability and transparency
5. Carry out basic human resources and financial management in the community
6. Plan, coordinate and mobilise the community to participate, along with themselves, in community dialogue and health action days through social mobilisation skills
7. Work closely with the Link Health Facility Committee to improve the access of the CU to health services
8. Facilitate negotiations and conflict resolution among stakeholders at level 1
9. Lead in advocacy, communication and social mobilisation
10. Monitor and evaluate the community work plan including the work of the CHWs through monthly review meetings
11. Prepare quarterly reports on events in the CU
12. Hold quarterly consultative meetings with the Link Health Facility Committee

In order for the Community Health Committees to effectively carry out these roles, it was decided that the competencies they need include:

1. Effective leadership and management skills
2. Communication skills
3. Mobilisation and management of resources
4. Networking
5. Report writing
6. Record/bookkeeping
7. Basic analysis and utilization of data
8. Basic planning, monitoring and evaluation skills

9. Performance appraisal skills
10. Conflict resolution skills

With Community Health Committees equipped to effectively carry out these roles, the Ministry of Public Health and Sanitation is confident that this will be a value added to the implementation of the Community Health Strategy which will become a robust foundation for the entire National Health System.



Dr. S. K. Sharif, Mb ChB, MMED, MSc, DLSHTM, MBS
Director of Public Health and Sanitation

ACKNOWLEDGEMENTS

Documents for establishing effective Community Health Committees in Kenya are three: The Curriculum for Community Health Committees, The Trainers' Manual for Community Health Committees and The Handbook for the Community Health Committees. The development of these three documents went through various stages and we acknowledge all the agencies and individuals involved in the preparation of these documents.

We acknowledge with thanks both the financial and technical support for work on Community Health Committees from USAID through Management Sciences for Health (MSH). For this, the Ministry records deep appreciation and gratitude. Further, we acknowledge those who took part in:

1. Stakeholders' Consultation on Community Health Committees held on 28th of March, attended by officers from the Ministry of Public Health and Sanitation as well as the Ministry of Medical Services (MOMS). At that consultation, decisions were made on roles and responsibilities for CHCs and the competencies that CHC Team Members need to have in order to carry out those roles and responsibilities. We acknowledge presentations by officers of MSH on curriculum development. We acknowledge the partners who participated in this consultation namely AMREF, JICA, MDG Village Project, JHPIEGO, USAID, MSH and UNICEF.

2. A weeks' retreat to develop the curriculum was held in April 2011. Those who participated in addition to the Health Sector Ministries included the partners AMREF, JICA, MDG Village Project, JHPIEGO, USAID and MSH.

3. Another retreat to review the manual once the consultant had developed it. We acknowledge the diligent work of officers from MOPHS and MOMS at this retreat. We also acknowledge our partners who took part namely AMREF, JICA, MDG Village Project, JHPIEGO, USAID and MSH.

4. A day's planning on how the pilot was to be carried out. We particularly acknowledge the guidance from the Provincial Focal Persons for the Community Health Strategy on who should be trained for training CHC Team Members and on who was to be in the Training of Trainers (TOT) workshop. We also acknowledge our partners who participated in this event, namely: AMREF, JICA, MDG Village Project, JHPIEGO, USAID and MSH.

5. The Master Trainers' planning day with the health sector Ministries and our partners at which the exact modalities to be used and the content for the TOT workshop was planned. These plans included communication approaches for training adult learners as well as the modalities to use for successfully passing on messages contained in the Trainers' Manual.

6. The week-long TOT workshop which was marked with 100% attendance at all sessions by both trainers and trainees during this critical week! We particularly appreciate the Provincial Focal Persons who came with those to be trained from the provinces and who presented an excellent example of sticking to the task by their own presence.

7. The successful undertaking of the pilot testing phase in Coast and Nyanza Provinces. We acknowledge the excellent leadership of the Provincial Directors and Provincial Focal Persons with their teams of trainers during the period of pilot testing.

8. The review of the appropriateness of the Trainers' Manual and modalities used as well as that of the Handbook for Community Health Committees as used in the pilot testing phase. It was at this review that final adjustments on the Training Manual and the Handbook were made.

The consultant services of Professor Miriam K. Were during this entire process is acknowledged and greatly appreciated.

A list of individuals & agencies involved at every stage is in the annex.

Dr. James Mwitari
Head, Division of Community Health Services

ACRONYMS

AMREF	African Medical and Research Foundation
CHS	Community Health Strategy
CHS	Community Health Services
CHW	Community Health Worker
CHEW	Community Health Extension Worker
CU	Community Unit
GOK	Government of Kenya
ICTs	Information and Communication Technologies
IEC	Information Education and Communication
ICC	Interagency Coordinating Committee
KEPH	Kenya Essential Package for Health
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MSH	Management Sciences for Health
NHSSP II	National Health Sector Strategic Plan II
PHC	Primary Health Care
UNICEF	United Nations Children's Education Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1.0 INTRODUCTION

1.1 Background

This Handbook for Community Health Committees is derived from the Trainers' Manual which in turn is based on the Curriculum that was developed by the Ministry of Public Health and Sanitation for training CHCs in collaboration with other stakeholders working at the community level.

Technical and financial support from USAID through Management Sciences for Health (MSH) which facilitated the preparation of training materials for the Community Health Committees (CHCs) including the preparation of the Curriculum, the Trainers' Manual and the Handbook in the period March - October 2011 is gratefully acknowledged.

1.2 Vision and mission of Ministry of Public Health and Sanitation

The vision of the Ministry is to make Kenya:
"A nation free from preventable diseases and ill health through primary healthcare interventions at individual, household, community and primary healthcare facility levels."

The mission of the Ministry of Public Health and Sanitation is to:
"Provide effective leadership and participate in the provision of quality Public Health and Sanitation services that are: equitable, responsive, accessible and accountable to Kenyans."

1.3 Vision and mission of Community Health Services

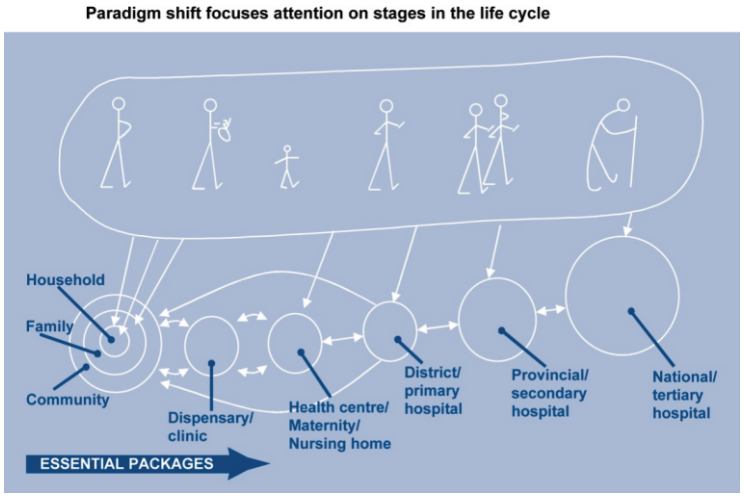
The vision for Community Health Services is that of healthy people living healthy and good quality lives in robust and vibrant communities that make up a healthy and vibrant nation.

The mission of Community Health Services is for the community health approach to become the modality for social transformation for development from the community level by establishing equitable, effective and efficient Community Health Services in Community Units (CUs) all over Kenya. This is to be a contribution towards achieving Kenya's Vision 2030 anticipated to result in healthy and vibrant communities that significantly contribute to a healthy and vibrant nation.

1.4 An overview of the National Health System

An evaluation carried out in 2004 on the health status in Kenya brought out the fact that rather than the expected improvement in health indices in Kenya following the formulation of the National Health Policy Framework of 1994, the health indices were worse. Such was the case for infant, child and maternal mortality rates. Therefore the theme of the 2005 – 2010 Health Sector Strategic Plan was REVERSING THE TRENDS. In order to reverse the trends, a life cycle approach was taken to the restructuring of the National Health System which starts with the community level as the foundation of the National Health System.

Life cycle approach in six cohorts



1st picture : Pregnancy

2nd picture : Mother & Newborn

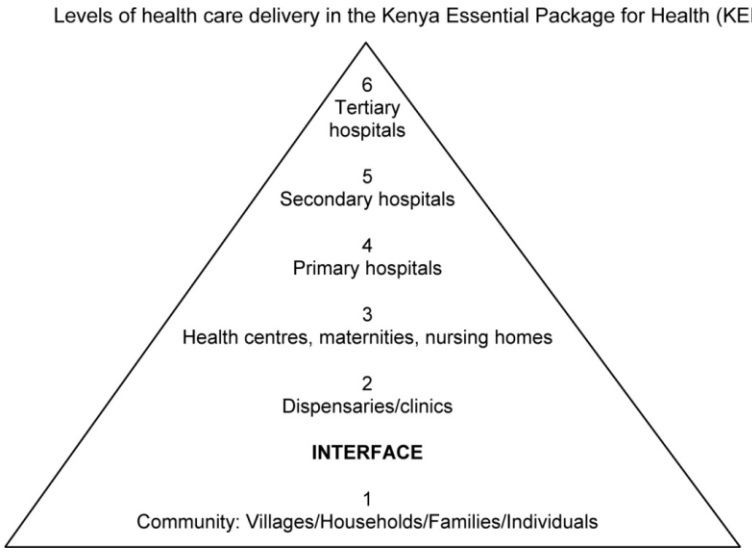
3rd picture : Childhood

4th picture : Adolescents & Youth

5th picture : Adulthood

6th picture : The Elderly

This translated into the 6 levels of the National Health System with the community level as the Foundation for the National Health System as shown below.



Recognition of the community level as the Foundation of the National Health System through the formal inclusion of this level within the formal National Health System was a very important occurrence. The modality for establishing community level health services in Kenya is the Community Health Strategy. The importance of including the community level presents a great opportunity to engage a critical mass of people who are in communities to adopt appropriate behaviour for health promotion and disease prevention as well as appropriate healthcare-seeking behaviour. Success in the majority of communities would result in reduction of the disease burden in the community and nation as a whole. This would subsequently reduce the healthcare demands on health facilities thus giving health facilities a chance to be more efficient and effective in service provision. In the Kenyan setting, the operational unit for implementing the Community Health Strategy is the Community Unit (CU) which is the administrative unit known as the sub-location. Each sub-location consists of several villages and each village is served by a Community Health worker (CHW). Thus there may be as many as 25 CHWs in one CU.

1.5 Justification for training materials for Community Health Committees

Implementation of the Community Health Strategy was launched in 2006. In the first phase (2006 – 2010) of implementing the Community Health Strategy, the focus was on training of Community Health Workers (CHWs) who actually provide healthcare at the community level and Community Health Extension Workers (CHEWs) who supervise the CHWs. Having these two members of the community level health workforce where implementation was taking place brought excitement among the people that at last they had their own health service providers.

However, in each CU, there are more than ten CHWs as each CHW works in only a part of the entire Community Unit (CU). Without any group taking on overall leadership and governance roles in the Community Unit, there was lack of coherence in the entire CU as to what exactly was happening in the community healthcare services. The vacuum from lack of those with leadership and governance role for the whole CU became clear to implementers, both within government and non-governmental organisations. These implementers then began to establish Community Health Committees (CHC) in a piece-meal manner to play this overall leadership role within the Community Unit. While this was a move in the right direction, each group was "doing its thing" more or less according to its whims! Some implementers trained their CHCs for a day. Some trained them for 2 days and so on. Furthermore, the content that the CHCs were trained on greatly varied. By the end of 2010, the need for clarity on the roles of CHCs was recognized. Also recognised was the need for guidance on content and on the modality for training activities for CHCs. The leadership of the Ministry of Public Health & Sanitation approached development partners for financial and technical support for the development of training materials to ensure that the CHCs would have responsibility for the leadership and governance roles at the community level. The positive response from Management Sciences for Health (MSH) supported by USAID was indeed welcome.

The first process in the preparation of training materials for the CHCs with the support of USAID through MSH took place on 28th March 2011 at a stakeholders' consultation when the Ministry of Public Health and Sanitation brought together stakeholders active in the implementation of the Community Health Strategy to consult on matters related to what roles and responsibilities CHCs should have and the competencies they required to carry this out. A number of events took place which has resulted in the preparation of 1) The CHC Curriculum, 2) The Trainers' Manual and finally, 3) this Handbook for CHC team members.

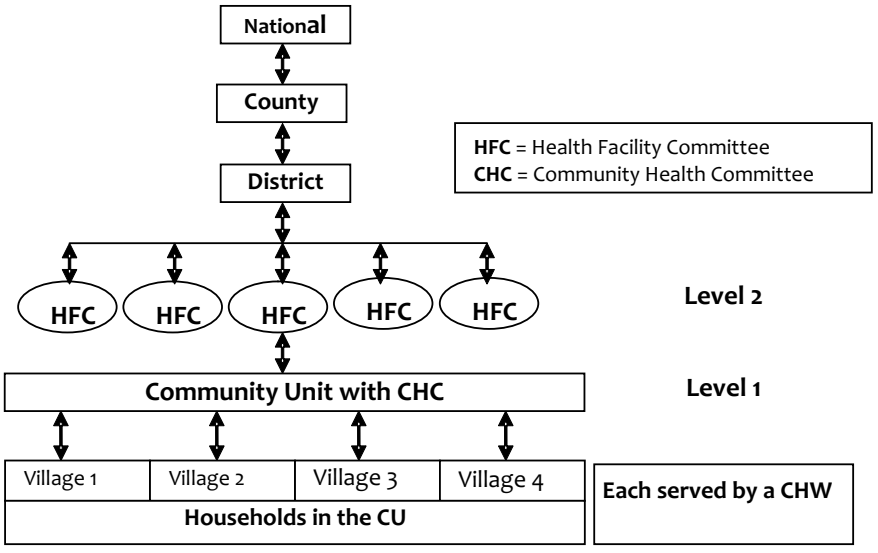
1.6 The linkage from the community level to the pinnacle of the National Health System

It was recognised from the onset that community health services could not be stand-alone services. Therefore, mechanisms were put in place to ensure that community level services in the CU have links to the rest of the National Health System.

The CU directly links to the rest of the health system through the first referral facility referred to as the Link Health Facility for the CU. Each CU has a specified Link Health Facility. The Community Health Extension Workers that supervise CHWs in the CU are attached to these Link Health Facilities and thus establishing direct links for CHWs with the first referral level. For most Community Units, the Link Health Facility is either a dispensary or a health centre, while those communities geographically close to level 4 or 5 facilities may have these facilities as their link facilities. The chairman of the CHC is a member of the Link Health Facility Committee and thus there is also a managerial link between the Link Health Facility and each CU. Thus when the CU prepares its Annual Operational Plan, this is reviewed by the Link Health Facility Committee.

The schematic presentation below shows how the community is linked to the National Health System as the foundation to that system.

The Community Linkages to the National Level



2.0 THE COMMUNITY LEVEL HEALTH WORKFORCE

Two members of the community level health workforce are the Community Health Workers who are the health care provider at level 1 and the Community Health Extension Workers who supervises the CHWs. Every CHEW supervises a number of CHWs in their health care provision roles. The third member of the community level health workforce is the Community Health Committee. The roles and responsibilities of the Community Health Committee are those of providing leadership and oversight/governance in the CU. The overall purpose of training materials for the Community Health Committees is to ensure that the CHCs are equipped to play these key roles in the CU.

2.1 The CHWs: roles and responsibilities

1. Teaching the community how to improve health and prevent illness by adopting healthy practices
2. Treating common ailments and minor injuries, as first aid, with the support and guidance of the CHEW
3. Tending the CHW kit with supplies provided through a revolving fund generated from users
4. Referring cases to the nearest health facilities
5. Promoting care-seeking and compliance with treatment and advice
6. Visiting homes to determine the health situation and dialogue with household members to undertake the necessary action for improvement
7. Promoting appropriate home care for the sick with the support of the CHEWs and level 2 and 3 facilities
8. Participating in monthly community unit health dialogue and action days organized by CHEWs and CHCs
9. Being available to the community to respond to questions and provide advice
10. Being an example and model of good health behaviour
11. Motivating members of the community to adopt health-promoting practices
12. Organizing, mobilizing and leading village health activities
13. Maintaining village registers and keeping records of community health-related events
14. 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.

2.2 The CHEWs: roles and responsibilities

1. Overseeing the selection of CHWs
2. Organizing and facilitating CHW training
3. Monitoring the management of the CHWs' kits
4. Supporting the CHWs in assigned tasks and coaching them to ensure achievement of desired outputs and outcomes

5. 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
6. Compiling reports from CHWs and forwarding to level 2 and 3 management committees
7. 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.
8. Following up and monitoring actions emerging from dialogue and planning sessions to ensure implementation.

2.3 The CHC: The Community Health Committee

This manual is on the training of Community Health Committees and will focus on this cadre in the rest of the document.

2.3.1 The process of establishing CHCs

The process for establishing CHC takes the following into account:

1. The CHEW is the Technical Adviser and Secretary to the CHC and shall oversee the operations of CHCs and CHWs in the CHEW's area of responsibility. The CHEW facilitates referrals from the CU to the referral health facility
2. The CHC shall be the first body constituted in the operationalisation of the CHS in a Community Unit and shall come before the selection of CHWs
3. The CHC chooses its own Chairman
4. CHCs should have at least one CHW (and a maximum of 2 CHWs) in its membership who will be selected by the other CHWs in the Community Unit
5. One CHW member of the CHC shall hold the position of treasurer
6. If a CHC member should be selected to be a CHW, he/she ceases to be a member of the CHC unless he/she is one of the two selected by the other CHWs
7. The chairman of every CHC should be a member of the Link Health Facility Committee
8. The CHC and CHWs shall work together on implementing Community Dialogue Days and Community Action Days (quarterly). Further, the CHC may call all CHWs to a meeting in case of need such as the occurrence of an epidemic in the area.

2.3.2 Roles and responsibilities of CHCs

The roles and responsibilities of the CHCs shall be to:

1. Provide leadership and governance oversight in the implementation of health and related matters in community health services at level 1
2. Prepare and present to the Link Health Facility Committee (and to others as may be needed) the community Annual Operational Plan (AOP) on health-related issues at level 1
3. Network with other sectors and developmental stakeholders towards improving the health status

of people in the Community Unit, e.g. Ministries of Water, Agriculture, Education, etc.

4. Facilitate resource mobilization for implementing the community work plan and ensure accountability and transparency
5. Carry out basic human resources and financial management in the community
6. Plan, coordinate and mobilize the community to participate, along with themselves, in community dialogue and health action days through social mobilisation skills
7. Work closely with the Link Health Facility Committee to improve the access of the CU to health services
8. Facilitate negotiations and conflict resolution among stakeholders at level 1
9. Lead in advocacy, communication and social mobilisation
10. Monitoring and evaluation of the community work plan including the work of the CHWs through monthly review meetings
11. Prepare quarterly reports on events in the CU
12. Hold quarterly consultative meetings with Link Health Facility Committee.

2.3.4 Composition of the Community Health Committee

1. The Committee shall be made up of 11 - 13 members from the Community Unit of whom at least one third shall be women with one of them being from a woman's group. There shall also be one each from faith community, youth and from people with disabilities. The rest shall be selected to ensure equality of representation of areas/ villages in the community but not exceeding 11 members in the CHC.

2. After forming the CHC, the CU may co-opt 3 – 5 members on the basis of specific qualities which the CU considers essential but which are not in the CHC.

2.3.5 Criteria /eligibility for membership in CHC

There should be 11-13 members in the Community Health Committee selected on the following bases, ensuring an odd number of members in each CHC:

1. Adult of sound mind and good standing in the community
2. He/she should be a resident in the area
3. Ability to read and write at least in one language: local or national
4. Elected/selected from the sub-location baraza
5. Demonstrated role model in positive health practices
6. Demonstrate leadership qualities
7. Representative of an interest group in the community, e.g. village, women who should be at least 1/3 of the CHC, faith communities, youth, disabled. The CHC shall ensure equality of representatives among the villages without going beyond 11 members
8. Demonstrated commitment to community service
9. The term of membership in a CHC is 3 years renewable once for a maximum of two terms unless the community specifically decides otherwise

10. It must be ensured that at any one time at least one third of the CHC members are continuing members unless the CU decides otherwise.

From the foregoing information, it is clear that the CHC team members have a very important role to play and this Handbook is for the easy reference of each member so that each is equipped to play the important role expected of them.

3.0 THE CURRICULUM

This Handbook for CHC team members is based on the CHC Trainers' Manual which is in turn based on the CHC Curriculum.

3.1 Aim

The aim of the Curriculum for Community Health Committees on which this Handbook is based is to provide the required content for training CHCs so as to equip them with appropriate knowledge and skills to coordinate and support the provision of health services at level 1. The competencies required in the CHCs provided the background for the development of the Curriculum.

3.2 Competencies required of Community Health Committees

1. Effective leadership and management skills
2. Communication skills
3. Mobilization and management of resources
4. Networking
5. Report writing
6. Record/bookkeeping
7. Basic analysis and utilization of data
8. Basic, planning, monitoring and evaluation skills
9. Performance appraisal skills
10. Conflict resolution skills

3.3 An outline of the modules in the Curriculum and the units in each module

MODULE 1: APPLYING THE PRACTICE OF LEADERSHIP IN THE COMMUNITY HEALTH CONTEXT

Units:

1. Roles and Responsibilities of CHCs
2. Factors that Hinder and Promote Health and Development in Communities
3. The Practice of Leadership and Management in the Community Context
4. Use of the Challenge Model in leadership Practice at the Community Level

MODULE 2: GOVERNANCE IN THE CONTEXT OF COMMUNITY HEALTH SERVICES

Units:

1. Governance Role of CHCs in the Community Unit
2. Primary Health Care that Highlighted the Importance of Community Participation
3. Kenya's Community Health Strategy

MODULE 3: THE ROLE OF CHCs IN EFFECTIVE COMMUNICATION, ADVOCACY, NETWORKING & SOCIAL MOBILISATION IN THE COMMUNITY UNIT

Units:

1. The Role of CHCs in Effective Communication
2. The Role of CHCs in Advocacy
3. The Role of CHCs in Networking and Partnership development
4. The Role of the CHC in Social Mobilisation

MODULE 4: PERSONNEL MANAGEMENT ISSUES

Units:

1. Human Resource Management by CHCs
2. Performance Appraisal of CHWs by CHC
3. Conflict Management and Resolution in the Community Unit

MODULE 5: RESOURCE MOBILISATION /FINANCIAL MANAGEMENT

Units:

1. The Role of CHCs in Resource Mobilisation for the Community Unit
2. Proposal Writing
3. The Role of CHCs in Financial Management in the Community Unit

MODULE 6: COMMUNITY HEALTH INFORMATION SYSTEM

Units

1. The Need For CHCS To Understand Basic Data Analysis & Utilization Of Data
2. The Need for CHCs to Understand the Importance of Record keeping
3. The Need for CHCs to Understand the Importance of Report Writing

MODULE 7: MONITORING & EVALUATION AND THE WAY FORWARD

Units

1. The role of CHCs in coordinating Monitoring & Evaluation in the Community Unit
2. Exposure of CHCs to preparation of a Plan of Action for 6 Months following Training & The Way Forward
3. The Final Session Conducted by the Chair of the Community Health Committee

3.4 Time allocation for carrying out the training by CHC trainers

It is recommended that the seven days of training be carried out in two weeks: three days in the first week and four days in the second week as shown in the following table.

Table 1. SCHEDULE FOR TRAINING CHC MODULES IN 7 DAYS*

Day	Time			
	8.30 - 10.30am	11 am - 1pm	2pm - 4pm	4.30 - 5.30pm
Week 1				
Tue	OPENING CEREMONY • Self introduction • Statement on competencies needed by CHC members • Opening by officials	Climate Setting*	Factors that hinder or promote health & development	
		Roles and responsibilities of CHCs	The practice of Leadership & Management in the community context	
Wed	Use of the challenge model in leadership at the Community level	The Governance role of CHCs in the Community Unit	Primary Health Care that highlights the importance of community participation	
Thurs	Kenya's Community Health Strategy	The Role of the CHC in Effective Communication	The CHC role in Networking & Partnership development	
		The Role of the CHC in Advocacy	The Role of the CHC in Social Mobilisation	
Week 2				
Mon	Human resource management in the Community Context	Performance Appraisal of CHWs by the CHC	Conflict Management & Resolution in the Community Unit	
Tue	The role of the CHC in Resource Mobilisation for the Community Unit	Proposal writing	The role of CHC in Financial Management in the Community Unit	
Wed	The need for CHCs to understand the importance of Basic Data Analysis & Use of Data	The need for CHCs to understand the importance of Record-keeping	Visit link health facility to see how data are collected, compiled and used	

		The need for CHCs to understand the importance of Report Writing		
Thurs	The role of the CHC in coordinating Monitoring & Evaluation in the Community Unit 8:30am - 11:00 am	Exposure of CHCs to preparation of a Plan of Action for 6 Months following Training, & The Way Forward 11:30am-1:30pm	The Final Session conducted by the Chair of the Community Health Committee 2:00 pm - 4:00 pm	Closing Ceremony • Congratu-lations • Awarding Certificates • Tea Party!

* **FOR CLIMATE SETTING** trainers are encouraged to make a list of what each CHC member can tell about herself/himself.

* **N.B:** On the first day in the afternoon, on Thursday of the 1st week and on Thursday of the 2nd week some adjustments have been made to provide more time for monitoring and evaluation

4.0 CONTENTS OF EACH UNIT WITHIN THE MODULES

MODULE 1:

APPLYING THE PRACTICE OF LEADERSHIP IN THE COMMUNITY HEALTH CONTEXT

MODULE 1:

APPLYING THE PRACTICE OF LEADERSHIP IN THE COMMUNITY HEALTH CONTEXT

Overall Purpose

The purpose of this module includes establishing an environment in which CHC members are comfortable enough with one another to work together as a team, for the CHC members to understand their roles and responsibilities and to get equipped for the practice of leadership in the Community Unit.

UNITS:

UNIT 1: Roles and Responsibilities of CHCs
UNIT 2: Factors That Hinder and Promote Health and Development in Communities
UNIT 3: The Practice of Leadership and Management in the Community Context
UNIT 4: Use of the Challenge Model in Leadership Practice at the Community Level

MODULE 1, UNIT 1:
ROLES AND RESPONSIBILITIES OF CHCS
(Day 1, 11:00 - 1pm, 2 hr)

1. Purpose

To ensure that members of the Community Health Committee are fully aware of the trust placed in them by the community and the specific roles expected of them in order for them to be successful in leading the Community Unit to higher levels of health.

2. Objectives

By the end of this unit, the participants will be able to:

1. State the process used to select member of the CHCs
2. State the criteria used in the selection of each member of the CHC
3. List at least 6 of the 12 roles of the Community Health Committee
4. State the 3 key roles of CHWs & 3 key roles of CHEWs

ROLES AND RESPONSIBILITIES OF CHCs

1. The community level health workforce

Two members of the community level health workforce are the Community Health Workers who are the health care provider at level 1 and the Community Health Extension Workers who supervise the CHWs. Every CHEW supervises a number of CHWs in their health care provision roles. The third member of the community level health workforce is the Community Health Committee. The roles and responsibilities of the Community Health Committee are those of providing leadership and oversight/governance in the CU. The overall purpose of training materials for the Community Health Committees is to ensure that the CHCs are equipped to play these key roles in the CU.

2. The process of establishing CHCs takes the following into account:

1. The CHEW is the technical adviser and Secretary to the CHC and shall oversee the operations of CHCs and CHWs in the CHEW's area of responsibility. The CHEW facilitates referrals from the CU to the referral health facility.
2. The CHC shall be the first body constituted in the operationalisation of the CHS in a Community Unit and shall come before the selection of CHWs
3. The CHC chooses its own Chairman
4. CHCs should have at least one CHW (and a maximum of 2 CHWs) in its membership who will be selected by the other CHWs in the Community Unit
5. One CHW member of the CHC shall hold the position of treasurer
6. If a CHC member should be selected to be a CHW, he/she ceases to be a member of the CHC unless he/she is one of the two selected by the other CHWs
7. The chairman of every CHC should be a member of the Link Health Facility Committee.
8. The CHC and CHWs shall work together on implementing Community Dialogue Days and Community Action Days (quarterly). Further, the CHC may call all CHWs to a meeting in case of need such as the occurrence of an epidemic in the area.

3. Criteria /eligibility for membership in community health committee

The trainer should make the point that those who are members of the CHC are people held in high regard in the community and who need to love up to it. The point should be made that the following criteria were taking into account in selecting CHC members.

1. Adult of sound mind and good standing in the community
2. He/she should be a resident in the area
3. Ability to read and write at least in one language: local or national
4. Elected/selected from the sub location baraza
5. Demonstrated role model in positive health practices
6. Demonstrate leadership qualities

7. Representative of an interest group in the community e.g. village, women who should be at least 1/3 of the CHC, faith communities, youth, disabled. The CHC shall ensure equality of representatives among the villages without going beyond 11 members
8. Demonstrated commitment to community service
9. The term of members in a CHC is 3 years renewable once for a maximum of two terms unless the community specifically decides otherwise
10. It must be ensured that at any one time at least one third of the CHC members are continuing members unless the CU decides otherwise.

4. Roles and responsibilities of members of the community level health workforce

4.1 roles and responsibilities of Community Health Committees

The roles and responsibilities of the CHCs shall be to:

1. Provide leadership and governance oversight in the implementation of health and related matters in community health services at level 1
2. Prepare and present to the Link Health Facility Committee (and to others as may be needed) the community Annual Operational Plan (AOP) on health related issues at level 1
3. Network with other sectors and developmental stakeholders towards improving the health status of people in the Community Unit e.g. Ministries of Water, Agriculture, Education, etc.
4. Facilitate resource mobilization for implementing the community work plan and ensure accountability and transparency
5. Carry out basic human resources and financial management in the community;
6. Plan, coordinate and mobilize the community to participate, along with themselves, in community dialogue and health action days through social mobilisation skills
7. Work closely with the link facility health committee to improve the access of the CU to health services
8. Facilitate negotiations and conflict resolution among stakeholders at level one;
9. Lead in advocacy, communication and social mobilization
10. Monitoring and evaluation of the community work plan including the work of the CHWs through monthly review meetings
11. Prepare quarterly reports on events in the CU
12. Hold quarterly consultative meetings with Link Health Facility Committee.

To carry out these roles, the CHC must have a good grasp on the roles of CHWs and CHEWs

4.2 The CHWs: roles and responsibilities

1. Teaching the community how to improve health and prevent illness by adopting healthy practices
2. Treating common ailments and minor injuries, as first aid, with the support and guidance of the CHEW

3. Tending the CHW kit with supplies provided through a revolving fund generated from users
4. Referring cases to the nearest health facilities
5. Promoting care-seeking and compliance with treatment and advice
6. Visiting homes to determine the health situation and dialogue with household members to undertake the necessary action for improvement
7. Promoting appropriate home care for the sick with the support of the CHEWs and level 2 and 3 facilities
8. Participating in monthly Community Unit health dialogue and action days organized by CHEWs and CHCs
9. Being available to the community to respond to questions and provide advice
10. Being an example and model of good health behaviour
11. Motivating members of the community to adopt health-promoting practices
12. Organizing, mobilizing and leading village health activities
13. Maintaining village registers and keeping records of community health-related events
14. Reporting to the CHEW on the activities they have been involved in and any health problems they encountered that need to be brought to the attention of higher levels.

4.3 The CHEWS: roles and responsibilities

1. Overseeing the selection of CHWs
2. Organizing and facilitating CHW training
3. Monitoring the management of the CHWs' kits
4. Supporting the CHWs in assigned tasks and coaching them to ensure achievement of desired outputs and outcomes
5. 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
6. Compiling reports from CHWs and forwarding to level 2 and 3 management committees
7. 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
8. Following up and monitoring actions emerging from dialogue and planning sessions to ensure implementation
9. Acting as secretary to the CHC and keeping minutes of CHC meetings and files of the CHC
10. Filling the community chalkboard with information from the CHCs.

MODULE 1, UNIT 2:
FACTORS THAT HINDER AND PROMOTE HEALTH AND DEVELOPMENT IN COMMUNITIES
(Day 1, 2 - 3pm, 1 hr)

1. Purpose

To equip CHC members with the knowledge of factors that hinder and promote Health and Development to enable them appreciate the need for community participation in health and development for improving the quality of life in the community.

2. Objectives

At the end of this unit, the participants will be able to:

1. Give the definition of development
2. Give the definition of health as presented in the constitution of the World Health Organisation
3. Identify factors that hinder health challenges within their community
4. Identify factors that promote health within their community
5. Describe the relationship between health and development

FACTORS THAT PROMOTE AND HINDER HEALTH AND DEVELOPMENT

1. Definition and relationships:

Development is a process through which there is change in a population's attitudes, knowledge and skills towards good quality life by raising the health, economic and political status of the people involved.

The World Health Organizations defines health as "A state of complete physical, mental and social wellbeing and not merely the absence of disease or disability."

Relationship between development and health: Generally speaking, when development is moving in the direction of economic progress and improving the means of livelihoods, the health status of the population also improves. On the other hand, a healthy population contributes to greater productivity and can positively contribute to economic progress.

There are various factors which affect health and development in the communities where we live. These can be broadly divided into two categories: those that hinder good health and development and those that promote good health and development.

2. Factors hindering health and development

1. Unhygienic and careless personal behaviour
2. Dependency, lack of initiative
3. Diseases especially chronic illnesses
4. Cultural beliefs, traditions and attitudes that undermine health
5. Illiteracy, lack of knowledge and skills
6. Poverty and lack of resources, unemployment
7. Lack of individuals' voice in decisions affecting them
8. Availability and quality of land
9. Poor infrastructure
10. Political environment, poor leadership, poor policies
11. Corruption/lack of transparency and accountability
12. Disasters
13. Insecurity.

3. Factors that promote health and development

1. Taking initiative to find solutions to problems
2. Hygienic and careful personal behaviour
3. Fairness in relationships
4. Infrastructure
5. Opportunities
6. Human capital (essential elements of dignified life)
7. Democratic space and accountable leadership
8. Respect for the basic human rights of all people, regardless of gender or age
9. Creation of opportunities for employment and resource generation
10. Community capacity building to improve knowledge and skills
11. Community participation and involvement in development activities
12. Disaster preparedness and prevention.

4. Relationship between health and development

Health and development are interdependent:

1. To develop, people need to be healthy so they can be productive. And to be healthy people require access to development opportunities
2. The level of education can facilitate people being healthy and pursuing development
3. Both health and development require attitudes and behaviour that support good quality lives
4. Health is a component and indicator of development.

5. Reference materials:

- MOH (2007) Linking Communities with the Health System: The Kenya Essential Package for Health at Level 1; a Manual for Training Community Health Workers
- Ministry of Health (2007), Reversing the Trends; Community Health Strategy
- MOH (2005) National Health Sector Strategic Plan II 2005-2010 (extended to 2012)
- Organization and Management of Community-Based Health Care, National Pilot Project of Kenya Ministry of Health/UNICEF (1982), Were, Miriam K.

MODULE 1, UNIT 3:
THE PRACTICE OF LEADERSHIP AND MANAGEMENT IN THE COMMUNITY CONTEXT
(DAY 1, 3 - 4:30pm, 90 min)

1. Purpose

To equip the Community Health Committees with leadership and management skills to enable them effectively manage the delivery of health services at level one.

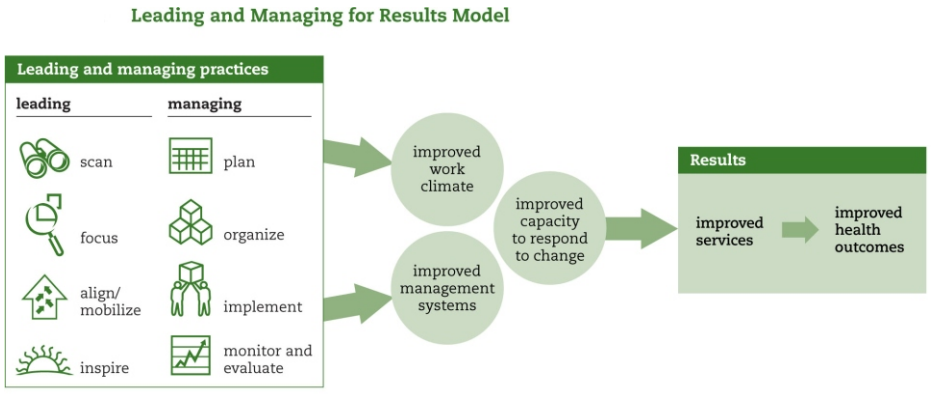
2. Objectives

By the end of the unit the CHCs should be able to:

1. Discuss the leading and managing practices
2. Describe the integrated leading and managing process

THE PRACTICE OF LEADERSHIP

1. Leading and managing practices



When applied consistently, good leading and managing practices strengthen organizational capacity and result in higher-quality services and sustained improvements in health.

From *Managers Who Lead: A Handbook for Improving Health Services* Cambridge, MA: Management Sciences for Health, 2005

Source: 2005 Management Sciences for Health

Note that:

Under leadership, there are the functions of scanning, focusing, aligning and mobilising.
Under management, there are the functions of planning, organizing, implementing and monitoring and evaluation.

When you lead and manage well, you can achieve the healthy communities you dream of. When you manage well, you ensure that processes and procedures, staff, and other resources are used in an efficient and effective manner.

Managing develops reliable operations that serve staff in their efforts to reach goals. As a result, your organization can consistently perform what it is set up to do.

Source: 2005 Management Sciences for Health

1.1 Summary table on the leading and managing practices

Leading	Managing
Scanning. Identifying internal and external conditions that influence desired results	**Planning.** Preparing a set of activities, timeline, and accountabilities to meet goals
Focusing. Directing attention and efforts to priority challenges and actions	**Organizing.** Developing structures, systems, and processes to support the plan of action
Aligning and mobilizing. Uniting and motivating internal and external stakeholders to commit resources to support desired results	**Implementing.** Carrying out and adapting the plan of action while coordinating related activities
Inspiring. Creating a climate of commitment and continuous improvement	Monitoring and evaluating. Observing, examining, and assessing progress

2. The training in leadership should help CHC members to:-

1. Carry out self-reflection
2. Appreciate themselves as leaders because one can be a leader at different levels under their chairman/executive committee
3. Encourage open communication
4. Understand leadership is reflected in those who have been empowered.

3. Discussing the definition of leadership and management

Leading means - mobilizing others to envision and realize a better future. A good leader creates an environment that enables others to face challenges and achieve the desired results. Note: Leadership is not about how you do things; it is about you empowering others to face challenges.

Managing means - planning and using resources efficiently to produce the intended results. A good manager must ensure that the people working with him/her are clear on the outcome/results of the activities they are engaging in. This keeps the team focused.

4. Leadership by X or Y approaches

What motivates employees to go to work each morning? Social psychologist Douglas McGregor of Massachusetts Institute of Technology expounded two contrasting theories on human motivation and management in the 1960s: The X Theory and the Y Theory.

Theory X

Theory X assumes that people are naturally unmotivated and dislike working, and this encourages an authoritarian style of management. According to this view, management must actively intervene to get things done. This style of management assumes people:

- Dislike working
- Avoid responsibility and need to be directed
- Have to be controlled, forced, and threatened to deliver what's needed
- Need to be supervised at every step, with controls put in place
- Need to be enticed to produce results; otherwise they have no ambition or incentive to work.

Theory Y

Theory Y expounds a participative style of management that is de-centralized. It assumes that people are happy to work, are self-motivated and creative, and enjoy working with greater responsibility. It assumes that people:

- Take responsibility and are motivated to fulfill the goals they are given
- Seek and accept responsibility and do not need much direction
- Consider work as a natural part of life and solve work problems imaginatively.

This more participative management style tends to be more widely applicable. In Y-Type organizations, people at lower levels of the organization are involved in decision making and have more responsibility.

Comparing Theory X and Theory Y

1. **Motivation:** Theory X assumes that people dislike work; they want to avoid it and do not want to take responsibility. Theory Y assumes that people are self-motivated, and thrive on responsibility.

2. **Management Style and Control:** In a Theory X organisation, management is authoritarian, and centralized control is retained, whilst in a Theory Y organisation, the management style is participative: Management involves employees in decision making, but retains power to implement decisions.

3. **Work Organisation:** Theory X employees tend to have specialized and often repetitive work. In Theory Y, the work tends to be organized around wider areas of skill or knowledge; employees are also encouraged to develop expertise and make suggestions and improvements.

4. **Rewards and Appraisals:** Theory X organisations work on a 'carrot and stick' basis, and performance appraisal is part of the overall mechanisms of control and remuneration. In Theory Y

organisations, appraisal is also regular and important, but is usually a separate mechanism from organisational controls. Theory Y organisations also give people frequent opportunities for promotion.

Application of the X & Y Approaches

Although Theory X management style is widely accepted as inferior to Y, it has its place in large scale production operation and unskilled production-line work. Many of the principles of Theory Y are widely adopted by types of organisation that value and encourage participation. Theory Y-style management is suited to knowledge work and professional services. Professional service organisations naturally evolve Theory Y-type practices by the nature of their work; even highly structure knowledge work, such as call centre operations, can benefit from Theory Y principles to encourage knowledge sharing and continuous improvement.

(Extracted from http://www.mindtools.com/pages/article/newLDR_74.htm)

5. Leadership styles

1. **Visionary.** This style is most appropriate when an organisation needs a new direction. Its goal is to move people towards a new set of shared dreams. "Visionary leaders articulate where a group is going, but not how it will get there - setting people free to innovate, experiment, take calculated risks," write Mr. Goleman and his co-authors.

2. **Coaching.** This one-on-one style focuses on developing individuals, showing them how to improve their performance, and helping to connect their goals to the goals of the organisation. Coaching works best, Mr. Goleman writes, "with employees who show initiative and want more professional development." But it can backfire if it is perceived as "micromanaging" an employee, and undermines his or her self-confidence.
   (Extracted from: http://guides.wsj.com/management/developing-a-leadership-style/how-to-develop-a-leadership-style/)

3. **Charismatic leadership.** A charismatic leadership style can seem similar to transformational leadership, because these leaders inspire lots of enthusiasm in their teams and are very energetic in driving others forward. However, charismatic leaders can tend to believe more in themselves than in their teams, and this creates a risk that a project, or even an entire organisation, might collapse if the leader leaves. In the eyes of the followers, success is directly connected to the presence of the charismatic leader. As such, charismatic leadership carries great responsibility, and it needs a long-term commitment from the leader.

4. **Democratic leadership or participative leadership.** Although democratic leaders make the final decisions, they invite other members of the team to contribute to the decision-making process. This not only increases job satisfaction by involving team members, but it also helps to

develop people's skills. Team members feel in control of their own destiny, so they're motivated to work hard by more than just a financial reward.

Because participation takes time, this approach can take longer, but often the end result is better. The approach can be most suitable when working as a team is essential, and when quality is more important than speed to market, or productivity.

5. **Servant leadership.** This term, created by Robert Greenleaf in the 1970s, describes a leader who is often not formally recognised as such. When someone, at any level within an organisation, leads simply by meeting the needs of the team, he or she is described as a "servant leader."

   In many ways, servant leadership is a form of democratic leadership, because the whole team tends to be involved in decision making.

   Supporters of the servant leadership model suggest that it's an important way to move ahead in a world where values are increasingly important, and where servant leaders achieve power on the basis of their values and ideals. Others believe that in competitive leadership situations, people who practice servant leadership can find themselves left behind by leaders using other leadership styles.

6. Transformational leadership

As we discussed earlier, people with this leadership style are true leaders who inspire their teams constantly with a shared vision of the future. While this leader's enthusiasm is often passed onto the team, he or she can need to be supported by "detail people." That's why, in many organisations, both transactional and transformational leadership are both needed. The transactional leaders (or managers) ensure that routine work is done reliably, while the transformational leaders look after initiatives that add new value.

Key points

While the transformational leadership approach is often highly effective, there's no one "right" way to lead or manage that fits all situations. To choose the most effective approach for yourself, consider the following:

1. The skill levels and experience of your team
2. The work involved (routine, or new and creative)
3. The organisational environment (stable or radically changing, conservative or adventurous)
4. You own preferred or natural style
5. Good leaders often switch instinctively between styles, according to the people they lead and the work that needs to be done. Establish trust - that's key to this process - and remember to balance the needs of the organisation against the needs of your team.
   (Extracted from: http://www.mindtools.com/pages/article/newLDR_84.htm)

6. Reference materials

- MOH (2007), A Manual for Training Community Health Workers, Nairobi, Kenya: MOH - SPMD
- MOPHS (2011), Integrated Curriculum for Training Community Health Workers in Kenya, Draft, Nairobi Kenya, MOPHS - DCHS
- Management Sciences for Health (2005), Managers Who Lead: A handbook for improving health services

MODULE 1, UNIT 4:
USE OF THE CHALLENGE MODEL IN LEADERSHIP PRACTICE AT THE COMMUNITY LEVEL
(Day 2, 8:30 - 10:30am, 2 hrs)

1. Purpose

To equip CHC members with the skills to think in terms of challenges rather than problems and take them through the process of developing personal and shared visions & missions.

2. Objectives

By the end of this unit, the CHC Members should be able to:

1. State the difference between seeing an obstacle as a challenge and seeing it as a problem
2. Describe the 8 steps of using the challenge model
3. Differentiate between vision and mission
4. Describe the process of moving from vision to result

THE CHALLENGE MODEL

1. Integrated leading and managing process

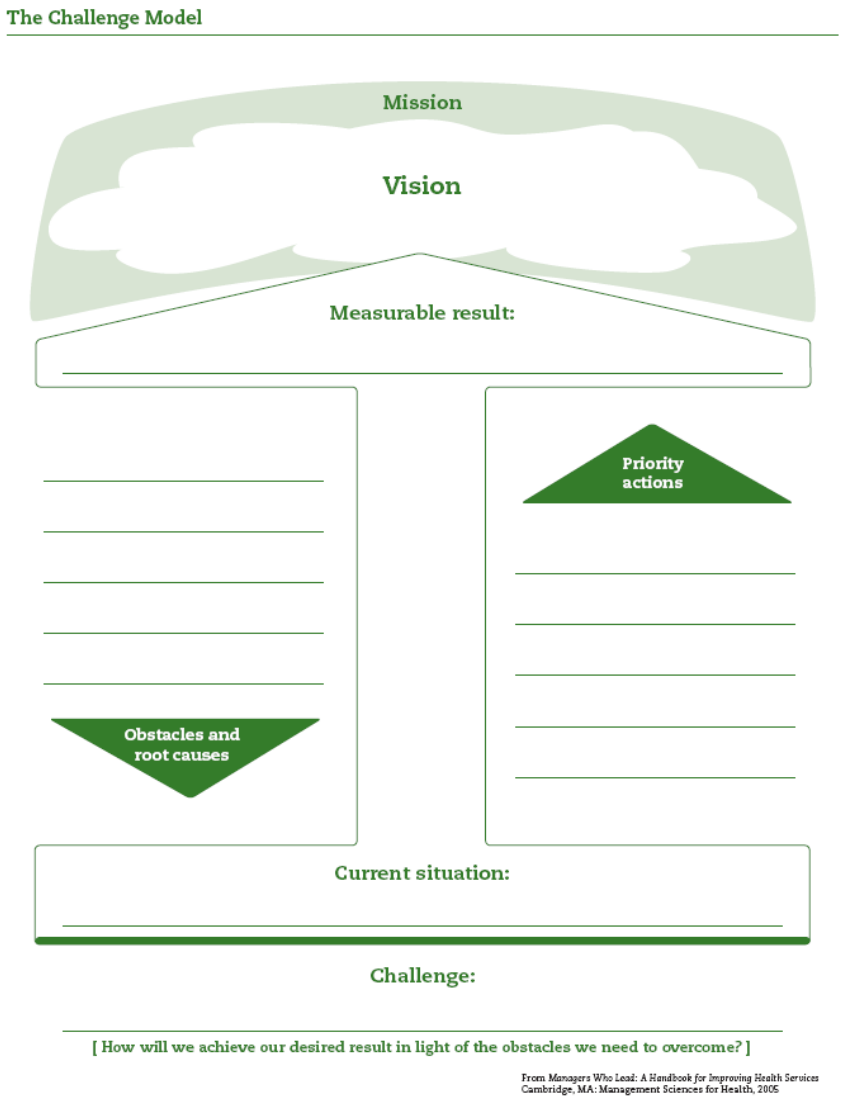
This will help the participants to understand that you cannot separate leadership and management and that for one to be effective they need to practice both leadership and management.

2. Distinguishing problems and challenges

This session is the first step in introducing participants to the Challenge Model
A problem is "out there" and is often blamed on external forces. A challenge is something you own and take on.

Most of the times the problems we experience are really challenges that we are afraid to take on and get solutions.

2.1 Using the Challenge Model



The Challenge Model enables people to move from vision to action. It helps in making a careful diagnosis of where you want to go and where you currently are before you decide on a plan of action. The Challenge Model offers a systematic approach to working together as a team to identify challenges and achieve results.

Definition of a team - a group of people who work together cooperatively to achieve a common goal

The process and the experience of applying the Challenge Model strengthen the team and build confidence among the members so that they can effect real change in the health of their communities.

2.2 Eight steps of using the Challenge Model

Step 1. Point to the mission at the top of the Challenge Model and say:
In Step 1, you will work to review your mission and strategic actions. Knowing your mission will help you shape a vision and will ensure that it contributes to your personal priorities.

Step 2. Point to the vision "cloud" and say:
In Step 2, you will create a personal vision. This vision will inspire you to face any challenge that comes your way.

Step 3. Point to the measurable result and say:
In Step 3, you will select one aspect of your vision and decide on one result that will move you closer to this vision. It has to be a result you can measure. This result will be what you commit to achieving in the next four to six months. It should be a "stretch" for you and you will be required to monitor and evaluate progress toward this result.

Step 4. Point to the current situation and say:
In Step 4, you will assess the current situation. To do this, you will scan your internal and external environments to form an accurate baseline of the conditions that describe the current situation, especially as it relates to your result.

Step 5. Point to the obstacles and root causes and say:
In Step 5, you will identify the obstacles that you have to overcome to reach your result. You will use tools to analyze the root, or underlying, causes of these obstacles so that you can address them.

Step 6. Point to the challenge and priority actions and say:
In Step 6, you will frame your challenge and select priority actions. You will develop a written statement of your challenge, indicating the result you plan to achieve in light of the obstacles you will face. You will then select priority actions to address the root causes.

Step 7. Point to the Action Plan and say:

In Step 7, you will develop an Action Plan. This plan will include the human, material, and financial resources needed. It also includes a timeline for implementing the required actions. Finally, the plan will include how you will monitor progress toward your desired result. All the actions in your plan need to be ones you can implement.

Step 8. Say:

In the final step, you will implement the Action Plan and monitor and evaluate its progress. Monitoring and evaluating your progress will help you make adjustments in your plan to keep you moving toward your intended result.

Note: Give participants the handout "Using the Challenge Model." This handout explains the steps that have just been reviewed and will help participants fill out their Challenge Models.

3. Difference between Mission and Vision.

A mission states why something exists.
A vision is a picture of a desired future. It describes where the group or the organization wants to be in the future. It includes an image that you can see in your mind.

Example
Vision and mission statements

Mission Statement: The ministry of health has as its purpose to serve the health needs of the entire population, especially those most in need.

Vision Statement: We see healthy children walking to school on safe roads.
(This is a vision created by a team from a rural health unit in Afghanistan.)

a) A vision is a picture we create in our mind of a desirable future toward which we can begin to act.
b) Visioning enables us to play an active role in creating the future

3.1 Creation of a personal vision

Now ask participants to get comfortable and relax, and take them through the following visualization process. It is important to speak slowly and carefully and to pause between compartments to allow time for participants to silently reflect on each of the questions.

Ask the following 4 questions:

1. Think about your personal life. What do you want your state of health to be? Imagine yourself and your body exactly the way you want it to be.

2. Think about your family and your relationships. Imagine yourself and others doing things and being exactly the way you want yourself and them to be. See a picture of yourself and them together in happy state.

(Pause and allow people to think)

3. Think about your work/what you do for a living. Imagine what you most want to be doing. Who are you working with, who are you serving and what are you doing?
4. Think about your contribution to the world. What would you most like to contribute, to give back? What does it look like when you are giving something to society or to your organisation that you are proud of?

After the participants have reflected on these questions, ask them to take a few notes on what they saw in their mind's eye.

Put the four heading of each question on flipchart that refer to (personal life, family/relationships, work, and contribute to society).

Ask the participants to share with someone in the room their vision in the present tense (e.g. Say "I am" or "I have"…….) Give the participants about five minutes to share.

If some participants are willing to share their personal visions with the larger group, ask for some examples.

3.2 Summary

Creating a vision is the first step in using the challenge model.
The challenge model provides a framework for identifying ways to realise the vision.
In plenary discuss the participants' thoughts on this exercise (usually the participants will report that it was an inspiring, energizing and unusual experience).

Ask why they think the personal vision is important/ relevant to people working together in a team. This conversation should be used as a bridge to creating a shared vision.

3.3 Creation of a shared vision

A shared vision has power. When a team develops a shared vision, they own it and feel compelled to work together to achieve the desired results. The shared vision is important because it inspires, motivates and also helps to remind the team what they are doing. It provides the big picture and the inspiration to keep a team going in the face of obstacles as it strives to achieve its results. The vision provides a picture of the desired future.

3.4 Process of creating a shared vision

Step 1 - Imagine the future

" Ask participants to think of a time in future. Say, "Imagine 3 years from now and you are looking back. You have accomplished all that is important to the health of the community. What picture do you see in your mind that represents the accomplishment?" Each individual writes a few words to describe what has been accomplished.

Step 2 - Integration of the visions

- Have the participants share in pairs their vision of a healthy community.
- In groups of 4 or 5 ask the participants to discuss and try to combine their visions to arrive at a shared vision and then draw a picture on a flip chart of the shared vision.

Step 3 - Record the key elements of the vision statements

- In plenary, ask each of the groups to present their combined vision and record the key elements.
- Ask for a volunteer in class who will draw the combined vision for the group (pictorial presentation).

Step 4- Prioritizing the elements

- From the list of elements presented, work with the team to prioritize and then select three through consensus.

Step 5 - Present the shared vision statement

- Combine the key elements /phrases into one vision statement and write it on top of the flip chart where the combined pictorial presentation was done. Put it in the front of the room to guide further discussions and also to help the participants see where they want to achieve as a team.

4. Developing a measurable result

The measurable result comes from the vision and should relate to the priority health needs in your community. Sometime it may concern/ cover only one element of the vision but if achieved it will move you closer to your vision.

To ensure that your measurable result in clearly defined, it is important to follow the SMART rule:

A SMART result is...

- Specific (S): clearly written to avoid different interpretations
- Measurable (M): allowing a team to monitor and evaluate progress toward achieving its desired result
- Appropriate (A): in line with the scope of a team's programme or work activities, and within the team's ability to control or influence

- Realistic ®: sufficiently demanding to stretch the team's capacities, yet achievable within the time allowed
- Time-bound (T): with a specific time period for reaching completion

Example of a measurable result:
The number of voluntary counselling and testing sites in the district/ location has increased by 50% (from 4 to 6 sites) in the next 6 months

Process

1. Put the participants into 2 groups and ask them to develop two measurable results in relation to their vision elements.
2. Ask the two groups to share in plenary. Ask the team to identify one measurable result they can work on as a team.
3. Using the identified measurable result, ask the participants to go back to their groups and each identify 3 priority actions that must be taken to help achieve the measurable result and write them on a flip chart.
4. Ask the teams to share in plenary and choose three of the six priority actions presented.
5. Ask the team to identify one obstacle that is likely to arise from each of the priority actions during implementation and suggestions on how to address them.
6. Help the team to develop the challenge question. "How will we achieve (statement of the measurable result) in the light of (statement of the obstacles)?"
7. Ask them to refer to the Challenge Model and input all the information as discussed. Each of them should keep a copy of the Challenge Model which has all the information, i.e. the mission, shared vision, measurable result, priority actions, obstacles, statement of the current situation of the community and the statement of the challenge.
8. The Challenge Model will be very useful in the action planning process. The priority actions will form the basis for activities on the action plan.

5. Reference materials

- MOH (2007), A Manual for Training Community Health Workers, Nairobi, Kenya: MOH - SPMD
- MOPHS (2011), Integrated Curriculum for Training Community Health Workers in Kenya, Draft, Nairobi Kenya, MOPHS - DCHS
- Management Sciences for Health (2005), Managers Who Lead: A handbook for improving health services

MODULE 2:

GOVERNANCE AND COMMUNITY HEALTH SERVICES

MODULE 2:

GOVERNANCE AND COMMUNITY HEALTH SERVICES

UNITS:

UNIT 1: Governance Role of CHCs in the Community Unit
UNIT 2: Primary Health Care that Highlighted the Importance of Community Participation
UNIT 3: Kenya's Community Health Strategy

MODULE 2, UNIT 1:
GOVERNANCE IN THE COMMUNITY UNIT CONTEXT
(DAY 2, 11am -1 pm, 2 hrs)

1. Purpose

To equip Community Health Committees (CHC) with knowledge and skills on governance.

2. Objectives

By the end of the unit, participants will be able to:
1. Define governance and describe its importance in community health
2. Discuss good governance principles and practices
3. Describe governance roles and responsibilities
4. Describe organization and participation of committee meetings

GOVERNANCE:

1. Definition of governance

Governance relates to decisions that define expectations, grant power bestowed by the CHC constitution, or verify performance. It consists of either a separate process or as part of management or leadership processes. Governance implies the practice of decision-making in ways that are transparent and fair/honest. Through this process the interest of local communities are protected.

2. Importance of governance

The presence of good governance practices at community level clarifies authority, simplifies decision-making, and ensures leaders and institutions are accountable for their actions and decisions.

Specifically, good governance:

1. Promotes trust in the institutions and the community
2. Enhances services to the community and stakeholders
3. Improves decision-making and the quality of these decisions
4. Connects institutions to the community and stakeholders
5. Enhances the perception of the institutions among community members and stakeholders
6. Improves the ability to weather a crisis
7. Improves financial stability

3. Principles of Good Governance

Good governance assures that corruption is minimized, the views of minorities and marginalized groups are taken into account and that the voices of the most vulnerable in society are heard in decision-making. It is also responsive to the present and future needs of community.

3.1. Participation

Participation by both men and women is a key cornerstone of good governance. Participation at community level could be through legitimate intermediate representatives (the CHC members representing the community).

It is important to point out that representatives shall strive to ensure that the concerns of the most vulnerable in the community would be taken into consideration in decision making.

Participation needs to be informed and organized.

3.2. Transparency

Transparency means that decisions taken as well as their enforcement are done in a manner that follows guidelines and regulations. It also means that information is freely available and directly accessible to those who will be affected by such decisions and their enforcement. It also means that enough information is provided and that it is provided in easily understandable forms and media.

3.3. Responsiveness

Good governance requires that institutions and processes try to serve all community members and stakeholders.

3.4. Consensus oriented

There are several actors and as many viewpoints in a given society. Good governance requires mediation of the different interests in society to reach a broad consensus in society on what is in the best interest of the whole community and how this can be achieved. It also requires a broad and long-term perspective on what is needed for sustainable community health outcomes and how to achieve the goals of such development.

This can only result from an understanding of the historical, cultural and social contexts of a given community.

3.5. Equity and inclusiveness

A community's well-being depends on ensuring that all of its members feel that they have a stake in it and do not feel excluded from the mainstream of the community. This requires that all groups, but particularly the most vulnerable, have opportunities to improve or maintain their well being.

3.6. Effectiveness and efficiency

Good governance means that processes and institutions produce results that meet the needs of the community while making the best use of resources at their disposal. The concept of efficiency in the context of good governance also covers the sustainable use of natural resources and the protection of the environment.

a. Accountability

Accountability is a key requirement of good governance. Not only governmental institutions, but also community based organisations must be accountable to the community they serve and to their institutional stakeholders.

In general the CHC is accountable to the community that will be affected by its decisions or actions. Accountability cannot be enforced without transparency and the rule of law.

4. Governance roles of CHC members

4.1. Voice of the people

1. Collect the views and opinions and proposals of women and men and present these to the CHC and level 2 health facilities.
2. Report to the community the general decisions of the CHC and the actions taken to solve problems raised by community members.
3. Maintain close contact with community members and consult them on issues to be discussed in the CHC.
4. Provide both technical support and information to the CHC to enable them to take informed decisions in planning processes.

4.2. Revenue and resource mobilisation

1. Educate community members on their respective support to the health activities and programmes in their community.
2. Maintain frequent contact and good relationships with key partners and stakeholders in the community to strengthen networks and funding opportunities.
3. Ensure transparency and effective utilization of resources mobilised.

4.3. Oversight of health activities

1. Monitor all health activities in the community.
2. Link various health project activities with appropriate Line Ministries.
3. Ensure efficient utilization of inputs received from development partners.

4.4. Community mobilisation

1. Mobilise community members to actively participate in health activities.
2. Ensure sustainability of health projects.
3. Take part in and encourage communal and development activities focusing on improving the health of community.
4. Promote community ownership of health programmes and initiatives.

5. Conducting effective meetings

CHC Members should note that:

1. All official business of the CHC is conducted through CHC meetings
2. Attending CHC meetings is not optional, but a must for all CHC members

5.1. Best practices

Meeting notice shall be circulated to all CHC members on time.

1. Start and end meetings on time. Make sure everyone knows the start and end time. This time should be strictly observed.
2. Material to be discussed in meetings shall be distributed to members on time.
3. Meetings shall be guided by an agenda.
4. All meetings must be documented in CHC meeting minutes.
5. All CHC members shall be given equal time to contribute to discussions during CHC meetings.

5.1. Chairing of CHC meetings

1. The Chair of CHC shall chair all CHC meetings.
2. In the absence of the Chair, members appoint a member among themselves to chair that particular meeting.
3. When chairing CHC meetings, the chair shall:
   - Determine whether quorum is present
   - Declare when the meeting starts and adjourns
   - Make calls when order is lost or unruly members dominate the floor
   - Summarize long discussions and state the agreed decision
   - Ensure that discussions are addressed through the chair
   - Ensure that members are accorded equal opportunity to contribute to a discussion

5.2. Frequency

1. The CHC shall meet at least four (4) times a year.
2. The schedule of CHC meetings shall be pre determined most probably in the beginning of the calendar year.
3. Meeting schedule coincides with key calendar events such as planning & budgeting.

5.3. Quorum and attendance

1. CHC members must attend meetings to fulfil their duty and responsibility.
2. Quorum shall refer to the majority voting members.
3. Meetings quorum shall be at least 5 members, including the secretary.
4. Without a quorum, the CHC meeting is not official and the decisions not binding.

5.4. CHC Meeting notice

1. The Secretary shall give written notice of meetings to all CHC members.
2. Notice is 7 days prior to the time for the meeting.

3. The notice should clearly indicate the time and place of the meeting.
4. A tentative agenda may be attached.

5.5. CHC meeting agenda

1. The Secretary shall prepare all agendas for meetings, in consultation with the Chair.
2. Agenda shall be distributed to members by the Secretary 3 days prior to regular meetings and as soon as practicable before special meetings.
3. The Chair and Secretary shall ensure the agenda is prioritized.

5.6. CHC minutes

1. All CHC meetings must be documented in CHC meeting minutes. Minutes shall be:
   - A necessary legal review record of CHC meeting
   - Reference materials
   - Orientation tool for new CHC members
   - CHC history
2. The Secretary ensures accurate minutes are taken.
3. The minutes shall be circulated to the CHC members 2 wks before the next meeting.
4. Corrections to the minutes shall be addressed at next meeting.
5. A member who disagrees with a particular decision and is concerned about personal liability should have their dissent noted in the minutes.
6. Minutes of the meetings must be:
   - approved/confirmed
   - signed by the Chair and Secretary
   - filled

5. Reference materials

" MOH (2007), A Manual for Training Community Health Workers, Nairobi, Kenya: MOH - SPMD
" MOPHS (2011), Integrated Curriculum for Training Community Health Workers in Kenya, Draft, Nairobi Kenya, MOPHS - DCHS
" Managers who Lead (2005), A handbook for improving health services
" GRANTfinder Ltd, Enterprise House, Carlton Road, Worksop, S81 7QF 8

MODULE 2, UNIT 2:
PRIMARY HEALTH CARE THAT HIGHLIGHTED THE IMPORTANCE OF COMMUNITY PARTICIPATION
(Day 2, 2 - 4pm, 2 hrs)

1. Purpose

To expose the CHC to the Primary Health Care (PHC) concept from the 1978 International Conference on PHC in Alma Ata which emphasized Community participation in health improvement and service from which the Kenya's Community Health Strategy arises.

2. Objectives

By the end of this unit, the participant will be able to:
1. Present the definition of Primary Health Care from Alma Ata
2. State the Elements of Primary Health Care from Alma Ata and those added by Kenya

PRIMARY HEALTH CARE

1. Definition of PHC

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally 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 of 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. Alma Ata article VI

2. Elements of primary health care from The Alma Ata Declaration (From Article VII):

1. Education concerning prevailing health problems and the methods of preventing and controlling them
2. Promotion of food supply and proper nutrition
3. An adequate supply of safe water and basic sanitation
4. Maternal and child health care, including family planning

5. Immunization against the major infectious diseases
6. Prevention and control of locally endemic diseases
7. appropriate treatment of common diseases and injuries
8. Provision of essential drugs

3. Elements added by Kenya to Alma Ata

1. Mental Health
2. Dental Health
3. HIV/AIDS
4. Community-based Rehabilitation

MODULE 2: UNIT 3:
KENYA'S COMMUNITY HEALTH STRATEGY
(Day 3, 8:30 - 10:30am, 2 hrs)

1. Purpose

To equip the CHC with the knowledge of Community Health Strategy as an approach to deliver Kenya Essential Package for Health (KEPH) at level 1 and that community level health services is the foundation of the National Health System.

2. Objectives

By the end of this unit, the participant will be able to:

1. Define what a Community Unit (CU) is in the context of this strategy and what it is composed of
2. Enumerate the strategic objectives of Kenya's Community Health Strategy
3. Describe how the Community Health Strategy links into Kenya's Vision 2030
4. Describe how the Community Health Strategy links into the Millennium Development Goals (MDGs)
5. State the use of the 6 groupings of the human life cycle approach to understanding the national health challenges
6. Describe the 6 levels of the national health system
7. Explain that as the base of the pyramid in the 6 level structure, the level of community health services is the foundation of the national health system
8. State the key functions (promotive & preventive in one group and curative in the other group) of each of the 6 levels in the national health system
9. Define the Kenya Essential Package for Health for level 1 (KEPH 1)
10. Explain how the community level links to the rest of the national health system

11. Identify key actors (stakeholder analysis) for health at level 1
12. Identify health priorities for each cohort (age group) for service delivery at level 1 in their community
13. State why importance is laid on the group "Mothers and Children" in the community

KENYA'S COMMUNITY HEALTH STRATEGY

1. Description of a Community Unit (CU) in Kenya's Community Health Strategy

In the Kenya setting, the operational unit for implementing the Community Health Strategy is the Community Unit (CU) which is the administrative unit known as the Sub location. Each sub location consists of several villages and each village is served by a Community Health Worker (CHW). Thus there may be as many as 25 CHWs in one C.U.

2. Objectives of Kenya's Community Health Strategy

1. Providing level 1 services for all cohorts and socioeconomic groups, taking into account their needs and priorities.
2. Establish and building the capacity of level 1 human resource (the community health extension workers [CHEWs] and community health workers [CHWs]) to provide services at level 1.
3. Strengthening health facility-community linkages through effective decentralization and partnership for the implementation of level one services.
4. Strengthening the community to progressively realise their rights for accessible and quality care and to seek accountability from facility based health services.

3. Links of the Community Health Strategy to Kenya's Vision 2030

Kenya Vision 2030 is the country's development blueprint covering the period 2008 to 2030. Its objective is to help transform Kenya into a "middle-income country providing a high quality life to all its citizens by the year 2030". The Community Health Strategy is the flagship programme towards realisation of this economic blueprint. The Community Health Approach is focused on promoting health among all Kenyans through equitable and accessible health care services and thus improving the productivity of all, reducing poverty, child and maternal death as well as improving education performance all stages of the life cycle. In so doing, the Community Health Strategy contributes to Kenya's achievement of all the Millennium Development Goals but in particular promotes the achievement of the three specifically health-related Millennium Development Goals (see the three goals with asterisks * below in section 4).

4. Links of the Community Health Strategy to the Millennium Development Goals

In September, 2000, the UN Summit attended by heads of state from around the world adopted the Millennium Declaration through which the international community recommitted itself to promoting global well being. In so doing, they established 8 Millennium Development Goals (MDGs) which were to be achieved by every country and by the whole world by 2015. These 8 goals stated that the world was to:

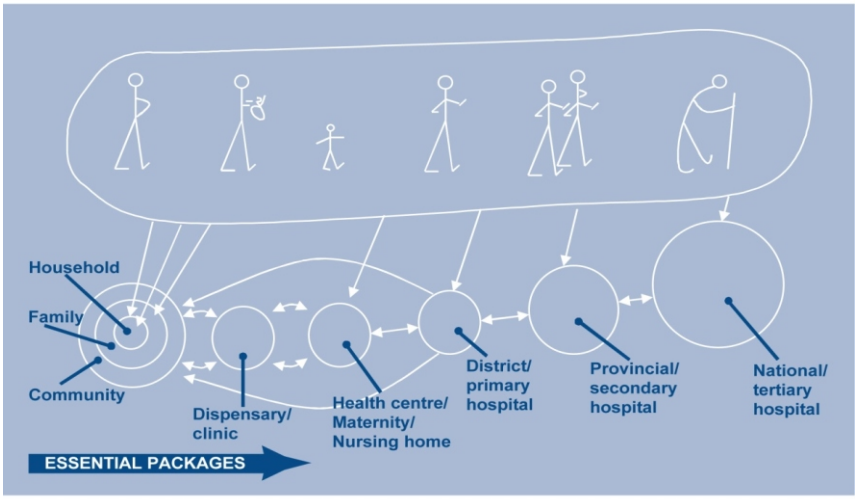
1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality*
5. Improve maternal health*
6. Combat HIV/AIDS, malaria and other diseases*
7. Ensure environmental sustainability
8. Develop a Global partnership for development

Therefore, as Kenyans work to promote health in their communities, they become partners for achieving Kenya's Vision 2030 and also for achieving the internationally set 8 MDGs. Kenya's success in achieving MDGs will contribute to International success towards global development! All of us engaged in any way in promoting the Community Health Strategy can be truly proud of ourselves for being players in both the national and international arenas! HONGERA!

5. Life cycle approach in six cohorts to the organisation of health services

(Verbally describe what each human "picture" depicts)

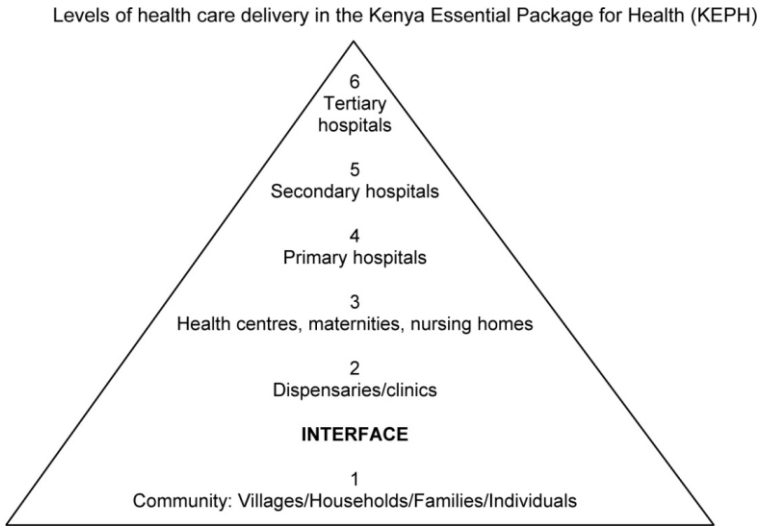
Paradigm shift focuses attention on stages in the life cycle



1st stage	: Pregnancy
2nd stage	: Mother & Newborn
3rd stage	: Childhood
4th stage	: Adolescents & Youth
5th stage	: Adulthood
6th stage	: The Elderly

6. The six tier pyramid of the Kenya National Health Care System

(Describe what each level in the diagram represents)



7. The community as the foundation of the National Health System

The community level is where people live. Therefore, this is the level at which most health promotive and disease prevention activities can take place because these are strongly related to the behaviour of people. When health promotion and disease prevention take place, this results in a healthy population. When the people are healthy, the load on health facilities is reduced and therefore health facilities work more efficiently and more effectively. This is why the community level is the foundation of the national health system. If health services at the community level are strong, the national health system will be strong.

8. Functions at various levels of the National Health System

Expertise by level of services		
	Promotive & preventive	Curative & rehabi-litative
Level 1: Community health services	+++	—-
Level 2+3: Primary health services	+++	+—
Level 4+5: Referral hospitals (public)	+—	+++
Level 6: Teaching hospitals	—-	+++

Key: *+++ type of services in which the level is most active*
---- type of services in which the level is least active

9. Kenya Essential Packages for Health (KEPH) matrix by Cohort and Level

For each of the 6 levels in the national health system, there has been formulated the Kenya Essential Package for Health (KEPH). Therefore, there is a KEPH for level 1. The Essential Package for Health at Community Level is presented on the following page.

KEPH service delivery matrix by cohort and level

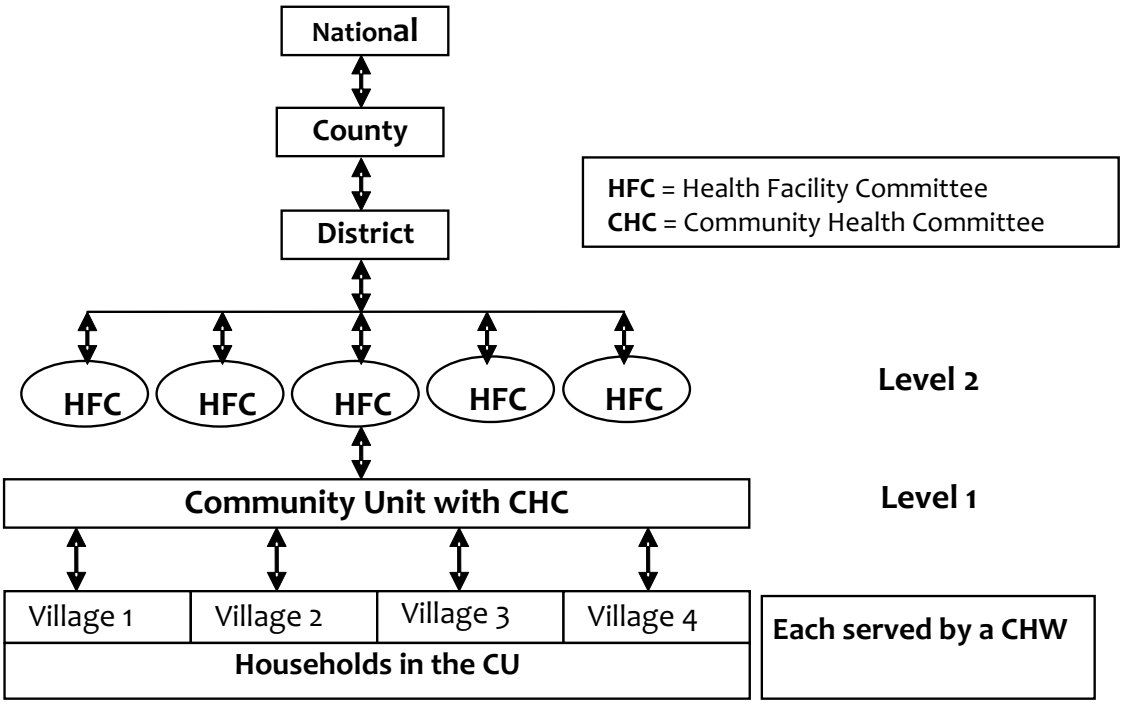
Cohort	KEPH level 1	KEPH levels 2 and 3
1. Pregnancy and newborn	▪ IEC on early recognition of danger signs; referral ▪ Birth preparedness ▪ Health promotion ▪ Community midwifery	▪ Focused ANC, IPT for malaria ▪ VCT, PMTCT or referral ▪ Basic emergency obstetric care, post-abortion care, referral services ▪ Oversight of CHW services ▪ Maternal death review
2. Early childhood	▪ Behaviour change communication (BCC) to promote key household care practices in prevention, care of the sick child at home, service seeking and compliance, promoting growth and development ▪ Community dialogue and action days ▪ Referral services	▪ Immunization, growth monitoring, treatment of common conditions (pneumonia, malaria, diarrhoea) ▪ Community dialogue ▪ Oversight of CHW services ▪ Essential drugs list ▪ Referral services
3. Late childhood	▪ School enrolment, attendance and support ▪ Support for behaviour formation and good hygiene	▪ Screening for early detection of health problems
4. Adolescence and youth	▪ BCC and IEC ▪ Community-based distribution (CBD) services ▪ Peer education and information ▪ Supply of preventive commodities ▪ Referral services	▪ All basic youth-friendly services, BCC and IEC ▪ Syndromic management of STIs ▪ Lab diagnosis of common infections ▪ Essential drugs list ▪ Referral services ▪ Oversight of CHW services
5. Adulthood	▪ BCC and IEC, community dialogue ▪ CBD services; home care, treatment compliance (TB, ART) ▪ Supply of preventive commodities ▪ Water and sanitation ▪ Referral services ▪ Promotion of gender and health rights	▪ BCC and IEC, VCT, ART and support groups ▪ Syndromic management of STIs ▪ Diagnosis and treatment of common conditions; TB treatment ▪ Essential drugs list ▪ Manage clients' satisfaction ▪ Referral services
6. The elderly	▪ IEC and BCC to reduce harmful practices ▪ Referral services	▪ Advocacy; management and rehabilitation of clinical problems ▪ BCC and IEC ▪ Screening, early detection of disease and referral

10. The linkage from the community level to the pinnacle of the National Health System

It was recognised from the onset that community health services could not be stand-alone services. Therefore, mechanisms were put in place to ensure that community level services in the CU links to the rest of the National Health System.

The CU directly links to the rest of the health system through the first referral facility referred to as the link health facility for the CU. Each CU has a specified link health facility. The Community Health Extension Workers (CHEWs) that supervise CHWs in the CU are attached to these link health facilities and thus establish direct links for CHWs with the first referral level. For most Community Units, the link health facility is either a dispensary or a health centre while those communities geographically close to level 4 or 5 facilities may have these facilities as their link facilities. The Chairman of the CHC is a member of the Link Health Facility Committee and thus there is also a managerial link between the link health facility and each CU. Thus when the CU prepares its Annual Operational Plan, this is reviewed by the link health facility committee.

The schematic presentation below shows how the community is linked to the National Health System as the Foundation to that system.



11. Key actors for health at the community level

The key actors include:

1. Individuals and households in the communities
2. Leaders of various groups in the community, e.g. religious groups, special interest groups such as women, young people with disabilities, people living with HIV, etc.
3. The administration representing government at the local level
4. The link health facility and members of the district health management team
5. Development partners working in the area or who could be invited to work in the area
6. The 3 cadres of the health workforce: CHWs, CHEWs and CHCs

12. Examples of health priorities for each cohort (age group)

Cohort 1 = Pregnancy and newborn care
Cohort 2 = Early childhood: 2 weeks to 5 years
Cohort 3 = Late childhood: 6 - 12 years
Cohort 4 = Adolescents and youth (13-24 years)
Cohort 5 = Adults (25-59 years)
Cohort 6 = Elderly persons (over 60 years)

13. The greatest urgency is for improved health of mothers and children

Sub Sahara Africa has only 10% of the world population but accounts for more than 50% of the mothers who die from pregnancy related conditions and over 50% of children who die under the age of five years. In Kenya, maternal and child death rates are still very high. In 2010 the MCH Booklet was launched in Kenya to be used in the programme for improving the health of mothers and children.

The value of the MCH Handbook/booklet includes:

1. Having one record for a child from pregnancy to at least five years of age
2. One document to record the mothers health during pregnancy as well as the child's health and therefore to be aware how a mother's health may have affected the child during pregnancy or the newborn stage, e.g. when a mother is HIV positive
3. The MCH Handbook is kept in the family such that if a mother moves from one health clinic she moves with the record of her pregnancy and that of the child
4. By having the MCH booklet at home showing both the mothers and child's records, the mother is encouraged to discuss the contents of the MCH booklet with the father of the child. This way fathers are to be encouraged to take an interest in the health of their wives during pregnancy up to child birth and in the health of the newborn up to 5 years. The father is encouraged to work closely

with the wife in getting services of antenatal care, skilled delivery, family planning and child health services such as immunisation and nutrition.

14. Reference materials

- MOH (2007). Linking Communities with the Health System: The Kenya Essential Package for Health at Level 1; A Manual for Training Community Health Workers
- Ministry of Health (2007). Reversing the Trends; Community Health Strategy
- MOH (2005) National Health Sector Strategic Plan II 2005-2010 (extended to 2012)
- Organisation and Management of Community-Based Health Care, National Pilot Project of Kenya Ministry of Health/UNICEF (1982), Were, M.K.
- *http://www.princeton.edu/~oa/manual/sect9.htm*
- http://www.beta.undp.org/undp/en/home/mdgoverview.html

MODULE 3:

THE ROLE OF CHC IN EFFECTIVE COMMUNICATION, ADVOCACY, NETWORKING & SOCIAL MOBILISATION IN THE COMMUNITY UNIT

MODULE 3:

THE ROLE OF CHC IN EFFECTIVE COMMUNICATION, ADVOCACY, NETWORKING & SOCIAL MOBILISATION IN THE COMMUNITY UNIT

UNITS:

UNIT 1: The Role of CHCs in Effective Communication
UNIT 2: The Role of CHCs in Advocacy
UNIT 3: The Role of CHCs in Networking and Partnership Development
UNIT 4: The Role of CHCs in Social Mobilisation

MODULE 3, UNIT 1:
THE ROLE OF CHCS IN EFFECTIVE COMMUNICATION
(Day 3, 11am - 12 noon, 1 hr)

1. Purpose

As CHCs have a critical role as effective communicators, the purpose of this unit is to provide CHCs with knowledge and skills on communication for effective leadership and management at level one health services

2. Objectives

By the end of the unit, the participants will be able to:-

1. Define communication
2. Explain the importance of communication
3. Describe communication process
4. Describe channels of communication
5. Identify types of communication
6. Describe qualities of a good communication
7. Identify barriers to effective communication and ways of overcoming them
8. Discuss consequences of ineffective communication

THE ROLE OF CHCs IN EFFECTIVE COMMUNICATION

1. Definition of communication

Communication is a process by which information is sent and received to create common understanding.

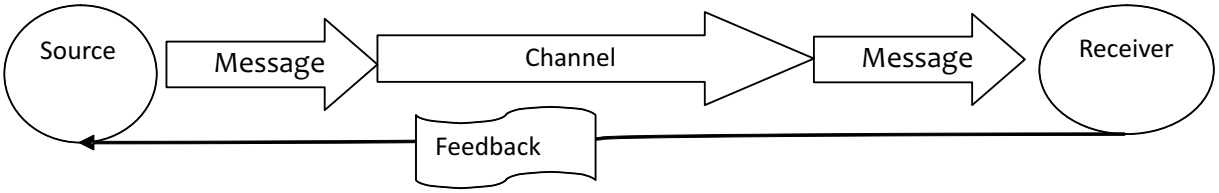
2. Importance of communication

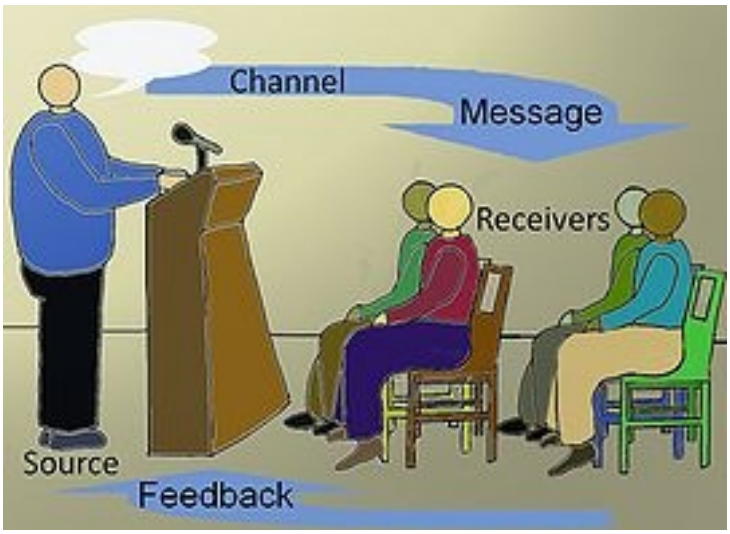
We communicate when we want to:

1. Create awareness
2. Explain new ideas
3. Persuade people to take action
4. Give feedback

3. Communication process

Communication cycle





Source/sender: The person who is the source/origin of the message.

- At the source, the message must be clear by stating why you are communicating and what you want to communicate.
- The information you are communicating must be useful and accurate

Message: The information that is being passed from the sender to the receiver.

Channel: The means through which the information is passed.

- The channels of communication include meetings, emails, phone calls, verbal exchanges, reports, presentations.

- Different channels have different advantages and disadvantages. A long list of verbal communication is not effective, while criticizing someone strongly through phone text message or in writing may quickly cause a problem.

Receiver: The audience or person for whom the message is intended.

- It is important to consider your receiver first before you deliver your intended message.
- Keep in mind that each individual enters into the communication process with ideas and feelings that will undoubtedly influence their understanding of your message, and their response.
- To be a successful communicator, you need to consider these points before delivering your message and act appropriately.

Feedback: Is the reaction of the receiver.

- Feedback can be verbal or nonverbal reactions to the message.
- The receiver is expected to interpret the message and respond to the sender (give feedback), and then communication starts all over again.
- Feedback is the mechanism by which confidence is gained that the message is understood by the audience or receiver.

4. Types of communication

A variety of verbal and non-verbal means of communicating exists such as body language, eye contact, sign language and media such as pictures, graphics, sound, and writing.

4.1 Nonverbal communication

Nonverbal communication describes the process of conveying meaning in the form of non-word messages. Research shows that the majority of our communication is non verbal, also known as body language. Some of the non verbal communication includes gestures, body language or posture; facial expressions and eye contact, object communication such as clothing, hairstyles, architecture, symbols and info graphics, and tone of voice as well as through an aggregate of the above.

Non-verbal communication is also called silent language and plays a key role in human communication in day to day life.

Speech also contains nonverbal elements known as paralanguage. These include voice quality, emotion and speaking style as well as features such as rhythm, intonation and stress. Likewise, a written text is part of nonverbal communication such as posters, brochures, letters, etc.

4.2 Verbal communication

Sometimes this is referred to as oral communication. Verbal communication involves words, language and vocal tone. It occurs through the act of speaking or writing.

Features of oral communication include:

- Tone
- Words
- Language

Examples of oral communication include speeches, conversation, radio, television, songs and music.

5. Channels of communication

Communication can be split into two parts the message and the content. Different channels have different strengths depending on the communication needs and targeted population. Communication channel can have influence on the communication. Channels for communication include the phone, radio, email, faxes, banners and posters.

6. Qualities of an effective communicator

1. ***Knowledgeable:*** Has relevant knowledge of the topic
2. ***Good Listener:*** Listens keenly to the learners
3. ***Friendly:*** Should not be harsh to learners
4. ***Observant:*** Should be able to discover learners' problems by observation
5. ***Positive:*** Has a good attitude towards learners
6. ***A good planner:*** Plans messages and learning sessions in advance
7. ***Patient, confident, clear, and audible:*** Motivates learners, varies dialogue methods

To have effective communication, one needs to take all the factors into consideration.
The different realities, the space the communication takes place in, verbal as well as non-verbal messages, the intended meaning versus the perceived meaning.

7. Qualities of effective communication

A good message must have the attributes of 7 "Cs" of communication. It must be (1) clear; (2) concise; (3) concrete; (4) correct; (5) coherent; (6) complete; and (7) courteous.

1. **Clear:** When writing or speaking to someone, be clear about your goal or message. Try to minimize the number of ideas in each sentence. Make sure it is easy for your reader to understand your meaning. People shouldn't have to read between the lines and make assumptions on their own to understand what you are trying to say.
2. **Concise:** When you are concise in your communication, you stick to the point and keep it brief. Your audience doesn't want to read six sentences when you could communicate your message in three.
3. **Concrete:** When your message is concrete, then your audience has a clear picture of what you

are telling them. There are details and vivid facts but not too many. Your message is solid.

4. **Correct:** Correct communication fits the audience. Correct communication is also error-free communication. Do the technical terms you use fit your audience's level of education or knowledge? Have you checked your writing for grammatical errors? Are all names and titles spelled correctly?
5. **Coherent:** When your communication is coherent, it's logical. All points are connected and relevant to the main topic and the tone and flow of the text is consistent.
6. **Complete:** In a complete message, the audience has everything they need to be informed, and if applicable, to take action. Does message include a "call to action," so that your audience clearly knows what you want them to do? Have you included all relevant information - contact names, dates, times, locations and so on?
7. **Courteous:** Courteous communication is friendly, open and honest. There are no hidden insults or passive-aggressive tones. You keep your audience's viewpoint in mind, and you are empathetic to their needs. A little bit of courtesy, even in difficult situations, can go a long way.

8. Barriers to effective communication

Establishing a common bond through communication does not always come easily. There are many barriers that make it difficult for communication to achieve its goal. Some of these barriers are:

1. Age/status differences: When the sender and the receiver are of different age groups or social standings, communication may suffer. Old men, for example, may not want to listen to a young sender, depending on the message. A lawyer may not want to hear what a peasant farmer has to say.
2. Language: The use of language that is not understood by the audience will stop communication in its tracks. For example, the use of sheng' may be appropriate for urban young people, but not a rural adult audience. The audience may also use language in a way that is not understood by the sender, e.g., the use of riddles.
3. Political differences: People of different political orientations may find it difficult to accommodate messages/ideas from each other.
4. Communication overload: Too many messages at one time may be so confusing that people cannot comprehend them.
5. Mistrust: If either the sender and/or the receiver do not trust each other, communication may be delayed or halted.
6. Gender roles: Men may not agree to listen to women.
7. Timing: The message may be too late for effective action, or the audience may not have time to listen to it.
8. Competition for attention: Everybody wants to talk, or other distractions interfere with attention.
9. Incomplete messages: When only part of the message is delivered, either through ignorance or oversight, this causes confusion.
10. Personal traits: The "know it all," a negative personality, inferiority and superiority complexes, individual mannerisms, and other personality traits can all be barriers to effective communication.

9. How to overcome barriers

Because communication is a two-way process, the sender and the receiver must cooperate. The audience must play its own part responsibly and try to remove their own barriers, e.g., their own personal traits that hinder communication. To help the audience be more receptive, the sender should:

- Make it a point to understand the audience's background, interests, etc.
- Be sure the message is meaningful, clear, concise and to the point
- Be sure the message is delivered at the right time and place
- Acknowledge and encourage participation from both sexes

10. Consequences of ineffective communication

1. Misinterpretation of the message
2. Inaccurate response
3. Wrong feedback
4. Lack of accurate response

11. Reference materials

- Community Strategy implementation guidelines for managers of KEPH at Community Level
- Linking communities with the health system: KEPH at level one, a manual for training CHEWs (March 2007)
- MOH (2007), A Manual for Training Community Health Workers, Nairobi, Kenya: MOH-SPMD
- MOPHS (2011), Integrated Curriculum for Training Community Health Workers in Kenya, Draft, Nairobi Kenya, MOPHS - DCHS
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- Daniel Chandler, "The Transmission Model of Communication", Aber.ac.uk Partners IN Salford, 2nd Floor, Unity House, Salford Civic Centre, Chorley Road, Swinton, M27 5FJ 0161 793 2929 partnersinsalford@salford.gov.uk Privacy policy

MODULE 3, UNIT 2:
THE ROLE OF CHCS IN ADVOCACY
(Day 3, 12 noon -1 pm, 1 hr)

1. Purpose

To empower the CHCs with knowledge and skills on how to advocate within as well as on behalf of the community to achieve the desired health and health related outcomes.

2. Objectives

By the end of this unit the participants should be able to:

1. Define the term advocacy
2. Outline the steps in advocacy
3. Outline types of advocacy
4. Describe the benefits of advocacy
5. Describe strategies and approaches in advocacy
6. Demonstrate skills for developing an advocacy plan

THE ROLE OF CHCs IN ADVOCACY

1. Definitions of advocacy:

Advocacy is speaking up for an issue or action taken to influence a decision, or working together for common change, or speaking up for the people who cannot speak for themselves.

1.1 Some examples of types of advocacy

- **Health advocacy:** supports and promotes patients' health care rights as well as enhances community health and policy initiatives that focus on the availability, safety and quality of care.
- **Ideological advocacy:** in this approach, groups fight, sometimes during protests, to advance their ideas in the decision-making circles.
- **Media advocacy:** is the strategic use of the mass media as a resource to advance a social or public policy initiative.
- **Mass advocacy:** is any type of action taken by large groups such as petitions, demonstrations, etc.
- **Legislative advocacy:** the reliance on the state as part of a strategy to create change/
- **Budget advocacy:** budget advocacy is another aspect of advocacy that ensures proactive engagement of Civil Society Organisations with the government budget to make the government more accountable to the people and promote transparency.

2. Benefits of health advocacy

- Assist in developing/changing policy
- Ensure accountability to the people
- Representation of the voiceless
- Mobilise the people to participate in the desired change process
- Support the development of a culture of freedom

3. Strategies for advocacy

- Empowerment - People being aware of themselves and their needs
- Persuasion - lobbying and negotiation (bargaining for common ground, minimally ceding ground and maintaining respect for disagreement) and clout (showing the power of support from people)
- Public education and media - can be through music, video and songs, as well as through radio and television
- Policy meetings - to get public support for reforms
- Collaboration - joint agreement between organisations
- Organisation and constituency building - alliance building
- Litigation - where people have been accused with abuse of power. Can be through the court or community justice systems.
- Elections - an opportunity to involve a broad base of citizens in public debate, raise issues, criticize officials and current policy, influence candidates, political parties, and policy makers, and present policy alternatives and people's platforms
- Research - can convince the Government of the need to implement a particular programme

4. Implementation of advocacy activities

1. Prepare a plan of action
2. Budget and identify resources
3. Do a risk assessment: Consider what activities or situations can affect the project or activity, and rank each of them as low, medium or high risks.
4. Monitor and Evaluate: The process and results should be evaluated not only at the end of the planned timeframe but on a regular basis so that adjustments, if needed, can be made to the strategy and plan of action. Advocacy invariably takes place in a dynamic environment. The policy terrain can change for social, political or economic reasons that are independent of the advocacy initiative underway. The ability to react quickly and flexibly, to spot windows of opportunity, and to anticipate new challenges requires close monitoring of the policy context and of broader trends.

5. Steps in advocacy development

1. Identify the problem

2. Set an agenda
3. Assess the external policy influence and environment
4. Assess resource needs, financial and human
5. Choose and plan the right campaign strategy
6. Implement
7. Evaluate
8. Celebrate
9. Plan follow-up actions

6. Reference materials

- Community Strategy implementation guidelines for managers of KEPH at Community level: Linking communities with the health system: KEPH at level one, a manual for training CHEWs (March 2007)
- MOH (2007) A Manual for Training Community Health Workers, Nairobi, Kenya: MOH-SPMD;
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- Advocacy Strategies and Approaches: Overview Paper Steve Buckley
- Adapted from Miller, Valerie. NGOs and Grassroots Policy Influence: What is Success? Institute for Development Research, Vol. 11, No.5, 1994
- Adapted from Schuler, Margaret, "Conceptualizing and Exploring Issues and Strategies" in Empowerment and the Law: Strategies of Third World Women, OEF International, 1986
- Adapted from Institute for Development Research. Strategic Thinking: Formulating Organisational Strategy. Facilitator's Guide. Boston, 1998; Developed and refined by Valerie Miller and Lisa VeneKlasen; see also V. Miller, ibid

MODULE 3: UNIT 3:
THE ROLE OF CHCs IN NETWORKING AND PARTNERSHIP DEVELOPMENT
(Day 3, 2pm - 3pm, 1 hr)

1. Purpose

To empower Community Health Committees with networking skills to enable them develop long lasting relationships with stakeholders for the mutual benefit of their communities.

2. Objectives

By the end of this unit the participants should be able to

1. Define networking and partnership
2. Define characteristics of a successful and unsuccessful partnership and networking
3. Demonstrate skills in networking and partnership
4. Describe the strategies of networking
5. Describe principles of partnership
6. Describe community entry process
7. Describe the benefits of networking and partnership

THE ROLE OF CHCs IN NETWORKING AND PARTNERSHIP DEVELOPMENT

1. Definitions

1. Networking is the act of inter-relating among people or organisations, such as to exchange information and other resources.
2. Partnership is collaboration between two parties or more based on trust, equality and mutual understanding for the achievement of a specified common goal.

2. Skills for networking and partnership

- Genuine interest in others
- Communication skills (listening skills, conversational skills, body language)
- Interpersonal skills (ability to build rapport, confidence without arrogance)
- Analytical skills
- Negotiation skills
- Problem solving skills
- Resource mobilisation skills

- Ability to adapt your approach according to the person and situation
- Knowledge of the subject matter
- Willingness to push yourself out of your comfort zone

3. Principles of partnership

The principle of partnership is pegged on the following points:

- Clearly defined and agreed on objectives and benefits (immediate, mid term and long term) to all partners
- Collective understanding of the purpose of the partnership and its intended outcome
- Roles and tasks identified and agreed on according to the ability of each partner
- Recognition that skills and contribution of each partner are valuable to the success of the partnership
- Resource mapping of the partners
- Appreciation of both the risks and benefits of the partnership
- Mutual trust and confidence that must be nurtured through effective performance and linkages
- Engagement in joint action that focus on areas of own influence not on needs
- Establishing and promoting the values of the partnership through effective communication and commitment
- Developing skills, knowledge and experience in order to govern effectively
- Engaging all partners equally and making accountability real

Note: If one partner receives from the partnership more than one contributes, this weakens the role and voice of the one receiving. Furthermore, it reinforces dependence and weakness to external factors of influence and undermines partnership relationships. Fear replaces cooperation and those affected become threatened and defensive.

4. Community entry process

The establishment of the Community Health Committee with oversight responsibilities places them in the position of guiding all those who come to work with the community on the entry process they need to follow for successful work with the community. Through this process, the Community Health Committee is in a position to establish net-working relationships with incoming potential partners and thus to establish new partnerships for the community.

5. Specific steps involved in community entry process

Step 1 - Creating awareness

Create awareness through locational and sub locational leaders, Churches/Mosques, Schools and social welfare organisations.

Step 2 - Situation analysis, household registration and mapping

This includes the following approaches:

- Exploration - This is a fact finding stage to help the teams working in the community in understanding of life as it is lived in that community. This stage can be done in the chiefs' or assistant chiefs' baraza or at the agreed community forum.

  The findings should be written up and shared with the community highlighting the facts that community members speak about with emotions such as fear, frustration, anger, joy, hope and anticipation.
- Participatory assessment - The scope of the assessment should include the population size; community structures, e.g. existing institutions, organisations and committees; resources in the community; services available in the community and access to these services; health status based on the agreed indicators, status of food security and nutrition, and the environment (water, sanitation, shelter, soils, and infrastructure).

  Conduct a stakeholder analysis to ascertain individuals whose involvement may be critical to the success of the programme goal. Interact informally with customers and other people in the environment, conduct a 'mini survey' on leaders in the site; note that leadership as applied here may include individuals or groups that can influence others to achieve set goals through dialogue and action.

  Arrange to meet and discuss the programme with identified leaders, first on an individual level, then as a group. At the group meeting, agree on date, roles and responsibilities of all stakeholders, venue, time, agenda and other logistics for the open community meeting after obtaining their support for the programme.

  Identify dialogue centres and groups (religious institutions, schools, civic leaders, youth groups, their roles and responsibilities).

  The assessment methods may include a transect walk, direct observation, mapping of seasonal calendar of events, activities, diseases, food availability, etc. as well as daily activities by gender.

  Other tools for data gathering may include key informant interviews, and focus group discussions.

  Carry out participatory mapping of the sites as presented in the community mapping toolkit.

Steps in mapping:

1. Identify community members who know the subject matter and are willing to share their knowledge.
2. Together with community members, choose a suitable place.
3. Let the members agree on what object each item/material represents.
4. Community members participate in drawing the map (starting from a prominent site like the chief's house, a place of worship, etc.).

5. Participants could be asked to identify their house and their neighbour's houses (or household), their farm land.

The map should:

1. Show major infrastructure (health centre, local government offices, schools, brothels, worship centres, water source, etc)
2. Show other features of relevance to the team
3. Be transferred faithfully to paper, using a pencil
4. Include the mappers' names on the map in recognition of their contributions
5. Include the date and place for record purposes

Step 3 - Planning actions to improve health individual and community health

The information gathered is used for dialogue in the agreed forums where issues are prioritized and decisions taken for action.

6. Strategies for networking

- Have a clear purpose to your networking. Ask these questions: Who do you want to meet? What do you want to learn and why? Think of places where you can meet people to help you.
- Reflect on what you want give. Who and what do you know that may help others? Remember that networking is about mutual benefits.
- Set yourself targets of a set number of new contacts you will make within a specified period of time, e.g. a week, a month or so.
- Create a networking business card that will promote you effectively.
- Keep accurate record of your contacts.

7. The benefits of networking and partnerships

- Linkages to facilitate communication and learning among groups and organisations with similar programmes
- Platforms to coordinate programmes, activities and resources of multiple groups and organisations to achieve shared policy or programme goals
- Increased visibility and legitimacy through networking
- It attracts new programmes, initiatives and innovations locally, regionally, state-wide and internationally
- It provides a voice that enables individuals, group or society to contribute their views and advice to a wider, collective voice on issues of importance
- It is time saving on sector development and issues

8. Reference materials

- Community Strategy implementation guidelines for managers of KEPH at Community level: Linking communities with the health system: KEPH at level one, a manual for training CHEWs (March 2007)
- MOH (2007), A Manual for Training Community Health Workers, Nairobi, Kenya: MOH-SPMD
- MOPHS (2011), Integrated Curriculum for Training Community Health Workers in Kenya, Draft, Nairobi Kenya, MOPHS - DCHS
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MODULE 3, UNIT 4:
THE ROLE OF THE CHC IN SOCIAL MOBILISATION
(Day 3, 3 - 4pm, 1 hr)

Purpose

The purpose of this unit is to equip CHC members with knowledge and skills in social Mobilisation for effective engagement of community members and structures in addressing their health.

Objectives

By the end of the unit, the participants will be able to:

1. Define social mobilisation
2. Identify principles of social mobilisation
3. Describe the steps in social mobilisation
4. Identify approaches used in social mobilisation
5. Understand the techniques of social mobilisation

THE ROLE OF THE CHC IN SOCIAL MOBILISATION

1. Definition of social mobilisation

Social mobilisation refers to the process of organizing people in the same community for a specific purpose. Social mobilisation is an activity involving planned actions and processes of reaching, influencing and involving all relevant segments of society across all sectors from the national to the

community level in order to create an enabling environment and effect positive behaviour change. It's a process that makes things happen and guides people towards achievement of a common goal. It can be done at national or local levels. It's about sensitizing and motivating social partners to work together in raising awareness and pulling resources, targeting interested organisations, individuals and health related sectors along with CBOs, NGOs, professional associations and the private sector.

2. Steps in social mobilisation

1. Situational analysis
2. Plan with stakeholders
3. Review previous social mobilisation campaigns
4. Identify realistic and measurable behaviours
5. Identify communication objectives to address the behaviour
6. Develop messages
7. Set out a social mobilisation plan with stakeholders with clear coordination mechanisms
8. Implement a blend of communication interventions
9. Monitor and evaluate results

3. Approaches to social mobilisation

1. Political mobilisation: Aims at winning political and policy commitments
2. Government mobilisation: Aims at informing and enlisting cooperation and help of service providers and other government organisations that can provide direct or indirect support
3. Corporate mobilisation: Aims at securing the support of national and international companies in promoting appropriate goals
4. Social mobilisation by CHCs: Aims at getting communities mobilised for action
5. Community mobilisation: Aims at informing and gaining commitment of local, political, religious and traditional leaders as well as local government agencies and non government organisations, women's groups and cooperatives
6. Beneficiary mobilisation: Aims at informing and motivating programme beneficiaries towards the achievement of the set goals and objectives
7. Sustained appropriate advertising: Engaging and reminding people about the merits of a behaviour
8. Point of service provision: Emphasizes easily accessible and readily available services

4. Principles of social mobilisation

- The presence of a support institution whose leadership has confidence in the capacity of people to uplift themselves
- The support institutions should be autonomous and can mobilise resources for social mobilisation
- They should uphold the vision of the community

- Building of linkages and networks
- Sensitive to socio cultural and gender values of the community
- Collective action

5. Strategies in social mobilisation

- **Participation:** Participation ensures that the beneficiaries of any intervention are, as a means, consulted and contributing to a particular development activity, and as an end, reach the point where they (communities and individuals) define and control their own development.
- **Collaboration:** Through multi-sectoral collaboration among ministries, donors, and local organisations at the national, district, and community levels, leaders must be involved consistently through all phases of the campaign.
- **Partnership:** Whether its partnerships with ministries, communities, or other NGOs, it is important that there is shared recognition for implementation and success, transparency, and joint decision-making.
- **Equity:** "The quality of being just or impartial," equity is at the core of every social mobilisation campaign. Success will rest on equity being applied to all dichotomous areas of society - gender, race, class, literacy, and even health status.
- **Quality:** Often used interchangeably with "exceptional," quality must be achieved in all components of a successful campaign.

6. Techniques to social mobilisation

- Audio
- Print media
- Meetings

7. Reference materials

- Social Mobilisation for Health Promotion, WHO 2002
- Social Mobilisation Programme-Sarhad Rural Support Programme, 1994-2007
- Making Advocacy, Communication, and Social Mobilisation (ACSM) Work for TB Control; PATH, the Stop TB Partnership Secretariat, USAID, and WHO Regional Advisors
- A handbook for trainers on participatory local development: the Panchayati- FAO 2003-07
- Communication for Development, UNICEF

MODULE 4:

PERSONNEL MANAGEMENT ISSUES

MODULE 4:

PERSONNEL MANAGEMENT ISSUES

UNITS:

UNIT 1: Human Resource Management by CHCs
UNIT 2: Performance Appraisal of CHWs by CHCs
UNIT 3: Conflict Management and Resolution in the Community Unit

MODULE 4, UNIT 1:
HUMAN RESOURCE MANAGEMENT BY CHC
(Day 4, 8:30 - 10:30 am, 2 hrs)

1. Purpose

To equip the CHCs with knowledge and skills to enable them to manage human resources for the Community Unit.

2. Objectives

By the end of the unit, participants will be able to:

1. Define human resource management
2. Describe some elements of human resource management
3. Outline the selection criteria of CHWs
4. Describe the roles of CHCs, CHWs and CHEWs
5. Describe the retention and motivation system for CHWs
6. Describe ways of rewarding and disciplinary actions within the community set up
7. Outline advantages of teamwork and its challenge

HUMAN RESOURCE MANAGEMENT BY CHCs

1. Resource management

1.1 Definition of resource management

It is the efficient and effective deployment for an organisation's resources when they are needed.

1.2 What do resources consist of?

Such resources may include financial resources, human skills, production resources, e.g. information technology (IT) and time.

2. What is human resource management?

- A strategic and comprehensive approach to managing people, the work-culture and environment.
- Effective human resource management enables people to contribute effectively and productively to the overall goal of the group and in the accomplishments of the group's objectives and goals.
- In the case of this discussion, the group and organisation under consideration is the Community Unit.

3. Definition of human resource management

Human resource management (HRM) is the function within an organisation that focuses on recruitment of, management of, and providing direction for the people who work in the organisation as well as the factors that motivate people to do good work.

4. Levels of management

- Lower management is normally concerned with directing or supervising staff in detailed, narrow tasks structures and processes
- Middle management generally directs other managers, translates and implements top management policies and strategies (relieve pressures on top management)
- Top management creates policy, objectives and strategies that are used to guide the organisation to achieve its aims

5. Elements of human resources management

5.1. Motivation

Motivation is the driving force by which humans achieve their goals. It is what makes people want to work.

Elements of motivation

- Rewards
- Social recognition
- Appreciation of performance by self & others

- Appreciation of productivity by self & others

  "Kujivunia kazi yako"

5.2. Delegation

Delegation is the process of assigning tasks, duties and granting of authority for responsibility and accountability to one who is to perform the tasks and duties on behalf of another person.

Elements of delegation

- Assignment of duties
- Granting of authority
- Assigning of responsibility and accountability

5.3. Team Work

Team work is people working together effectively to achieve a common goal

Elements of teamwork

- Team organisation: How do you organize a team to be effective?
- Team responsibility: How do you promote team responsibility?
- Team leadership: How to create leadership in the team that motivates others members?
- Having a good understanding of the responsibility of others working in the Community Unit.

Six characteristics of successful teams

1. All those in the team are focused on the same goal, vision and mission with a clear idea of the progress they would all like to see happen
2. The team feels empowered enough to have the courage to set goals, establish rules and guidelines of how to work
3. Every member of the team is involved in the work of the team;
4. There is cooperation in generating new ideas towards finding solutions for the progress they want to see and willing to take risk
5. The Members of the team spend their energy in pulling in the same direction in a united way rather than scattering their energy in various directions;
6. The members of the team are willing to make changes that are necessary to make progress.

Using these general rules for a successful team, the CHC is to apply these ideas to provide leadership in the improvement of health

6. Community Unit Health Workforce

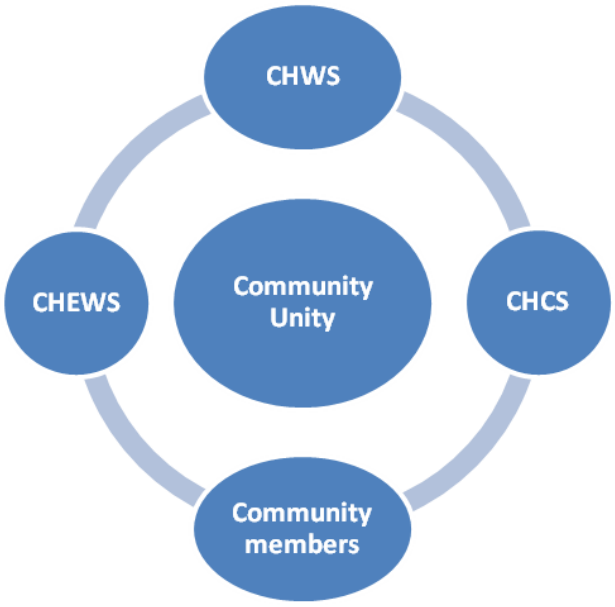
6.1. Composition and the roles and responsibility of the Community Unit Health Workforce

- CHWs
- CHEWs
- CHCs

These members of the community health workforce are closely linked together as shown in the diagram that follows. Each of them has their specific roles within the community health workforce team

6.2 The Community Unit Health Workforce working together with the people to the benefit of the Community Unit

The diagram on the following page illustrates how the cadres of the health workforce work together to benefit the Community Unit.



Roles

- **CHWs:** To provide data and health services in the community
- **CHEWs:** To supervise the work of CHWs and work with the CHC as their secretary
- **CHCs:** To provide leadership & governance guidance to the work in the Community Unit
- **Community members:** To be mobilised and motivated to take up appropriate behaviours and activities that promotes healthy living.

The CHC needs to support the work of the CHWs for retention, motivation & disciplinary action for CHWs, as illustrated in the table below.

Retention & Motivation	Disciplinary Action by CHC & the health sector
• Appreciation events, e.g. Annual CHW day • Exchange visits to neighbouring Cus • Capacity building through trainings • Financial & non-financial incentives - involve in planned health activities • Explore opportunities for professional development for the very successful CHWs	• Verbal warning by leaders of the committee • Summoning in front of the committee • Conflict resolution through CHCs • Warning letters for inappropriate behaviours • Involvement of local public administration in case of no change • Carrying out formal appraisal of the work of CHWs every year

Advantages and challenges of team work, as illustrated in the table below.

Advantages for CHC to enhance	Challenges for CHC to avoid & address
• Team members share responsibility under the overall leadership of the chairman and executive committee • Team develops scope of work • Team members are mutually accountable for their work • Performance of team is based on team members efforts	• Conflicts • Favouritism • Laziness • Indiscipline • Poor leadership • Lack of motivation The CHC should warn members in the CHC or among CHWs who are seen to be involved in these activities

4. Reference materials

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MODULE 4, UNIT 2:
PERFORMANCE APPRAISAL OF CHWS BY CHCs
(Day 4, 11 am - 1:00 pm, 2 hrs)

1. Purpose

To familiarize CHC members with knowledge and skills on the criteria used to appraise CHWs performance.

2. Objectives

By the end of this unit, the participants will be able to:

1. Define performance appraisal
2. Describe the criteria for a performance appraisal
3. Discuss the structure/steps to be applied for bringing about improvement in performance
4. Outline the criteria of recognizing of good performance on priority activities

PERFORMANCE APPRAISAL OF CHWs BY CHCs

1. Definition of performance appraisal

A performance appraisal is a part of guiding and managing career development. It is the process of obtaining, analyzing, and recording information about the relative worth of a person's skills. Performance appraisal is an analysis of a person's recent successes and failures, personal strengths and weaknesses, and suitability for tasks assigned. It is also the supervisor's judgment of a person's performance.

2. Importance of performance appraisals

Performance appraisals provide supervisors and supervisees with information on strengths and weaknesses with opportunities to discuss areas in which the supervisee excels and those in which the supervisee needs improvement. Performance appraisals should be conducted on a regular basis, in order to identify areas in which the supervisee deserves praise and areas in which improvement is needed.

3. Generally, the aims of a performance appraisal are to:

1. Give feedback on performance
2. Identify training needs

3. Provide the opportunity for community diagnosis and development
4. Facilitate communication between supervisee and supervisor
5. Improve performance through counselling, coaching and development
6. Give praise for the areas of good/excellent performance

4. Purposes of a performance appraisal

Regardless of the type of format used, the following criteria are recommended as important components of an effective performance appraisal:

1. Providing examples of outstanding performance
2. Identification of areas needing improvement
3. Discussion of goals and objectives for upcoming year
4. Opportunity for the supervisee to furnish information on achievements and performance
5. Feedback from colleagues, subordinates, customers, as applicable
6. Suggestions of training and professional development opportunities for upcoming year
7. Opportunity for response by supervisee
8. Give praise for good/excellent performance

5. Appraisal at Level I of the health system

The appraisal at this level is intended as a review of the quality of the work of Community Health Workers (CHWs). It is to be noted that the appraisal of the CHW is one of the responsibilities of the Community Health Extension Worker (CHEW) who is the supervisor of the CHW. Using the appraisal tool developed by the Division of Community Health Services, the CHEW shall carry out the appraisal of the CHW.

Therefore the CHEW is provided with the guidelines on how to undertake the appraisal of the CHWs that she/he supervises. As a member of the CHC, the CHEW should brief the CHC members of the performance of CHWs in the CU. The CHC members are to provide input into this appraisal for the CHW working in their geographical area/village. The CHC should focus on looking into how to improve the performance of the CHW in case of need.

6. Components of effective appraisal

1. Provide examples of outstanding performance
2. Identify areas needing improvement
3. Discussion of goals and objectives of the upcoming year
4. Opportunity for supervisee to furnish information on achievements and performance
5. Feedback from colleagues, subordinates and customers as applicable

7. Reference materials

- MOH (2007). Linking Communities with the Health System: The Kenya Essential Package for Health at Level 1
- A Manual for Training Community Health Workers
- Ministry of Health (2007). Reversing the Trends; Community Health Strategy
- Ministry of Health (2005) National Health Sector Strategic Plan II 2005-2010 (extended to 2012)
- Ministry of Health (2010). Community health information system tools (MOH 513, 514, 515, 516)

MODULE 4, UNIT 3:
CONFLICT MANAGEMENT AND RESOLUTION IN THE COMMUNITY UNIT
(Day 4, 2 - 4pm, 2 hrs)

1. Purpose

Familiarize the CHCS on underlying issues of conflict resolution and steps

2. Objectives

1. Define conflict resolution
2. State negative effects of conflicts and benefits of conflict resolution
3. Define steps in conflict resolution
4. Define principles of conflict resolution
5. Determine steps in resolving conflicts in the Community Unit

CONFLICT MANAGEMENT AND RESOLUTION IN THE COMMUNITY UNIT

1. Introduction to conflict resolution

In many places where people live or work conflicts seems to be part of life. This could be due to different opinions or ways of life. There can also be personal difference. Conflict is behaviour in which people oppose one another in their thoughts, feelings, and/or actions. Anger, hostility, fear, jealousy, insecurity, pain or sadness, and inadequacy, are some of the feelings underneath conflicts.

Although most conflicts involve disagreements of some kind, some of them can be more about feelings than thoughts. Whether conflict exists or not is entirely up to the perception of the parties involved. This is why one person can be angry with another person and the person who is the subject of the anger is completely oblivious. This difference in perceptions is why someone can say, "but I didn't do anything

wrong" and really mean it. What is conflict to one person may mean nothing to another person. All conflicts have an action component - external behaviour such as body movements, facial expressions, or speaking. More often than not, conflict resolution can make a difference in different relationship.

Conflict resolution is a solution to a problem that allows the participants to appreciate that their disagreement has been addressed.

2. Negative effects of conflicts

1. Lost productivity: Since there is tension , the productivity and morale of those involved might be worn down
2. Fuel Anger and frustration
3. Gossip, failure to work and forgetfulness
4. Increased absenteeism or unwillingness to work
5. Drop out or high attrition
6. Court cases
7. Escalated violence

When conflict cannot be contained in a functional way, it can erupt in violence, war, and destruction. The harmful aspects of conflict are pretty obvious if you read the newspaper or watch the news. Less obvious is the loss of productivity on the job, the destruction of relationships, organisational breakdown, and psychological damage to individuals.

3. Benefits of resolving conflicts

1. Increased understanding: People become aware of their problems and address them without allowing them to effect their goals and objectives, without undermining or frustrating each other's efforts.
2. Improved self knowledge: Conflict resolution makes people understand what is important to them and helps them leave behind things that do not add value to their lives and their goals.
3. Increased/improved relationships: The conflicting parties become closer, develop respect for each other and they renew their faith in the work they are doing.
   Conflict can have some benefits if it is contained before people turn violent. It can motivate people to what needs to be done and break them out of complacency. Sometimes conflict is necessary to bring an awakening to dysfunctional relationships or behaviour.
4. Improved productivity

4. Conflict resolution steps

1. Create a forum for the conflicting parties outside of their normal environment.
2. Emphasize that conflict is a mutual problem, without pointing a finger at one person, and that it can be resolved by both parties.

3. Listen keenly to both sides and restate whatever they mention and be assertive o other than submissive or aggressive. Please rephrase statements as follows:
   - "It sounds like you are saying..."
   - "Do I understand you to mean...?"
   - "Let me make sure that I understand your point. Do you mean...?"
4. Get to know what each of their needs and concerns are. Please remember to emphasize than you will listen to them in turns, and you will need them to cooperate to solve the problem.
5. Focus on issues related to the goals other than personal issues.
6. Try to assess the conflict in an objective way: Is the conflict affecting performance of either of them? Does it affect team work?
7. Agree on the problem and build consensus on solutions through brainstorming.
8. Have both sides agree with the solution so that they have a "win-win" situation.

5. Principles of conflict resolution

1. Be calm. Control emotions and behaviour so that you don't shout, threaten or intimidate.
2. Be patient. Pay attention to what the parties are expressing.
3. Be respectful. Avoid disrespectful words and actions.
4. Encourage effective communication. Communicate clearly and assertively and listen to the parties.
5. Focus on the current issue.
6. Separate the people from the problem.
7. Generate a variety of possibilities before deciding what to do. Realise that solving their problem is also a way of solving yours. Look for ways that they will both benefit ("win-win"). Don't assume that there is only one single answer (theirs, or yours!)

6. Negotiating/addressing conflict at the CHC

1. Conflict is reported to the CHEW or CU chairperson.
2. The chairman collects information about the conflict.
3. Discuss at the CU and come up with solution. Remember to record minutes.
4. If the conflict is not resolved, seek mediation from the local administration, HFC. Mediation helps to discuss issues, repair past injuries, and develop the tools needed to face disagreements effectively. Mediators may help participants see their blind spots, broaden their perspectives, and even muddle through the problem-solving process. Yet, successful mediators remember that the challenges are owned by the stakeholders and do not attempt to short-circuit the process by solving challenges for them. Mediators facilitate the process by:
   - Understanding each participant's perspective through a pre-caucus
   - Increasing and evaluating participant interest in solving the challenge through mediation
   - Setting ground rules for improved communication
   - Coaching participants through the joint session
   - Equalizing power (e.g. between persons in different organisational levels)

- Helping participants plan for future interaction

Understanding each participant's perspective through a pre-caucus: The pre-caucus is a separate meeting between the mediator and each stakeholder, before the stakeholders are brought together in a joint session. During the pre-caucus the mediator will briefly explain the issue of confidentiality and the mechanics of the mediation process so stakeholders will not be surprised or have a sense of being lost. The mediator also should offer stakeholders the opportunity for regular caucusing (a meeting away from the other stakeholder) any time they feel a need for it. It is important that stakeholder control is emphasized throughout the process. Participants should not agree on something just for the sake of agreement. If there are yet unmet needs, these should be brought up. Sometimes, a few changes in a potential solution can make the difference between an agreement that will fail or succeed. Although any talking between the mediator and one of the stakeholders alone can be perceived as suspect and potentially influence the neutrality of the mediator, such fears assume a mediator-directive approach where the third party wields much power and often acts as a quasi-arbitrator. When the mediation process is understood, from the beginning, as one where each of the stakeholders retains control over the outcome, less importance is given to mediator neutrality. The pre-caucus provides each stakeholder an opportunity to be heard and understood. One of the reasons why conflict situations are so challenging is the natural tendency of stakeholders to each want to express their respective perspectives first which to some degree takes place in the pre-caucus. The more deep-seated and emotional the conflict, the greater this need.

Arbitration: The supervisor as an arbiter may do everything a mediator does but, at the end, will make a judgment that the supervisee are expected to follow. It may be clear from the outset that supervisee expect the supervisor to take the role of an arbiter. Or, it may become increasingly evident as mediation is taking place that an arbiter will be needed. Because it is normally preferable for all parties involved to have a conflict solved at the mediation rather than arbitration stage, it helps for a supervisor to be slow in taking on the role of an arbiter, especially when these two individuals will have to continue to work together. During the process of listening to the various perspectives, and before making a decision, an arbiter may wish to offer employees the opportunity to work out their own problem, or to work out difficulties through mediation.

At times, a judge and a judgment are needed. Supervisors who have to arbitrate should avoid trying to make both parties happy with the decision. Most of the time, this is simply not possible. It may be an admirable goal for mediation, but not for arbitration. Instead, the arbitrator is required to be impartial (there is no room for favouritism) and fair (even if this seems one sided).

If not resolved use authority to make the decision and justify it, clearly spelling out all the steps that had been taken to lead to this decision.

Conclusion: Conflict cannot always be avoided (especially when fundamental differences, as opposed to perceived differences, are involved) and not all conflict is negative (sometimes it 'clears the air'). The important thing is to keep wasteful and damaging conflict to a minimum and, when it does occur, use the relevant steps to resolve or at least ease it.

7. Reference materials

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- International Learning Association Homepage (ILA). (2004 September 20). Retrieved October 20, 2004, from www.listen.org
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MODULE 5:

RESOURCE MOBILIZATION, PROPOSAL WRITING & FINANCIAL MANAGEMENT

MODULE 5:

RESOURCE MOBILISATION, PROPOSAL WRITING AND FINANCIAL MANAGEMENT

UNITS:

UNIT 1: The Role of CHCs in Resource Mobilisation for the Community Unit
UNIT 2: Proposal Writing
UNIT 3: The Role of CHCs in Financial Management in the Community Unit

MODULE 5, UNIT 1:
THE ROLE OF CHCs IN RESOURCE MOBILISATION FOR THE COMMUNITY UNIT
(Day 5, 8:30 - 10:30 am, 2 hrs)

1. Purpose

Equip the CHCs with knowledge and skills to enable them mobilise resources for the community.

2. Objectives

By the end of the unit, participants will be able to:

1. Define a resource
2. Define resource mobilisation
3. Identify the resources in and outside the community unit
4. Identify partners in and outside the community unit
5. Describe resource mobilisation strategies for the community
6. Discuss the challenges of resource mobilisation in the community and how to overcome them
7. Describe ways of generating income and its sustainability, accountability and transparency

THE ROLE OF CHCs IN RESOURCE MOBILISATION FOR THE COMMUNITY UNIT

1. Definition of resource: A resource can be tangible or non tangible. A resource generally means a source of help and this can be physical or virtual. Resources can be time, money, finance, people or other materials in the community that can help a person or a group of people to achieve their goals.

Types of resources include: human beings, money, property owned by people in the community such as land, trees, rivers & animals. Other examples include institutions and infrastructure, e.g. halls. Time is also a resource.

2. Resource mobilisation is the process of obtaining various types of resources and bringing them together towards achieving a specified goal.

3. Definition of resource mobilisation: Resource mobilisation means bringing different types of help together for the purposes of achieving set objectives.

3.1 Steps in resource Mobilisation

1. Doing resource mapping
2. Looking at opportunities
3. Identifying priorities
4. Assigning responsibilities
5. Streamlining decisions
6. Making decisions
7. Outlining the request in writing or verbally depending on situation

3.2 Factors to consider in mobilising resources

1. What work needs to be done?
2. What are the roles and responsibility of each person/group?
3. Who will be in charge of what?
4. Where are those charged with resource mobilisation located?
5. How do we want to communicate?

3.3 Strategies in resource mobilisation

1. Donor support
2. Partnership
3. Networking
4. Income generating activities
5. Individual contribution and contribution
6. Voluntary work
7. User charges - charging for the use of toilets, halls, etc.
8. Corporate giving

3.4 Guiding principles in resource mobilisation

1. Trust

2. Transparency
3. Accountability
4. Effective communication
5. Partnership commitment
6. Coordination

3.5 Ground rules in resource mobilisation

1. Consider language of use
2. Do not interrupt while people are speaking
3. Stay informed about the subject
4. Commitment. For example: We the residents of MALIMOTO are ready to invest our time skills and other available resources as below.

DOCUMENTING COMMUNITY RESOURCE CONTRIBUTION

The following table can be created to document the resources contributed from the community:

Resources (skills/other)	No. of hours	Value if it can be costed/where applicable
Skills		

MODULE 5, UNIT 2:
PROPOSAL WRITING
(Day 5, 11am - 1:00 pm, 2 hrs)

1. Purpose

To expose CHC members to the preparation of proposals as a way of seeking resources to support the community health work in their Community Unit.

2. Objectives

By the end of this session, participants will be familiar with the process of proposal development including:

1. The definition of a proposal
2. Generating the questions that a proposal addresses
3. The elements that constitute the structure of a good proposal
4. The 10 steps that may be followed in preparing a proposal

PROPOSAL WRITING

1. Definition and general explanations about a proposal:

A proposal is a document that is prepared to present a project or a programme for consideration by others for the purpose of approval. It is usually prepared with the intention of seeking financial support for implementing a set of activities, a project or a programme. In seeking funds from development partners or agencies, note that:

1. Some funding agencies provide forms with blank spaces to be filled while others provide guidelines to be adhered to when writing comprehensive proposal for funding.
2. Some agencies may not fund certain items of a budget like recurrent expenditures, i.e. rent and salaries.
3. Factors which Influence whether a proposal is funded or not include:
   - Credibility of the applying organisation: adequate research, relation with funding agency
   - Credibility of the approach or project design and implementation framework and whether or not the community is a partner and what roles the community plays
   - Coherence of the idea: Concrete and aligned with the organizing capacity and vision of the applying organisation
   - Realistic budget, i.e. one that is not inflated and which accurately reflects the forecasted implementation cost.

2. Questions to address in a proposal

1. What does the organisation want to do?
2. Why is the project important? Why is the intervention important?
3. Who will the project benefit? (Project beneficiaries)
4. When will the project take place? Time frame.
5. How will the project be implemented? (Methodology)
6. How much will the project cost?

3. Structure of a good proposal

There is no simple model for the structure of a funding proposal. However, the following elements are normally required by most organisations and funding agencies:

1. Background information
2. Statement of the problem or need
3. Justification of the project
4. Goals and objectives
5. Planned activities

6. Methodology
7. Work plan and budget
8. Sustainability

4. Steps that are often followed in preparation of a proposal:

Step 1 - Background
The background provides an introduction and should include the following:

- A brief history of the organisation
- The current situation of the group
- Current and past activities
- The reason for this situation (health, socio economic and political)
- Sector analysis information on specific sector

Step 2 - Statement of the problem
The statement of the problem describes a condition affecting people in a specific location. Stating the problem clearly is an important step in writing a proposal because funding agencies must see the project will address a community problem.

Tips on stating the problem:
- State the problem using facts and figures.
- Use statistics that are clear and support the argument.
- Make sure the data collected is well documented.
- If possible, give anecdotes (stories) of beneficiaries as realistic examples of the problem.
- Limit the explanation of the problem to the target group in a geographic focus area.

Step 3 - Justification
After the problem is stated, the need for the project must be demonstrated. The justification should include information such as:

- The problems to be addressed
- The situation expected at the funding period
- Whether the impact anticipated justifies the budget cost
- Local community participation
- Type of beneficiaries
- Sustainability of the improvement to be made
- Examples of how to state a justification:

    1. Currently 130 million people in the world are faced with starvation. This is due to lack of rainfall, soaring prices of basic food commodities and use of maize to produce automobile fuel in America and other developed countries.

2. Almost ¾ of the affected persons are in Sub-Saharan Africa where 11 countries including Kenya are found. The countries have been faced with violent riot threatening security status.
3. Rift Valley and Western Provinces, where almost 80% of Kenya's maize reserve is produced, are affected to the extent that farmers have resorted to subsistence maize farming while bigger chunks of land are lying fallow.
4. Already some communities have resorted to eating wild fruits and rats. The rise in basic farm inputs should be checked otherwise the country will start experiencing death as a result of starvation.

Step 4 - Goals and Objectives

Goal: Is a broad statement that describes the changes that you want to happen.

- You may need more than one goal in a project.
- Each goal to focus on one change.
- The goal must be realistic and attainable.
- Each goal may take amount of time to accomplish.
- The goals should be prioritize according to the community needs.

Objectives

Are specific, measurable statements of desired change(s) that one work or organisation intend to accomplish by a given time.

Points to remember when developing objectives:

- What the programme or the project will change
- The great group
- The direction of change (increases or improves decreases or reduces)
- The degree of change to be achieved
- The time frame for reaching the desired degree of change

Characteristics of a good objective: "SMART"

- Specific - Tells exactly what the problem is that will be addressed
- Measurable - Framed in terms of how much and how many
- Attainable - Achievable within the time frame
- Realistic - Available resource versus the desired change
- Time bound - Gives specific date for its achievement

Step 5 - Identification of activities

The activities identified should strive to achieve the goals and objectives. The tasks and sub asks should be clear and detailed.

- Relate the activities to the problem and objectives
- Make sure the organisation has resources to support each activity
- Explain the reason for each activity

- Build one activity on the other (all activities should work towards the same end)

Step 6 - Methodology or implementation strategy to be indicated in the proposal

- Implementation is the process of transforming inputs into outputs.
- In developing the implementation procedure, think about the time frame: How long will the activities last? Who will be involved in each activity?
- To prevent unreasonable expectations and possible disputes, the responsibilities of each partner for the activities should be clearly defined.

Step 7 - Work plan and budget

- It is advisable to present information in the form of a work plan rather than as a narrative text. The work plan can subsequently be used to guide the various phases of the project's implementation. As the project progresses, the work plan will become a tool to help monitor the project.
- In the work plan, a column should be provided indicating the amount of money required to carry out each tasks or subtask.
- However, a separate chart that includes the description of the items needed, their unit cost, quantity and total cost should be provided separately. This is known as the budget justification as it details how the amount posted per every activity in the work plan was arrived at.
- Everything expected to be funded by the donor must be included in the budget.

Work Plan matrix

Objective	Task	Timeline or time frame	Responsible person	Amount required

Budget Matrix

Item	Quantity	Unit cost	Total cost	Indicator

Step 8 - Monitoring and evaluation framework for what is in the proposal

" It is important that the funding proposal includes a description of the systems that will be used to monitor and evaluate the project to identify the weaknesses and learn from them so as to reduce chances that they will arise again.

" Monitoring should be a continuous process that is built into the design of the project.

" Additional periodic evaluation may also be required by the funding agency.

" Be sure to mention who is responsible for the monitoring and evaluation, and how the results will be shared with the funding agency and other partners. This can be in the form of site visits or written reports.

Step 9 - Sustainability

- The proposal should also include information about how the organisation plans to phase out and ensure continuity of the activities (sustainability).
- Describe local communities or another patron who will take over the organisation's activities and responsibilities once the funding comes to an end.

Step 10 - The report presentation plan

- This addresses when reports are expected to be written and presented.
- The reports generally contain a report on both the activities and the expenditure preferable in a way that the expenditure relates to the activities carried out.

5. Reference materials

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MODULE 5, UNIT 3:
THE ROLE OF CHC IN FINANCIAL MANAGEMENT IN THE COMMUNITY UNIT (Day 5, 2 pm - 4 pm, 2 hrs)

1. Purpose

Equip the CHCs with knowledge and skills to enable them manage financial resources for the community unit

2. Objectives

By the end of the unit, participants will be able to:

1. Define financial management
2. Outline steps of basic financial management
3. Outline the principles of financial management
4. Define book keeping and its purpose and benefits
5. Describe the different types of financial records

THE ROLE OF THE CHC IN FINANCIAL MANAGEMENT IN THE COMMUNITY UNIT

1. Definition of financial management

Finance management is the art of raising and managing money in an organisation. There is need to always use available funds effectively and efficiently in order to achieve maximum health returns or benefits for the available money.

2. Basic steps to financial management

1. Step 1: Identification of financial sources
2. Step 2: Understanding funder's requirements so as to comply with terms
3. Step 3: Identification of activities
4. Step 4: Preparation of a budget on the basis of available (or expected) resources for the identified activities
5. Step 5: Regular budget tracking through efficient bookkeeping
6. Step 6: Timely sharing and dissemination of reports

3. Principles of financial management

1. Consistency in allocation of funds according to resources
2. Accountability by ensuring that the expenditure is in line with the budget
3. Transparency by keeping all involved fully in the picture through appropriate and timely reports
4. Viability
5. Integrity by ensuring honest and truthful bookkeeping
6. Stewardship by those who manage the funds seeing themselves as acting on behalf of others
7. Keeping to accounting standards through seeking the advice and technical input of professional accountants

4. Use of budget in planning and disbursement

1. When developing a budget, it is necessary to have the amount available or expected income.
2. The items/activities for expenditure are then indicated with the estimated costs against each item/activity.
3. On the one hand, this establishes the basis for the total expected expenditure.
4. On the other hand, this is also used to guide and review the disbursement of funds for each item/activity.
5. Book-keeping is used for proper management of the budget.

5. Bookkeeping

5.1 Definition of bookkeeping

1. Bookkeeping involves the systematic recording of the financial transactions and the maintenance of the correct & up-to-date financial records.
2. In business, effective management of the bookkeeping makes the managers acutely aware of the losses and the profits. In programme management, effective accounting makes those responsible for the programme aware of how much is being achieved in activities from the funds allocated.
3. Bookkeeping brings the result of the economic or programme activities to the surface.

5.2 Purpose of bookkeeping

1. In business, the essential purpose of bookkeeping is to reveal the amounts and sources of the losses and profits for any given period. In programme management, bookkeeping helps managers to have a clear idea of whether or not funds allocated are going to the assigned programme and with what results.
2. Proper bookkeeping should also reveal the nature and value of the assets/ liabilities of a firm, as well as its net worth at the close of that period.

5.3 Features of bookkeeping services

1. Cash flow management
2. Management controls

5.4. Benefits of bookkeeping

1. Provides detailed, accurate, and timely records that can prove valuable for management decision-making, and for use by auditors
2. Peace of mind

5.5 The process of bookkeeping involves three basic steps

1. Analyzing financial transactions and assigning them to specific accounts codes
2. Posting entries to ledger account
3. Adjusting entries at the end of each accounting period

6. Financial records

The financial records of a business or a programme can hold a wealth of information.

1. **Types of records:** Account books, financial documents, other record types

2. **Cash book:** The cashbook essentially is a daybook that contains only the transactions involving cash received or cash paid
3. **Bank book** keeps track of deposits and withdrawals

7. Financial documents

There are also many different types of financial records, but the main ones are:

1. **Bills:** Documents that contain a record of the buyer, seller, items purchased, prices, and bill total receipts.
2. **Invoices:** May also be referred to as accounts receivable, are issued by a person upon the delivery of a goods or services. They are closely related to shipping slips, which make note of the method of delivery, usually by rail or ship.
3. **Account statements:** Documents that list the debits and credits in an account. These follow the same format as a ledger, but might be as detailed as a daybook.
4. Other record types
   - Correspondence, legal cases and minute books also offer more insight into the operations of a business.
   - Minute books are vital to understanding the operations and administration of a business.

8. Accountability

1. The obligation of an individual or organisation to account for its activities, accept responsibility for them, and to disclose the results in a transparent manner.
2. Accountability also includes the responsibility for money or other entrusted property.

9. Transparency

9.1 Definition of transparency

1. The state in which all relevant information is fully and freely available to the public.
2. Transparency and accountability have become important themes in financial management.
3. Accountability and transparency improve business and citizen confidence.
4. Integrating transparency within financial management reforms is considered an excellent approach by practitioners.

9.2 Need for transparency

1. Lack of transparency encourages wasteful and corrupt spending of a budget?
2. A budget (from old French bougette, purse) is a list of all planned expenses and revenues.
3. It is a plan for saving and spending. A budget is an important concept in microeconomics, which

uses a budget line to illustrate the trade-offs between two or more goods. In other terms, a budget is an organisational plan stated in monetary terms.
Source: http://en.wikipedia.org/wiki/Budget

10. What are financial controls?

10.1 Definition of financial control

Financial control is exercised through the use of financial reports. The primary financial report is the budget. Through the use of proper and ethical bookkeeping, it is possible to have a clear record of an organisation's income as well as its expenditures. This provides the balance sheet which states the exact nature of the financial status of an organisation. Another statement that is of use in financial controls is the cash flow statement. The cash flow statement is the detailed indication of cash received and cash expended for each month of the year. A projected cash flow statement helps you determine if the organisation has positive cash flow. If your organisation's projections show a negative cash flow, the organisation needs to review its expenditure plan and make adjustments according.

10.2 Use of financial controls

A qualified accountant/auditor can examine the records and determine whether they are properly kept or not. Thus the accountant/auditor can pick up errors and/or anomalies/ fraudulent bookkeeping and make recommendations on what action to be taken. People often end up in jail from fraudulent accounts. Correct and transparent bookkeeping is of paramount importance for an organisation to maintain its credibility as an organisation of integrity.

11. Reference material

- Huber, D.L (2006). Leadership and Nursing Care Management. (3rd edition) Philadelphia: Saunders Elsevier.

MODULE 6:

COMMUNITY HEALTH INFORMATION SYSTEM

MODULE 6:

COMMUNITY HEALTH INFORMATION SYSTEM

UNITS:

UNIT 1: The Need for CHCs to Understand Basic Analysis & Utilization of Data
UNIT 2: The Need for CHCs to Understand the Importance of Record Keeping
UNIT 3: The Need for CHCs to Understand the Importance of Report Writing

MODULE 6, UNIT 1:
THE NEED FOR CHCs TO UNDERSTAND BASIC DATA ANALYSIS AND UTILIZATION OF DATA
(Day 6, 8:30 - 10:30am, 2 hrs)

1. Purpose

To equip CHC members with the basic skills in data analysis for overseeing evidence based implementation of Community Health activities.

2. Objectives

By the end of this unit, the participants should be able to:

1. Define data and information
2. Review the types of community data/ information to be collected at HH level
3. Demonstrate basic data analysis techniques
4. Describe the methods of information dissemination

THE NEED FOR CHCs TO UNDERSTAND BASIC ANALYSIS AND UTILIZATION OF DATA

1. Definition of data

Data is raw information or unorganized form such as alphabets, numbers, or symbols that refer to, or represent conditions, ideas, or objects OR unprocessed information collected from the source.

2. Definition of information

Information is data that has been verified to be accurate, timely, specific and organized for a purpose and presented within a context that gives it meaning and relevance for use in decision making for increased understanding and decrease in uncertainty OR data that is collated, summarized, analyzed and stored or presented for dissemination.

3. Types of data

Data can be classified as either primary or secondary.

- **Primary data:** Primary data means original data that have been collected specially for the purpose in mind. It means when an authorized organisation or an investigator or an enumerator collects the data for the first time himself or with the help of an institution or an expert then the data thus collected are called primary data.
- **Secondary Data:** Secondary data are data that have been collected for another purpose and which has been subjected to statistical methods for analysis.

After performing statistical operations on primary data the results become known as secondary data.

4. Types of data to be collected and basic tools to be used at level 1

Data collection at level 1 is to be collected using the following tools:

4.1 CHWs register

Instruction in the register:

	Describe the tools, what does it collect, when it should be completed, who should complete, when and to whom it should be submitted
Description:	The household register is a record where we write major household events or services.
	The head of the household should be able to respond and give details of information at the household level.
What type of information collected?	The basic information collected is factual based on what was done or identified in the household and to whom in the households served. Basically information is collective information for the household.
Who should fill and what to measure?	The household measures the actual CHW's outputs and outcomes of the household visitations.
	Basically information collected at household level gives an account of what happens at the household level.

REPUBLIC OF KENYA – MINISTRY OF HEALTH MOH: 513

CHIS HOUSEHOLD REGISTER

Province:			
District:			
DIVISION:			
LOCATION:		**SUB-LOCATION:**	
		NAME OF VILLAGE:	
		NAME OF CU:	
		NAME OF CHW:	
Start date:		**End date:**	

Column	WHAT IS IN THE COLUMN?	AN EXPLANATION ON HOW TO RECORD IN THE REGISTER
A	Date of Data Collection	Record date when the household member was registered (recorded as DD:MM:YY, i.e. 11/12/2009)
B	Individual Code	The number assigned by CHW that individually identifies an individual in the household
C	Name of Household Member	Record the individual names that individually identify a household member. Record at least THREE names. FOR EXAMPLE James Karani Bosire
D	Date of Birth	Record the actual date, month and year of birth
E	Sex (M/F)	This should be recorded as M for male and F for female
F	Relationship to HH (1=HHH), 2=Spouse, 3=Child(B), 4= Child (R), 5=others	This should be recorded using the key, as 1 for Household Head, 2 for Spouse, 3 for Child by Birth, 4 for Child by Registration, and 5 Other Member of Household.
G in	Clinic Card (√)	Record by marking a tick (√) when the child less than 5 years the household has child welfare card, and leave the space blank when the child has no child welfare card
H	Penta1 given. (√)	Record by marking a tick (√) when the child less than 5 years in the household was given Penta1, and leave the space blank when the child has not been given Penta 1
I	Penta 3 given (√)	Record by marking a tick (√) when the child less than 5 years in the household was given Penta 3, and leave the space blank when the child has not been given Penta 3
J	Measles given (√)	Record by marking a tick (√) when the child less than 5 years in the household was given Measles vaccination, and leave the space blank when the child has not been given the vaccination against measles.
K	Fully immunized (√)	Record by marking a tick (√) when the child less than 5 years in the household was given ALL vaccinations required and completed, and leave the space blank when the child has not been given ALL vaccination against the required immunisations.
L	Vitamin A given (√)	Record by marking a tick (√) when the child less than 5 years in the household was given Vitamin A in the Last 6 months, and leave the space blank when the child in the last 6 months was not given Vitamin A supplementation.

M	Severely malnourished (√)	Record by marking a tick (√) when the household child mid upper circumference is red (< 11.5cm) and leave blank when the child in the household has mid upper circumference that is not red.
N	Moderately malnourished	Record by marking a tick (√) when the household child mid upper circumference is yellow (< 12.5cm) and leave blank when the child in the household has mid upper circumference that is not yellow or red.
O	Exclusively breastfeeding (√)	Record by marking a tick (√) when the child in the household is less than 6 months and is exclusively breastfed, and leave it blank when the child less than 6 months in the household was not exclusively breastfed.
P	ANC (4 + times) (√)	Record by marking a tick (√) when the pregnant woman in the household has completed at least 4 Ante Natal Clinic (ANC) (4 + times) and leave the space blank when the pregnant woman has not completed the 4+ times of the Ante Natal Clinic visits
Q	Skilled attendant (√) ITN use (√)	Record by marking a tick (√) when the pregnant woman in the household was assisted by qualified nurse, midwife or doctor and leave the space blank when the delivered woman was not assisted by any qualified nurse, midwife, doctor or clinical officer+C4
R	Latrine use (√)	Record by marking a tick (√) when the household has a latrine in use and leave blank when the household does not have a latrine that is in use.
S	Water treatment (√)	Record by marking a tick (√) when the household uses water that is treated and leave blank when the household does not treat water for household use.
T	Hand washing facilities (√)	Record by marking a tick (√) when the household has a hand washing facility in use and leave blank when the household does not have a hand washing facility in use.
U	ITN use	Record by marking a tick (√) when the household member use Insecticide Treated Net (ITN), and leave it blank when the household member does not use ITN.
V	Chronic illness or cough (√) (2 Weeks and above)	Record by marking a tick (√) when the household member has a chronic illness or cough for more than 2 weeks and leave it blank when the household member does not have a chronic illness or cough for 2 or more weeks.

W	Knows HIV Status (√)	Record by marking a tick (√) when the household member knows his/her HIV status, and leave it blank when the household member does not know his/her HIV status.
X	Accessing Home Based Care programmes (√)	Record by marking a tick (√) when the household member has access to Home Based Care programmes and leave it blank when the household member does not have access to Home Based Care programmes.
Y	Accessing OVC programmes (√)	Record by marking a tick (√) when the household member has access to Orphans and Vulnerable children programmes and leave it blank when the household member who is an Orphan does not have access to Orphans and Vulnerable children programmes.
Z	Disabled (√)	Record by marking a tick (√) when the household member has any type of disability and leave it blank when the household member does not have a disability.
AA	Staple food available (√)	Record by marking a tick (√) when the household has staple food and leave it blank when the household d0es not have staple food.
AB	Level of Education (√)	Record by marking a tick (√) the specific number using the codes; for the highest level of education attained: 1.None [ ] 2.Primary [ ] 3.Secondary [ ] 4.Universities and Colleges [ ] 5.School drop outs [ ]
AC	Has basic IEC materials with the 21 key messages (√)	Record by marking a tick (√) when the household has basic Information, Education and Communication (IEC) materials with the 21 key messages and leave it blank when the household member does not have basic IEC materials with the 21 key messages
AD	Deaths (√)	Record by marking a tick (√) when the household member is dead and leave it blank when the household member is alive. This should be marked if that member of the household died within the past six months.
AE	Has birth certificate (√)	Record by marking a tick (√) when the child in the household has birth certificate and leave it blank when the child has no birth certificate.
AF	Others (specify)	It would be useful to collect information on any health problem requiring visit to health facility or practitioner and hospitalization or any unique features that require intervention in the blank column AF-AI.
AJ	Remarks	Any comments for the individual household member.

A1	Date of Death	Record date when the household member died (recorded as DD:MM:YY, i.e. 11/12/2009)

Inside the register: Refer to each column in the hard copy and discuss various types of data to be collected by a CHW at the household level

5. Basic data collection and analysis techniques

What are the methods of data collection at community level?

1. Observation: Look, listen and learn
2. Interviews: Questionnaires, discussions and checklist
3. Desk reviews: Reports, publications and documentaries

6. Data Analysis Techniques

1. Summary (tabulation)
2. Statistically

7. Presentation of Information

1. Tables
2. Graphs (bar graphs)
3. Charts (pie charts)

8. Dissemination of Information

Information can be disseminated through the following channels

1. Public forums: dialogue health days, barazas, stakeholders forums
2. Meetings: Technical Working Group Meetings
3. Conferences as paper or poster presentations
4. Correspondence through reports and publications

9. Reference materials

- Integrated Curriculum for training community Health workers in Kenya (Jan. 2011)
- A Guide for training Community Health Committees (CHC) - AMREF
- Community Strategy Implementation Guidelines for Managers of KEPH at Community Level: Linking communities with the health system: KEPH at level one, a manual for training CHEWs (March 2007)

- Handout 2.2: Community Collaborations: A Growing Promise in Child Welfare. Best Practice/Next Practice: Family-Centered Child Welfare. Volume 1, Number 2, Fall, 2000. Washington, DC: National

MODULE 6, UNIT 2:
THE NEED FOR CHCs TO UNDERSTAND
THE IMPORTANCE OF RECORD KEEPING
(Day 6, 11 am - 12 pm, 1 hrs)

1. Purpose

To equip the Community Health Committees with knowledge and skills on record keeping to enable them to understand data/information storage and retrieval for informed decision making in planning, management for action and reference.

2. Objectives

By the end of this unit the participants should be able to:

1. Define record keeping
2. Outline the purpose, importance and benefits of record keeping
3. Describe the characteristics of good record keeping/storage
4. Describe the different types of records needed for level 1
5. Describe the information gathering process and the type of information to record.

THE NEED FOR CHCs TO UNDERSTAND THE IMPORTANCE OF RECORD KEEPING

1. Introduction

One of the most important tasks of the CHC's is to keep good records on the services provided at the Community Unit (CU). The records are used to show others what happens at the CHU, ongoing improvements that bring change, and make reports each month.

2. Definition

Record keeping is the process of collecting information about people's activities and storing it for planning and future reference.

3. Purpose of record keeping

Many people use records to keep track of things in their lives as basis for informed decision making. Some examples are:

- A child's birth record
- A child's immunization schedule
- A doctor's file on each patient
- A record of how much money someone earns or spends in a month
- A bank record book
- A loan schedule for a microcredit programme
- A farmer's list of how many cows they have or how many seeds they have planted

4. Importance of records

It is difficult to keep all the information about a variety of clients in one's head. Important information should not be lost, therefore it should be recorded. Once recorded, information will help us communicate our activities to our supervisors and the village health committee for decision making. This will support the identification of priority problems to be tackled and planning for the next meeting with the committees.

Written records also provide evidence needed for monitoring and evaluating community health activities.

In summary, record keeping assists in:

- Tracking change
- Identifying gaps
- Planning for the future
- Providing evidence of performance
- Providing reference for research, planning
- Demonstrating accountability and transparency
- Avoiding bad and dead stock
- Making decisions
- Knowing the fast moving drugs and other commodities
- Detecting morbidities

5. Characteristics of good record keeping

- Consistency
- Accuracy
- Timeliness

- Reliability
- Cost-effectiveness
- Relevance
- Complete
- Systematic
- To the point
- Orderly
- Kept well/secure

6. Types of records needed for level 1

- CHIS forms: Information collected quarterly so that 50 HHs are visited at least once using a designed tool (20 variables). HHs under a community- based child centre (CBCC) programme to be covered monthly.
- Household (HH) Register: Information collected annually from households (head, mother or guardian) using household register book; information coded according to a predesigned framework (district name, name of CHW, village name(s), sub- location code/ household code/ individual 8- digit code)
- Chalkboard
- CHW log book
- CHEW summary
- Growth monitoring promotion in the context of the combined record of the Mother and Child Booklet (MCHB) (MOH 216)
- Child feeding: document kept at household level to record number of times/ types of food a child is fed
- CHW referral book, workload record in relation to staff complement

7. What information to record

In the community where we work and learn from it is important to have information on:

- Population - households
- Map - area of coverage
- Health problems/needs
- Activities planned to address problems
- Births and deaths
- Community health activities, e.g., hygiene messages disseminated
- Common diseases
- Use of chlorine and water storage facility with spigot
- Number and nature of meetings convened
- Latrine coverage and water supply situation

8. Information gathering process

The members of the community will provide most of the information we need. Gathering that information requires:

- Listening: Listen to what people say about their health and ask all you need to know about their health
  1. Their health problems and needs
  2. Their health seeking behaviours
- Observation: Observe things that are important for the health of the community; for example, latrine and wells, are they safe? Are they utilised well? Do they need improvement?
- Surveillance: Check and count things or events, e.g., how many latrines are there? How many cases of diarrhoea per week? Take note of action taken to manage diarrhoea and the outcome. What is the situation at the moment about the problem? For example, about diarrhoea.

9. How to keep records

Records can be kept using various ways and methods (CHIS tools). Among these are registers, notebooks and diaries, and computers. A register is a book in which specific information that has been gathered is recorded, for example, CHW household register, CHW Log book, a water and hygiene promotion register, CHEWs summary register etc.

CHW log books are registers in which the CHWs write their daily schedules for the month and what they have accomplished. These activities include:

- Health education and advice given
- Home visits - action taken to improve sanitation and cleanliness in the homes
- Meetings with the village committee

Computers provide a means of storing information so that it is easily retrievable and analyzed. With advent of digital technology, computers are becoming increasingly available to communities through IT village centres. It is important to record information as soon as possible after obtaining/ collecting it so that the details are not forgotten. It is also critical to write clearly so that the records can be read.

10. Reference materials

- Integrated Curriculum for training community Health workers in Kenya (Jan. 2011)
- A Guide for training Community Health Committees (CHC) - AMREF
- Community Strategy Implementation Guidelines for managers of KEPH at Community level: Linking communities with the health system: KEPH at level one, a manual for training CHEWs (March 2007)

- Handout 2.2: Community Collaborations: A Growing Promise in Child Welfare. Best Practice/Next Practice: Family-Centered Child Welfare. Volume 1, Number 2, Fall, 2000. Washington, DC: National

MODULE 6, UNIT 3:
THE NEED FOR CHCs TO UNDERSTAND
THE IMPORTANCE OF REPORT WRITING
(Day 6, 12 pm - 1 pm, 1 hr)

1. Purpose

To equip the CHCs with knowledge and skills on report writing at the community level.

2. Objectives

By the end of this unit, the participants should be able to:

1. Define report writing
2. Discuss why reports are written and who writes reports
3. Identify sources of data and information for report writing
4. Demonstrate how to write a report
5. Explain the benefits of report writing
6. Outline types of reports
7. Describe how to disseminate a report
8. Explain the process of conducting meetings
9. Explain how to take minutes in a meeting

THE NEED FOR CHCs TO UNDERSTAND THE IMPORTANCE OF REPORT WRITING

1. Definition of a Report

Reports are written or verbal records or accounts of events that have occurred within a given time frame. From the reports we are able to know:

- What we have achieved.
- What our strengths are
- Which areas need improvement

2. Type of reports

Report types include status reports, progress reports and minutes of meetings.

2.1 A status report is also referred to as a baseline report. It indicates the current state of activities in the community. For health activities, this may include details on:

- Number of households/homesteads
- Available water sources
- Latrine coverage
- Number of dish racks constructed
- Incidence of common diseases
- Health seeking behaviour
- Births and deaths

2.2 Progress reports provide an indication of events / occurrences within a given period. These reports may be prepared at specific intervals, e.g., weekly, monthly, quarterly or annually, or on demand.

2.3 Minutes of meetings

1. Definition of minutes: This is a systematic and accurate record of the proceedings of a meeting
2. Structure of minutes:
1. Heading (the type of meeting, venue, time and date)
2. List of participants (those present, absent and absent with apologies)
3. Agenda (number the items in the agenda): welcome note, confirmation of previous minutes, matters arising from previous minutes, agenda items for the day
4. Number the proceeding systematically, e.g. Min/1/2011
5. As the last minute, Min/…/ AOB
6. Adjournment (secretary, chairman to sign the minute)

3. Structure of a report

A well-prepared report has a definite logical structure. Examples of this are

- Introduction: Overview of health activities in the community.
- Body: Planned activities against achievements to date and reasons for deviations if any. The activities that may be captured may be drawn from the community chalkboard

4. Conclusions and recommendations

- What the report writer regards as most significant aspects of the information whether positive or negative
- Any recommendations for action to address problems

5. Sources of information for report writing

- Level 1 data tools (MOH 515; 516)
- Minutes
- Reports from other stakeholders

6. Reference materials

- Integrated Curriculum for training community Health workers in Kenya (Jan. 2011)
- A Guide for Training Community Health Committees (CHC) - AMREF
- Community Strategy Implementation Guidelines for Managers of KEPH at Community Level: Linking communities with the health system: KEPH at level one, a manual for training CHEWs (March 2007)

MODULE 7:

MONITORING & EVALUATION & WAY FORWARD

MODULE 7:

MONITORING & EVALUATION AND THE WAY FORWARD

UNITS:

UNIT 1: The Role of CHCs in Coordinating Monitoring & Evaluation in the Community Unit

UNIT 2: Exposure of CHCs to the Preparation of a Plan of Action for 6 Months Following Training & the Way Forward

UNIT 3: The Final Session Conducted by the Chair of the Community Health Committee

MODULE 7, UNIT 1:
THE ROLE OF CHCs IN COORDINATING MONITORING & EVALUATION IN THE COMMUNITY UNIT
(Day 7, 8:30 - 11 am, 2 ½ hrs)

1. Purpose

To equip CHCs with the basic knowledge and skills in monitoring and evaluation in order for the CHC to coordinate these events in the Community Unit and make informed decisions on the trends of health indicators in the community.

2. Objectives

At the end of this unit, the participants should be able to:

1. Define monitoring and evaluation
2. Outline the process of monitoring and evaluation
3. Outline the key indicators in health
4. Describe the importance of basic monitoring and evaluation
5. Describe types of evaluation.

THE ROLE OF CHCs IN COORDINATING MONITORING & EVALUATION IN THE COMMUNITY UNIT

1. Define monitoring and evaluation

Monitoring: The continuous tracking of the key elements of programme/project performance, usually

inputs and outputs, through record keeping, regular reporting and surveillance systems, as well as health facility observation and client surveys.

Evaluation: The periodic assessment of the change in targeted results that can be attributed to the programme or project/project intervention. Evaluation attempts to link a particular output or outcome directly to an intervention after a period of time has elapsed.

2. Key indicators in health monitoring and evaluation

What is an indicator?

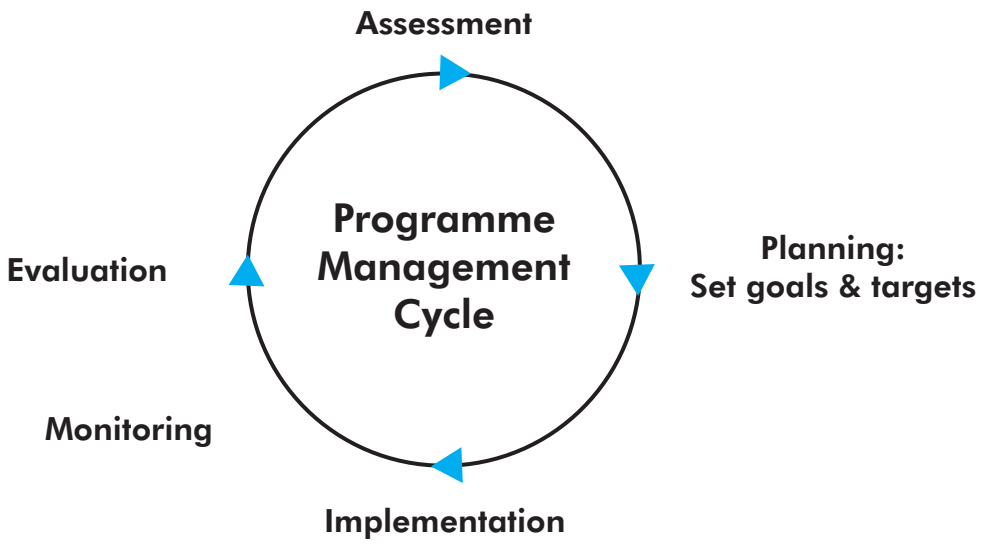
Indicators are a measure that can be used to help describe a situation that exists and to measure changes or trends over a period of time. Health indicators are necessary in order to:

1. Analyse the present situation
2. Make comparisons
3. Measure changes over time

Characteristics of good indicators:
Indicators should be: SMART

S - **Specific:** Concerned particularly with the subject specified.
M - **Measurable:** Changes in the indicator immediately reflect changes in the actual situation under study.
A - **Accurate:** Truly measures what is of interest/intended to change.
R - **Reliable:** Provides the same results even if used by different people.
T - **Timely:** Done or occurring at a favourable or useful time; opportune.

Project/Programme Management Cycle



Examples of Process and Output Indicators currently used in the Community Health Services as sourced from Chalk board.

1. Number of community health action days held in a specified period of time.
2. Number of dialogue days held in a specified period of time.
3. Number of meeting held with CHWs in a specified period of time.
4. Number of proposals written in a specified period of time.
5. Number of reports written in a specified period of time.
6. Number of planning meetings held in a specified period of time.
7. Number of stakeholder's forums held in a specified period of time.
8. Number of consultative meetings held with HFC in a specified period of time.
9. Number of conflicts resolved in a specified period of time.
10. Number of CHWs in their CU in a specified period of time.
11. Number of stakeholders in their CU in a specified period of time.
12. Number of CHWs appraised in a specified period of time.
13. Number of villages in their CU in a specified period of time.
14. Number of households in their CU in a specified period of time.
15. Total population in their CU in a specified period of time.
16. Number of household not treating water in their CU in a specified period of time.
17. Number of individuals not using ITNs in their CU in a specified period of time.
18. Number of households without hand washing facilities, e.g. leaky tins, in use in their CU in a specified period of time.
19. Number of households without functional latrines in their CU in a specified period of time.
20. Total women 15-49 years in their CU in a specified period of time.
21. Total children 0-6 months in a specified period of time.
22. Total children under one year old in a specified period of time.
23. Total children under five years old in a specified period of time.
24. Total adolescent and youth-girls (13-24 yr) in a specified period of time.
25. Total adolescent and youth-boys (13-24 yr) in a specified period of time.
26. Total population of the elderly (60+ years) in a specified period of time.
27. Number of pregnant women in a specified period of time.
28. Number of pregnant mothers not attending at least 4 antenatal clinic (ANC) visits, within a specified period of time.
29. Number of deliveries by unskilled attendants in a specified period of time.
30. No. of women (15-49years) receiving FP services in a specified period of time.
31. Number of children not fully immunized in a specified period of time.
32. Number of immunization defaulters traced in a specified period of time.
33. No. of children 6 months to less than 5 years not receiving vitamin supplements in a specified period of time.
34. No. of children <6 months not exclusively breastfed in a specified period of time.
35. No. of children severely malnourished (in RED) in a specified period of time.
36. No. of children moderately malnourished (in YELLOW) in a specified period of time.

37. Number of children not de-wormed in a specified period of time.
38. Number of fever cases managed in a specified period of time.
39. Number of injuries and wounds managed in a specified period of time.
40. Total no. of coughs more than 2 weeks referred in a specified period of time.
41. Number of elderly receiving routine checkups in a specified period of time.
42. Number of births in a specified period of time.
43. Number of Households without staple food in a specified period of time.
44. Number of school drop outs in a specified period of time.
45. Number of CHWs in a specified period of time.
46. Number of stakeholders in a specified period of time.
47. Number of CHWs appraised in a specified period of time.

The Key Indicators Survey (KIS) is designed to help meet the monitoring and evaluation needs of programmes involved in population and health activities in developing countries, especially to produce data for small areas - regions, districts, catchment areas - that may be targeted by an individual project, although they can be used in nationally representative surveys as well. The KIS tool includes questionnaires, interviewer's manuals, guidelines for sampling and a tabulation plan.

EXAMPLES OF INDICATORS
INDICATORS ON FAMILY PLANNING

1 Total fertility rate
2 Contraceptive prevalence rate
3 Birth spacing (36 months or more)
4 Births to young mothers (under age 18)
5 High parity births (birth order 5 or more)

INDICATORS ON MATERNAL HEALTH

6 Skilled delivery assistance
7 Antenatal care from skilled health personnel
8 Institutional deliveries

INDICATORS ON CHILD HEALTH

9 Childhood immunization coverage
10 Oral rehydration use for children with diarrhoea
11 Safe disposal of children's stools
12 Vitamin A supplementation among children under 5
13 Underweight prevalence
14 Exclusive breastfeeding of children under 6 months
15 Drinking water treatment

INDICATORS ON HIV/AIDS

16 Higher risk sex among women/men 15-49
17 Condom use at higher risk sex among women/men15-49
18 Youth sexual experience among women/men 15-19

INDICATORS ON INFECTIOUS DISEASES

19 Household ownership of insecticide-treated nets
20 Use of insecticide-treated nets by children under 5

3. Describe the importance of basic monitoring and evaluation

Monitoring and evaluation provides information that will be useful in:

1. Analyzing the situation in the community and its project
2. Determining whether the inputs in the project are well utilized
3. Identifying problems facing the community or project and finding solutions
4. Ensuring all activities are carried out properly by the right people and in time
5. Using lessons from one project experience on to another
6. Determining whether the way the project was planned is the most appropriate way of solving the problem at hand.

M&E is an opportunity to influence the design and execution of community development projects. Furthermore, by providing feedback on whether programmes are achieving aims in line with community needs and desires, M&E is a powerful accountability mechanism.

4. Types of evaluation

4.1 Baseline evaluation

This is also referred to as 'Situation Analysis' carried out BEFORE an intervention in order to establish the situation against which to measure progress or lack of it.

4.2 Process evaluation

Process evaluation involves judging the activities (or strategies) of your project while it is in operation. This often involves looking at what has been done, who has been reached, and the quality of the activities. It involves seeking answers to questions such as:

- Is the project reaching the appropriate people?
- Are all the projects activities going to plan? If not, why not?

- Were any changes made to the intended activities? If so, why?
- Are materials, information, presentations of good quality?
- Are the participants and other key people satisfied?

4.3 Midterm evaluation

This is an evaluation carried out midway in the life of a project/programme. For example it is carried out two and a half years into a five-year programme. It is a specialized type of process evaluation. It points to how well a project/programme is doing or how poorly. It is planned to give an indication of the operative factors affecting progress. From this evaluation, major changes may be introduced into the project/programme in order to increase the chances of getting the desired outcomes.

4.4 Outcome evaluation/ end term/ summative evaluation

An outcome evaluation/ end term/summative evaluation is carried out at the end of a project/programme. Its measures are mostly output measures which indicate the direction the programme/project took; whether towards the desired goal or not. It involves judging the extent to which the project has had an effect on the changes you were seeking; the extent to which the project has met its goal and objectives. The question being asked is what progress has been made toward achieving the goal.

However, this type of evaluation comes short of aiming at the ultimate desired result. For example, it may indicate increased or reduced occurrences of events, e.g. increase in contraceptive prevalence or reduced childhood illnesses may not indicate reduced fertility rate or reduced child mortality rate which take a much longer time to come about. Some of the questions asked in this kind of evaluation are:-

- To what extent has the project met its objectives?
- How effective has the project been at producing changes?
- Are there any factors outside of the project that have contributed to (or prevented) the desired change?
- Has the project resulted in any unintended change?
- What were the main benefits and disappointments?
- What things helped and hindered the project?
- In retrospect, what could have strengthened it?
- What would you advise others embarking on something similar?
- What aspects will be sustained and how?
- Is it worth continuing in its current form? Why/why not?
- What recommendations have emerged about where to go from here?

4.5 Impact evaluation

Impact evaluation measures the long-term effect of a programme or project which may be long seen

EXPOSURE OF CHC MEMBERS TO PREPARATION OF A PLAN OF ACTION FOR 6 MONTHS FOLLOWING TRAINING & THE WAY FORWARD

1. An action plan

1.1 Definition

A sequence of steps that must be taken, or activities that must be performed well, for a strategy to succeed. In the case of the Community Health Committee, the strategy is establishment of effective health services in the Community Unit (CU).

1.2 Elements of an action plan

An action plan has three major elements:-

1. Specific tasks: what will be done and by whom.
2. Time horizon: when will it be done?
3. Resource allocation: what funds are available for specific activities

An action plan must be S.M.A.R.T: Specific, Measurable, Accurate, Reliable and Time bound.

2. The action planning process

1. Problem identification by using the CU - chalkboard
2. Problem ranking/prioritizing - by use of ranking matrix
3. Problem analysis - root causes and opportunities
4. Opportunity ranking
5. Action planning matrix
6. Implementation plan

3. Problem identification

1. Brainstorm problems - in plenary/chalkboard
2. List all answers on a flipchart
3. Agree on most serious/common problems, e.g. malaria, typhoid, HIV, TB, STI

after the programme/project came to an end. It indicates long-term commitment to the interventions introduced during the life of the programme/project. For example, it shows how persistent contraception has continued beyond the life of the programme/project to bring about reduced fertility rate in the population. Similarly, it measures the persistence of a programme such as Integrated Management of Childhood Illnesses (IMCI) that results in reduced child mortality rate.

5. Reference materials

- MOH (2007) Linking Communities with the Health System: The Kenya Essential Package for Health at Level 1: A Manual for Training Community Health Workers
- Ministry of Health (2007), Reversing the Trends
- Community Health Strategy
- MOH (2005) National Health Sector Strategic Plan II 2005-2010 (extended to 2012)
- MOH (2010) Community health information system tools (MOH 513, 514,515, 516)

MODULE 7, UNIT 2:
EXPOSURE OF CHCs TO THE PREPARATION OF A PLAN OF ACTION FOR 6 MONTHS FOLLOWING TRAINING & THE WAY FORWARD
(Day 7, 11 am - 1 pm, 2 hrs)

1. Purpose

To equip Community Health Committee (CHC) members with knowledge and skills in action planning in order to develop an action plan for six months that follow the training.

2. Objectives

At the end of this unit the participants will be able to:

1. Formulate a vision and mission for their community unit
2. Define an action plan
3. Describe the process of developing an action plan
4. Develop an action plan for their community unit for six months following the training
5. Describe how to monitor and evaluate the implementation of the action plan.

4. Problem ranking - using the Pairwise Ranking Matrix

4.1 The process

This process is used to prioritize indentified problems/needs in a participatory manner. This is done as follows:-

1. Problems are listed on both vertical and horizontal axis in same order
2. Each problem on vertical axis is discussed and compared against others on the horizontal axis (consensus building)
3. Comparison is done on basis of importance, intensity, seriousness
4. Tallying is done to get problem with highest score
5. Ranking done in order of problem with highest tally

4.2 Practicing the process

An example of PAIRWISE RANKING MATRIX

	Malaria	Typhoid	HIV	TB	STI	Totals	Rank
Malaria	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXX	M	M	M	M	4	1
Typhoid	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXX	HIV	TB	STI	0	5
HIV	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXX	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXX	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XX	HIV	HIV	3	2

TB	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXX	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXX	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XX	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXX	TB	2	3
STI	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXX	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXX	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XX	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX	XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XXXXXXX XX	1	4

Totals = The number of times a problem appears
Rank = The problem with the highest number is given first position and the rest follow.

4.3 Deciding on the most serious problem from the ranking matrix

Most serious disease in order of rank
1. Malaria
2. HIV
3. TB
4. STI
5. Typhoid

5. Problem analysis

5.1 The process

1. For each problem, brainstorm root cause(s) of the problems identified and ranked
2. For each problem, discuss coping measures, current practices
3. For each problem, explore and list existing opportunities, and other possible solutions and activities

5.2 An example of Problem Analysis Matrix using malaria

Problem	Causes	Coping Measures	Existing Opportunities
Malaria	Lack of information	Awareness by PHO	1. Health education 2. Prevention by use of ITNS
	Poor drainage	1. Draining stagnant water 2. Filling up holes	1. Disinfecting 2. Involving all stakeholders

6. Opportunity ranking

6.1 The process

From the problem analysis matrix, the group reviews the possible actions that can be taken. Then analyse and rank opportunities in terms of:

1. Acceptability
2. Cost Effectiveness
3. Social Impact
4. Time Factor
5. Environmental impact

Scores can be awarded as follows:
Highest - 3
Medium - 2
Lowest - 1

6.2 An example of Opportunity Ranking Matrix for Malaria

Existing opportunity	Acceptability	Cost effectiveness	Social impact	Environmental impact	Time factor	Total	Rank
Health education	H (3)	M (2)	H (3)	H (3)	H (3)	14	2
Use of ITNS	H	H	H	H	H	15	1
Disinfecting	H	M	H	L	H	12	3
Involving all stake holders	M	M	L	M	H	4	4

7. The action plan

From the analysis, make decisions on

1. What activities are to be undertaken? (existing opportunities)
2. Who is going to do it? (responsibility)
3. How are we going to do these activities? (methodology)
4. When are activities going to be done? (time factor)
5. What shall we need (resources) to do this activity?
6. What are the verifying indicators by which we shall know if we are succeeding? (M&E)

7.1 Action Planning Matrix

Activity	By who	How	By when	Resources	Indicators

An action plan by the Community Health Committee can include action to tackle several problems, such as:

- Reduction of malaria as shown by the example
- Child immunisation
- Use of antenatal clinic by pregnant mothers
- Adoption of family planning methods for child spacing to promote the health of the mother and child
- Promotion of latrine construction for every household
- Provision of safe clean water for household use

8. Way forward/next steps

1. Develop a Detailed Implementation Plan (DIP)
2. Share work plan with stakeholders
3. Resource mobilisation - identify sources of support and proposal development
4. Brainstorm on indicators and timelines
5. Identify likely obstacles/challenges and possible solutions
6. Assign tasks to members of the CHC
7. Plan weekly meetings to review progress
8. Start work on social mobilisation to get everyone involved

9. Reference materials

- http://www.bonner.org/resources/modules/modules_pdf/BonCurActionPlanning.pdf

MODULE 7, UNIT 3:
THE FINAL SESSION CONDUCTED BY
THE CHAIR OF THE COMMUNITY HEALTH COMMITTEE
(Day 7, 2 pm - 4 pm, 2 hrs)

1. Purpose

The purpose of this session is to authenticate the leadership role of the chair of the CHC team and to start the process of team-building within each CHC. This is particularly important when the group in training is made up of more than one CHC.

2. Objectives

By the end of the session, CHC members will be able to:

1. Describe themselves as a team
2. State how they will approach their work
3. Accept the leadership role of the chair of the CHC

In a situation where two or more CHCs have been trained together for this session they should be in separate rooms/spaces so that each CHC chair is with his/her CHC members.

CLOSING CEREMONY
(4:30 - 5:30pm)

1. A joyful skit by the workshop participants
2. Comments of the chairs of the CHC committees represented
3. AWARDING OF CERTIFICATES as developed by the Division of Community Health Services at HQ of the Ministry.
4. Speeches by officials, congratulating CHC members for completing the training
5. A joyful tea party with lively music crowns the end of CHC training!

Annex 1

Training Community Health Committees in Kenya Development of the Handbook

Participant List

	Name	Organization
1	Ruth Mutua	DCHS
2	Judy Khanyola	MSH/LMS
3	Prof. Miriam Were	Consultant
4	Josephine Mbiyu	MSH/LMS
5	Christopher Lengusuranga	PDPHS Coast
6	Joseph Kimwele	PDPHS western
7	Hillary Chebon	DCHS Afya House
8	Agripina Muthoni Mbuba	APHIA Plus zone 4
9	Adirahaman Farah	PDPH
10	Paul Adipo Odongo	MOPHS
11	Geoffrey Kiugu	PDPH & SAN Central
12	Gladys Kariuki	DMOH/MOPHS
13	Rakeli Kiiru	PMO Nyanza
14	Charity Kule	MOPHS
15	J.G Mugenyo	PDPHS & SANITATION
16	Barbara Tobin	MSH/LMS
17	Caroline Ndegwa	PDPHS
18	Joseph Kweso	MOPHS
19	Charity Tauta	DCHS/MOPHS-Afya House
20	Joshua Chweya	MOPHS
21	Leonida Ogake Asanya	MOPHS
22	James Oguk	MOPHS
23	Ibrahim Shiwalo	MOPHS
24	Darius Mbela	MOPHS
25	Clementine Gwoswar	MOPHS
26	Salome Kangangi	MOPHS

27	Simon Ndemo	MoPHS-Afya House
28	Rukiya Maalim Kahiya	PDHS/MOPHS
29	Ramson Gitari Ndii	MOPHS
30	George Oele	MOPHS-Afya House
31	Gideon Nyaringita	MOPHS
32	Jackline Aridi	MDGS Centre
33	Ruth Ngechu	MOPHS
34	Stanley Mbuva	MOPHS
35	Baya Karisa	MOPHS
36	Leah Rutto	MOPHS
37	Assumpta Atamba Matekwa	PDPHS-Western
38	Caroline Sang	MoPHS-Afya House
39	Nyawa Benzadze	PDPHS Coast
40	John Beku	MSH/LMS
41	Daniel Kavoo	MoPHS-Afya House
42	Wilfred Marete	CLUSA/APHIA Plus Coast
43	Omar A.Omar	MSH/LMS
44	Catherine Munywoki	MOPHS
45	Abdullah Munga Ngonyo	Madamani Dispensary
46	Ramdhan Rashid	Madamani Dispensary
47	Deborah Mapenzi	Madamani Dispensary
48	David Mulewa	DHMT/MOPHS
49	Vincent Iduri	MOPHS
50	Eric Maitha	DHMT/MOPHS
51	Dr.Anisa Omar	PHMT/MOPHS
52	Community Health Committee Members	Madamani Community Unit, Kilifi
53	Community Health Committee Members	Maekani Community Unit, Kilifi
54	Community Health Committee Members	Mogori-Komasimo Community Unit, Kuria
55	Community Health Committee Members	Nyamagagana Community Unit, Kuria
56	Community Health Committee Members	Komomange Community Unit, Kuria

Notes

Notes

Notes

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