



AFRICAN PROGRAMME FOR  
ONCHOCERCIASIS CONTROL

# CURRICULUM AND TRAINING MODULE ON THE COMMUNITY-DIRECTED INTERVENTION (CDI) STRATEGY FOR FACULTIES OF MEDICINE AND HEALTH SCIENCES



## TRAINERS' HANDBOOK





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**African Programme for Onchocerciasis Control,  
World Health Organization (APOC/WHO)**



**AFRICAN PROGRAMME FOR  
ONCHOCERCIASIS CONTROL**

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Finally, acknowledgments are extended to all partners for their continual support with the publishing of this training document.

## LIST OF ACRONYMS

<b>ACTs</b>	Artemisinin-Based Combination Therapy
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>APOC</b>	African Programme for Onchocerciasis Control
<b>BCC</b>	Behavioural Change Communication
<b>CBIS</b>	Community-Based Information System
<b>CBM</b>	Christofel-Blinden-Mission
<b>CBOs</b>	Community Based Organizations
<b>CDDs</b>	Community-Directed Distributors
<b>CDI</b>	Community-Directed Interventions
<b>CDTI</b>	Community-Directed Treatment with Ivermectin
<b>CSM</b>	Community Self-Monitoring
<b>CSS</b>	Community Systems Strengthening
<b>DOTS</b>	Directly Observed Treatment Strategy
<b>FLHF</b>	Frontline Health Facility
<b>HIS</b>	Health Information Systems
<b>HIV</b>	Human Immunodeficiency Virus
<b>HMM</b>	Home-Management of Malaria
<b>HSS</b>	Health System Strengthening
<b>IMA</b>	Inter-Church Medical Assistance
<b>IEC</b>	Information, Education and Communication
<b>IEF</b>	International Eye Foundation
<b>ITNs</b>	Insecticide Treated Bed Nets
<b>IPT</b>	Intermittent Preventive Treatment
<b>LGA</b>	Local Government Area
<b>LLINs</b>	Long Lasting Insecticide Treated Bed Nets
<b>LF</b>	Lymphatic Filariasis
<b>MCH</b>	Maternal and Child Health
<b>MDGs</b>	Millennium Development Goals
<b>MDP</b>	Mectizan Donation Program
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MoH</b>	Ministry of Health
<b>NGDO</b>	Non-Governmental Developmental Organization
<b>NGOs</b>	Non-Government Organizations
<b>NOC</b>	National Onchocerciasis Committees
<b>NOTFs</b>	National Onchocerciasis Task Force
<b>NTDs</b>	Neglected Tropical Diseases
<b>OCPC</b>	Onchocerciasis Control Programme in West Africa
<b>OPEC</b>	Organisation pour la Prévention de la Cécité
<b>ORS</b>	Oral Rehydration Salt
<b>PDTI</b>	Programme Directed Treatment with Ivermectin

<b>PHC</b>	Primary Health Care
<b>PSM</b>	Procurement and Supply Management
<b>RBF</b>	River Blindness Foundation
<b>RBM</b>	Roll Back Malaria
<b>RDTs</b>	Rapid Diagnostic Test
<b>SAEs</b>	Severe Adverse Experiences
<b>SCI</b>	Schistosomiasis Control Initiative
<b>SI</b>	Sightsavers International
<b>TB</b>	Tuberculosis
<b>TBAs</b>	Traditional Birth Attendants
<b>TDR</b>	WHO Special Programme for Research and Training in Tropical Diseases
<b>UNDP</b>	United Nations Development Programme
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>VHW</b>	Village Health Worker
<b>WFME</b>	World Federation for Medical Education
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization

# Preface



The communities, in partnership with health professionals, can manage the prevention and treatment of selected diseases that are prevalent in their environment. This has been confirmed by a multi-country study on Community Directed Treatment with Ivermectin (CDTI) to control Onchocerciasis (river blindness). This strategy can be effectively and efficiently applied as a means of bringing multiple health interventions to the poorest communities, especially in remote areas. Such an approach is known under the generic name of Community Directed Intervention (CDI).

CDI empowers communities to get involved in decision-making for their own health. Therefore it has the potential to strengthen Primary Health Care, in particular where resources and infrastructure are insufficient. CDI is also a good approach for boosting community participation in health delivery systems. For these reasons, APOC initiated the development of a curriculum for medical and nursing schools as a means of disseminating CDI in Africa.

In 2007, APOC invited six experts, under the chairmanship of Professor Mamoun Homeida (University of Medical Sciences & Technology, Khartoum, Sudan), to develop a curriculum on CDI Strategy. The members of the team were: Mrs. Georgette Abangla and Professor Abdoulaye Diallo (West African Health Organization, Bobo Dioulasso, Burkina Faso), Professor Oladele Akogun (Parasite and Tropical Health, Federal University of Technology, Yola, Nigeria), Professor Khaled Bessaoud (Institut Régional de la Santé Publique de Ouidah, Bénin) and Professor Grace Offorma (Department of Arts and Education, University of Nsukka, Nigeria).



Subsequently, the draft curriculum and training manual were presented at a meeting of experts from ECOWAS countries, held in Bobo Dioulasso and aimed at harmonizing the programmes of different institutions. Fourteen countries were represented at that meeting.

A review and repackaging of the curriculum was completed in 2008. Since then high level review meetings of vice chancellors, deans, senior academics and heads of schools of nursing have been convened in Abuja (June 2009) and in Nairobi (November 2010) during which the curriculum and training module were finalized and adopted. One of the main recommendations from these consultations was to develop and produce a trainers' handbook.

Under the Chairmanship of Dr Yankum Dadzie, former Director of the Onchocerciasis Control Programme in West Africa (OCP) and former Interim Director of APOC, a team of experts was convened at a workshop in Ouagadougou in August 2011 to develop the trainers' handbook. The team included Professors Oladele Kale (University of Ibadan, Nigeria), Joseph Okeibunor (Dean, University of Nsukka Nigeria), William R Brieger and Bright C Orji (The Johns Hopkins University), Oladele Akogun (Parasite and Tropical Health, Federal University of Technology, Yola, Nigeria,) and Dr Uche Amazigo (Former Director, APOC). On behalf of the African communities, APOC Partners and Donors, we thank all these contributors.

We are hopeful that this trainers' handbook will effectively contribute to the preparation and production of future generations of health personnel empowered to use the CDI strategy to scale-up priority health interventions at community level.

*Dr Paul-Samson Lusamba-Dikassa*  
*Director*  
*African Programme for Onchocerciasis Control*





# UNIT 1

## BACKGROUND TO THE HEALTH CARE DELIVERY SYSTEMS

# UNIT 1

## BACKGROUND TO THE HEALTH CARE DELIVERY SYSTEMS

### SECTION A: TRAINING OUTLINE

**PURPOSE:** The purpose of this unit is to provide learners with knowledge and understanding of the health systems, community health systems and the CDTI/CDI strategy.

**PREREQUISITE MODULES:** None.

**MODULE TIME:** 2 hours.

*(N.B. Trainers should adjust the time accordingly depending on methodology used for teaching.)*

#### LEARNING OBJECTIVES:




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

- a) give an account of the background to Primary Health Care and Ouagadougou Declaration;
- b) describe the Health Systems and enumerate the six building blocks of the Health Systems;
- c) describe Community Health Systems;
- d) describe different approaches to Community Health Care and health services and indicate their advantages and disadvantages;
- e) explain the history of CDTI and its evolution to CDI.

#### PRESENTATION PLAN:

- Historical overview and the background to Primary Health Care and Ouagadougou Declaration.
- Health Systems, WHO Health Systems framework and Community Health Systems.
- Approaches to Community health care and health services.
- Evolution of CDTI and CDI.

## OVERVIEW • UNIT ONE

Step	Time	Activity/ method 	Content 	Resources needed 
1	5 min	Introductory Presentation to unit	Title, learning objectives, content outline (presentation plan)	Slides 1–3
2	30 min	Presentation & Discussions	<b>Historical Background:</b> Primary Health Care & Ouagadougou Declaration.  <b>Health Systems:</b> What are Health Systems based on? What are the values of primary health care? What are Community Health Systems?	Slides 4–11
3	45 min	Presentation & group exercise	Approaches to Community health care and health services	Slides 12–15
4	30 min	Presentation & discussion	Evolution of CDTI and CDI	Slides 16–20
5	10 min	Conclusion	Evaluation & summary of the Unit session	Slides 21

## **MATERIALS AND EQUIPMENT CHECKLIST:**

- PowerPoint slides
- Computer with LCD projector
- Flip chart
- Giant notepad
- Felt markers
- Blackboard.

## **TEACHING GUIDE/ADVISORY NOTES TO TEACHERS:**

For each of the following topics, **ask participants** to explain or to give a definition:

- WHO constitution;
- Primary Health Care and Ouagadougou Declaration;
- what are Health system and the six building blocks of a Health System?
- what's Community health system?
- approaches to community health care service delivery.
- CDTI and CDI Evolution.

> **WRITE** the points on the flipchart. > **USE** the list to facilitate a discussion, allowing participants to show key elements of each definition or explanation.

## **TEACHING METHODS AND TECHNIQUES:**

- Introductory presentation
- Brainstorming
- Questions & answers
- Group work/exercises
- Discovery method.

## SECTION B: NARRATIVE



### HISTORICAL OVERVIEW AND THE BACKGROUND TO PRIMARY HEALTH CARE AND OUAGADOUGOU DECLARATION

In Africa, the weakness of the health systems remains a major constraint to achieving the Millennium Development Goals (MDGs) due to insufficient human resources in the health sector, lack of financial resources, lack of adequate sanitation and the application of inappropriate strategies. This has resulted in the inability of the health systems to meet the health needs of communities, thereby causing in the populations a loss of trust in the health systems, hence the failure of health interventions. Even when communities were involved in the intervention programs, their role was solely that of beneficiaries.

On the other hand, key factors such as cost-effectiveness, accessibility, equity in health services were not taken into account and the geographical coverage of health interventions was too low. There was also a great disparity in the populations served, both geographically and between the sexes. Although psychologically the populations depended on the health services provided for various reasons, the non-attendance of these health services by the people who

needed health care led to absenteeism and desertion of the health post by the health staff. Moreover, the health staff were often not motivated and poorly prepared to meet the health needs of the populations due to several factors, including the inadequacies of the training system. Some initiatives were tried to address these problems, in particular:

- the introduction of new health policies;
- the creation of supportive environments;
- the strengthening of community participation;
- the acquisition of individual skills;
- the transfer of tasks;
- a reorientation and refocusing of health services.

The Declaration of Alma Ata of September 1978 sets out in Chapters 5 and 6 that the solutions require "... the full participation of the community 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. These two elements are part of the

national health system ...". These principles were largely repeated in the Ottawa Charter of November 1986 which notes that:

- community participation and empowerment ensure the sustainability of health programs;
- they ensure better collaboration between the community and routine health services, thus strengthening the national health system and thereby its ownership by the community.

In 1987, the Bamako Initiative highlighted the community's role in the financing of health services. In 1988, the World Federation for Medical Education (WFME) formulated the recommendation that the curriculum in medical schools be restructured to strengthen the health workforce for an improved delivery of health services. The Jakarta Charter of July 1997 reiterated the absolute need to strengthen community participation.

The MDGs (1990-2015) confirm the importance of human resources and partnerships as prerequisites for successful development programs in the health sector. Given the limitations shown by previous initiatives and projects, Community-Directed Interventions (CDI) have been tried and tested particularly in the control of onchocerciasis. The Community-Directed Treatment with Ivermectin (CDTI) initiated by the African Programme for Onchocerciasis Control (APOC) was a success for the following reasons:

- accessibility to treatment against onchocerciasis in the difficult to access areas, which are often neglected by health systems; this allows to ensure greater equity;
- strengthening of community involvement in the delivery of health care;
- empowerment and self-reliance of the affected communities through their

participation in the decision-making process;

- since its launching, APOC, through the use of CDTI, has gradually expanded the coverage of treatment of these communities by the distribution of ivermectin. 54 million people received ivermectin in 2007 from the hands of 600 000 community-directed distributors (CDDs) chosen from their ranks;
- the CDI strategy has strengthened primary health care (PHC) through the training of health workers. In 2007 APOC trained over 35 000 health workers on the use of CDI;
- the CDI strategy was instrumental in establishing sustainable health programs in several countries;
- in addition to the distribution of ivermectin for onchocerciasis control, scientific studies have demonstrated the effectiveness of the CDI strategy in other health interventions such as the distribution of vitamin A, the treatment of lymphatic filariasis (LF), schistosomiasis and deworming;
- CDI has the advantage of empowering the vulnerable and hard to reach target populations, including those of post-conflict areas. It also allows a better management of programs and resources, a reduction of disparities and the establishment of extended partnerships;
- It is therefore useful to integrate this disease control approach in the curricula of schools of medicine and health sciences. Until the creation of the World Health Organization (WHO) in 1948 by the community of nations, community health care delivery service got implemented as vertical campaigns against specific epidemic outbreaks whilst medical facilities mainly located in cities and towns dominated service delivery in the form of curative services. A significant change occurred when in pursuit of the



implementation of WHO's constitution<sup>1</sup> the World Health Assembly (WHA) in 1977 passed a resolution calling for "Health for all by the year 2000", committing governments and the WHO to work towards attainment by all people of the world of a level of health that will enable them to lead socially and economically productive lives.

With the view to promote the WHA resolution, WHO and the United Nations Children's Fund (UNICEF) convened the époque making International Conference on PHC in Alma Ata in the former Soviet Union in September 1978. The Alma Ata Conference identified PHC as the way to achieve the goal of health for all. It saw PHC as the strategy that would seek to reorient health systems to enable the whole population to have effective and essential care and to promote individual and community involvement in health, as well as intersectoral collaboration. As a philosophy, PHC is based on the principles of social justice and equity, self-reliance and community development in the promotion of health.

### **Ouagadougou Declaration**

An international conference on PHC and Health Systems in Africa was convened in April 2008 in Ouagadougou to address and revamp the weak African health systems thirty years on in order to contribute towards the attainment of the health related MDGs. The Ouagadougou Declaration reaffirmed the principles of the Declaration of Alma-Ata, particularly in regard to health as a fundamental human right and the responsibility that governments have for the health of their people. The Conference expressed the need

<sup>1</sup> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

for accelerated action by African governments, partners and communities to improve health. The Conference also reaffirmed the importance of the involvement, participation and empowerment of communities in health development in order to improve their well-being. It recognized the importance of a concerted partnership, in particular between civil societies, the private sector and development partners, to translate commitments into action.

### **Primary health care in Africa**

Article VI of the Alma Ata Declaration states: PHC 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.

At a meeting in Lusaka in 1985 African Health Ministers took a decision to strengthen their national health systems using PHC approach (1). The strategy was to make the district the cornerstone of the organizational framework for implementing PHC in which the community health and related activities would support the community's economic and social development. The economic downturn in the 80's provoked by high petroleum oil prices had an exceptionally negative impact on African countries' economy which particularly affected the health sector and its development.

## HEALTH SYSTEMS, WHO HEALTH SYSTEMS FRAMEWORK AND COMMUNITY HEALTH SYSTEMS

### What is a health system based on the values of PHC?

#### WHO Health systems

The Constitution of WHO states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...”. Certain core values underpin efficient and effective health care systems. These values have been articulated in the Alma Ata Resolution on PHC since 1978 and include equity, social justice, universality, people-centeredness, community protection, scientific soundness, self-determination, and self-reliance. Health systems that are built on the principles of PHC have tended to achieve better health and better value for the money invested in health.

Health systems can be understood in many areas. WHO defines Health systems as “all the organizations, institutions and resources that are devoted to producing health actions”. A health system consists of all organizations, people and actions whose *primary intent* is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services.

It involves the broad range of individuals, institutions, and actions that help to ensure the efficient and effective delivery and use of the spectrum of products and information for prevention, treatment, care and support to people in need of these services. A health system needs staff, funds, information, supplies, transport, communications

and overall guidance and direction. And it needs to provide services that are responsive and financially fair, while treating people decently.

This definition includes the full range of players engaged in the provision and financing of health services including the public, non-profit, and for-profit private sectors, as well as international and bilateral donors, foundations, and voluntary organizations involved in funding or implementing health activities. Health systems encompass all levels: central, regional, district, community and household. Health sectors projects engage with all levels and elements of the health systems and frequently encounter constraints that limit their effectiveness.

The ultimate responsibility for the overall performance of a country’s health system lies with government, but good stewardship by regions, municipalities and individual health institutions is also vital.

#### Goals of Health system goals

Health systems have multiple goals. WHO defined overall health system outcomes or goals as: improving **health** and **health equity, in ways that are responsive, financially fair**, and make the best, or most **efficient**, use of available resources.

#### What’s Health System Strengthening?

At its broadest, Health System Strengthening (HSS) can be defined as any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage quality, or efficiency. Strengthening health systems and making them more equitable have been recognized as key strategies for fighting poverty and fostering development. Problems with health systems are not confined to poor countries. Some rich coun-

tries have large populations without access to care because of inequitable arrangements for social protection. Others are struggling with escalating costs because of inefficient use of resources.

### Health system building blocks

In order to function well, health systems must carry out a number of basic functions. WHO has categorized these functions into the following “six essential building blocks”. To achieve their goals, all health systems have to carry out some basic functions, regardless of how they are organized: they have to provide services; develop health workers and other key resources; mobilize and allocate finances, and ensure health leadership and governance (also as stewardship, which is about oversight and guidance of the whole system). For the purpose of clearly articulating what WHO will do to help strengthen health systems, the functions identified have been broken down into a set of six essential “building blocks”. All are needed to improve outcomes. This is WHO’s health systems framework (see Figure 1).

The aims and desirable attributes of the **six building blocks** of a health system are as follows:

1. Good **health services** are those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources. A good health system must deliver quality services to all people, when and where they need them. Typically, networks of close-to-client primary care are organized as health districts or local area networks with the back-up of specialized and hospital services responsible for defined populations. Besides, a package of benefits is provided with a comprehensive and integrated range of clinical and public health interventions that respond to the full range of health problems of their populations, including those targeted by the MDGs.
2. A well-performing **health workforce** is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances,

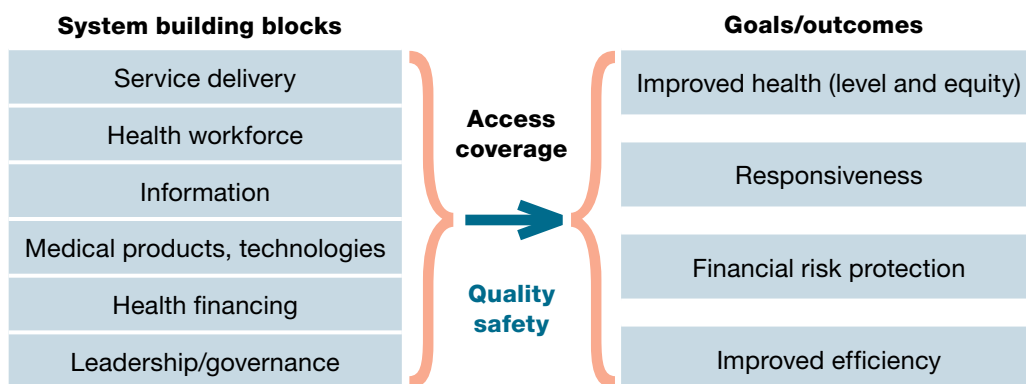


Fig. 1: **The WHO Health Systems Framework**

i.e. there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive. The workforce has to respond to the needs and expectation of people and be fair and efficient in achieving best outcomes given available resources and circumstances. The performance of Health workers therefore needs to be effectively addressed. This includes education, training, regulatory mechanisms to ensure system wide deployment and distribution in accordance with needs, incentive related payment system to enhance productivity and performance and enabling environment among others.

3. A well-functioning **health information system** is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status. A well-functioning Information System should be established to collect and analyse information on health challenges, on the broader environment in which the health system operates, and on the performance of the health system including social factors, workforce distribution and health financing to enable effective support and ensure good governance.
4. A well-functioning health system ensures equitable access to essential **medical products, vaccines and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use. There should be easy access to affordable essential medicines, vaccines, diagnostics and health technologies of assured quality, which are used in a scientifically sound and cost-effective way. Their procurement and sales need to be regulated and supported by relevant legislation with safety monitoring, enforcement mechanisms, an inspectorate and access

to a medical products quality control laboratory.

5. A good **health financing** system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. A good health financing system may be established by making health financing a key policy instrument to improve health and reduce health inequalities in order to facilitate universal coverage by removing financial barriers to access and preventing financial hardship and catastrophic expenditure. In this regard a system needs to be developed that raises sufficient funds for health fairly or that pools financial resources across population groups to share financial risks.

6. **Leadership and governance** involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system-design and accountability. Good leadership and governance ensure that a country's health authorities develop through a transparent process, a commitment to high level health policy goals, health equity, people-centeredness, sound public health policies, supported by well-considered financial implication for human resources, pharmaceuticals, technology, infrastructure service delivery with relevant guidelines, plans and targets and adequate monitoring and evaluation (M&E). It also ensures dialogue with other sectors and mechanisms and institutional arrangements to channel donor funding and alignment to country priorities.

A well-functioning health system responds in a balanced way to a population's needs and expectations by:

- improving the health status of individuals, families and communities;
- defending the population against what threatens its health;
- protecting people against the financial consequences of ill-health;
- providing equitable access to people-centered care;
- making it possible for people to participate in decisions affecting their health and health system.

Keeping health systems on track requires a strong sense of direction, and coherent investment in the various building blocks of the health system, so as to provide the kind of services that produce results. It is useful to analyse health systems by looking at their component parts or functions – such as the 6 building blocks. The weakest part of the system may determine the outputs from that system. Any actions to be taken must be evaluated for their potential effects on the functioning of entire system and their effect on health outcomes. Health systems in Africa remain very weak. Lack of staff motivation, poor training, poorly equipped health facilities and absence of in-service re-training or continuing education have been identified as important factors contributing to the weak African health systems which are made worse still by inadequate financial input and application of often inappropriate strategies.

## COMMUNITY HEALTH SYSTEM

The involvement, participation and empowerment of communities in health development are enshrined in PHC as set out in the Alma Ata declaration article VI and which has recently been re-affirmed by the Ouagadougou Declaration. In Africa inadequate financial input in the health sector has resulted in unequal distribution of services with rural populations either

poorly or not at all served particularly those in difficult to access areas. There is a real need to address this shortcoming of the health system through PHC principles. CDTI strategy, now known as CDI, has been offering some components of health activities that community systems implement to enhance community health.

**Community systems** are defined as community-led structures and mechanisms used by communities through which community members and community based organizations and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities.

**Community systems strengthening (CSS)** is an approach that promotes the development of informed, capable and coordinated communities and community based organizations, groups and structures. CSS involves a broad range of community actors, enabling them to contribute as equal partners alongside other actors to the long-term sustainability of health and other interventions at community level, including an enabling and responsive environment in which these contributions can be effective. The goal of CSS is to achieve improved health outcomes by developing the role of key affected populations and communities and of community based organizations in the design, delivery, monitoring and evaluation of services and activities related to prevention, treatment, care and support of people affected by human immunodeficiency virus (HIV), tuberculosis, malaria and other major health challenges.

It is quite clear therefore that the CDI approach which identifies community health needs in consultation and discussions with the community itself, and goes on to empower the community by providing them with the necessary health information which enables them to direct the agreed upon health intervention and trains the commu-

nities' selected implementers in the skills of delivering the relevant health package, effectively strengthens the community systems to achieve better health outcomes. CDI therefore strengthens the health systems by delivering an effective health service at the community level through the community systems, particularly in the difficult to reach rural areas where the health systems' services hardly reach. Furthermore it has been found that rural communities have embraced this approach and other programmes are using the strategy more and more to deliver other health interventions to rural communities.

## **APPROACHES TO COMMUNITY HEALTH CARE AND HEALTH SERVICES**

Vertical campaign teams against epidemic outbreaks or endemic diseases such as yaws, sleeping sickness, malaria and lately small pox offered the only health care service delivery to communities in the rural areas during the colonial era that lasted most of the last century in Africa. This approach was not particularly friendly to the communities who were often coerced to receive the intervention. On occasions the cooperation of the village community was sought through their chief to enable the campaign team to deliver their intervention. It was clearly a top down approach and in the process, some members of the communities even hid away to abstain from participation out of fear. The partners were the colonial masters but this mode of health care delivery lingered on for some time after the attainment of independence, when Ministries of health of independent countries assumed responsibility for the health of the rural communities. The communities viewed the health services delivered to them with very high suspicion since they did not understand the activity and hence could not perceive any benefit therein to them.

Since attainment of independence in the sixties, countries started to build more and more health centres and health posts closer to the rural communities to deliver health services. In time however, the effectiveness of the services delivered waned often because medical products were not available in the facilities.

Since the era of PHC, community-based approaches for delivering health packages have been used, particularly by non-governmental developmental organization (NGDO) partners in different forms. They have been friendlier, approaching the communities and respecting to some extent, some norms of the communities and providing some information on the health package to the community. However, community participation and empowerment in implementation of the health programmes have been minimal, contrary to the principles of PHC. The community acceptance of the health interventions has been moderate since they do not understand the activity and the therapeutic coverage has been quite unsatisfactory.

Until recently, conventional opinion has considered African village communities to be too simple to understand the complexity and implication of health interventions that are being offered to them. Besides, it had also been observed that their perception and attitudes to health problems were based on views far from biological factors but more on mystic considerations. Hence, the health systems have neither sought the views of rural communities on their health needs nor have they involved them in determining health priorities, despite the fact that numerous health facilities have been built close to rural populations since the launch of primary health care. In some cases village health committees have been created but their function has been to rally the support of the communities to benefit from the intervention, the design and plan of which they are not consulted.



In the course of time as more and more products became available for delivery to the communities the NGDO health partners made an effort to improve the acceptance of health packages and their approach to the communities by conforming more and more to the norms of the communities. The partners particularly improved health education to the communities, developing it on the bases of studies on the communities' knowledge attitude and perception which were carried out before launching the health package. They also identified members in the communities whom they recruited and trained to deliver the package under supervision. However their action still fell short of empowering the communities to oversee the intervention. Community acceptance of the intervention

has naturally improved and with it the therapeutic coverage of the intervention.

The use of CDTI now termed CDI has changed the approach to community health care and health services fundamentally. The CDI approaches the community respecting community norms and trusting in the communities' capability to direct their own treatment. CDI sets about with the communities in consultation and discussions to identify their health needs and priorities. It then provides the community with health information about the identified health needs and offers training to their selected implementers to provide the tools with which the communities can address their health intervention in the way they consider appropriate. This approach has shown that communities are able to

carry out health interventions of different levels of complexity. The communities' acceptance of the approach has been very remarkable and coverage of the communities has been high both therapeutically and geographically.

It is worthy of note that although PHC is based on community participation in health care delivery, community-based health interventions in the past have not fully involved communities. The resultant effect has been inadequate population coverage, as a proportion of community members often refuse to take part in the intervention, whilst the sustainability of the intervention in time became problematic because of lack of ownership by the community.

Three levels of community participation have been described (2). In the first, marginal participation, the community has very limited influence on the development process of the health intervention. This level may be likened to the colonial approach to the community with vertical teams during the colonial era.

In the second, substantive participation, community members have an opportunity to determine their needs, contribute to the activities and receive the benefits of the intervention. They however have no role in decision making. This may be likened to the improved NGDO partner approach.

In the third level, structural participation, community members play a direct and active role in project development. Members of disease-endemic community are expected, within the disease control framework, to play major roles in decision-making with respect to the distribution of particular health services. There is thus a shift in power and decision-making, which allows for communities to play a more substantive role with support from the health system and other facilitators.

CDI is built strictly on the model of structural participation of the community, with the result that the community takes decision on when, how and who implements its ivermectin treatment. The health system therefore needs to set about the process of introducing CDI in the community correctly in order to achieve optimal results and get communities, who are often sceptical about the health system and who are not used to being entrusted with responsibility, to fully cooperate. Annexes 2.1 AND 2.2 summarises the partners/facilitators that are involved in community health care and the differences between strategies used for community health care.

## EVOLUTION OF CDTI AND CDI

In 1987 the pharmaceutical firm Merck & Co. Inc. made available ivermectin, an effective microfilaricide, free of charge for the treatment of onchocerciasis for as long as it would be necessary. The donation of ivermectin offered a simpler and by far cheaper tool for the control of onchocerciasis thus enabling the control of onchocerciasis in endemic areas of Africa outside the eleven countries of the Onchocerciasis Control Programme in West Africa (OCP) which employed vector control against onchocerciasis. Most importantly, it also gave rise to the search for an efficient and cost-effective way of delivering a drug to achieve high population coverage.

### Ivermectin distribution to treat onchocerciasis by mobile teams

The OCP which was already well established as an extremely efficient vertical programme naturally undertook distribution of ivermectin initially with vertical health teams transported in 4-wheel-drive vehicles to the onchocerciasis endemic villages to treat populations.



An existing OCP health team was retrained in the skills of health education. This enabled the team to administer health education consisting of information on the disease and its treatment modalities including those who were or were not eligible for treatment and side effect and how it would be managed. Mass treatment was then carried out at a convenient central point in the village after which it was indicated to the communities as to where to locate the team in the event of occurrence of a serious case of side effect.

Later, the procedure was devolved to the countries of OCP. The Ministries of Health were requested to establish treatment teams of nurses and medical officer as the leaders within the National Onchocerciasis Committees (NOC). The teams were then trained in the process of ivermectin treatment. They then took over the treatment of onchocerciasis endemic villages in their countries. The medical officers then became the trainers and supervisors of the treatment activities of the teams and reported thereon to OCP.

### **Community-based ivermectin distribution**

Some NGOs, mainly eye NGOs which saw an opportunity to add another tool to their mission of blindness prevention implemented community-based treatment with ivermectin, supervised by an agent, usually a nurse, reaching the villages on a motorcycle. Other NGOs went a step further to involve community-based organisations to help organise the village population for community treatment with ivermectin.

A village health worker (VHW) with some basic school education and who could read and write was identified in the community. At the first meeting with the village, health education consisting of information on the disease, the treatment to be administered

and its side effect was provided. Often authorities or dignitaries in the district were recruited to assist in the approach to the village to reinforce the health education. The identified VHWs from several villages were then brought together to a central place, usually a bigger village, to be trained in the skills of mass distribution of ivermectin including how to dose eligible individuals by weight originally and later by height, how to record the activities and how to tally the results of treatment at the end.

The supervisor brought all the necessary materials to the trained VHW at the start of the mass distribution and also supervised the VHW's work for a few hours before leaving him to continue the treatment from house to house, recording the number of people treated in each household and the number of tablets given. The nurse went round communities being treated, supervising, checking on progress and providing any assistance needed. The VHW was paid a little allowance for the work done. It usually took about a week or so to treat up to 500 persons. NGOs that were involved in mass ivermectin distribution before the launch of APOC were: Africare, Christofel-Blinden-Mission (CBM), Inter-Church Medical Assistance (IMA), International Eye Foundation (IEF), Organization pour la Prévention de la Cécité (OPEC), River Blindness Foundation (RBF) and Sightsavers International (SI). These NGOs were donors as well as facilitators to the countries they supported or carried out their activities.

### **Development of CDTI**

The pending launch of APOC in 1995 to control onchocerciasis in African countries outside the OCP countries, with the primary objective of establishing within a period of 12 years effective and self-sustainable community-based ivermectin treatment throughout the remaining endemic African countries, created a situation whereby the

need for an efficient, sustainable ivermectin distribution method to ensure the achievement of its primary objective became crucial.

In response, UNICEF, the United Nations Development Programme (UNDP), World Bank and WHO Special Programme for Research and Training in Tropical Diseases (TDR) in collaboration with OCP undertook the timely study with the goal to identify and develop simple, acceptable and sustainable methods for use in the treatment of endemic communities with ivermectin.

A Multi-country study was conducted in eight sites in five countries spread over West, Central and East Africa to compare the effectiveness of two approaches: (a) Programme Directed Treatment with Ivermectin (PDTI); and (b) CDTI.

The PDTI was simply the community-based approach which was then being applied widely by NGOs, in which the communities were given no role in decision making and had to follow strict directives the Programme staff had given out about ivermectin treatment.

The CDTI was based on the ideals of PHC, empowering the community to be fully in charge of their own treatment. In this, the community was provided with explicit health information on onchocerciasis, the effectiveness of ivermectin, the need for annual treatment of all eligible members of the community, and the required treatment procedure such as height measurement to determine dosage. The community was then invited to design a method for the delivery of the drug by the community itself and then select a member to be trained to carry out the treatment.

The results of the study showed CDTI to be more effective and to achieve better treatment coverage than PDTI (3).

APOC therefore adopted CDTI as its strategy. CDTI has since proven to be extraordinarily effective and a model to apply for other health interventions (4, 5).

Other studies have been conducted since the inception of CDTI to determine its impact. These studies have shown CDTI to be successful in ensuring equity and to achieve



wider coverage among community members and also to be sustainable (6, 7, 8).

The effectiveness of CDTI has stimulated other disease control programmes to duplicate the system and structures in their control activities. Thus it has been found that many of the trained CDDs are also being involved in such programmes as Vitamin A distribution, malaria treatment, polio immunisation, guinea worm eradication and water protection as community health workers.

### **Evolution of CDTI to CDI – CDI to control multiple diseases**

The impact of CDTI both in the APOC community and external to it has been remarkable. An external evaluation team of the APOC programme remarked that “CDTI has been a timely and innovative strategy and communities have been deeply involved in their own health care on a massive scale... CDTI is a strategy, which could be used as a model in developing other community-based health programmes and is also a potential entry point in the fight against other diseases (9).

With the view to promote its wider use to improve the health care of rural populations, the Joint Action Forum, the board of Governors of APOC requested TDR to collaborate with APOC to undertake a multi-country study on the use of community-directed treatment approach for other diseases (10). This request formally marked the change of CDTI strategy into the larger concept of CDI in order to test the feasibility of integrated delivery of other diseases using community directed intervention strategy.

The three year study was carried out in seven research sites comprising 35 health districts in Cameroon, Nigeria and Uganda in a total population of 2.35 million that have been implementing CDTI for onchocerciasis for several years. At each site five

districts were identified of which four were randomly selected to be CDI intervention districts and the fifth was a comparison district where all interventions for the study including Vitamin A distribution, distribution and retreatment of insecticide treated net (ITN), tuberculosis case detection and referral and directly observed treatment strategy (DOTS), and home-management of malaria (HMM) were delivered through the regular non-integrated procedures currently employed by the health systems of the participating country.

In the first year of the study, one of the four interventions was introduced to the on-going ivermectin distribution in each of the four CDI intervention districts. In the second year yet another intervention was added to each of the CDI intervention districts and in the third and final year, the last two remaining interventions were introduced to each of the four CDI intervention districts such that in the third year each of the CDI intervention district was delivering all four interventions and ivermectin distribution. The effectiveness of the process was assessed through (a) coverage data on each of the five interventions carried out, and (b) data on measurement of the cost of carrying out the interventions. The data thus collected were compared between the CDI intervention districts on the one hand and the district where the interventions were being carried out by the ongoing health systems on the other.

The CDI approach was found to be more effective than the currently used delivery approaches for all interventions studied except DOTS.

More than twice as many children with fever received appropriate anti-malarial treatment in districts where HMM was integrated into the CDI package. Furthermore the percentage receiving appropriate treatment exceeded the roll back malaria (RBM) target of 60%.

Possession and utilization of ITNs was twice higher in the CDI districts, despite shortage of ITNs in most study sites.

Vitamin A coverage was significantly higher in the CDI districts than in the comparison districts.

Furthermore, the addition of multiple interventions to the CDI package did not have any negative effect on ivermectin treatment but, in fact, boosted ivermectin treatment coverage by an additional 10%.

The study showed that at least 4 to 5 interventions could be effectively and simultaneously implemented through the CDI process.

### Setting up CDI with other diseases

CDI is built on the same process as CDTI. However additional advocacy needs to be extended to stakeholders of the targeted disease interventions to be added to the CDTI. The following process may be followed:

1. Meetings with partners at national, sub-national and district levels (health systems and others, including private sector) to plan, define and agree upon a CDI strategy, and the roles and responsibility of the different partners. This should include:
  - a) selection of interventions to be offered through the CDI package;
  - b) plan for continuous advocacy and health education using appropriate information, education and communication (IEC) strategies and materials at all levels;
  - c) plan for training of health personnel at all levels on CDI and available interventions.
2. Training of district health staff and front line health facility staff:
  - a) introducing to the CDI process and its effectiveness;
  - b) training in the available CDI interventions as required;
3. Approaching and meeting with community leaders:
  - a) Discussions of target diseases and interventions:
    - i. Definition of the health problems and discussions of community experience with the diseases;
    - ii. Information on the benefits of the available interventions;
    - iii. Availability of help from health service and contributions of other partners for the interventions.
  - b) Discussion on roles and responsibilities of the community: community members collectively decide whether they want the proposed interventions to be delivered at the community level. If this is agreed they then decide how, when, where and by whom the interventions are to be implemented; decide what support to provide to implementers; and how to supervise and monitor the process, including the specific steps below:
    - i. Identification of specific tasks and resources;
    - ii. Collective selection of community implementers;
    - iii. Authority to make decisions on timing of interventions;
    - iv. Decisions on suitable methods for intervention delivery;
    - v. Flexibility to change the timing and methods of delivery of the intervention if found to be necessary;
    - vi. Collection of intervention materials;
    - vii. Supervision of implementers by community members;
    - viii. Management of side effects (if any) and referral of serious cases to the nearest health posts;
    - ix. Decide on support (financial or otherwise) to implementers.

4. Approaching and meeting with the entire community including:
  - a) health education of entire community on the intervention and their benefits, conducted annually prior to beginning of intervention activities;
  - b) discussion of roles and responsibilities of the community in the CDI process (repeat the steps described above in 3.b.i-ix);
  - c) community decision-making on how, when, where and by whom the intervention is implemented;
  - d) collective selection of community implementers.
5. Training of community implementers by the health services.
6. Implementation of the intervention by community implementers:
  - a) census-taking for information on quantity of intervention materials required;
  - b) collection of intervention materials;
  - c) delivery of the interventions;
  - d) record keeping.
7. Monitoring and reporting:
  - a) supervision and monitoring by community and health care services;
  - b) reporting by community implementers to the health services.

*Setting up of CDI is further elaborated in details in all the Units that follow.*

## CONCLUSION

Health care delivery systems have undergone significant changes in the last century from a narrow medical facilities based curative services to delivery of comprehensive health needs of all people based on the principles of primary health care. In Africa this trend is being revamped based on the framework for health systems strengthening with six components. The CDI strategy developed and used extensively by APOC has proven to strengthen community systems even in rural areas with difficult access to produce better health outcomes, thus filling out a useful gap in the health systems in Africa.





# UNIT 2

## THE COMMUNITY

# UNIT 2

## THE COMMUNITY

### SECTION A: TRAINING OUTLINE

**PURPOSE:** To get participants to appreciate the important place of community in CDI process and provide them with knowledge and an understanding of the critical concepts to be encountered in the communities.

**PREREQUISITE MODULES:** Knowledge and an understanding of health system, community health system, CDTI/CDI (Module 1).

**MODULE TIME:** 2 hours.

#### LEARNING OBJECTIVES:

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




- a) use in their proper meaning, and illustrate with example, the concept 'Community';
- b) describe the composition, structure, organization, social norms, values, socioeconomic and political characteristics of a community;
- c) describe the different types of motivation (incentives) of community players in the health care and health services system.

#### PRESENTATION PLAN:

- Give the generic and operational definition of community.
- Discuss the following in relation to health care delivery:
  - community attitude and practices
  - composition
  - structure
  - organization
  - social norms
  - socioeconomic and political characteristics
  - motivational devices (incentives)
  - value of community participation.



## OVERVIEW • UNIT TWO

Step	Time	Activity/ method 	Content 	Resources needed 
1	5 min	Introductory Presentation to Unit	Title, learning objectives, content outline (Presentation plan)	Slides 1–3
2	30 min	Presentation & discussions	<ul style="list-style-type: none"> <li>• Generic and operational definition of community</li> <li>• Community attitude and practices</li> <li>• Social norms</li> </ul>	Slides 4–10
3	45 min	Presentation & group exercise	<ul style="list-style-type: none"> <li>• Composition</li> <li>• Structure</li> <li>• Organization</li> <li>• Socioeconomic and political characteristics</li> <li>• Motivational devices (incentives)</li> </ul>	Slides 11–15
4	30 min	Presentation & discussion	Value of community participation	Slides 16–20
5	10 min	Conclusion	Evaluation & summary of the Unit session	Slides 21

### MATERIALS AND EQUIPMENT CHECKLIST:

- PowerPoint slides
- Computer with LCD projector
- Flip chart
- Giant notepad
- Felt markers
- Blackboard.

## TEACHING GUIDE METHODS/ADVISORY NOTES TO TEACHERS:

**Refresh the participant's knowledge** of Module 1, by asking them to explain:

- what are health system & the six building blocks of a health system?
- what is community health system?
- approaches to community health care service delivery;


**Then proceed to ask them to:**

- define community from the perspective of their individual communities;
- discuss some typical attitudes and practices in their communities;
- describe the composition and structure of their communities;
- identify the key organizations in their communities;
- discuss some of the key social norms and their implications for every day living in their communities;
- characterize their communities socioeconomically and politically.

> **WRITE** the points on the flipchart. > **USE** the list to facilitate a discussion, allowing participants to show key elements of each definition or explanation.

## TEACHING METHODS AND TECHNIQUES:

- Introductory Presentation
- Brainstorming
- Questions & Answers
- Group work/exercises
- Discovery method.

Slide number 	Teaching points
1	<b>Module 2: Community</b>
2	<b>Learning objectives</b> > <b>STATE</b> the objectives on the slide.
3	<b>Content outline/Presentation Plan</b> > <b>EXPLAIN</b> that the topics listed are those that will be covered in this Unit. > <b>REFER</b> to the slide/flipchart frequently so that participants are sure where they are in the module.
4 & 5	<ul style="list-style-type: none"> <li>• Generic definition of community</li> <li>• Operational definition of community in the context of CDI</li> </ul>
6–10	<ul style="list-style-type: none"> <li>• Community attitude and practices</li> <li>• Social norms</li> </ul> <p>Note that the things communities do or fail to do are critical to the successful implementation of CDI projects. Thus it is important to identify and understand the various factors that could hinder or facilitate their participation in a CDI project, such as going against the community norms. Some communities detest the use of measuring poles to determine dosage.</p>
11–15	<ul style="list-style-type: none"> <li>• Composition</li> <li>• Structure</li> <li>• Organization</li> <li>• Socioeconomic and political characteristics</li> <li>• Motivational devices (incentives)</li> </ul>
16–20	<ul style="list-style-type: none"> <li>• Value of community participation.</li> </ul> <p>&gt; <b>ASK</b> participants to give examples of community projects in their various communities. They should distinguish those in which community participated at varying degrees and compare with where the communities were mere recipients. These should be compared to evaluate the contributions of the community to the successful implementation of the projects.</p>
21	<b>Evaluation and Conclusion</b> <ul style="list-style-type: none"> <li>• Questions (oral) and answers</li> <li>• Teachers check list</li> <li>• Conclusion/Summary: Emphasize some key points</li> </ul>

## SECTION B: NARRATIVE



### INTRODUCTION

Lessons are being learned about the need for, and role of the community in health service delivery as health interventions are being scaled up to improve access to treatment of life threatening diseases among the underserved people in the poorest corners of the world, and meet the MDGs. The community is germane to the success of some innovative approaches designed to address the large coverage gaps of key interventions into many tropical diseases, which are preventable but remain major killers in Africa due to poor delivery mechanisms (11, 12). While there are many community approaches, the CDI approach is fundamentally distinct in its level of community involvement and success in bridging the coverage gaps of many interventions.

The CDI approach has been the bedrock for ivermectin distribution through APOC, ensuring annual treatment of endemic communities with high coverage. The CDI platform has worked well for filariasis control and has been demonstrated to be useful for distribution of insecticide treated nets resulting in “substantial improvement in insecticide-treated bed net ownership and usage, without adversely affecting mass drug administration coverage” (13). Furthermore, the WHO multi-country studies demonstrated the effectiveness of the strategy in the delivery of multi-disease interventions for malaria control, vitamin A supplementation, among others (5, 14, 15).

According to APOC the members of the target communities are the heart-beat of health systems and the community is a critical partner for realization of PHC. Citing the experience of APOC, Amazigo emphasized that communities made APOC to increase its responsiveness to country needs and the needs of communities. For APOC, communities exemplify accountability and transparency, yet the community potential is poorly understood and often overlooked in planning, analysis and policymaking for delivery of health intervention. This unit explores and documents the key community potentials that would drive successful delivery of health interventions in Africa.

## GENERIC AND OPERATIONAL DEFINITIONS OF COMMUNITY

There exists a plethora of definitions of community. According to Hillery (16), there were 94 distinct definitions of the term by the mid-1950s. Efforts to define community have thus led to significant debate, and agreement is yet to be reached on a sociological conceptualization of the term 'community'. The choice of the definition depends on the use into which it is put. However, to lay a background for a comprehensive understanding and appreciation of the operational definition of community in CDI, its generic definition is important here.

### Generic definition of community

The Oxford English Dictionary defined community broadly as a group of people living together in one place, especially one practising common ownership. On the other hand, Miriam Webster Online Dictionary (<http://www.merriam-webster.com/dictionary/community>; accessed: April 13, 2011) brought in different ramifications in conceptualizing community. It sees communities in three major dimensions, namely as a unified body of individuals, society at large and common attribute.

As a unified body of individuals, community is epitomized by the state or commonwealth, a people with common interests, living in a particular area; an interacting population of various kinds of individuals (as species) in a common location; a group of people with a common characteristic or interest living together within a larger society; a group linked by a common policy; a body of persons or nations having a common history or common social, economic, and political interests; a body of persons of common and especially professional interests scattered through a larger society. Community, here, also implied joint ownership or participation for community goods; common character;

likeness; *community* of interests; social activity; fellowship and social state or condition.

These definitions suggest that community could mean different things to different groups. In biological terms, a community would refer to a group of interacting organisms sharing a populated environment. In human communities, intent, belief, resources, preferences, needs, risks, and a number of other conditions may be present and common, affecting the identity of the participants and their degree of cohesiveness. Community has been defined, traditionally, as a group of interacting people living in a common location. The word is often used to refer to a group that is organized around common values and is characterized with social cohesion within a shared geographical location, generally in social units larger than a household. The word can also refer to the national community or international community.

The word "community" is derived from the Old French *communité* which is derived from the Latin *communitas* (*cum*, "with/together" + *munus*, "gift"), a broad term for fellowship or organized society (17). With the dawn of the Internet, the concept of community expanded beyond the original geographical limitations as people can now virtually gather in an online community and share common interests regardless of physical location.

All the same, German sociologist Ferdinand Tönnies distinguished between two types of human interaction: *Gemeinschaft* ("community") and *Gesellschaft* ("society" or "association"). Tönnies argued that community is perceived to be a tighter and more cohesive social entity due to the presence of a "unity of will" (18). He added that family and kinship were the perfect expressions of *Gemeinschaft*, but that other shared characteristics, such as place or belief, could also result in *Gemeinschaft*. According to Mess

(19), this prototype of communal networks and shared social understanding has been applied to multiple cultures in many places throughout history. *Gesellschaft*, on the other hand, is a group in which the individuals who make up that group are motivated to take part in the group purely by self-interest.

Sociologists argue that in the real world, no group was either pure *Gemeinschaft* or pure *Gesellschaft*, but, rather, a mixture of the two. In other words, every form of human interaction comprises of community and associations built on shared social understanding and interests. Some basic features to delineate a community include shared social capital, culture, archeological realities and social philosophy.

With community life come both freedom and security, where community takes on a life of its own, as people become free enough to share and secure enough to get along. The sense of connectedness and formation of social networks comprise what has become known as social capital. Putnam (20) defined social capital as “the collective value of all social networks and species (who people know) and the inclinations that arise from these networks to do things for each other (norms of reciprocity).” Social capital in action can be seen in all sorts of groups, including neighbours keeping an eye on each others’ homes.

Cultural (or social) anthropology views community through the lens of ethnographic fieldwork and ethnography continues to be an important methodology for study of modern communities. Other anthropological approaches that deal with various aspects of community include cross-cultural studies and the anthropology of religion. Archaeologically, community is defined informally as a place where people used to live, synonymous with the concept of an ancient settlement, whether a hamlet, village, town, or city. The second archaeological definition of community is similar

to the usage of the term in other social sciences, namely a community is a group of people living near one another who interact socially. Most archaeological reconstructions of social communities rely on the principle of social interaction conditioned by physical distance. Archaeologists typically use similarities in material culture – from house types to styles of pottery – to delineate communities in the past. This is based on the assumption that people or households will share more similarities in the types and styles of their material goods with other members of a social community than they would with outsiders (21, 22).

### Operational definition of community in CDI

In CDI a disambiguated definition of community will see it as a group of interacting people guided by shared norms and culture and sharing a defined geographical entity under an autonomous traditional/political head. It is the lowest level of political organization, with the highest being National leadership. It is thus defined as the lowest autonomous unit of homogenous groups with its members linked to one traditional/political head, and share resources in common. In other words, community in CDI refers to a group of people who occupy a defined territory under common leadership, with access to shared local resources, as the base for carrying out the greatest share of their daily activities. Such a group may vary by country to include villages, quarters, and groups of hamlets, mobile populations, and temporary settlements. ***It is an operational area for delivering a minimum health care package.***

Here, members of the community have shared social and health concerns as well as shared human and material resources that could be mobilized to address the shared concerns. In this sense a small village settlement constitutes a social community, and

spatial subdivisions of cities and other large settlements may also have formed communities. In this second format, one could find multiple communities within one large geographical entity. For instance in many Nigerian cities, we have clusters predominated by a people with particular ethnic or regional identities, and the cluster is so named. In other words, community in CDI will refer to a distinct geographical entity with its distinct name and a common way of life among its members with one political head closest to it. In a very extended situation, like one would find in large urban settlements in Africa, community will refer to a sub cluster of the big entity, so long as the sub cluster has and maintains attributes (lowest political head, language and culture and its members have shared access to its human and material resources for solving shared problems), that are distinct from the larger group.

## **COMMUNITY ATTITUDE AND PRACTICES**

Attitudes are “opinions, concerns and feelings that may be conditioned by perceived social norms and standards” as well as experiences (23). In CDI, attitudes refer to people’s disposition to act in a particular way in response to health issues depending on certain prevailing socio-psychological and cultural conditions. It is an expressed way of feeling that people and groups have towards health, health services and the health system. Individual or community attitudes are feelings that may be influenced by perception, experience, knowledge and awareness. Provider attitudes are feelings, which health workers and other suppliers of health services have towards patients, community members, health services and the health system. These feelings may influence individual- and community-level perception of health services.

Practices, on the other hand, refer to human actions taken in response to definite situations. Community practices in CDI will refer to those actions that are commonly taken by community members in order to promote good health. Often, such actions come from a long period of socialization and experiences in the community. Community practices about health conditions are known to be influenced by their attitudes, which are formed from experiences with the health condition. An example of community attitude is the opinion or feelings about the cause of a particular disease, while community practice refers to the common health seeking pattern in the community. Where the majority of community members hold the opinion that the cause of a certain health condition is traditional, they will act towards getting traditional remedies to the health condition.

For effective implementation of CDI in any community, it is important to understand the attitudes, in other words, opinion or feelings of the community members to the health intervention that is intended for delivery through CDI. It is also important to understand actions taken in response to the health conditions in the past. The facilitator of the CDI process should get the community members to review the effectiveness of their past efforts and think of alternative ways of handling the same health problem.

## **COMMUNITY COMPOSITION**

Here, focus is on the socio-demographic characterization of the population of the community on the basis of distinct groupings such as income or asset inequality, age, sex and ethnic diversity all of which have significant impact on production, allocation and utilization of local resources for public good (24, 25, 26, 27, 28). In CDI, one finds a substantial degree of heterogeneity in the composition of the communities. In every community, for instance, one must find men

and women, aged, adult, youth and children, rich and poor. In some, one finds dominant and minority ethnic and religious groups among other differences.

An understanding of community demographic composition is germane to the realization of the goals of any CDI.

Community composition may affect local public good provision if the people in the different components of the community have different group preferences over communal services (29, 30). When these preferences are correlated with demographic characteristics like ethnicity or citizenship status, sex and age then increasing demographic diversity implies reduced consensus on provision of local public services like health. Individuals with divergent preferences, looking forward to certain health packages chosen by the median population, will differ relatively substantially from their own preferred outcome and will choose lower levels of tasks and fewer services.

Divergence in preferences over certain types of communal goods and services may be expected, especially if service provision involves choices about social or cultural factors (e.g. provision of services to married women in societies with male-dominant ideologies). Alesina, Baqir & Easterly (29) emphasize that many other public services may have a non-obvious ethnic or cultural dimension, if, for example, choices must be made about the mode of delivery of the social services. However, there are certainly classes of public services for which it is difficult to understand why ethnic groups' preferences would significantly diverge, such as health infrastructures.

Even with identical tastes for public services, diverse communities may opt for less involving public good tasks if the population exhibit "within group affinity" (24, 31) or "discriminatory community preferences" (28). In this scenario, individual involvement and contribution to the process of providing

public goods is a function of consumption, public goods, and community welfare, where the welfare of members of different groups within the community may be subjective (32). When individuals prefer that benefits accrue to members of their own group, they choose lower levels of task in the process when they find themselves in relatively heterogeneously or diversely composed communities.

In the event that the enforcement of social sanctions is less costly within groups than across groups, and such sanctions are important for determining the quality of participation in public services, more diverse communities may choose lower levels of participation even when preferences are identical and within-group affinity is absent. In many rural African settings, social sanctions are critical for overcoming collective action problems and compelling adherence. Consequently, networks and norms that exist within ethnic and cultural groups, but which may be lower or missing across groups, result in higher levels of participation on public ventures in less diverse communities. Community composition may also affect outcomes of community goals because community demographics result in differential benefits across groups. Here people with different group affiliation are disproportionately willing to invest their time and resource to the implementation of local projects.

It is also important to ensure the involvement of the main categories of a community in any CDI process. For instance, as mentioned elsewhere, we have males and females; the elderly, adults, youth and children. Each of these categories of community population is crucial to the successful implementation of any CDI project. However, often the women and children are ignored in decision making. On the contrary, women are often the producers of health care in the homes and cater for the



children. Together, the women and children constitute the majority of populations in many African communities. It is therefore important that the facilitator of any CDI project undertakes a gender analysis of the population to understand where and how to get people of all gender in the community adequately sensitized and mobilized. It is important to know the socioeconomic activities of the people and ascertain the best approach to targeting the different groups.

In summary therefore, for a successful implementation of a CDI programme, there is need to understand the composition of the community and ensure that all the elements of the community are carried on in the planning and implementation stages.

## COMMUNITY STRUCTURE

Communities are often fragmented and sometimes at odds within themselves (33). A community is a complex of different parts and structures. Businesses, social services, education, and health care, political systems among others coexist within their own

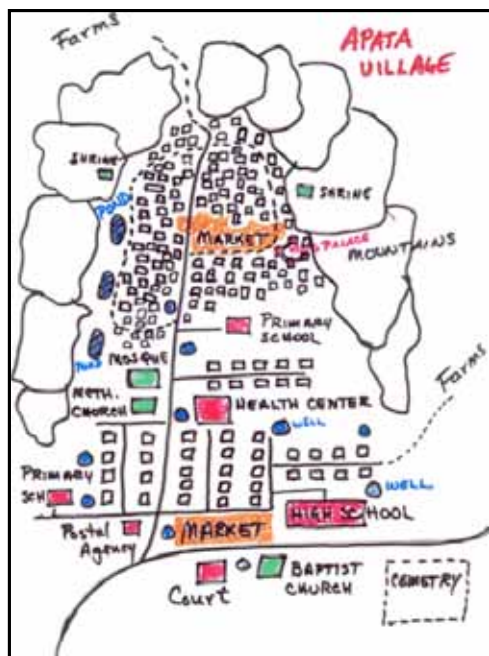


Fig. 2: Village structure

world and within the community. People are usually integrated into communities of interacting structures or parts. A community is an assemblage of independent parts and structures. A community is comparable to a super-organism and the parts or people are like the organs in a body.

Every community has emergent properties, all of which form the structure. Community structure and function express interactions of individual species in local associations.

**Community structure thus refers to the existence of groups connected in interaction for the purpose of attaining shared goals.**

In discussing community structure one is mindful of the physical and social relationship components of the community.

### Physical Structures

- Health facilities and providers
- Schools, Religious Institutions
- Boundaries.

### Social Relationships Structures

- Existing organizations and level of activity
- Wards, kinship groups
- Utilization patterns and barriers

In CDI, it is important to have a sense of:

- where do people live?
- where are the problem areas?
- where are the community resources?
- where are others doing their activities?

Community mapping is thus an important component of the implementation of CDI project. It is a joint activity with the community where all can learn more. Mapping helps to link people in need with the services and resources they need. Mapping provides useful tools for making sense of social networks and behaviors related to the intervention. In health intervention we are interested in:

- in the size of the high risk target group;

- their utilization behaviors;
- the places and persons to whom they go for help;
- what attracts them to the people and places.

When community members are involved in mapping they learn more about the problems and resources in their community. They can visualize service quality issues like access and equity. During the community meeting ask the group to mention key persons and organizations in the community that can help promote the program. Identify any possible opposing people or road blocks. Learn about past efforts at community development and why these succeeded or not. Ask people to mention and describe the location of key health and development resources that the community values:

- healers
- opinion leaders
- medicine shops
- local associations, etc.

**Ask people about major sub-divisions of the community such as wards, clans, etc.**

**Specifically ask about resources – people and organizations – that sick people go to for advice and help:**

- Where do they get advice?
- Are there women who regularly deliver babies?
- Where do they get medicines?
- From whom do they get financial, emotional and other support?

**Use the map developed to:**

- develop the criteria of best types of people to assist with the implementation of the intervention;
- determine sub-communities (wards, clans, families, neighborhoods) that could form basis of selecting implementers;

- determine gender relations, noting particularly where and when women, men and youth meet.

**Some factors that may influence the structure of a community include:**

- the status and concentration of the services in the area;
- whether it is urban or rural;
- the way people utilize the services that are there.

**Some Rural Issues**

- Greater community cohesion
- Smaller and more dispersed units
- Seasonal habitation
- Poorer generally.

**Some Urban Issues**

- Weaker identity and cohesion
- More compact, but people travel far for work and social needs
- Financial gain often supersedes
- Poverty and wealth.

## COMMUNITY ORGANIZATIONS

Sometimes known as community-based organizations, these are *civil society non-profit organizations* that operate within a single local *community*. They are basically a part of the wider group of non-profit organizations found everywhere in the world today operating to deliver essential goods to disadvantaged populations. Thus, like other non-profit organizations, community organizations are often run on a *voluntary* basis and are self-funded. Community organizations vary in terms of size and organizational structure. Some are formally incorporated, with a written constitution and a board of directors, while others are much smaller and are more informal. Most of the organizations one finds in the communities where CDI is implemented in Africa are often informal. The existence of community organizations, especially in developing countries, has



**Fig. 3: Community organization**

strengthened the view that these “bottom-up” organizations are more effective in addressing local needs than larger charitable organizations.

Generally, community organizations are categorized into community-service and action, health, educational, personal growth and improvement, social welfare and self-help for the disadvantaged, depending on the role the members perform in the communities. These community organizations are ubiquitous and are found in developing and developed worlds alike. In the developed climes, we have such organizations as sports clubs, school groups, church groups, youth groups and community support groups are all typical examples of community organizations. In developing countries, like those in Sub-Saharan Africa, on the other hand, community organizations often focus on community strengthening, creating health awareness, human rights, health clinics, orphan children support, water and sanitation provision, and economic issues, among others.

With their ubiquity and effectiveness in mobilizing communities to action, these organizations must be identified and involved in the planning and implementation of any CDI project in the communities. This is in line with the operationalization of essential health care, which is currently the focus of health care delivery in the communities. “Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made accessible to individual and families in the community through their full participation and at a cost that the community and country can afford to maintain in the spirit of self-reliance and self-determination” (34).

These community organizations have been known to be central to most community development projects, community work or community planning to improve the social well-being of local communities. Less formal efforts, called *community building* or *community organizing*, seek to empower individuals and groups of people by providing them with the skills they need to effect change in

their own communities (35). These skills often assist in building political power through the formation of large social groups working for a common agenda. CDI implementers must understand both how to work with individuals and how to affect communities' positions within the context of larger social institutions.

## SOCIAL NORMS

Social norms are informal rules that govern behaviour in any human society. They specify the types of behaviour considered appropriate in particular situations (36). Like culture they facilitate the adaptation of individuals to certain environments and make such individuals acceptable as participating members of the society. Social norms are customary rules of behavior that coordinate our interactions with others (37). Once a particular way of doing things becomes established as a rule, it continues in force because people prefer to conform to the rule given the expectation that others are going to conform (38).

This refers to both simple rules that are self-enforcing at a primary level, such as forms of greetings or giving right of way while driving at an intersection, and more complex rules that trigger sanctions against those who deviate from a first-order rule. While some scholars refer to the former simply as *conventions* and the latter *norms* (39, 40, 41), there are numerous gradations and levels of response to norm violation that make this dichotomy problematic.

Generally, behaviours in society are structured, and relationships between members of any society are organized in terms of rules which stipulate how people are expected to behave. Rules can be formal like country's constitution or informal like unwritten codes of acceptable behaviours. The latter is referred to as norms. Thus, "norms are specific guides to action, which tell you,

for example, how you are expected to dress and behave at a funeral or at a party" (36). Norms also dictate how to respond to childhood illness. In many developing societies, response to childhood febrile illnesses are delayed because of the norm which compels the mother to seek the approval of the child's father or his relatives before the child is taken to hospital. Similarly, norms dictate the way people receive strangers and also define what a stranger should do in response to the hospitality from the host.

It also defines the elements of a health intervention that are acceptable and those not acceptable and demanding functionally equivalent or alternative ways of implementing a particular aspect of the intervention. For instance, in some societies in Africa it is objectionable to count or ask a woman how many children she has, because she will fear that sorcerers in the community may decide to kill some of the children if they are considered too many. So, an alternative way of asking the question is 'how many grains of pepper do you have?' In the same token, people do not accept to be measured with sticks in some rural African communities, arguing that only a dead person is so measured.

Meanwhile, the calibrated pole is an important tool for determining dosage in CDTI for instance. What many communities did to take care of this is that a portion of a wall in the house of the community leader, CDD or the village hall, and in some cases individual homes are calibrated and eligible persons are asked to stand against the wall to determine their dosage of ivermectin by height.

Social norms are not always negative, because social relationships are patterned and recurrent, thanks to the existence of social norms. Thus, for the effective operation of any CDI project, the norms of the society must be sufficiently understood and respected so long as they do not hinder the progress of the project. Where however, the

norms are found to be retrogressive, very humane and polite steps should be taken to sensitize the people to the pros and cons of the norms *visà vis* their life.

Understanding the norms of any society, prior to the implementation of any CDI project is relevant to the success of the project. The social norms of the society will highlight the acceptable mode of interaction; how to get the stakeholders interested in the project. In some societies, there is a high sense of hospitality while others may be less hospitable due to their experiences. In some societies, it is offensive to refuse gifts and signs of friendships such as sharing and eating of Kola nuts, which comes in different forms, depending on the mood of the host. Demonstrating knowledge of the norms of the community, makes the stranger one with the people and the project is often on the right path to being acceptable.

Among the functions of social norms is to coordinate people's expectations in interactions that possess multiple equilibria (37). Norms govern a wide range of phenomena, namely rights and privileges, as well as rules of obligations and reciprocity, forms of communication, and concepts of justice. Social norms impose uniformity of behavior within a given social group, but often vary among groups. They shape our sense of obligation to family and community and determine the meanings interacting individuals in a community attach to words and actions. A general opinion is that it is hard to think of a form of interaction that is not governed to some degree by social norms (38, 39, 41, 42, 43, 44, 45). Over time norm-shifts may occur due to changes in objective circumstances or by subjective changes in perceptions and expectations. All the same attention must be paid to the social norms of any society where the CDI process is to be introduced.



## **SOCIO-ECONOMIC AND POLITICAL CHARACTERISTICS OF THE COMMUNITY**

Social, demographic, economic and political factors are closely linked to environmental issues and the people's efforts at development. While, social norms and political experiences may enhance or hinder efforts to achieve sustainable solutions, different groups of people will have varying needs and desires as to what makes a community sustainable. It is important to be aware of the current political, demographic, social and economic patterns which may facilitate or impede planning and implementation of development plans or strategies.

### **Population and demographic characteristics**

The identification of population and demographic characteristics will help to provide a better understanding of the community that is being served with the CDI project. Characteristics that may be helpful in creating a community profile include population, population density, heterogeneity (indigenous with non-indigenous populations), occupational composition, median age, age and sex distributions, educational attainment, median and/or per capita income, and proportion of persons below poverty.

It is also important to identify housing patterns because this will also be helpful in developing a community profile. Housing or residential patterns that may be helpful in developing the community profile could include: household size, housing type, housing density, age of housing stock, and the percentage of owner and renter occupied units. Here, it is also crucial to recognize the layout of houses and the types of people found in the different layouts of the communities. In many large communities, people tend to congregate in terms of the homo-

geneity of the cultures. That is people with similar cultural backgrounds and norms tend to live together in a definite layout.

### **Economic Characteristics**

Communities can very easily be characterized on the basis of their economic realities. The economic realities of any community go a long way to predict the readiness of communities to support projects that are designed to improve on their lives. It follows therefore that the identification of the current economic characteristics of a community will also be an important part of defining the community. Several economic characteristics that should be collected include information on major employers, employment by sector (agriculture, manufacturing, wholesale trends, retail trend and services), journey to work data and unemployment data, employability of the population. CDI requires capable hands that are resident in the communities and not frequently removed for issues of employment.

### **Political Characteristics**

Every community is organized on the basis of some definite relationship between the leadership and followership. Communities can be characterized on the basis of their political systems. Many rural communities in Africa can be divided into those with centralized and those with decentralized authorities. In the centralized system, there is an overall political head of the domain. The overall head here however has court officials and representatives who ensure the maintenance of the administration as well as conformity to rules and norms.

In the decentralized system, we have segmentary lineage structure, which forms the basis for political organization. In some communities, we have other forms of political authority which are diffused and



**Fig. 4: Typical political characteristic of communities in Africa**

are found in clanship, priest, titleholders, secret societies, age grades, lineage heads and women associations.

It is important to understand the political system of any community where CDI projects are planned for implementation. The reason for this is not far-fetched. CDI is a process which aims at empowering the communities to take charge of the planning and implementation of health and development interventions for the benefits of their populations. The process starts with first identifying and sensitizing the political leadership before moving down to meet the community members to sell the project ideas. The political leaders also set the

standards of relationships in the community and help in conflict management. Some political characteristics that should be collected include: the political system (centralized or decentralized); diffuseness or superimposition of traditional, religious, economic and social power; number of leaders/sub leaders; the role of men, women, youth and non-profit organizations in the leadership of the community.

## MOTIVATIONAL DEVICES (INCENTIVES)

It bears reiteration to state that communities have definite roles to play in the implementation of any CDI project within their domain. Chief among the roles of the communities is to select members of the community to be trained by the health workers on the delivery of specific health interventions. Those community members so trained have the task of ensuring that everyone eligible for the intervention commodity does not only access the intervention in good quantity and quality but also adhere to the recommended use of the commodities. Sometimes, ensuring proper use of these intervention commodities may entail visiting the homes of eligible community members to give them the commodities and monitor utilization. In other cases, distribution could be done in a central place. In yet another case, the community may decide that the community agent, trained for the delivery of the intervention commodities

first distribute the commodities in a central place and later go from house to house to ensure that all eligible persons are covered. Some commodities, irrespective of the central place distribution may require house visits from the community agent to monitor compliance. All of these entail man-hour put into the delivery of the interventions on the part of the distributor. Accounting for this man-hour put into the distribution of intervention commodities as well as carrying out other functions, such as community mobilization, sensitization and health education, is a major concern in the successful implementation of CDI projects. There is thus the need to consider some incentive schemes to motivate and sustain the commitment of the community distributors to the successful implementation of the CDI project.

Another responsibility of the community, beyond selecting a member of the community, who will be trained to deliver the intervention, is catering for the distributor and making sure that the distributor is

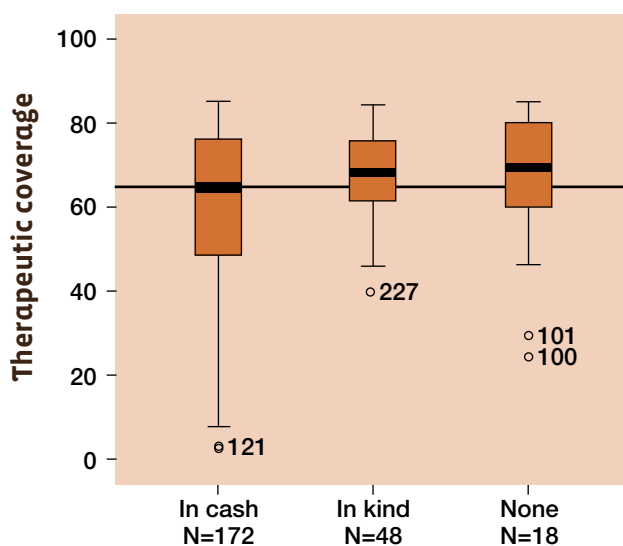


Fig. 5: Effect of incentives on therapeutic coverage



sufficiently motivated to do his/her work. The use of incentive schemes is an important instrument to motivate workers. This is particularly true for volunteers in projects in resource poor communities, who may lose their livelihood to provide services to other members of the community. However, experience has shown that different community centred projects come with different forms of incentives, some of which undermine the sustainability of the projects implemented at the community levels.

There are two basic types of incentives that are applied to motivate workers: explicit and implicit incentives. Explicit incentives are a direct way to stimulate workers basing their pay on productivity, for instance through a system that allows for piece-rates. This type of incentive is appropriate when the individual output is easy to observe and quantify. Some countries implementing the CDI system have tried to pay the community volunteers based on number of persons covered. This has its merits and demerits. The major merit of this system is the increased zeal and determination to cover many people. The demerits however are many. First, there could be cases of false declaration of high coverage. This in turn obscures the true case of defaulters, and creates a large pool of reservoirs of health problems and infections. Secondly, experience has shown that decision to pay on prorata basis is often political and is not sustainable.

Another system is the implicit incentives approach. Here incentive is not directly connected to productivity. It is often indirect and the recipient does not make serious claim to quantity of incentive since no quantity was agreed on.

Incentives could be pecuniary or non-pecuniary. Some organizations have been known to give direct financial incentives to motivate volunteers. Others give in-kind incentives instead. In-kind incentive could come in the

form of training, training materials, fez caps, T-shirts, writing pens among others.

The ultimate decision on how to motivate the distributor; what to motivate the distributor with, and in what quantity or quality the motivation should be lies with the community. Experience with CDTI is that communities give incentives such as exempting the volunteer from other community tasks, some provide labour for the volunteer, and other give farm products, seedlings and mineral. Yet others simply give their blessings to the volunteer, among others.

APOC assesses the forms of incentives given to the CDDs and their impacts on the programme coverage. The results showed that of the over 200 communities examined, 172 gave financial incentives; 48 gave in-kind incentive while 18 gave no incentive at all. In terms of the impact of the incentives on coverage, it was observed that coverage was higher among communities with no incentive and those with in kind incentive (5). There were wide variations in the coverage rates in communities with cash incentives. While the difference could be attributed to the sampling errors due to large differences in sample size, the results showed that communities are capable and do give different forms of incentives to their volunteers.

Experience from monitoring and evaluation (M&E) of CDTI projects in many African communities show that communities have different ways of motivating or compensating their volunteers. Where they fail to compensate their volunteers, reasons are often adduced for such lack of overt expression of appreciation in one form or another. In Ruvuma CDTI project area, a community leader was asked why the community selected only one CDD instead of the recommendation to get at least two CDDs per community. He responded that more CDDs will mean lose of more hands to communal

efforts. In other words the community exempted CDDs from other community duties. In other communities, the reason for not giving any incentive is because the CDDs are doing their normal community service. A community leader in Cameroon queried 'why should I pay or thank my child for sending him on errand'. Yet in others, volunteers were satisfied with the recognition of their contributions to their communities and regarded their sacrifices as God's work.

### THE VALUE OF COMMUNITY PARTICIPATION IN A CDI PROJECT

Participation means the active involvement of the local population in the decision making for and implementation of development and health projects. This is the bedrock of CDI. In CDI communities are empowered to take the major decisions in the implementation of any project delivered through the CDI strategy. The community both determines collective needs and priorities, and assumes responsibility for these decisions. The community also:

- formulates the health program;
- enables its residents to understand and make informed choices;
- reconcile outside objectives with community priorities.

The assumptions about the effects of community participation in any development or health intervention are not farfetched. First, community participation is known to increase programme acceptance, ownership and sustainability. It also ensures that programmes meet local needs and may reduce costs using local resources. When the communities are involved in the implementation of project, they are better positioned to identify and use local/familiar organizations, problem solving mechanisms – more efficiently.

Some examples of success stories recorded in the involvement of communities in health and development interventions could be found in ivermectin distribution. When communities are in charge there is often better coverage than when there is centrally organized distribution by a health agency. The original CDI field testing in 1995,

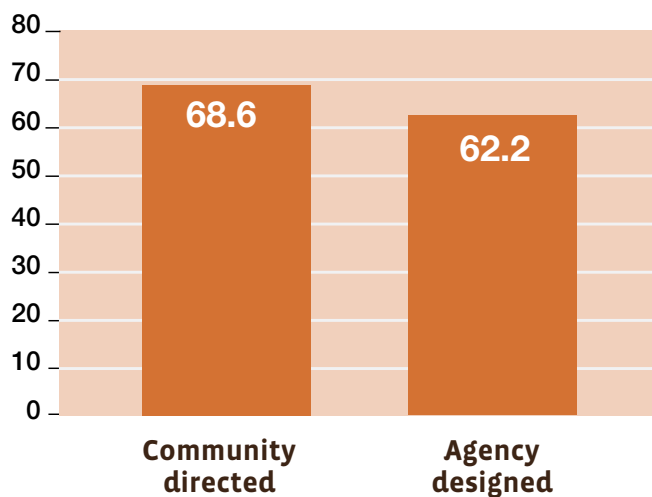


Fig. 6: Ivermectin coverage in 8-site project

showed better ivermectin coverage when the community was in charge of distribution.

In Guinea Worm eradication programmes, filter sales were better where village-selected health worker takes part in raising money, help in digging the well, dedicating the well as well as supervising use and maintenance. Similarly, in malaria management the HMM was designed to address access gap and enable communities to home-serve as first 'hospital'. This strategy relies on the community and services offered by the formal and informal private health sectors to meet the needs of the communities. An integral part of malaria case management with the overall RBM strategy lies here.

It is also argued that production of health is at home. What the people do or fail to do is crucial to the success of any CDI project. Hence the CDI strategy is designed to use a network of community resource persons both in planning, decision making and implementation. It follows therefore that a facilitator of a CDI project should think of what communities can do.

- Provision of manpower - Role Model Mothers, CDDs, traditional birth attendants (TBAs), trained community based workers and community leaders shall.
- Mobilize/sensitize the communities on the value of the intervention.
- Promote other control measures especially use of intervention commodities.
- Refer cases promptly to appropriate level of care.
- Encourage the community to acceptance and use of intervention services and commodities.

- Local resource people understand the cultural, social and economic realities of their own communities.
- These people can serve as volunteers and opinion leaders to promote malaria control and other interventions:
  - Traditional birth attendants (TBAs)
  - Religious Leaders
  - Teachers
  - Local Chiefs.

## CAN YOU NAME OTHERS?



- Community members represent a vital missing link in efforts to control health problems in their communities.
- Communities can mobilize members and resources for effective malaria control efforts and other interventions.
- Community involvement can strengthen facility and community linkages.
- Community agents can address and reduce the factors that impede control efforts.





# UNIT 3

## CONCEPT AND PHILOSOPHY OF CDI STRATEGY



# UNIT 3

## CONCEPT AND PHILOSOPHY OF CDI STRATEGY

### SECTION A: TRAINING OUTLINE

**PURPOSE:** To provide participants with knowledge and understanding on Community-Directed Intervention Strategy and to acquire the skills necessary for successful approaches to communities.

**PREREQUISITE MODULES:** Units 1 and 2.




**MODULE TIME:** 2 hours.

#### **LEARNING OBJECTIVES:**

At the end of the unit, the learners should be able to:

- a) define CDI;
- b) discuss the evolution of CDI from community participation principles;
- c) explain the roles of the various partners in CDI.
- d) discuss the influence of CDI on the accomplishment of Health for ALL;
- e) identify factors that enhance and inhibit the use of the CDI strategy.

## OVERVIEW • UNIT THREE

Step	Time	Activity/ method 	Content 	Resources needed 
1	5 min	Introductory Presentation to Unit	Learning Objectives and Content Introduction	Slides 1–3
2	15 min	Participatory presentation & Discussions	Definition of CDI	Slide 4–7
3	15 min	Participatory presentation & Discussions	Philosophy of CDI	Slides 8–11
4	20 min	Participatory presentation & Discussions	Roles of Health System in CDI Strategy	Slides 12–17
5	20 min	Participatory presentation & Discussion	Roles of the community, training institutions & partners	Slides 18–19
6	30 min	Participatory presentation & Discussion	Influence of the CDI Strategy on health Care delivery	Slide 20–21
7	10 min	Participatory presentation & Discussion	Factors that enhance and impinge on CDI	Slide 22–23
9	5 min	Conclusion	Evaluation & Summary of the Unit session	Slide 24

### MATERIALS AND EQUIPMENT CHECKLIST:

- PowerPoint slides
- Computer with LCD projector
- Flip chart
- Giant notepad
- Felt markers
- Blackboard.

## TEACHING GUIDE METHODS/ADVISORY NOTES TO TEACHERS:

For each of the following topics, > **ASK** participants to explain or to define in their proper meaning the following concepts:

- CDI approach is a **strategy** in which communities in **collaboration** with the *health service* and other partners jointly identify a **health problem** and subsequently **commit resources** for the planning and **implementation of interventions** against it;
- philosophy of CDI;
- roles of Health System in the CDI Strategy;
- roles of the Community, training institutions and partners;
- influence of the CDI Strategy on Health care delivery,
- factors that enhance and impinge on CDI.

> **WRITE** the points on the flipchart. > **USE** the list to facilitate a discussion, allowing participants to show key elements of each definition or explanation.

## TEACHING METHODS AND TECHNIQUES:

- Introductory presentation
- Brainstorming
- Questions & answers
- Group work/exercises
- Discovery method.



## SECTION B: NARRATIVE



### INTRODUCTION

CDI against health problems in Africa is probably the most widely discussed health-care delivery strategy in recent times. Although community participation in health intervention had become generally accepted as the best approach to ensure “Health for all”, the strategy for accomplishing it through community participation remained a challenge. The development of CDI through series of community participatory implementation research resolved the challenge. Research has not only identified the critical elements for community participation in long term health intervention, it has described the sequence of application of the elements for optimal effect. This strategy has been described as community directed intervention or CDI for short. The definition of CDI attempts to include the acceptable minimum factors that make it a discipline for delivery of primary health care.



## DEFINITION OF CDI

CDI approach is a **strategy** in which *communities* in **collaboration** with the *health service* and other partners jointly identify a **health problem** and subsequently **commit resources** to the planning, and **implementation of intervention** against it.

The above definition can be rephrased or translated to any other language. However certain key words must be easily identifiable whenever it is rephrased or translated. Can you identify them? The definition imposes certain conditions or requirements for a CDI to operate.

- **Strategy.** CDI is a strategy because it is a deliberately and thoughtfully planned scheme with a sequence of activities that must be followed in order for it to be called CDI. Once any step is missing or interchanged with another in sequence, it will lose the stratagem that makes it a CDI.
  - **Collaboration.** CDI can only operate within a partnership. The community and the health service are the main pillars of the partnership. Others are external agents such as development organizations, training and research institutions, and commodity and fund donors (or other facilitators such as the military in case of conflict areas). Without the community there cannot be any intervention, and there will not be any CDI. The reach and influence of the health service differ from one country to the other and may vary widely even within the same country. However, this should not be a reason to ignore whatever operates as the health service in the area. The initiating partner must identify the entity that represents and functions as the health service in the area and engage it as partner within the CDI strategy.
  - **Health problem.** Needless to mention, a health problem must exist for an intervention against it to be planned.
- There are several health problems in any given community. The health problem that is being addressed even if at the initiative of an external agent, must not only be acknowledged by the community as important, it must also have an intervention plan which offers opportunity for community to carry out a set of activities. For example, a drug trial or an implementation research is not an intervention but an investigation which falls into a different category even if the protocol has community participation in it, it is not yet an intervention. However, the distribution of pills on a large scale in a defined area (such as ivermectin or albendazole) or the *application of a procedure* for alleviating suffering due to some infectious diseases (such as consistent washing and hygiene for LF morbidity management) are examples of health problem interventions.
- **Commit resources.** Community must be a major investor in the entire process measured by and not merely a recipient or consumer of service, instructions and directives no matter how well thought out or well-meaning these may appear. Community participation is the amount of resource that the community invests (puts) into the various stages of intervention (planning, organization, implementation, monitoring and impact review). The community resource commitment is negotiated at the onset of the intervention and consists of a set of activities and obligations such as: head counting, collection, selecting a local provider, making local rules to ensure high coverage. Evaluators often assume wrongly that cash contribution is the only resource that counts. Community members may contribute time (for meeting, training), skills (making “tablet dosage poles”, organizing its members, advocacy, and mobilization) and various other services

of values without cash. These are highly valued and valuable resources.

- **Implementation of intervention.**

For a CDI to operate there must be an intervention against a health problem that is operational in the community.

**Can you list any possible health problems that can be implemented using CDI?**

## PHILOSOPHY OF CDI

### Community participation – from involvement to ownership

Long before now, man has recognised the right of the individual within the society to health. The health service in primitive societies is built around this concept. A right is an inalienable component of being human. Although the concept may have been founded on ethics, it has tremendous economic benefits since development is anchored on a healthy population.

The recognition of health as a human right issue led to resolution of the WHA to accomplish the goal of 'Health for All' by the Year 2020. The Alma Ata declaration of 1978 has had appreciable influence on country programmes, policies and strategies since it placed emphasis on removing the inequality in health care provision and making PHC the main focus of health systems and socio-economic development.

Constraints to Health for All are numerous but the most outstanding are resource (human and material) limitation for PHC delivery. The resources are not just for training health providers and personnel but for building infrastructure (roads, health facilities) and channels for delivery of service and supplies. The second is the absence of strategy for improving on the effectiveness of the current health system. These constraints imposed the need to generate knowledge for developing appropriate interventions

within communities and restructure the health system so that primary health would take the centre stage for increasing access to health care.

Although long practiced, the concept of community participation in health care was viewed with renewed interest.

## COMMUNITY PARTICIPATION

It is a fact that members of a community will come together to solve communal problems without external nudge or prompting. The origin of community participation is as old as man's effort to survive culminating in retention and actual passing on from one generation to the next those elements that were useful for survival of the species. Survival elements of trust, compassion, altruism, credibility and courage were rewarded hence their survival through the ages within the community.

There are recent examples of community members coming together to protect and secure their neighbourhoods against unwanted persons, to provide utilities such as water and to guarantee credit facilities to its members as well as to build roads and bridges and provide health services.

Following the Alma Ata declaration community participation was naturally the most attractive approach to follow in increasing the level of effectiveness of PHC delivery in order to achieve *Health for All*.

Every organization, health intervention manager and health care provider immediately embraced community participation as the strategy to use. Varying versions of community participation were introduced to ensure community involvement in a myriad of health problems. Empirical evidence of what works best and or how best practices could be replicated was lacking. It was difficult to identify the critical factors in community participation and their differential contribution to health. This is not new.

There is a historical perspective to community involvement in health with different levels of accomplishments.

This dilemma is also not surprising.

Health has always been founded on curative intervention even in industrial Europe and other parts of the advanced world, curative services took precedence over preventive until the latter half of the 19<sup>th</sup> century.

However, there are several examples of community involvement in health from colonial historical perspectives to use for situating the current CDI approach.

In colonial health care administration in Africa community participation was conceived as a means of getting local population to accept the biomedical concept of health problem prevention and drastically reducing the burden of infectious diseases.

The concept of community participation as a means of improving the efficiency and effectiveness of the health care delivery has been around for a long period. The extension

of medical services from a central hospital to rural communities through the establishment of health posts, mobile health visits, dispensaries ensured that more people are more promptly served. These extensions ensured that notification of epidemics was more rapid than dependence on hospitals. This is the crudest form of making health a right.

The success of this approach led to the introduction of mass involvement of the local people in health care delivery services (see Annex 2.3).

The most basic form of community participation is the involvement of the community in some specific task which they may neither understand nor be willing to perform.

An authority-based process of community participation using coercive enforcement of participation in Malawi (see Box 1) will yield results at the first practice but can hardly be applied for a project that is planned for much longer than one year.

### Box 1.

#### Community-based Small pox control in colonial Malawi (Nyasaland)

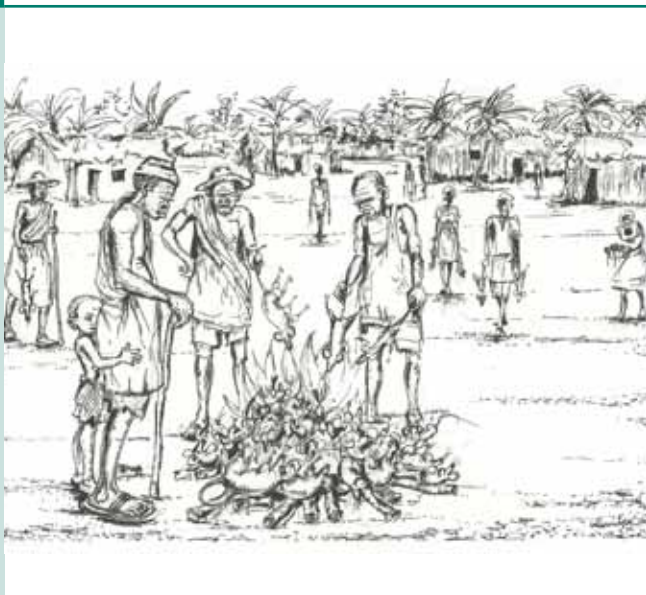
The health personnel goes to a village with the local police team and would round up the children and forcefully inoculate all of them against small pox. None of the children would be allowed to leave until the last one has been inoculated. Communities resisted this practice and would hide their children whenever the campaign teams were spotted. This trend changed when health officials informed and sought the support of local leaders.



## Box 2.

### Plague control in Colonial Congo

In colonial Congo, health authorities engaged communities to kill rats and pile up the carcasses on a pyre for public cremation at the village square! The spectacle of communal burning of the rats was exciting and served as motivation for participation. The children looked forward to the ritual of making fires for burning the days catch.



Authoritative, non-democratic government such as the colonial administration in many parts of Africa could while being authoritative make the process of participation a game to the extent that the participants would willingly take part. In the Congo, the reward of participation in rat destruction is the excitement inherent in the activity (see Box 2).

The attraction for community participation is based on certain observations that:

- a) When local communities are involved in disease prevention and the treatment of the sick the limited reach of the health service is extended and the prevailing inequality in the distribution of health care service minimized or removed;
- b) Community participation drastically reduces the cost and time of service delivery per person served (efficiency) and a higher proportion of communities within an area receives the service (geographical coverage) and the proportion of the population that receives the

service is significantly higher (therapeutic effectiveness) than when communities are mere recipient of service;

- c) With the participation of the community an intervention that is regular can be sustained over a long period.

### ASSESSMENT OF COMMUNITY PARTICIPATION IN HEALTH CARE DELIVERY APPROACHES

Without communities taking part in planning, designing and implementation it is almost impossible for an external agent to identify the various social factors that will influence intervention service absorption within the village.

Community participation takes place when community members perform specific tasks to resolve a community health problem. Community is involved when the community as an entity acknowledges the health problem and its members(s) carries out a specific task to resolve it. In CDI involvement is extended to include negotiated community

responsibility to ensure that the programme conceived design and implementation plan is acceptable to the community and that community commits resources to the intervention without coercion.

Health intervention experts noted that being based in the community or being involved are not enough guarantee for extending health for all.

The limitations of quick-fix *vertical approaches* to ensuring “Health for All” through limited community participation were observed to be the major hindrance to PHC development. The approaches keep the community perpetually a dependent recipient of service, at the whims and convenience of the health system and its partners. Issues of inequitable delivery of service, cost of service delivery, gender and cultural aloofness to programmes are best resolved when community processes of decision-making are considered in programme implementation. Active community investment builds collective confidence which in turn empowers the community as a unit to take on responsibility for its own health, make demand of the health service as a right and ensure that its members use the health intervention service as an obligatory contribution to the health of the entire community. The desired approach must therefore bypass these inherent weaknesses within the health system which focuses on the health facility and the health personnel.

## CDI AGAINST HEALTH PROBLEM: EVIDENCE-BASED COMMUNITY PARTICIPATION STRATEGY

Current development and understanding of community participation process was centered on the late 1980s around a black fly that transmits a blindness-causing worm against which a pharmaceutical company. In 1987, Merck donated the curative/preventive medicine, ivermectin free to all countries, *as long as needed*. The blindness-causing disease is endemic in at least 31 African countries with >37 million people infected. The challenge before the health system was how to ensure that all those affected receive the drug once every year! Although highly effective over the health-facility based approach to delivery of the annual single dose of the drug, community *involvement* alone was insufficient to reach all those that needed the ivermectin every year. Not-for-profit external agents introduced various versions of the community participation model to increase effectiveness and efficiency of delivery of the pill. Implementers and advocates of community participation in health care delivery relied on anecdotal reports of community capability when empowered, to reach out to skeptical donors to fund operational activities. In the absence of scientifically tested evidence to convince policy makers and assuage concerned stakeholders, enthusiastic advocates of health for all and community participation in the delivery of the pills faced stiff resistance to any task allocation to the community. Needless to say there was no shortage of skeptics. Knowledge about the extent to request communities to take active role was limited.

A 3-year interdisciplinary, multicountry intervention research team from East, West and Central Africa working across diverse health systems, policies, economies and socio-cultural settings but using the same protocol concluded that when empowered,

communities would raise the prevailing therapeutic coverage of ivermectin delivery from a miserly 62.2% to at least 65% and the geographical coverage to 100% (3). The study identified the conditions for CDI (Table 4):

- community must be provided all the information necessary for its members and leadership to acknowledge the health problem, appreciate the need for the intervention at that period, and understand the importance of its participation;
- community, as partner is given opportunity to review programme (externally) designed intervention approach or to develop their own intervention design, make input into the implementation plan (particularly determine the time and mode of delivery of service);
- community processes for selecting its service provider(s) and to determining those who represent it in the intervention team should be respected;
- health system must be an integral partner linking community with other external agents in the intervention process;
- specific responsibilities of partners especially that of the community and its capacity development needs for carrying out specific activities should be negotiated, clearly identified and accepted from the onset.

The affirmative conclusion of the study led to the adoption of the CDI in 1997 by APOC as the main strategy for ivermectin delivery in the control of riverblindness in endemic communities throughout Africa. With this fresh evidence-based knowledge many countries reviewed their policies to accommodate the strategy for ivermectin delivery. The approach was used to upscale ivermectin delivery from 1.5 million people treated in 1996 to over 75 million people treated in over 130 000 endemic African communities in 2010. The strategy enables the penetration

of areas that were once described as hard-to-reach and hence abandoned.

About ten years of implementation with outstanding success of accomplishment in taking the ivermectin to all, many governments, donors and stakeholders in health adopted the CDI strategy for multiple interventions. This is pertinent since health problems exist in multiples and an integration of multiple approaches may be the right way to go. An interdisciplinary study involving several countries was sought to identify factors that influence the community to participate in multiple interventions against health problems. Interventions involving a variety of health problems including the simple delivery of nutritional supplements (vitamins), ivermectin, bed net distribution and periodic impregnation with insecticide, malaria management to tuberculosis control were tested. CDI has probably attracted a great deal more research scrutiny than any other health issue in recent times addressing a variety of implementation questions from dosage regimen, simplified dosage determination schemes, decision-making structure, to community service provider workload, compliance and adherence to dosage regulations and pattern of participation. Drug-management issues, including dosing, shelf-life, safety, and the reporting of severe adverse experiences (SAEs), performance of CDDs when given additional responsibilities for other health and development activities within their communities have also attracted operational research. This indicates that the strategy filled the gap between the health care services and the communities.

The excitement that followed the realization of the numerous possibilities to which the CDI may be applied led to an array of definitions that are found in current literature. But the critical factor in CDI is that it is a step-wise **process** often initiated by health personnel and other external agents (Annex 2.4).

## ACTIVITY

- Insert Annex 2.4 into Annex 2.3 to make a single Table.
- Develop a flow chart for the evolution of CDI.



## SUSTAINABILITY

### Empowerment

is based on the skills that the community and/or its selected members must have to appreciate the importance of the problem and the benefits that its resolution will bring to the community. In order to appreciate the need for collaboration and identify resources that can be brought to the partnership the community and its chosen providers and representatives must be empowered.

- a) **Community as a whole** must receive information about the problem they have identified, its impact and severity in the

community or area, how it is contracted and available intervention against it. The community also must be informed of the contributions of various partners and what community must do in order to resolve the health problem. Specific issues of empowerment are discussed in Unit 4?

- b) **Individual empowerment** involves the transfer of specific skills to the community service provider (also referred to as community resource person, CDD or by other names) for specific activities. The training is given by the health personnel nearest to the community sometimes in conjunction with other health personnel or external agents. The focus of empowerment is to ensure that the individual from within the community is competent to provide specifically identified and agreed tasks on a regular and sustainable basis under the broad supervision of the health personnel nearest to the community.

Empowerment within CDI created demand which the health system was to meet (see Box 3).

### Box 3.

#### A concerned blind man led the village protest against delay in the supply of antimalarial and ITNs

In Garbacede, Taraba State Nigeria, there was delay in supply of antimalarial and insecticide treated nets to the community that has been on CDI for three years. Led by a blind man, the women protested to the health facility to ask for the commodities.





There is the argument that the sustainability of CDI project is measured by the ability of the community.

### **The community is better informed**

- i. About the health problem they had identified, particularly its pathology, economic effect on the community and mode of transmission.
- ii. To recognise those that have the problem in the community by observation of the symptoms.
- iii. About the roles of other partners and particularly about available intervention supplies.
- iv. About how they may access the intervention supplies that are available, particularly the conditions that are necessary for effective partnership with others.
- v. What the community is expected to do in order to benefit from available intervention.

### **When empowerment of the entire community takes specific concrete action**

- i. Determine how much of the intervention supply the community should request.
- ii. Appoint at least one community member that will be responsible for providing service to the community in respect of the intervention (often called the Community directed service provider or CDD). Note the word “directed”. This word is important and may not be removed from whatever term is used for describing the person.
- iii. Hold a meeting to plan the community resources that will be made available for intervention:
  - a) venue such as the school, faith house;

- b) time when meetings will be held or when intervention will be applied: time of day, period of the year (such as after harvesting, or before the rains);
  - c) mode of application of the intervention such as house-to-house, central point delivery;
  - d) monitoring and supervision of the process to ensure that service providers and users for the service comply with the conditions;
  - e) review how well they had ensured that all eligible community members for the intervention receive it.
- iv. Act as equal partners to other stakeholders.
  - v. Demonstrate control of the process of intervention for as long as the health problem persists and ownership of the outcome.

### **The health service and external agents also become better informed**

- i. Understand the biological epidemiology of the disease in the community (who is affected and to what extent).
- ii. Understand the cultural epidemiology of the health problem including:
  - a) community assessment of the extent and concern about the disease;
  - b) local knowledge, beliefs and perception about causation and effect;
  - c) community indigenous practices to alleviate the problem;
  - d) community willingness to collaborate with others to resolve it.
- iii. Collaborate with the community as equal partners.

## THE ROLES OF HEALTH SYSTEM IN THE CDI STRATEGY

The responsibility of the health system is to ensure compliance with intervention rules, coordinate supply chain as well as provide community confidence before, during and after the intervention. The specific activities of the health system within the CDI strategy are:

- i. The health system determines the intervention that is available and the activities that are required of the community within the broad intervention plan.
- ii. Approach and introduce the intervention to the community.
- iii. Provide information, education and communicate the planned programme in a manner that the community understands it.
- iv. Counsel/refer the individual.
- v. Provide referral services at the time of the community implementation. This is essential for ensuring that reactions and adverse events are immediately managed to avoid untoward situations that may demotivate the community selected providers.
- vi. Fill any information gaps and manage side effects that may arise.
- vii. Monitor compliance and notify of reactions.
- viii. Provide community confidence assurance and counseling.
- ix. Collate and compile reports.
- x. Record the number of people with adverse reactions in the summary form.
- xi. Evaluate the Treatment Exercise and determine:
  - a) proportion that received the service in the entire community;
  - b) proportion that refused and the reasons for refusal;
  - c) extent to which community met its obligation (express appreciation to the leaders and the community at the earliest opportunity);
- d) identify things that could have been done differently;
- e) identify unique initiatives for commendation.
- xii. Meet the community leaders and other interest groups to:
  - a) share observations with the community leaders;
  - b) ensure that specific and firm decisions are taken to improve the programme in the next distribution.
- xiii. Planning the next distribution:
  - a) request feedback from the supervisor on how the community has performed (take the suggestions of the supervisor as sincere advise);
  - b) inquire about the next refresher training/retraining;
  - c) discuss with community leaders about period of next distribution and the requirements (e.g. more CDDs to be trained, transport to training centre etc.).

## THE ROLES OF THE COMMUNITY

The roles of the community are essentially complementary to that of the State since it is unit of government with a governance structure complete with legislation, administration and judiciary. It also has authority to make rules, give rewards and impose sanctions. Community governance is based on norms and on a huge amount of information on the individual members which no other institution has. Communities are resilient and have several ways of resolving problems. Contrary to traditional economic assumptions individuals are not exclusively motivated by extrinsic incentives but since the oldest and most enduring incentives are intrinsic. Communities still value and use trust, credibility, courage, honesty, compassion, and diligence for allocating tasks to

its members and giving reward. CDI has shown that these factors are still the greatest commodity for community governance. CDI processes include organization, planning, evaluation, cooperation and contribution of time, labour and resources by the community. It is the responsibility of the community to implement the intervention at the community level and ensure that all eligible individuals receive its benefits. The specific activities of the community are:

- i. Select community service provider.
- ii. Decide mode and time of service delivery.
- iii. Attend training and education sessions.
- iv. Estimate number to be served by the intervention.
- v. Collect intervention supplies from agreed collection point.
- vi. Store the intervention supplies at a pre-agreed facility (contact the health personnel supervisor if unsure).
- vii. Deliver service to community members following the training protocol.
- viii. Ensure adherence to intervention rules.
- ix. Provide leadership for intervention management:
  - a) supervise the Community service provider;
  - b) make local rules to ensure optimal compliance (community farming holiday, sanctions for defaulters);
  - c) motivate community members carrying out community activities using community reward system.
- x. The community service provider has a responsibility to the community that selects him/her to perform specific tasks:
  - a) attend training and other educational programmes in respect of the intervention programme;
  - b) provide information, education and communication to the community;
  - c) conduct census and estimate the population that will need the service;
  - d) collect or ensure that intervention commodities are available in the community;
  - e) keep record of how the intervention was delivered;
  - f) submit a record of intervention to the supply collection point;
  - g) provide feedback to the community.

## THE ROLES OF TRAINING INSTITUTIONS

The main role of the training institutions is to sustain the dynamism of continuing development of CDI into a viable and central discipline for the study and implementation of PHC.

- i. Develop into a learning discipline. That PHC is being taught to medical schools has become axiomatic despite the equally self-evident knowledge that the strategy for implementing it to ensure that health services reach all those in need is yet unclear. Training institutions will develop the CDI strategy as a discipline for the implementation and evaluation of PHC much similar to the discipline of epidemiology which assists the development of public health.
- ii. Promote the inclusion and further development of CDI within the curriculum of training institutions. This will be of immense benefits to MDGs and further the realization of the goals of the Alma Ata declaration of equity in healthcare.
- iii. Conduct research. Within training and educational institution and in the hands of students and faculty, CDI can undergo further development in response to a dynamic global need. The educational setting is ardent at evidence-based investigations and therefore the most suitable for sustaining current research needs of the CDI strategy. As

an evolving discipline, mutual benefits are likely from incorporating CDI into formal educational system. Issues such as non compliance, satisfaction, demand indices of mobilization efforts and training techniques will be routinely and frequently debated and addressed through research.

- iv. Train and mentor students and young professionals through regular and formal workshops and courses to acquire and use CDI skills for PHC delivery.
- v. Participate in independent and external participatory monitoring and evaluation of CDI projects
- vi. Develop training, teaching and implementation materials for use by implementers and policy makers. Training Manuals will facilitate the teacher's task and ensure uniformity in implementation.

## ROLES OF OTHER PARTNERS

The external agencies are often the initiators of most health interventions since they often have privileged information on resources that are available and possess the skills for harnessing them. The external agents are mainly civil society organizations, non-government, not-for-profit development organizations, donor organisations, research and development organisations and facilitators of development. Their responsibility is very critical to any intervention particularly CDIs. Some of the roles they play are:

- identification of opportunities and resources that can be applied to health problem;
- advocacy and mobilization of broad partnership for health problem intervention (such as WHO; Merck, Sharpe and Dome; GlaxoSmithKline for filarial elimination);

- procurement of intervention supplies such as ivermectin, vitamins, deworming medicines;
- establishment of core working groups such as APOC for health problem intervention;
- development of the most efficient and effective intervention plan and setting objectives to be achieved;
- serving as prompters and vessels of development;
- facilitation of core activities such as conducting situational analysis, initial entry into community and stakeholders consultation meetings;
- facilitate development of CDI supportive activities such as information, education and communication materials, conduct monitoring and evaluation and periodic programme review.

## THE INFLUENCE OF THE CDI STRATEGY ON HEALTH CARE DELIVERY

Gingered by its several indirect benefits, including the de-worming of children who receive ivermectin, increased school attendance, general improvements in community and individual health, and increased food production at such a cost the implementation community made haste to use the CDI approach for health service delivery of all sorts of services. CDI effectiveness at raising the levels of intervention coverage including the level of vaccination programmes has endeared it to implementers.

From its use for the sole delivery of ivermectin to rural communities, CDI has evolved rapidly, to become a necessary tool for integrating health and development services at the community arena, in urban and rural areas of Africa irrespective of the nature of the health system in operations. The dynamic nature of the strategy that allows its use in health systems that are stable and in

those that are non-stable for delivering a wide range of services has increased its advocacy as PHC tool. CDI has a large number of advocates for its use as the tool for implementing PHC in Africa. The reasons for this are:

- i. It is able to take service to the largest proportion of the targeted population (actual coverage) than any other method currently in use and at the shortest possible time. For example a region of 4 million people living in about 17,000 villages and towns spread across an area of 72,000 square kilometres could receive the intervention commodity such as bed nets within 5 days of distribution at the district health facility to community representatives.
- ii. It is able to ensure that all communities, segments within communities, irrespective of social and cultural differences, are reached thus ensuring 100% coverage and surmounting obstacles that hinder other strategies such as bad roads, climate, and inequity. Once a community is able to select and send a representative to the health commodity collection centre, such a community is served.
- iii. It is capable of regularity and consistency over a long period of time. In fact as long as the commodity is available the community will ritually perform the activity as requested. For example in Uganda, it has been used to ensure that over 70% of people living in endemic areas consistently received ivermectin for 10 years.
- iv. Its superior effectiveness over other approaches in the control of lymphatic filariasis has also been acknowledged in several other studies
- v. The strategy is highly efficient as the cost of delivery of intervention per community is shared among all partners (community, health system, external agencies). For example, community contribution to ivermectin delivery through the strategy is comparable to



- the contribution of the health system. The economic return from using the strategy for ivermectin delivery is estimated at 17%, making it far much cheaper than other approaches.
- vi. The inherent components of CDI such as capacity-building, mobilization of resources and empowerment of communities have an added value to the PHC.
  - vii. The CDI provided veritable vehicle conveying other programmes far beyond traditional sphere of the health facility to the poor in rural hard-to-reach hamlets.
  - viii. PHC programmes were developed for the communities by health experts who assume knowledge of the community.
  - ix. Non-government organizations (NGOs) and development partners were quick to observe the opportunity that the strategy provided for “scaling up” “expanding” “upgrading” and rapidly increasing coverage of their services.
  - x. It reduced the burden of work on the inadequate human resources for health care delivery and makes the accomplishment of the MDGs for health more likely.
  - xi. The assurance of a strategy for delivery of supplies to communities is motivation for agencies to donate highly valuable commodities and supplies for distribution to large populations in far flung areas of Africa.
  - xii. It has the advantage of carrying services beyond traditional reach of the health system and of surmounting often cited barriers to extending services beyond the immediate locale of the health facility.
  - xiii. It costs less on aggregate to use CDI than any other strategy yet conceptualized for health care service delivery. CDI surmounts factors that create inequity in health care access such as social class, sex, religion and several other factors that mitigate against the use of health facility.
  - xiv. CDI strategy is versatile enough to enable its use for the delivery of multiple interventions even when such interventions require a series of skills and logical sequence of actions such as malaria diagnosis and treatment.
  - xv. The CDI strategy taught the health system to develop simple non-evasive health problem recognition techniques, to value partnership, the benefits of working with community institutions and the importance of operations research for resolving implementation puzzles.

## FACTORS THAT ENHANCE AND IMPINGE ON CDI

The government and its functionaries have powers to enforce rules that govern the interaction between individuals, private agents and associations including communities. The use of these powers may enhance or impinge on CDI practice and may even destroy its gains. It is useful to study how government policies and individual decisions and actions may enhance CDI and discuss how the converse may also occur.

### Enhancement factors

Public policy is the central factor that can enhance the desirable aspects of CDI. Public policy guides the relationship between the partners and its influence on CDI is critical to the outcome.

- i. Communities that invest resources into solving collective problems such as health problems are allowed to own the fruit of their labour. Too often government or functionaries of government and politicians take over the outcome of community efforts. In CDI the community has been largely protected from this phenomenon despite occasional usurpation of achievements by some local councillors seeking recognition. There are reports

of local political figure giving money to CDDs in an area to win votes. Such donations should be given to the community as a whole and not to a segment in the chain of contribution to CDI. The CDD is not the only player in the CDI project at the community level and singling out the CDD for payment is unfair to the others including the village head and other organisers who may withdraw their efforts as a result of this action.

- ii. Policies that increase the viability of the actions of the peers in communities are recognized. Every community has rules which are neither repugnant to natural justice nor unfair. These rules include decision-making, reward system, task allocation schedules. CDI has ensured that communities are allowed to use these mechanisms for implementing health intervention.
- iii. CDI is enhanced by harnessing selfishness motives to socially valued ends. For example if a politician wants to donate, it is given to the community or used to buy bicycles for all the health facilities in the area, sinking a well in a community that has consistently had the highest coverage in five years. These are enhancers of CDI that were observed in the field.
- iv. CDI functions very well in an environment that is legally favourable where government is open to voluntary work, does not alter policies arbitrarily and has respect for communal initiatives. Where government is authoritative and non-democratic, CDI may flounder and die.
- v. CDI does exceeding well, where government functionaries in the health system and other partners meet their obligations within the negotiated strategy for implementation. For example the health system supplies the commodities to the collection point, trained the CDDs

and partners delivered on promises, etc. A delay without explanation to the community or failure to keep an obligation has a negative perception and over time becomes a norm associated with the defaulting partner.

### Impinging factors

As the most advance form of community participation, CDI is like any organized resource governance regime and therefore highly vulnerable to threats from both internal and external challenges of their long term viability. However these challenges can be curtailed by ensuring that the community remains the unit of governance of the implementation activities. For example, activities in one community may not be linked to what other community will do or must not do.

- i. The community must be so defined that it remains small scale and relatively homogeneous.
- ii. Share the skills and information that are available to the selected provider with other members of the community in order to avoid exploitation by providers.
- iii. Where communities have sharply defined outsider-insider distinction, divisiveness along race, religion, nationality and sex may be exacerbated and contribute to collapse. Politicians often exploit these attributes of communities in order to win votes. At the moment there are no recorded examples of this challenge from CDI.
- iv. The loss of a major investor in the partnership such as a funder of operations or an advocate, or a contributor of much needed resource may alter the viability of CDI
- v. Imposition of rules on all communities in a region by a superior authority such as imposing cost on voluntary work

- may alter the CDI and in fact harm it drastically.
- vi. Rapid changes in technology such as replacement of insecticide treated bed nets (ITNs) with long lasting insecticide treated bed nets (LLINs) or alteration of antimalarial or provision of transport by an external agent to the CDDs may be a challenge to the community commodity of trust, compassion, credibility and altruism.
  - vii. Transmission failure from one generation to the other, of the norms, values and operational principles on which CDI is built may lead to distortion or complete misinterpretation. Inclusion in institutional curriculum and development of training manuals will circumvent this challenge.
  - viii. Ignoring the community for a very long period particularly as a result of complacency by the external facilitator if they seem to be doing well may lead to apathy and decay. Introduction of new initiatives and face to face communication will improve cooperation and give impetus to community action.
  - ix. Absence of institutional arrangement or mechanisms for partners to resolve conflict may lead to dissatisfaction. For example, communities should have a place in the Ministry of Health where a grievance against a partner can be taken without fear of retribution.
  - x. International aid and other external agents that ignore indigenous knowledge and motivation discourage CDI to flower and yield desired outcome.

The belief that local communities must accept without question and in fact with gratitude the biomedical concept and whatever prescription the health service makes for alleviating the community health problem is a challenge to CDI.

- xi. Health system inability to keep their own negotiated agreement with the community, such as commodity supply time and adequacy, training period etc.
- xii. Slow approach to applying the CDI strategy for the implementation of existing PHC services in an integrated manner in order to enhance the latter which a resistant PHC may either delay or put in jeopardy since ultimately it is the health system that must use CDI to strengthen its ability to deliver services in order to achieve and maintain optimal level of service delivery.

### Self-evaluation

- Identify the essential keywords in CDI definition.
- Translate the definition of CDI into a language other than English and underline the keywords
- Distinguish between community participation and community involvement.
- Give example of community-based, community involvement and CDI.
- Mention 3 roles that the health system, community, partners and training institution must play within a CDI project.
- Write an essay on CDI as an emerging discipline for the implementation of PHC doctrine of Health for All.



## SUGGESTIONS FOR DISCUSSION



We need to have very firm discussions and come to a conclusion on the following terms:

- a) **Community participation**, community involvement, community-based viz-a-viz community-directed.
- b) **Partners**. Are communities, health system also in partnership? If so then what do we call the external agents such as training institutions, NGOs, donors, facilitating agencies? I ask this because we list roles of health systems, community, training institutions and then “partners” which I assume to mean “external agencies”.
- c) **Sustainability**. Must this be hinged on the community being able to do without an external agent? I do not think so. Sustainability should be the ability of a community to continue to carry out its activities within the agreed framework despite changing situations of CDD attrition, delayed drug arrival, changing economic variables, etc.





# UNIT 4

## CRITICAL COMPONENTS OF THE CDI STRATEGY

# 4

# UNIT 4

## CRITICAL COMPONENTS OF THE CDI STRATEGY

### SECTION A: TRAINING OUTLINE

**PURPOSE:** The purpose of this Unit is to enable learners to identify the essential components of an intervention that uses the CDI approach, recognizing the dynamic interactions between the health system, the communities and various stakeholders and development partners.

**PREREQUISITE MODULES:** Modules 1 to 3 will assist the learner in understanding the structure and functioning of two of the critical components of CDI – the health system and the community.




**UNIT TIME:** 3 hours.

#### **LEARNING OBJECTIVES:**

At the end of the unit, the learners will:

- a) outline the role effective communication plays in implementing and sustaining CDI;
- b) conduct a critical stakeholder's analysis for rolling out CDI;
- c) describe how the six basic health systems building blocks contribute to the implementation of CDI;
- e) explain the essential community processes and steps needed to implement CDI;
- f) discuss the broader impacts CDI has on health, development, social, political and economic systems in the community.

## OVERVIEW • UNIT FOUR

Step	Time	Activity/ method 	Content 	Resources needed 
1. Introduction to the Unit and basic concepts	15 min	<ul style="list-style-type: none"> <li>• Talk to review unit objectives and schedule</li> <li>• Discussion on objectives and expectations</li> </ul>	Unit objectives	<ul style="list-style-type: none"> <li>• Handout with objectives</li> <li>• Objectives posted on flipchart or chalkboard</li> <li>• Unit narrative document</li> </ul>
2. Communication processes essential to implementing and sustaining CDI	60 min	<ul style="list-style-type: none"> <li>• Brief lecture on audiences and messages for CDI in this country/location</li> <li>• Group work to complete communication analysis chart</li> <li>• Reporting by Groups</li> <li>• Role play delivering messages to different audiences using appropriate language levels with feedback</li> </ul>	See section 4.1	<ul style="list-style-type: none"> <li>• PowerPoint slides</li> <li>• Slide handouts</li> <li>• Charts for communication analysis</li> <li>• Role play scenarios printed</li> </ul>
3. Stakeholder analysis for implementing CDI	60 min	<ul style="list-style-type: none"> <li>• Brief lecture</li> <li>• Brainstorming potential stakeholders relevant to setting</li> <li>• Group work to fill out stakeholder analysis chart</li> <li>• Group reporting</li> </ul>	See section 4.2	<ul style="list-style-type: none"> <li>• PowerPoint slides</li> <li>• Slide handouts</li> <li>• Flipchart paper or chalk board</li> <li>• Markers or chalk</li> <li>• Printed copies of stakeholder chart</li> </ul>
4. Review of health systems dynamics and building blocks needed for CDI	60 min	<ul style="list-style-type: none"> <li>• Lecture</li> <li>• Group work on determining health system dynamics and building blocks to CDI in specific country setting (6 groups – one per building block) with reports from groups</li> </ul>	See section 4.3	<ul style="list-style-type: none"> <li>• PowerPoint slides</li> <li>• Slide handouts</li> <li>• Flipchart paper and markers for group work</li> </ul>

Step	Time	Activity/ method	Content	Resources needed
5. Essential Community processes to start up and sustain CDI	60 min	Participatory presentation and Discussion	See Section 4.4	<ul style="list-style-type: none"> <li>• Flipchart or chalk board with markers or chalk</li> <li>• PowerPoint</li> <li>• Slide handouts</li> <li>• Video</li> <li>• Role play scenario</li> </ul>
6. Discussion of broader systems effects of CDI	30 min	Participatory presentation and Discussion	See Section 4.	<ul style="list-style-type: none"> <li>• PowerPoint slides</li> <li>• Slide handouts</li> <li>• Case study handouts</li> </ul>
7. Wrap-up	15 min	Participatory presentation and Discussion	Evaluation and summary of the Unit session	<ul style="list-style-type: none"> <li>• Session evaluation forms</li> </ul>

### MATERIALS AND EQUIPMENT CHECKLIST:

- Projector and screen
- Flipchart paper and/or chalkboard
- Markers and/or chalk
- Masking tape to hang completed flipcharts
- Printed hand-outs – slides, case studies, worksheets, scenarios.

## TEACHING GUIDE METHODS/ADVISORY NOTES TO TEACHERS:

- > **SHARE** the narrative section of this unit as reference materials for the learners.
- > **ASK** learners to review key lessons from previous units at the beginning of the unit.
- > **GUIDE** the learners to understand the importance of communication in launching the CDI process and the fact that different target audiences will receive different but appropriate messages through culturally acceptable channels and media.
- > **ENCOURAGE** learners to identify and engage the main stakeholders on how they can ensure success of CDI roll out at national, state/regional, district and community levels and the different roles they play.
- > **PRESENT** the six main building blocks of a health system and explain the dynamics of how these contribute to a successful CDI program design and intervention.
- > **STRESS** that CDI is a process driven by the community and hence we must learn how to engage, empower and enlist community leaders, members and volunteers.
- > **HIGHLIGHT** the fact that community involvement in specific health issues creates broader system multiplier effects to improve local development.

## TEACHING METHODS AND TECHNIQUES:

Active learning is stressed, but we also take time to present basic knowledge in more standard didactic formats also. Therefore teaching of this unit uses:

- Brief lectures
- Group exercises
- Role plays
- Case studies
- Readings
- Sharing of experiences.

## SECTION B: NARRATIVE



### COMMUNICATION SKILLS

CDI requires good communication skills from beginning to end and at all levels. Communication helps create a sustainable system. Communication is needed with all district level partners to ensure each provides human, financial and material support for CDI efforts. Advocacy involves communication by partners to ensure adequate funding and policies. Communication is required to make sure all people involved from the program manager to the community member understand the CDI philosophy.

While there are university degrees offered in the field of communications, which we cannot replicate here, there are some basic communications issues that will facilitate the successful roll out of CDI. These include:

1. The use of easy-to-understand language in communicating with stakeholders. Since stakeholders might include lay people who are potential health service consumers, it will be very important to ensure that issues are conveyed at a level everybody will understand.
2. Interpretation of technical issues using most culturally appropriate mechanisms in communication especially in discussing disease causation and prevention technique etc.

3. Selection and use of appropriate channels or media based on audience segmentation will help to determine the extent of communication specialization.
4. Design and pre-testing of culturally appropriate and technically accurate behaviour change communication materials.

As we will see in the following sections there are several key audiences at different stages of CDI planning and implementation. The first key audience is the stakeholders at national, regional and district levels. The second key audience is the community.

Communications analysis is needed for implementing and sustaining CDI. Each partner and stakeholder requires certain information, messages and support to make their participation in CDI most effective. Even among a key group of stakeholder, there may be sub-group leading to the need for audience segmentation when formulating messages and channels. Different communication tools and channels may be required to reach different audiences. These issues are briefly addressed in Annex 2.5, but this needs to be adapted to the partners/stakeholders, culture and available communications media and channels in each setting.



## STAKEHOLDER PROCESS

CDI start-up and maintenance occurs in two different settings. In one setting CDI can build on existing CDTI projects where there already exists a network of communities and CDDs who have been oriented to the participatory processes underlying CDI. In other communities, there is no history of CDTI, but there may be other programs that have used community volunteers to extend services. Building CDI on an existing CDTI foundation may be somewhat easier than starting CDI in a fresh setting with no history of CDTI because of familiarity with the participatory concepts involved. In either case there will be stakeholders and partners who are unfamiliar with the concepts and principles of CDI and need to be brought on board.

Community level involvement in the delivery of basic health interventions has been recognized by a variety of organizations as an essential component of service delivery, without which coverage targets cannot be met. This vision of the community's role has not always been matched at the national level, or if it has been recognized, the collaboration among local partners to make it happen has not always been strong. Therefore, the need exists to identify and mobilize stakeholders to secure commitment to the CDI process from national to community level. Proponents of CDI must undertake advocacy for each specific intervention that is to be delivered through CDI.

Experience has shown that crucial and initial stakeholder advocacy and mobilization can take many months, and if not planned and executed properly, will further delay implementation of essential health interventions that communities need. Two big challenges exist when working with stakeholders. First do they recognize and accept an active role for the community in service delivery? Secondly, do they see value in integrating services through CDI or are they competing

over program territory? These questions must be answered through a proper stakeholder analysis (46).

The term stakeholder means that a person or group has not only an interest in a particular program or goal, but they are also willing to invest time, effort and resources to influence the outcome of that program or goal. Thus, the first step in stakeholder analysis is taking an inventory of all groups that are actively interested in the prompt and efficient delivery of a basic package of health interventions. Their actual role in the process of delivering basic services to the community must be outlined. These interested parties or groups must be identified specifically so that they can be contacted and potentially enlisted in the promotion of CDI.

Stakeholder analysis continues by determining their potential impact on a process like CDI along four dimensions: 1) nature of their interest in CDI; 2) their level of power or influence in program success; 3) their position in favour or opposition to a CDI approach; and 4) how the issue may impact on them.

Right from the start it must be noted that such stakeholders, while being interested in service delivery, this interest may vary from high to moderate to low depending on how important the particular program is to their overall organizational goals. Some organizations because of their level of funding or recognized expertise may wield more power over the direction of programs than others. Such power or influence on the adoption and outcome of program approaches may also vary from high to moderate to low.

While all may be interested to some extent, each may hold different attitudes and positions that are supportive, opposed, uncertain/undecided or neutral concerning service delivery through CDI. Finally, while the interest of these groups may influence the direction of CDI programming, the adoption

of CDI may have impact on the status or the group itself, being an enhancement or a threat or neutral impact.

The chart in Annex 2.6 provides a simplified outline of the analysis process. This may need to be repeated at national, regional and district levels. A final column is added for the purpose of planning stakeholder advocacy and mobilization. A simple rule of thumb follows:

Once an interested group of stakeholders has been identified, it is then necessary to bring them together to plan how the CDI process will be implemented nationally, regionally, in districts and in communities given the resources available from different programs and donors.

Part of the planning process among stakeholders will be agreeing on a basic start-up package of a few key community interventions that can be delivered through CDI by CDDs with their community's support. Stakeholders at this point need to share program manuals, behavioural change communication (BCC) materials and training guides that they have developed so that these can be harmonized.

The group will also need to plan how to defend the CDI approach against those who are opposed and monitor those who might potentially become interested in the future. This may involve presenting the case for CDI as a way of delivering integrated community interventions to important policy makers and high level officials.

To give a sense of reality to the stakeholder processes, we have listed below some of the common complaints we have encountered and that you may need to defend against using your communication skills:

- we believe community agents are good at health communication, and maybe handing out a drug like ivermectin, but we do not believe they can handle community case management of malaria and pneumonia;

- we are worried that community volunteers cannot maintain the confidentiality needed for a successful TB DOTS program;
- our community-based mass drug administration efforts have been successful in the past, so why should we change our strategy?
- our donors expect us to report on indicators for a particular disease control effort. If we join with you on CDI how can we get the statistics we need for reporting our own program results?
- community volunteers will demand too many incentives and we do not have funds to sustain that.

These concerns are natural. CDI is a new way of working among agencies and with the community that involves sharing power and influence. It will take time for all stakeholders to feel comfortable with such sharing.

## HEALTH SYSTEM DYNAMICS

This section addresses the key health systems requirement for CDI success and uses WHO's Basic Building Blocks of Health System framework to address the issue (47). These building blocks include: 1) Service delivery; 2) Health workforce; 3) Information; 4) Medical Products and Technologies; 5) Health Financing; and 6) Leadership/Governance.

Stress is needed again that CDI strengthens health services. CDI is not a separate system. Therefore providing ivermectin and other basic health services through CDI shows that the health system needs CDI to achieve coverage targets and CDI needs the health system to ensure basic commodities are available. The two are interdependent and result in a partnership between community and health services. CDI is not a typical volunteer program – it is a partnership program.

## Service delivery

Unit 1 provided a background on challenges of health systems in delivering primary health care at the grassroots. CDI and its forebear, CDTI, brought the community to the forefront in the timely delivery of basic services at the doorsteps of the community. By encouraging the community to take charge of service delivery it is possible to achieve coverage targets of key interventions that save lives.

Stakeholders must decide on the basic package of interventions and services that will be delivered through CDI in their own regions, states and districts depending on locally endemic diseases and the availability of the commodities themselves.

## Health workforce

Countries that are implementing CDI are often faced with workforce shortages. Such shortages may include lack of trained professionals who have left the country and may also refer to imbalances such as a dearth of staff in rural areas. By involving the community in health care delivery, CDI plays an important role in addressing health workforce gaps.

One of the essential features of CDI is that it strengthens the health workforce in these resource limited settings. An obvious contribution of the CDI process is bringing to bear the energies and contributions of community members on the solution of health problems and delivery of health services. We should not forget though that by training district and front-line health staff in CDI processes, we are giving them the skills to find creative solutions through community involvement to address workforce gaps.

The key concept is that first the existing health workers at district and facility level must be oriented and trained to set up and manage CDI processes. Secondly, these

trained staff will mobilize communities to select volunteers (CDDs), who will then be trained by front-line health workers. The types of staff to be trained depend largely on which cadres are available at each level. The whole district health team requires orientation since CDI will entail a package of interventions that will rely on supervisors in the areas of disease control, pharmacy, maternal and child health, and M&E. At the front-line level, all existing staff, whether they be nurses, midwives, health extension workers, environmental officers or pharmacy technicians, have a role to play.

Details about training and supervision at all levels are found in Units 6 and 7 respectively. In Unit 6 we will also see reference to a CDI training manual. Broadly speaking, CDI training and supervision would consist of two components: 1) technical updates for all staff on the interventions that comprise the CDI package in a given setting; and 2) specific CDI organizational skills for those designated as CDI coordinators at district and facility levels.

## Information

We have seen above that a common concern for stakeholders who want to join forces over an integrated community service delivery process is the need to secure data that shows they are successfully delivering the services to their target populations. Again starting at the community level one needs to include design and provision of community register books so that a page can be given to each household and its members and columns for services given. Reporting sheets must be locally appropriate so that they:

- account for all health commodities provided;
- enable recording of health education sessions;
- be easy to mark for low literacy level CDDs;
- be no longer than one page.

CDD training should include a session on how to keep records and submit monthly summary forms. In addition, health staff should review on a regular basis the records kept by the CDDs they supervise. One method for regular data collection is holding of monthly CDD review and supervisory meetings where CDDs bring their summary forms. More details on information processes for CDI are found in Unit 8, which focuses on M&E.

### Products and technologies

CDI strategy creates demand for appropriate products and technologies, to succeed with the roll out of implementation activities there must be adequate supply to meet demand. This places an additional task on the health system. Normally procurement and supply management (PSM) processes are geared to ensuring that essential drugs and supplies are made available at the front line health facility from where all catchment communities receive their supplies.

CDI requires facility staff to be proactive and forecast their needs based on population estimates for their catchment areas as usage records. Obtaining good reliable population data becomes paramount. This can be achieved through community mapping and head counts usually conducted with the assistance of the community-selected CDDs. The data generated will be used for the first initial forecast and estimate of commodity needs, while replenishment is made over time as consumption is established. Once the above is achieved, there is need for sustained advocacy to ensure adequate stock management and storage facilities at all levels and point of service delivery. This underscores the need for good storage facility and stock maintenance that will include adequate space, shelves and ventilation that would ensure that medicines are kept at an adequate temperature, humidity, stability and safety.

Monitoring medicines' safety and stability are also very important to ensure that commodities maintain the same quality they were supplied prior to use. Once these are put in place it is also necessary to ascertain if there are existing channels of distribution or making demand for the delivery of intervention commodities and services. A good cold-chain management will require putting in place a good record keeping system. This system will involve the use of inventory, requisition forms and bin-cards. The overall goal of procurement and supply chain management is to ensure regular, adequate and timely supply of all the materials to be delivered.

Of particular interest for starting up CDI is the agreement among stakeholders about the start-up basic package of interventions to be included. Five or six basic services could probably be handled during the initial training and start-up phase. Depending on local disease context this might include the following, for example:

Health Issue/ Condition	Start-up Commodities
Malaria	Sulfadoxine-Pyrimethamine for Intermittent Preventive Treatment (IPT) in Pregnancy
	Artemisinin-based Combination Therapy (ACTs) in the four age group packets
	Rapid Diagnostic Test (RDTs) Kits
	LLINs for "keep-up" supply
Pneumonia	Cotrimoxazole

Health Issue/ Condition	Start-up Commodities
Diarrhoea	Oral Rehydration Salt (ORS) Packets
Onchocerciasis	Ivermectin
Worms	De-worming Medicine

Starting at the community level, one of the first tasks performed after CDDs are trained is their mobilization of the community to conduct a community census and develop that into a community register. This register which has a page for each household and includes age and sex of each household member provides the basis for estimating the needs for different health commodities. These estimates are then shared with the CDI supervisory staff at the nearest health facility. The community also needs to make sure there is a safe place to store any medicines and commodities. This might be a lockable box or cupboard.

CDD training should include a component of supply management. The requirements for each commodity should be explained during training and samples of storage containers be presented.

When the staff of the front-line health facilities receive the census and commodity estimates from the communities in their catchment areas, they produce a combined forecast and request to the district medical/pharmacy stores (though in some countries health facilities are supplied directly by regional authorities). These front-line facilities must ensure that they have adequate and safe storage space for the commodities supplied for CDI. There needs to be adequate ventilation for those items that need to be kept relatively cool, shelves to ensure that medicines and supplies are not sitting on the

floor and can be easily organized and sorted, and provision for locking/keeping supplies secure.

## Health financing

Health care has many sources of financing and CDI is no different.

- Donor agencies such as the Mectizan Donation Program (MDP), the Global Fund to fight acquired immunodeficiency syndrome (AIDS), TB and Malaria, and WHO are involved in providing drugs, other commodities and technical guidance.
- National, state, regional and district health authorities (ministries, departments) budget for staff, transportation and other logistical support for CDI.
- National and international NGOs mobilize funds and provide technical staff to help implement community interventions.
- Communities themselves contribute through support of their CDDs and volunteering their own time to plan and manage CDI efforts.

Some of the major cost components of CDI include stakeholder meetings, training at various levels, supplies of medicines and commodities, transportation, BCC and M&E materials development, and supervisory and outreach activities.

The challenge in putting together a CDI package in a particular setting is trying to determine who will pay for what. Often there is vertical funding for specific interventions like home/community based malaria case management, HIV home based care, or ivermectin distribution for onchocerciasis or LF. If CDI is to be delivered as an integrated package, one needs to ascertain who will pay for stakeholder and planning meetings, for training health staff, for mobilizing and training community members, for providing commodities and for producing other required materials.

Recently Bauchi State in Nigeria received funding for malaria control from the World Bank Booster Program. The Booster program, in collaboration with the National Malaria Control Program agreed on promoting a 'Malaria Plus Package' that could potentially deliver 19 essential services at the community level. Some required health education and supportive materials while others required commodities. The Booster program guaranteed supplies of insecticide treated bednets and artemisinin-based combination therapy drugs. The State agreed to purchase sulfadoxine-pyrimethamine for intermittent preventive treatment for pregnant women and cotrimoxazole for treatment of pneumonia. Other donors such as UNICEF and USAID might supply ORS for diarrhoea. Training for the CDI approach was jointly covered by the Booster program and USAID, each sharing responsibility for 10 of the State's 20 districts. Situation analysis also found that there were other sources of basic health commodities in the State, such as the National Health Insurance Scheme special program of free medication for children below five years of age and pregnant women. Discussions were needed to see if there medicines could also be made available at local levels. Local governments also had funding to buy some essential drugs. Over half of the districts were involved in CDTI and thus there existed a foundation of CDDs on which to build CDI for the Malaria Plus Package. Coordination of all these financial resources and determining financial roles for each partner was needed to ensure successful implementation of CDI.

### **Leadership and Governance**

Leadership begins with the development of appropriate and enabling health policies. Delivery of health services in and by the community requires supportive policies. First, any medicines that will be provided

through CDI and will be given out by CDDs need to be approved as over-the-counter. Secondly, there must be policy and guidelines within the Ministry of Health that enables community case management of common illnesses.

We have two opposite examples of the enabling policy context. The Rwanda Ministry of Health places volunteer community health workers at the frontline in the fight against malaria. They are trained and equipped to conduct malaria RDTs and are supplied with ACTs. This widespread availability of community level malaria case management capacity has contributed immensely to Rwanda's shrinking malaria burden and is helping position the country to enter the malaria pre-elimination phase.

In contrast, other countries may have accepted CDTI with ivermectin but this may be the only drug which the MOH permits lay persons to distribute. If there is no policy in the MOH for community members to participate in community case management of other diseases, CDI will not succeed. The Global Fund has suggested that due to large coverage areas and the paucity of well-staffed PHC facilities in many locations, the only way to achieve malaria or other program coverage targets is to promote community case management. If the MOH remains reluctant to 'trust' the community with treatment drugs, coverage will not be achieved.

Another supportive policy for CDI is exemption for importation of basic health commodities. CDI will not function without adequate supplies of such things as medicines, bednets and others. Tariffs on these not only delay service delivery but also may put life saving technologies out of the reach of those in most need.

A consistent national policy on incentives for community work is also needed. Different programs use different incentives and this can discourage villages from participating

in CDI. Some years ago it was difficult to get volunteers in Uganda to have out ivermectin when they learned that a family planning program was giving its community agents bicycles and t-shirts. A national policy on community volunteers is needed so all agencies and NGOs approach the community in a consistent and acceptable way that guarantees maximum participation of the communities in health programs.

A first advocacy task among supportive stakeholders will be to lobby for enabling policies and guidelines that support direct community participation in the delivery of the basic package of health services. This may include making sure that medicines included in the basic package are approved as 'over the counter'. It may also require working with relevant professionals in developing guidelines, standing orders, treatment algorithms and training materials that will assuage any concerns about community competency in managing and preventing common health problems.

## COMMUNITY PROCESSES

The Global Fund to Fight AIDS, TB and Malaria provides important resources that can make community case management and CDI possible. A major goal of the Global Fund is to strengthen community systems. According to the Global Fund (48):

**Community systems** are community-led structures and mechanisms used by the communities through which community members, CBOs and other groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities. Many community systems are small-scale and/or informal. Others are more extensive – they may be networked between several organizations and involve various sub-systems. For example, a large care and support system may have distinct sub-systems for comprehensive home-based

care, providing nutritional support, counseling, advocacy, legal support and referrals for access to services and follow-up.

**CSS** is an approach that promotes the development of informed, capable and coordinated communities and CBOs, groups and structures. CSS involves a broad range of community actors, enabling them to contribute as equal partners alongside other actors to the long-term sustainability of health and other interventions at community level, including an enabling and responsive environment in which these contributions can be effective. The goal of CSS is to achieve improved health outcomes by developing the role of key affected populations and communities and of CBOs in the design, delivery, M&E of services and activities related to prevention, treatment, care and support of people affected by HIV, tuberculosis, malaria and other major health challenges.

CDI can therefore be seen as a major CSS strategy. The CDI approach to CSS includes: 1) engaging communities to think about and plan to meet their health needs; 2) empowering communities to make decisions and take actions; and 3) engaging community members as implementers of the programs they have planned.

## Engaging communities

Community mobilization is initially undertaken by health workers at the frontline health facilities. This leads to community participation through the community leaders who help their community members understand the CDI process and its values.

Community mobilization is a very important component of the CDI process and one of the roles of the health service. Communities are rallied around health facilities from where they receive health services. The natural community structure is used for service delivery. Communities are structured

into villages, hamlets, kindred and households. Several households make up hamlets/kindred while several hamlets/kindred make up villages. Several villages make up community. CDI strategy uses the smallest structure in the community such as hamlets/kindred groups. These are usually groups of people that share the same ancestry lineage and live in the same location sharing same language, social and cultural heritage. This promotes cohesion and loyalty and reduces incentive asking by the CDDs.

Before entering into and engaging communities, health workers must first map the community structure within the catchment area of their facility. We may find many levels of community ranging from the town that might be divided into villages which might be further subdivided into settlements or clan groups. There may be health and development committees and organizations at each of these levels who need to be approached and engaged in understanding the nature of community commitment in the CDI process. Ultimately we need to reach the smallest of the natural community units – clan, settlement, or hamlet – where mobilization will actually occur in terms of CDD selection and commitment to support CDDs and program implementation.

When these basic catchment area community units have been identified health workers can then assist communities to discuss their health problems, plan interventions to solve the problems, implement and evaluate together. For this to happen, active participation of the community is very essential. This informs the need to gain the support and commitment of the catchment communities.

A village/hamlet meeting is needed, but first the health staff need to hold preliminary discussions with community leaders to gain their understanding and support for community directed action. Usually this first meeting involves the clan heads,

elders, opinion, youth, women and religious leaders as locally appropriate and available. The simple message about CDI at this initial meeting is that while the health system can provide commodities, training and supervision, the community must also make contributions including:

- taking charge of the safety of the commodities;
- ensuring the equitable and appropriate distribution of those commodities; and
- reporting the results of their efforts back to the health facility.

Once the community leaders agree to get involved, they will call a community-wide meeting and invite the health workers back to discuss next steps. Such community meetings should ideally include all men, women, youth and even children. It may be necessary to arrange seating in a culturally appropriate way, but it is important that everyone living in the community hear the same basic message about CDI from the health workers.

At the full community meeting, the CDI process is again explained to the community members including resource mobilization, selection criteria for the community representatives/volunteers, welfare and community support and reward for the selected volunteers, training of the volunteers, meeting attendance, transportation and storage of commodities in the community as well as mode of commodity distributions. There are at least three modes of commodity distribution options in CDI process:

1. The community may choose that their volunteers go from door-to-door to deliver services to those at need;
2. Community members visit the volunteers at home to obtain the available service; and finally
3. The community can choose the option of meeting the volunteers at the community square/hall at agreed time and day to receive services.



Whatever option the community decides to adopt has implication in the kind of support that the volunteers would need. Example, if the community decides for the first option, the CDDs might need transportation support to visit households to deliver services, etc. More details on this process are found in Unit 6.

## Empowering communities

While outsiders technically cannot empower a community, we can provide the knowledge and skills through which communities can take charge of health programs and thus empower themselves to address their own health needs.

An empowered community can be seen through its decision-making processes. At the large community meeting where CDI is introduced, the health staff will explain the steps necessary to implement CDI. It is then left to the community to select its own distributors, encourage them to attend training and thereafter, support them to sustain the CDI strategy. Communities will also make decisions about how the

commodities will be distributed, how they will be kept safe, how records and registers will be maintained and how CDDs may be rewarded for service.

If CDI is correctly organized, the CDDs are first and foremost accountable to the communities that selected them. Health workers on the other hand are responsible for technical supervision. In a way we can say that the communities are responsible for the 'social supervision' of their CDDs – ensuring that the volunteers perform their duties in an acceptable way and providing social reinforcement/encouragement to sustain the CDDs in their roles.

Empowered communities will start CDI with the basic package of essential services, but because of the skills they gain in decision making they will be encouraged to take up other health and development projects for their own betterment.

In the CDI process roles and responsibilities are shared. It is important for all stakeholders to know their roles and responsibilities and are committed to them especially on the empowerment process of the commu-



nity. It is necessary that no stakeholder try to dominate but contribute according to their roles and responsibilities, and that they share common objectives. It is the role of the health service to empower the community

Basic CDI processes include:

- community entry and meeting chiefs;
- community orientation and facilitation meeting;
- community selects distributors;
- community volunteers trained;
- community conducts census;
- community plans dates, approach;
- community collects intervention commodity;
- community distributes intervention commodity;
- monitor, treat and/or refer reactions;
- community submits treatment records.

Firstly, the health service is orientated on the CDI process. This will involve training the frontline health care providers on the knowledge, skill and practices of CDI service delivery. Secondly, the health service approaches the community by organizing community meetings that will pull together the kindred groups to explain the CDI strategy.

### Engaging CDI implementers

CDI is a program that involves community volunteers, but it is not a typical volunteer VHW program that relies on individual VHWs for success. Since the community is in charge of decision making, the community decides how tasks get done. This may mean that several people are engaged as volunteers. Maybe one older woman volunteers to provide intermittent preventive therapy (IPTs) to pregnant women and counsel them on safe pregnancy. Maybe a man with a motorcycle volunteers to maintain LLIN supplies and carry out their distribution. A

mother in the community might volunteer to do the community case management of malaria, pneumonia and diarrhoea because she has a good way of handling small children.

Therefore, community mobilization involves the process whereby the health service map and identify her catchment communities to discuss their health problems, plan interventions to solve the problem, implement and evaluate together. For this to happen active participation of the Community is very essential. This informs the need to gain the support and commitment of the catchment communities.

The frontline health care providers send words to the community gate-keepers to introduce the strategy. Usually this first meeting involves the kindred heads, elders, opinion, and religious and youth leaders. At this meeting, available health services at the facility are introduced; conditions for obtaining the services and CDI strategy in health service delivery are thoroughly discussed. All concerns, technical issues and community mobilization are adequately addressed by the health service; date and venue for the expanded community meeting are agreed upon. Sometimes, community may like to discuss more on the issues presented to them before fixing date and venue of the subsequent meetings.

However, once the date of the second meeting is fixed, it is important to ensure that the meeting involves all the leaders, men, women, elders, youths and visitors living in the community. At this meeting, the CDI process is explained to the community members including resource mobilization, selection criteria for the community representatives/volunteers, welfare and community support and reward for the selected volunteers, training of the volunteers, meeting attendance, transportation and storage of commodities in the community as well as mode of commodity distributions.

## BROADER SYSTEM EFFECTS

CDI has been shown to have multiplier effects. In short, involving the community in planning, delivering and evaluating health services at the local level strengthens community systems to undertake other health and development activities. These multiplier effects include the following:

- increased community awareness about health services and needs;
- greater recognition of gender in program delivery including increased participation of women;
- community development effects by villagers who are inspired by their success in delivering the basic package of CDI services to undertake additional community improvement projects;
- health worker effects including enhanced self-confidence to engage the community and greater planning and management skills for program implementation.

Several key lessons were learned from the TDR's additional interventions study (10). When CDI was used to distribute insecticide treated nets, malaria home management medicines, vitamin A, DOTS for TB in addition to ivermectin there were changes at community and health systems levels beyond improvement in intervention coverage itself.

For example, "Communities became increasingly aware of public health issues, health commodities and their rights to access health services as a result of the CDI process. This awareness, in turn, reinforced their commitment to CDI and other health measures." Once aware of the extent of their rights and responsibilities, "they were more assertive about receiving adequate services from health authorities. Community awareness was translated in several villages into advocacy efforts with local health authorities which lead to increased access for health services generally."

Gender effects were observed. "Over the course of the study, more women attended meetings, spoke out and were selected as CDI implementers, particularly as a result of growing awareness of their potential role in malaria treatment. Over time, women became more outspoken, participated more actively, and demanded that responsibilities be assigned to them."

CDI had a broader effect on community development. "CBOs, including women's groups, became more involved over time." In one community, "the market women's association [played] an active role in CDI activities, mobilizing members to obtain CDI services. Interest in community development stimulated initially by CDI, gradually was observed to expand to other development efforts."

Health workers were also impacted beyond the specific intervention efforts. "Health workers became more engaged in outreach activities as a result of CDI. Health workers came to see community implementers as partners, involving them in other outreach activities as well, for example in prevention of sexually transmitted infections. Health workers also reported that they enjoyed the stimulation of training and supervising CDI implementers. The program coordinators for the different interventions engaged in "more advanced and coherent planning; dialogue between health system workers responsible for different interventions; and more interaction with community stakeholders. One such program coordinator was noted as saying, "We have put in place arrangements for problem solving. We hold only one meeting. We also have planning meetings where budgets are written for the year. The meetings allow members to give feedback to the Local Government Area (LGA) coordinator on their past activities, and it also helps us to know the way forward. The entire process of distribution is being looked at, problems identified and solutions to these problems produced."





# UNIT 5

## BEHAVIOURS AND ATTITUDE OF HEALTH WORKERS



# UNIT 5

## BEHAVIOURS AND ATTITUDE OF HEALTH WORKERS

### SECTION A: TRAINING OUTLINE

**PURPOSE:** To reinforce appreciation of the importance of the behaviours and attitudes of health workers (HW), in their professional performance and relationship with individual 'clients' and target communities in the successful implementation of CDI.

**PREREQUISITE MODULES:** Four subset modules, consisting of ten of the major HW characteristics as outlined in the 'Module Overview'.

**UNIT TIME:** Overall Unit time – 120 min (= 2 hours), approximately half of which will feature pre-prepared case studies (See Appendix) and role plays relevant to each module.




**LEARNING OBJECTIVES:** At the end of the Unit, learners should be able to:

- a) illustrate with relevant examples the importance of the various attitudinal characteristics listed as re-grouped in 'Module Overview' that are critical to the success of CDI;
- b) describe conditions that are conducive to the successful implementation of CDI;
- c) describe conditions that are not conducive to CDI implementation;
- d) prescribe appropriate programmatic and attitudinal remedies to enhance HW-Community harmony.

**PRESENTATION PLAN:** As outlined in 'Module Overview' will consist of:

- a) pre-test, using an MCQ, or short answer format to determine baseline knowledge of participants on salient HW behaviours and attitudes;
- b) formal lecture on components of each subset module;
- c) case studies;
- d) role play as deemed necessary;
- e) interactive discussion sessions;
- f) post-test using MCQ or short answer format.

## OVERVIEW • UNIT FIVE

Step	Time	Activity/ method 	Content 	Resources needed 
1	20 min	Introductory Presentation on Unit	Title, Learning Objectives, Content outline Pre-test: 10-20 MCQs or Short answer format	Slides 1–4 One setting out component of each module Test paper
2	80 min	Formal Presentation & Discussions 20mins per module (10 for presentation and 10 for case study)	<b>Module 1:</b> Demonstrate Compassion; Empathy & Friendly disposition <b>Module 2:</b> Ability to Listen attentively & Show patience <b>Module3:</b> Simplicity & Respect for Local Social Norms and Community Leaders & Cooperation. <b>Module 4:</b> Commitment & Punctuality for appointments	Each formal modular presentation is followed by an appropriate Case Study  n=4.
3	10 min	Post-test	Post-test 10-20 MCQs or short answer format	Each formal modular presentation is followed by an appropriate Case Study
4	10 min	Unit Course evaluation	Interactive session and feedback on course	n=4.
<b>Summary Total</b>	<b>120 min</b>	<b>Lectures and case studies</b>	<b>10 identified behaviours and attitudes of Health workers</b>	<b>4 number slides One flip chart with marker pens</b>

## **MATERIALS AND EQUIPMENT CHECKLIST:**

- PowerPoint slides
- Computer with accessories
- Projector
- Screen
- Flip chart (FC) with FC paper and Tape
- Coloured FC felt Markers
- Answer scripts for pre- and post-tests
- Printed case studies handouts
- APOC-generated Reference materials.

## **TEACHING GUIDE METHODS/ADVISORY NOTES TO TEACHERS:**

- The teaching sessions on this Unit are designed to be mainly interactive.
- Brief introduction to each modular subset to be followed by appropriate case study and role play.
- No brand new concepts are envisaged, beyond a refresher course to reinforce, with special reference to CDI, what is a generic set of wholesome HW behavior attributes.
- Draw extensively on experience with CDTI and as appropriate on findings from CDI research. (See list of APOC-generated Resource Reference Materials in list in Appendix.

## **TEACHING METHODS AND MATERIALS:**

(Vide supra)



## SECTION B: NARRATIVE



### INTRODUCTION

This unit deals with the behaviours and attitudes of health workers that are critical to the successful implementation of Community-Directed Initiatives (CDI). These attributes are 'generic' in nature and applicable in all health systems, and not peculiar to CDI. Experience, from CDTI and the studies so far on CDI has shown that the ten listed attributes are of vital importance in the successful implementation of community-directed initiatives.

A **Health Worker** in this context includes all personnel who have received formal training in the health sector, interact in one form or other with the general public in respect of health matters and who receive remuneration for their formal health-related activities in one form or the other from constituted health authorities. These include medical doctors, dentists, pharmacists, nurses and midwives, laboratory scientists, radiographers, physiotherapists, occupational therapists, health educators, social scientists, community health officers, environmental health officers, ambulance drivers, ward attendants etc.

Ten critical overlapping behavioural attributes are identified. These ten are regrouped into four intra- and inter-related modules.

## THE MODULES OF BEHAVIOUR AND ATTITUDES

- 1. Compassion, Empathy and a Friendly disposition** towards those who seek their 'professional' expertise under the CDI. These attributes require that the health worker reacts to his/her client in a manner that does not discourage or put the client off.
- 2. Listening attentively** to, and show **Patience** towards all who seek their 'professional' expertise under the CDI. Being able to listen attentively to a 'client' implies that the health worker should always exercise patience in dealing with clients. Such a positive attitude makes the client to be at ease and not feel intimidated by the health setting.
- 3. Simplicity, Respect for local Social Norms and community leaders** and ability for **Cooperation** with all those they interact under the CDI. This is often the most abused of the behavioral attributes of Health Workers. Failure to respect local norms and socio-cultural predispositions can spell disaster for a CDI programme. As clearly spelt out in other portions of this manual, simplicity in dressing and language as well as taken due cognizance of the culture and structure of the community and not imposing the health workers' will on the community are attitudinal characteristics that will promote the success of CDI. A condescending health worker is "bad news".
- 4. Commitment** to their and **Punctuality in keeping Appointments**. The perception of both the target community as well as the health worker's superior officer to his/her commitment to ensuring the success

of introducing and sustaining the CDI programme can be measured in many ways. One of this is the health workers punctuality in keeping appointments. Students should be asked, **during the teaching of this module, to identify other means of determining commitment**. These additional means could be incorporated into the final case study for the module.

## SUMMARY OF MESSAGES OF THE CASE STUDIES (ANNEX 1) USED TO ILLUSTRATE EACH COMPONENT OF UNIT 5

### Module 1

Compassion, Empathy and Friendly Disposition are manifested by the health worker when he/she relates directly with and is able to put the mind of the client at rest. It is important to remember at all times that the ill and those who care for them and may be responsible for bringing them to or getting in contact with the health facility do so under considerable emotional stress and are to be received by a compassionate, empathetic health worker with a friendly disposition. This helps considerably to ameliorate the stress.

### Module 2

Most 'clients' respond best to a health worker who not only listens attentively to what complaints have brought them to seek help but does so with lots of patience. It does not help the situation for the HW to lose patience with a client no matter how rambling the client's narrative might be.

### Module 3

Simplicity and respect for the local social and cultural norms and community leaders is a *sine qua non* and veritable basis for cooperation between the community and the health facility. In this regard the behav-

ior and attitude of the health worker, which should not be condescending, is paramount. The health worker should always realise that he/she is an ambassador of the health facility, and community response to the facility's activities is predicated on the community's perception of the regard it enjoys from the health workers.

## Module 4

A sense of commitment to duty as manifested, among other things, by punctuality in keeping of appointments invariably reflects job satisfaction of the health worker. Both the health worker's superior officer and the community would inevitably respond positively to a health worker who shows commitment to his/her duties and responsibilities.

### MODES OF INSTRUCTION:



- Lectures (interactive)
- Case studies
- Role Play.

### MODES OF ASSESSMENT OF ASSIMILATION AND COMPREHENSION:

- Pre-test and post-test
- Relevant case study analysis.





# UNIT 6

## SETTING UP THE CDI STRATEGY



# UNIT 6:

## SETTING UP THE CDI STRATEGY

### SECTION A: TRAINING OUTLINE

**PURPOSE:** To provide participants with knowledge and understanding of how to plan and set up the CDI Strategy and to acquire the skills necessary for successful approaches to communities

**PREREQUISITE MODULES:** Units 2, 3, 4 and 5.

**MODULE TIME:** 7 hours.

#### LEARNING OBJECTIVES:




At the end of the unit, the learners should be able to:

- a) describe different stages involved in setting the CDI Strategy;
- b) explain the activities involved at each step;
- c) identify the stakeholders involved at each stage;
- d) explain the required human and material resources for setting up the CDI strategy;
- e) identify the supervisory and monitoring roles of the stakeholders;
- f) set up a CDI strategy;
- g) understand how to approach communities;
- h) understand the importance and methodology for communities to conduct a census.

#### PRESENTATION PLAN:

- A.**
  - Definition and description of the methodology of planning and the processes such as meeting with partners, risk assessment.
  - Objectives and milestones.
- B.**
  - Practical steps involved in approaching the community.
  - Gender mainstreaming.
  - Simulation and role playing.

## OVERVIEW • UNIT SIX

Step	Time	Activity/ method 	Content 	Resources needed 
<b>Section 1</b> Planning				
1	15 min	Introductory Presentation to Unit	Definitions, Methodology	Slides 1–3
2	30 min	Participatory presentation & Discussions	Meeting with health partners MoH	Slides 4–7
<b>Section 2</b> Approaching the Community				
3	15 min	Introductory Presentation to Unit	Title, Learning Objectives, Content outline (Presentation Plan)	Slides 8–11
4	60 min	Participatory presentation & Discussions	– Introduction and description of skills required	Slides 12–20
		APOC Training video <b>Discussion</b>	<b>Training CDDs of ivermectin</b>	Video Video player
5	45 min	Participatory presentation & Discussion	Gender mainstreaming	Slides 21–24
6	60 min	Participatory presentation & Discussion Role play and seminars	Approaching the community leaders and approaching the entire community	Slides 25–29
7	60 min	Participatory presentation & Discussion Practical Seminars Audiovisual materials	<b>Census-taking</b>	<b>Reference manual for training CDDs on CDTI</b> (i) Audiovisuals from APOC, MDP, GSK, LF programme and SCI (See table below for a list of materials)
8	90 min	Practical		

Step	Time	Activity/ method	Content	Resources needed
9	15 min	Conclusion	Evaluation & Summary of the Unit session	Slides 30
10	1 day	Field visit	Practical activ- ity approaching a community; Dummy exercise on census-taking and record keeping	APOC CDTI Training Manual

### MATERIALS AND EQUIPMENT CHECKLIST:

- i. Use the Training video of APOC - Training CDDs of ivermectin (French and/or English versions).
- ii. Guide for procurement of drugs developed by the MDP and GSK.
- iii. Training videos on LF, Trachoma and Schistosomiasis on the definition of these diseases.
- iv. From APOC Film Library (download from APOC website or request directly from APOC):
  - a) Partnership & Promise;
  - b) Mara;
  - c) training CDDs on CDTI;
  - d) together we can win;
  - e) conquering River Blindness: *APOC Pathfinding legacy*;
  - f) there are several other audio visuals;
  - g) there are several films from TDR/Geneva Library which are very useful for this purpose (request from TDR Geneva);
  - h) films from NTD department in WHO/Geneva will be useful.



## TEACHING GUIDE/ADVISORY NOTES TO TEACHERS:

> **REFRESH** the participant's knowledge of Modules 1, 2, 3 and 4 by asking them to explain:

- state what is Health system & list the six building blocks of a Health System;
- what's Community health system?
- what is a community?
- approaches to community health care service delivery;
- principles of CDI;
- processes of CDI.

> **THEN PROCEED TO ASK THEM TO:**

- Discuss some typical ways issues are introduced into the community.
- Where is the usual point of entry?
- Who are the important people to meet first when new ideas are to be introduced into their communities?
- Characterize their communities socioeconomically and politically.

> **WRITE** the points on the flipchart. > **USE** the list to facilitate a discussion, allowing participants to show key elements of each definition or explanation

## TEACHING METHODS AND TECHNIQUES:

- Introductory presentation
- Brainstorming
- Questions & answers
- Group work/exercises.

## SECTION B: NARRATIVE



### PLANNING

Planning is an essential element of any management cycle: *situation analysis, planning, implementation, monitoring, supervision and evaluation.*

#### Generic definitions

According to the Thesaurus dictionary:

- a) **Planning** – an act of formulating a programme for a definite course of action.
- b) **Planning** – the act or process of drawing up plans or layouts for some project or enterprise design, designing – the act of working out the form of something (as by making a sketch or outline or plan); “he contributed to the design of a new instrument” city planning, town planning, urban planning – determining and drawing up plans for the future physical arrangement and condition of a community
- c) **Planning** – the cognitive process of thinking about what you will do in the event of something happening.

#### Operational definition of planning in CDI

In the context of CDI planning is to formulate a scheme or programme for the

accomplishment, enactment, or attainment of an objective. This involves drawing up a strategic and work plan before hand either by an individual or by a group of those who have a vested interest in the achievement of that objective (stakeholders).

Key words: *strategic plan, work plan, stakeholders and objectives.*

#### Method of planning

Start by determining the need for establishing a CDI programme through a situation analysis. This involves many activities i.e. disease mapping, discussions with MoH at different levels and communities.

Activities and intervention packages are then developed based on findings and strategies agreed upon (work breakdown structure).

#### Chronograms and deadlines (schedules)

- Schedule efficient, accurate, and useful.
- Milestones in your schedule (key point in time that must be reached).
- Indicate deliverables with the milestones.
- Include lag and lead time in your tasks.
- Schedule should be available to all.

## Risk Management Plan

All project team members and stakeholders should have a meeting to complete a first draft of the plan. This ensures everyone knows what problems could crop up. The meeting should also identify the response options for each risk. There are four common approaches:

- **MITIGATE:** Find ways to reduce the probability and impact levels of the risk.
- **AVOID:** Take steps to avoid the risk entirely. For example, if your chosen construction company may have a worker's strike soon, perhaps you could choose another company.
- **TRANSFER:** Transfer the responsibility for the risk to someone outside the project. This will decrease your liability, but it may also decrease your level of control too.
- **ACCEPT:** Accept that the risk could happen and choose not to act. This is the best approach for risks with low probability and impact ratings.

**Communication Plan: what, who, where, when, why and how.**

## MEETING OF HEALTH PARTNERS

Health Care Services and partners meetings are used to plan define and agree on partner roles and responsibilities, to identify socio-cultural organizations and to obtain vital health information on the community.

The unique partnership in the CDI strategy is what has made the strategy a very successful one. It is an interactive partnership with a win-win situation for all and therefore partners are bound to help one another. In the CDI process, identifying stakeholders is very important. Stakeholders are organized in a Task Force at country level that meet to implement the strategic plan for the intervention. The stakeholders and their roles and responsibilities have

been described in previous units (3 and 4). They meet regularly to develop work plans, review progress and propose solutions for improving performance. The Ministry of Health at the national level plays the role of the secretariat of the National Onchocerciasis Task Force (NOTFs) and convenes the stakeholders meetings. To ensure all parties play their respective roles, forums for discussions should be planned for all levels: international, national, regional, District, Frontline Health Facility (FLHF) and community levels. These planning meetings allow all to agree on an actual plan for:

- Goals, Objectives and milestones to be reached (*APOC strategic plan 2008-2015*).
- Activities and intervention packages (advocacy, sensitization, mobilisation, training health workers and community distributors, monitoring, supervision and evaluation).
- Agree on simple efficient strategies and procedures.
- Chronogram and deadlines.
- Budgets and sources of funding.
- Frequency and sequence of review meetings for all levels of implementations.

## APPROACHING AND MEETING WITH THE LEADERS AND ENTIRE COMMUNITY

### Part one

Launching a successful CDI programme depends largely on how community leaders and members are approached at the outset. In the last three decades, communities would have seen several programmes launched and implemented. For most programmes community members were asked to participate but they **were not engaged**. Decisions were made on behalf of the community by external persons with

little or no contribution from the community. The CDI strategy is different. The CDI strategy gives the community authority to make informed decisions. The strategy involves 'task-shifting' from health workers at front-line health facilities to community members; whilst theoretically straightforward this is a significant change that must be well managed if it is to be done successfully. It involves changed power relations as it takes some of the power and control away from the health workers and gives it to community members. This may be difficult for some health workers or even community members to accept, involving cultural and behavioural change that might be resisted (refer also to Unit 5). To achieve this successfully requires good communication with and between the communities and the health workers.

### Good listening skills

- Good listening skills are required for meetings and negotiating with community leaders and members. The trainers, students and team members should prior to launching a CDI (i.e. a community-driven programme) use role plays to practice how to be a supportive listener; maintaining eye contact and show regularly that you're interested in what community leaders and council members/chiefs have to say about the health status in their own community.
- Learn to recognize quickly a situation of conflict, or when you or your team is facing a crisis during meetings with community leaders.
- If a community had an ugly past experience with a health or any development programme, you are likely to face a crisis or reluctance in building trust. Ask a key informant – the health worker or the key informant who introduced the team to the leader what is wrong and pay attention to the answer.
- Always allow the community leader and his/her council chiefs at the first meeting to express their fears and frustrations towards external partners and programmes - listen - showing that you're interested in what they have to say. These skills will help the CDI strategy implementation team to build relationship and trust for community active participation.

### Build trust in Community – Programme relationship

- Dr Duane C. Tway, Jr., in his 1993 dissertation (49), defines trust as, “unguarded interaction with someone.” He calls trust a construct because it is “constructed” of three components: “the capacity for trusting, the perception of competence and the perception of intentions.”
- Implementation of CDI strategy needs a capacity to take a risk – to trust that non-educated community members can provide useful contributions and make decisions on matters concerning their own health. CDI implementers must have genuine perception of community competence and in role plays discuss **building Trust** as a key element of engaging community leaders and members.

Skills for meeting and negotiating with community leaders will be slightly different depending on religion, cultural and community past negative or positive experiences with health programmes and researchers who do not feedback findings nor allow communities to see what a worm looks like.

A big difference was made in a community when researchers began the mission by showing the chief and his council members in a simple microscope, worms in their stool. When the story got round before their next visit, community members were demanding and requesting to be told what they need

to do to stop these ‘*tiny animals from sharing their food-intake*’. Some members questioned to know if that was not witchcraft.

### Social support

Several of the NTDs have high morbidity burden in many communities and so it is important to build social support groups which can make certain diseases an agenda of the group. If a community has a high burden of LF for example, a social support group for LF can be created.

### Approaching and meeting the community leaders

There are unrecorded guidelines in almost every African community that should be followed to hold successful meetings with the leaders and the members of a community. The attitude of Health Workers - listening skills, compassion, patience and respect for social norms, simplicity, commitment and punctuality to appointments with communities are discussed in Unit five. Having a good knowledge of the CDI strategy, good listening skills and experience of the field are very important and students who attend this course should be assisted to have these as an outcome.

### Gender mainstreaming in approaching and meeting leaders and entire community

Gender roles, in particular, the involvement of women at meetings and in all CDI activities should be stressed. The composition of the health team is already a message to the community leaders as to the role women play in CDI. Highlight these roles during all meetings but do not over emphasize otherwise it could send a wrong signal to men of the community. CDI is about engaging men, women, youths and children in the community to play a vital role in their health programmes.

### Knowledge of Community dynamics is vital

There are common mistakes and wrong assumptions of partners implementing community-based health and/or development programmes. Some of the wrong assumptions are:

- i. In Africa, all/most communities are alike. The approach is “*one-size-fits-all*”
- ii. Community should participate not engaged in decisions. This means, partners outside the community think for the rural poor and plan health interventions without consultation of how community would like to organize themselves and if at all they want the intervention.

### APPROACHING AND MEETING WITH COMMUNITY LEADERS: STEPS

#### Approaching and meeting the community leaders

Prior to unit six of the curriculum it is assumed that the partners (MoH & NGOs) have agreed on common objectives of the intervention. The following arrangements are necessary prior to the meetings with leaders and community members:

- i. Knowledge about the cultural and religious norms of the community (Muslim or Christian), in particular, religion of the traditional chief/community leaders.
- ii. Political issues and groups that are in conflict in the community.
- iii. Existing and community preferred NGOs and CBOs and why are those preferred by the natives.
- iv. The health worker responsible for the community should **obtain an appointment** prior to the visit to meet the community leaders with or without the elders of the community.

- v. It is important that the health CDI team is punctual at this visit and the **dress code** must not indicate an affluent lifestyle or donor-driven rich programme.
- vi. After the welcome message, introduce yourself and members of the health team.
- vii. Ask about the **major health challenges/problems** of the community and how they are dealing with those. Listen carefully and advise, if possible, on some of the health challenges of the community.
- viii. Discuss the definition of their experience(s) with the diseases for which interventions are required. Malaria will feature high – and may be the main point of discussion at the initial stage of the meeting. The team should not consider this a waste of time. Remember you are here **to build a relationship** and your **listening skills and patience** are very important at this first and at subsequent meetings.
- ix. Gradually, the key informant, health worker or team leader should introduce the main purpose of the meeting and find out the experiences of the community.
- x. Provide information on benefits of the intervention(s), availability of drugs and commodities, the contributions of other partners towards the intervention(s).
- xi. Explain carefully the role of women, girls in CDI.
- xii. Negotiate the roles and responsibilities of the community at this onset. And do not make promises of what the government and partners cannot do.
- xiii. Inform the community leaders about advantages of **compliance to all treatments, safety of drugs** and side effects.
- xiv. Present all **possible side effects** and listen clearly to make sure the side effects are well understood by the chief and leaders of the community.
- xv. Referral of those with side effects must be clearly explained to the community and their fears allayed during this and subsequent meetings.
- xvi. Allow the community chief and leaders to advise on how to **engage the entire community**. Take note of their preferred steps for planning and supporting implementation of CDI.
- xvii. Agree with the chief and leaders the date the team will meet the entire community and stress the importance of women and children attending this meeting.
- xviii. **Summarize and repeat your understanding of what** they're saying so they know you're hearing them, and focus on the emotions they expressed during the meeting. Thank them for their time and hospitality.

### Approaching and meeting the entire community

- i. The health team should be punctual to the first and subsequent meetings with the community.
- ii. While waiting for the arrival of the chief and leaders of the community greet the members and ask about family well-being.
- iii. After the chief has welcomed the team, introduce yourself and members of the health team.
- iv. Ask about the major health challenges/problems of the community and how they are dealing with those. Listen carefully and advise, if possible, on some of the health challenges of the community.
- v. Repeat steps vii to xvii above – use the APOC Training video – **Training community – directed distributors (CDDs) of ivermectin**.

It is important that:

- i. The team discusses and plans how to manage the dynamics of the community

- prior to attending the meeting with entire community. If there are political, cultural or religious issues, there should be an agreed approach on how to ensure these do not affect the outcome of CDI intervention.
- ii. Let the community know everything possible about the CDI programme they are being engaged in.
  - iii. The entire community should be well informed about possible side effects, those eligible to treatment and non-eligible.
  - iv. Periodicity of treatment, compliance to treatment – single or multiple; **the individual and community benefits of the interventions** and counselling to those with side effects.
  - v. What the community will gain in being engaged in the CDI and joining with the MoH and external partners in the partnership.
  - vi. The Institution using the CDI should be presented as a partner to the MoH; also the CBOs, NGDOs.

*It is advisable to avoid presenting the CDI intervention being launched as a World Bank, UNICEF or WHO programme. It is a community-driven programme. To promote community leadership and ownership, this notion should be well understood by students who will use the training manual. The target communities should also understand the CDI intervention as theirs – the MoH and other partners are supporting by building the capacity of the community and its leaders. Lecture, Role plays and seminars should emphasize this point.*

- vii. Specify clearly the Roles of the partners- external, MoH and community.
- viii. *The community should understand the qualities of an implementer e.g. Community-selected distributor of drug.*
- ix. *Emphasize- that it is the responsibility of the community to decide who should be a distributor.*
- x. And the team will support their planning and management of the CDI and will not plan for them. Emphasize the team's mission is to “Engage the community to make informed decisions and take appropriate actions for their own well-being”.



## Mobilization and sensitization

- i. At the meeting with community leaders mobilization and sensitization should be discussed and agreed as the responsibility of the community. This should be reinforced during the meeting with the entire community.
- ii. Allow the community separate time to agree on those responsible for mobilization and sensitization but stress the importance of the chief of the community being the oversight person for these activities. **Community should be given time to discuss mobilization and sensitization while the team** waits for feedback before leaving the community. This usually will take about 30 minutes depending on the dynamics of the community.

## CENSUS-TAKING BY COMMUNITY SELECTED IMPLEMENTERS

The method and importance of taking the census of the eligible community by implementers selected by community members from among their own ranks has been very well described in the APOC training manual. It is useful to refer to this rather than repeat here the same process.

### Methods

There are additional methods to use for a clear understanding of how to conduct census:

- i Practical class;
- ii Seminar – training students and demonstration by Programme managers;
- iii Audio-visuals from APOC, MDP, GSK, LF programme and Schistosomiasis Control Initiative (SCI).

## TRAINING HEALTH SERVICE WORKERS AND TRAINING COMMUNITY SELECTED MEMBERS FOR IMPLEMENTING CDI

- Refer to the existing APOC training manual for CDDs.

Where the training covers multiple health interventions e.g. the distribution of treated bed-nets, anti-malaria drugs and medicines for treating the NTDs, audio-visuals by the GAELF and SCI should be used.

### These are important tips from the experiences of Onchocerciasis Control Programmes:

- i. All health workers at the front line health facility should be trained on CDI and be regularly part of the implementation team. This will avoid situations where due to sudden and incessant transfers a community is left without a health worker knowledgeable in CDI.
- ii. Their per diems for the training should be part of the annual budget of the CDI programmes.
- iii. There is a tendency to allocate one day for the training of community selected implementers. This is not sufficient for training in the first 3 years. Two to three days should be allocated for training CDDs. This includes one day of practical.
- iv. Two days (2) should be given to train health workers.

### Audiovisuals

- v. Use the Training video of APOC - Training community -directed distributors (CDDs) of ivermectin (French and/or English versions).
- vi. Guide for procurement of drugs developed by the MDP and GSK.
- vii. Training videos on LF, Trachoma and Schistosomiasis on the definition of these diseases



### viii. *From APOC Film Library:*

- a) Partnership & Promise.
- b) Mara.
- c) Training community-directed distributors (CDDs) on CDTI.
- d) Together we can win.
- e) Conquering River Blindness: *APOC Pathfinding legacy*.
- f) There are several films from TDR/ Geneva Library which are very useful for this purpose.
- g) Films from NTD department in WHO/ Geneva will be useful.

## PART TWO: METHODS AND TECHNIQUES OF CURRICULUM DELIVERY ON APPROACHING COMMUNITY LEADERS AND ENTIRE COMMUNITY

### Lecture

A total of 6 hours in one semester should be adequate. Audiovisuals and Role play are necessary during lecture.

- Referral of community members who experience side effects from treatment is an important topic for the combination of ivermectin and other drugs or ivermectin usage alone. The teacher should not forget to train students on this special topic.

### Practical

**Field trip (practicum): A field trip to a community is compulsory and will help the students.**

- i. While in school, medical students have rare chance of interacting with the rural poor. Nurses have higher chances than medical students. The CDI strategy field trip provides this unique opportunity. The course content cannot be covered in one or two field trips.

Therefore, it is recommended to:

- a) Use the field trip to Role play the different sections of Unit six – in particular, meeting with community leaders and the entire community, gender aspects and management of side effects.
- b) Conduct a dummy exercise on census-taking and record keeping.

**Simulation and role play should combine approaching the community leaders and the entire community.**

The Practical class/es for this section of CDI in the curriculum must be compulsory for the course credit. Of the 6 hours, two should be used for role play. To role play this important section, the class should be grouped to represent – (i) community chief; (ii) community leaders; (iii) key informant who introduced/linked the team to the community; (iv) CBOs; (v) NGO partners external to the community, (vi) health workers representing the district; and (vii) frontline health facility health workers; (viii) men, women, children and other members of the community; (ix) religious leaders; (x) any person with political position member of the community should be engaged at this meeting. Winning the support of the politicians at this meeting will hold them responsible for certain important tasks.

It is important during practical class(es) to spend sufficient time on some topics/aspects of drug delivery using CDI that are often difficult for front line health workers and CDDs. Student should have good understanding of the following:

- i. Census-taking and why it is important to take the census in the first year and update at least every two years.
- ii. Calculation of quantity of each drug/ commodity received, quantity used, quantity lost or remaining.
- iii. Safe-keeping of drugs/commodities- by communities –where in the community.

- The chief of the community must be involved in the decision making on safe-keeping and supervision of drugs.
- iv. Refer to the following for training health workers and community implementers of CDI:
    - a) The APOC manual for training of CDDs.
    - b) The APOC/AFRO/HMM/NTD/SSI new manual on training community implementers for the control of malaria and NTDs. This manual is being finalized.
    - c) Training books for LF, Trachoma and Schistosomiasis.
    - d) Sightsavers International has very useful reference books.
  - v. How to summarize the extent of treatment in a catchment area.
  - vi. How to calculate treatment – geographical and treatment coverage rates.
  - vii. Record keeping and report writing.
  - viii. Timely submission of reports is important for health staff to receive their salary and for maintaining external support.

The *team must trust that the community leader and members are capable of safe-keeping drugs* and other commodities. The OCP in West Africa provided convincing evidence that communities kept in their care thousands of drums of Insecticides. The APOC country programmes have for over a decade safely kept millions of tablets of Mectizan® with communities.

## Seminars

Organize one or two seminars for the class on CDI strategy. Use role play to illustrate how to approach the community- its leaders and members. During the seminar the different components should be repeated, including the following:

- **Gender mainstreaming during this seminar and during role play is extremely important.**
- Use audio-visuals, posters (good and poor ones) to show students the correct CDI approach.
- Review community activity. Quantity received, and used, lost or remaining, treatment, number.
- Using service, those excluded and reasons for exclusion, reactions to the provided service.
- How reactions were managed.
- Supervision and monitoring by community and health care services. Compliance monitoring, reactions, receiving referrals, health education.

## PART three

- Review community activity and drug usage. Quantity received lost or remaining, treatment, number using service, individuals excluded and reasons for exclusion, reactions to the provided service.
- Management of side effects by health workers.
- Summarize the extent of treatment in a catchment area.
- Record keeping and report writing.

## Resources for curriculum implementation

- i. Public Health staff with CDI strategy orientation.
- ii. Trainers with experience in CDI implementation such as in CDTI programme managers (for practicum).
- iii. CDI project or a suitable field site for training and practice.
- iv. Health education and training materials.
- v. CDTI training manual, posters, dosing for treatments.
- vi. Audio-visual materials – video tapes and posters etc.



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## Manifestations of Onchocerciasis



Photo: APOC/WHO/UNICEF/UNEP

Ethiopian Program for Onchocerciasis  
CDTI Activities Summary

Area	MANA	Year (A.C.)	1998
<b>1. Basic Information</b>			
No. of Health Facilities in CDTI areas	33		
No. of Health Personnel Trained for CDTI	25		
No. of Communities ("Management Units") Served	293		
Population in CDTI	937		
Total Population At Risk of Onchocerciasis	48859		
Total Population for Mass Treatment	42871		
<b>2. Training, Health Education and Social Mobilization</b>			
No. of Health Workers	10		
No. of Communities Supervised	35		
No. of Health Workers Trained	36		
No. of Communities Drug Distributors (CDIs)	271		
No. of Health Workers	45		



# UNIT 7

## SUPERVISION

# UNIT 7:

## SUPERVISION

### SECTION A: TRAINING OUTLINE

**PURPOSE:** To provide participants with knowledge and an understanding of the supervision system in CDTI/CDI process.

**PREREQUISITE MODULES:** Units 1,2,3,4,5 and 6.

**MODULE TIME:** 2 hours.

#### LEARNING OBJECTIVES:




At the end of the unit, the learners should be able to:

- a) define supervision in relation to monitoring;
- b) be able to use MOH supervision tools for CDTI/CDI;
- c) plan the supervision of community workers in the CDI strategy;
- d) identify problems of CDI implementation in the communities using the supervision system;
- e) take decisions on how to solve such problems of CDI implementation as seen in the communities and provide feedback to all levels involved.

#### PRESENTATION PLAN:

- Definitions
- Types and styles of supervision
- Responsibilities and Tools for Supervision system in the CDI Process
- The supervision process:
  - Planning supervision-techniques of supervision
  - Implementing supportive/formative supervision
  - Frequency of supervision and Feedback
  - Types of problems that can be identified during supervision
  - Possible solutions to problems identified
  - Feedback systems and mechanisms.

## OVERVIEW • UNIT SEVEN

Step	Time	Activity/ method 	Content 	Resources needed 
1	5 min	Introductory Presentation to Unit	Title, Learning Objectives, Content outline (Presentation Plan)	Slides 1–3
2	20 min	Presentation & Discussions	Definitions: Generic definition Concept definition or operational definition	Slides 4 and 7
3	30 min	Presentation & Group exercise and role play	Types and styles of supervision	Slides 8–15
4	1h	Presentation & Discussion, group work	Responsibilities and Tools for Supervision system in the CDI Process <ul style="list-style-type: none"> <li>• Levels of supervision in the CDI process</li> <li>• Role of supervisor</li> <li>• Supervision tools</li> </ul>	Slides 16–22
5			The supervision process <ul style="list-style-type: none"> <li>• Planning supervision- techniques of supervision</li> <li>• Implementing sup- portive/formative supervision</li> <li>• Frequency of supervi- sion and Feedback</li> <li>• Types of problems that can be identified during supervision:</li> <li>• Possible solutions to problems identified</li> <li>• Feedback systems and mechanisms</li> </ul>	Slides 23–30
6	10 min	Conclusion	Evaluation & Summary of the Unit session	Slides 31

## MATERIALS AND EQUIPMENT CHECKLIST

- PowerPoint slides
- Computer with LCD projector
- Flip chart
- Giant notepad
- Felt markers
- Blackboard
- CDI manual
- Available literature
- Audio-visual materials.

## TEACHING GUIDE/ADVISORY NOTES TO TEACHERS:

*Teachers activities- explanation, questioning, presentation of case studies, organization of students into groups for group work and tutorials, supervision of students' group activities, responding to students' question, presentation of case studies using audio-visual materials.*

*Students' activities- listening skills, responding to the teacher's questions, participating in group activities, reading case studies, asking the teacher questions, watching audio-visuals, participate in simulation activities.*

For each of the following topics, ask participants to explain or to give a definition:

- Supervision and monitoring. Although supervision is an activity of monitoring, monitoring will be covered in unit 8. Define the definition of supervision and monitoring and ask participants to write on a piece of paper their understanding of the two concepts. Remind participants of the importance of indicators in this unit as they make up part of the elements to look for during supervision.
- Types and styles of supervision. Use pictures to demonstrate each type and style of supervision. Dwell more on supportive/formative supervision which is more relevant to the CDI process. Explain the concept of adult learning and why supportive supervision is relevant in the CDI process. Skills and qualities of a good supportive supervisor must be inculcated in the students through role play, watching of audio films on CDI, etc.
- Take students through the planning of supervision making sure they understand that training of those to be supervised on the use of the tools is necessary. Resources and sources of funding



for supervision must be identified during planning. These resources include human and financial.

- Give out the tools for supervision system of the MOH. Discuss each tool bringing out what indicators should be checked during supervision and what possible problems could arise or identified.
- Give exercises to students for them to identify problems that may be encountered during supervision, i.e. show an example of a household register in which every member of the household received the same dose of medication. Help the students to identify the problem. What are the chances for everyone in the household to receive the same dosage and why? Is everyone the same age, same height, etc. Discuss this with students. There might have been shortage and the CDD decided to give everyone a tablet for instance.
- Use the flipchart to chart what the students say. This will later serve as a guide for discussion.

### **TEACHING METHODS AND TECHNIQUES:**

- Introductory presentation
- Brainstorming
- Questions & answers
- Group work/exercises
- Role play
- Discovery method.

## SECTION B: NARRATIVE



### INTRODUCTION

In the past several decades increasing importance is being laid on the need for quality control, quality assurance, quality management and accountability. This cannot occur if supervision systems are not put in place. Whereas before supervision services and systems seemed to be of great importance where notions like school inspectors and sanitary inspectors being current, in the early 70s the mention of such entities carried a negative connotation. Many countries dismantled their supervision services/systems and others never even created them. Even today there are still very few countries in Africa that spend money on supervision. Few programmes in-build supervision in their activities and even when supervision is in built fewer still actually carry it out. In practice supervision in health services remains poor. A recent study in Nigeria by Chukwuania et al. (50), shows that supervision is very poor and only few LGAs acknowledged any form of formal supervision. Since the 1990 several reasons have made governments and institutions to rethink supervision and quality monitoring. The reasons for renewed interest in supervision include increase in population which has led to increased demand of services which in turn has led to reduced performance of service providers and poor quality of services. More to that, the value for money syndrome has led to the demand for better quality services. And finally several studies have shown that poor supervision is one of the major factors of poor services. As a result of all these, more governments today see the need to ensure standards and equity.

The main aim of putting in place a supervision system is to ensure quality of performance of those involved in the processes leading to the achievement of set goals and objectives. This gives governments, civil society, development organizations and particularly programmes the means to build capacity for improved performance, maintain quality and ensure equity.

## DEFINITIONS

### Generic definition

According to the Oxford Advance Learner's dictionary to supervise is to be in charge of somebody or something and make sure that everything is done correctly, safely.

Morrison (51) says "Supervision is a process in which one worker is given the responsibility to work with another worker or workers in order to meet certain organizational, professional and personal activities. These objectives are competent, accountable performance, continuing professional development and personal support".

Supervision is a number of activities conducted in order to help those supervised execute their work well and to verify that the program moves towards its objectives. It is a continuous process that involves collecting and analysing information in order to determine how an activity, a programme or a policy is put in place as compared to the established procedures, processes and the expected outcome. During the implementation of an activity, a project or a programme, supervision is an internal activity and is carried out systematically, daily, weekly monthly or yearly.

This is accomplished through contact not only with the personnel but also with the target population. Supervision could be designed for individuals, groups or teams and is based on making sure that agreed processes and procedures established are being implemented correctly. In this sense it aims at improving personal and professional skills bringing to light issues about attitudes, emotions and actions of the health professionals; and hence improved services. Effective supervision will provide a process for describing successes, identifying problems and indicating potential solutions. This means to achieve effective supervision agreement has to be reached as to what

needs to be supervised, at what frequency and by whom in line with the goals of the programme, set protocols and rules.

Supervision is part of a continuum of activities that enable goals and objectives to be achieved but should be differentiated from monitoring which is the collection and recording of data in order to track a project's advancement. Supervision is one of the most important aspects of monitoring in that it assesses performance of those supervised and outputs in the light of the situation and the resources available. Effective supervision narrows the margin between what exists and what potentially can be achieved through allocating resources and proper training on the basis of the needs of individual facilities or health care workers. Supervision is a way of ensuring competence through observation, discussion, support and guidance.

The relationship between the items to be supervised can be demonstrated by organizing them according to Programme's targets, activities, activity indicators, performances and outputs. Each item has a causal link to the other items and reveals important information about the programme or project. In order to carry out the activities, it is necessary to select and plan for performances that compare current practices with established standards of performance and outputs. A variety of sources and tools will provide the information that should be compiled in optimal combination during supervision e.g. information from supervisory reports and monitoring tools. During supervision additional breakdown as deemed important, i.e. by age and gender could provide valuable information for subsequent intervention strategies. This combination of information can be more useful to programme managers in focusing on key problems and pointing to alternate solutions not previously envisaged.

## Concept definition or operational definition

In health services supervision, the supervised is trained, guided, and encouraged to improve their performance in order to provide high quality health services. In simple terms, supervision should be a systematic process for increasing the efficiency of health workers by developing their knowledge, perfecting their skills, improving their attitudes towards their work and increasing their motivation to perform better. It is thus an extension of training. Supervision is carried out in direct contact with the health worker. Supervision should be performed at all levels of health infrastructure. All health workers need help to solve problems and overcome difficulties. They also need feedback on their performance and encouragement in their work. Good supervision provides valuable information during monitoring and evaluation. In the CDI process it is important to remember that diverse categories of actors are implicated in the process and almost always are adult and have no prior knowledge of the strategy. Hence supportive supervision is more appropriate in this case to build synergies that will enable expected outcomes to be achieved.

## TYPES AND STYLES OF SUPERVISION

### Types of supervision

#### Professional supervision

This is a formal arrangement for professional, as individuals or as a group, to meet and discuss their work regularly with someone who is more skilled and knowledgeable in the domain. We can say it is a professional meeting outside the work place. Such a forum allows sharing of perceptions and mutual enrichment. It can assist

professionals to grow and enhance their performance. They may belong to different institutions or companies. Examples are nursing associations, Youth groups, coaches groups, etc.

In the CDI process such groups could also be used to expand the knowledge and use of the CDI strategy.

#### Educational or pedagogical supervision

According to Kilminster et al. (52), education supervision is the provision of guidance and feedback on matters of personal, professional and educational development in the context of a trainee's experience in providing safe and appropriate patient care. It can apply to an individual trainee or a group of trainees. In this type of supervision, teaching competencies and skills, developing confidence and self-sufficiency in the trainees are key aspects to consider. Examples of these are training of medical doctors and nurses in which educational supervision is required throughout their training. The concept and elements of adult learning should be used. It is usually the trainee's responsibility to organise meetings with his educational supervisor.

#### Team supervision

Team supervision is a way of developing collaboration between multi-disciplinary teams. This may be used in the domains related to professional interventions with clients, managing conflict and relations with other institutions, or developing means of communication. This kind of supervision is aimed at teams that are working at geographically separate areas and can communicate virtually. The duration of team supervision is variable and may depend on the needs of the team or organisation. The main objective of team supervision is therefore to support teams to effectively accomplish their task, strengthen net-works and reduce conflict.

## Intervention supervision

This kind of supervision is done during an intervention and aims at identifying problems and improving the workings of an institutional system by identifying new institutional options for better performance. It brings out the strengths, weakness and opportunities of an intervention.

## Styles of supervision

**delegating supervision** involves low directive or task communications with low supportive behaviour. Typical use would involve managing a competent and motivated staff where the person (or the team) provides much of their own support and guidance. A Delegating style would provide only that degree of task information and support that is appropriate, given the ability and motivation of the member/volunteer. Delegation is not abdication or “dumping”. Appropriate oversight or monitoring is maintained so that additional guidance or help can be provided as needed. A Delegating Supervisor will jointly with the supervised define problems and set goals. He will review the plan proposed by the supervised and respect their decisions and the way they go about it. Performance is periodically evaluated and makes sure the supervised takes responsibility and credit for the outcome. This type of supervision is suitable for health workers at national/regional/district levels.

**Coaching Supervision** involves high directive and high supportive behaviour. Typical use would involve managing an uncertain or reluctant learner, someone who needs convincing or support along with task guidance. A Coaching style makes use of clear, assertive and supporting communication behaviours. A Coaching Supervisor: identifies problems, sets goal, recognizes and praises progress, explains decisions, solicits ideas, makes final decisions after hearing the

staff's, opinions and continuously evaluate the staff. Whitmore (53) says the aim of this type of supervision is to unlock someone's potential to maximally improve their performance. This is suitable to use in the CDI process when dealing with community implementers.

**Directing Supervision** involves high directive or task communications with low support or relationship behaviour. Typical use would involve managing an enthusiastic newcomer to the particular task (motivated, but needs guidance). A Directing style makes use of clear, assertive communication behaviours: setting expectations, proposing, reasoning and evaluating, and the use of incentives and pressures (sometimes implied). A Directing Supervisor: identifies problems, sets goals and define roles, develops an action plan to solve problems, controls decision making, provides specific directions, initiates problem solving and decision making, announces solutions and decisions, closely supervises and evaluates work. This is suitable at national/regional/district supervision.

**Supportive Supervision** involves low directive and high supportive behaviour. Typical use would involve managing a competent but insecure staff/volunteer. A Supportive style makes use of bridging or attracting communication behaviours: involving/drawing out the other person, active listening, disclosing, finding common ground, and visioning (attracting the other person to a course of action). Qualities of Supportive Supervisor:

- Encourages the staff/volunteer in identifying problems and setting goals.
- Helps the staff/volunteer to take the lead in defining how the task is to be done or the problem is to be solved.
- Provides assurance and support, resources and ideas.
- Shares responsibility with staff/volunteer for problem solving and decision making.

- Listens and facilitates problem solving and decision making by the staff/volunteer.
- Evaluates staff/volunteer's work with the staff/volunteer.

Supportive style supervision is particularly suitable in the CDI process especially at Frontline health facility and community levels.

Staff at FLHF are usually very few and overworked and so have very little time to spend on learning new things or absorbing new ways of doing thing. It is therefore very important to be very patient and supportive when training and supervising at this level.

At community level one should not lose sight of the fact that those at this level, like community leaders, community members and selected community distributors, though willing to learn and serve their peers, are adults, volunteers and very often not literate in the language we are using.

Adults as compared to children and adolescents learn differently and have special learning needs and requirements. Malcolm Knowles the pioneer in this domain says the characteristics to recognize are:

Adults are *autonomous* and *self-directed*; they have accumulated a foundation of *life experiences* and *knowledge from different areas work, homes, social environment etc.* All of these make them react differently when exposed to new ideas. They could become very suspicious as to why this is being brought to them at this point. One good example is that community members are not used to being trusted with health activities and so at the beginning of setting up any CDI process a longer period is needed to convince some communities. In teaching adults it is important to draw from their experiences. According to Stephen Lieb adults are *goal-oriented*, *relevancy-oriented* and *practical*. They usually know what they want and can be obstinate in their ways.

In the CDI process it is paramount to show respect and used motivational approaches

to train and supervise at all levels and especially at community levels. For instance at the end of the training or supervision a certificate of satisfaction could be given.

## RESPONSIBILITIES AND TOOLS FOR SUPERVISION SYSTEM IN THE CDI PROCESS

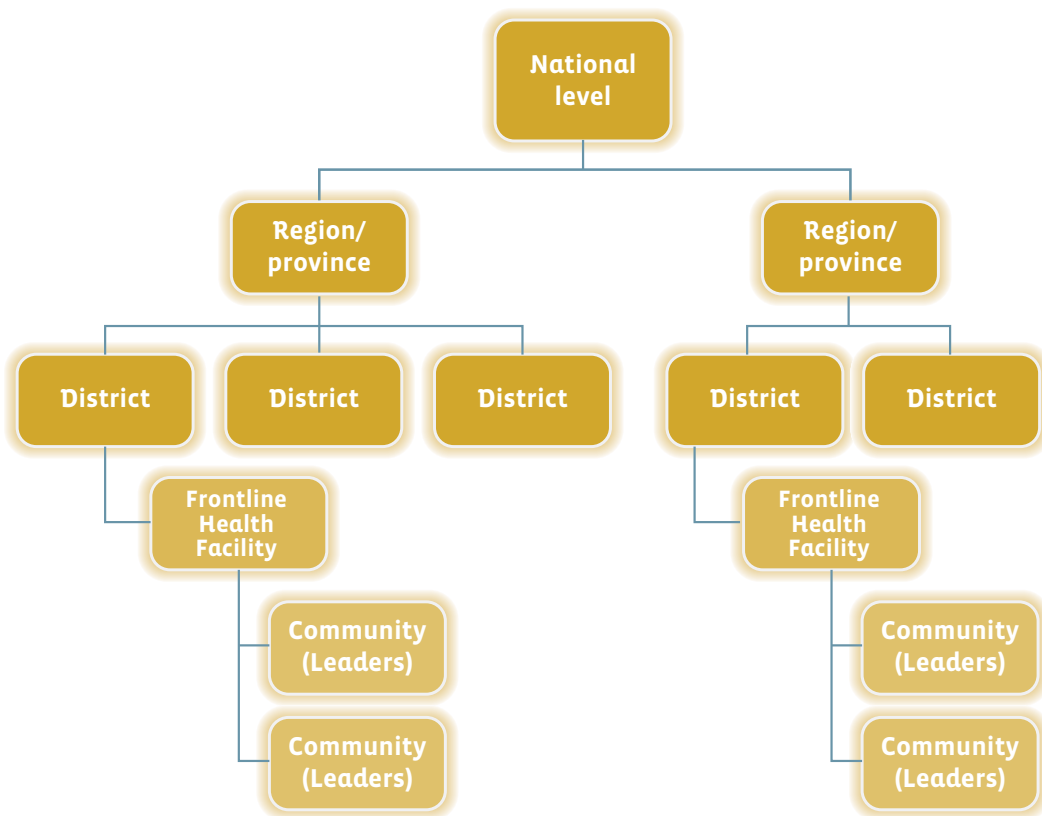
It is the role of the national level to assist the periphery to set realistic targets to be achieved, identify indicators and develop supervision guides, plans and budgets in a participatory manner involving all levels of implementation. In the CDI process supervision of activities lies with the peripheral, district or regional implementation teams while the central management team plays an important overall supervisory role.

## LEVELS OF SUPERVISION IN THE CDI PROCESS

In the CDI process supervision is organized in a cascading manner, the upper level supervising the level immediately below it although ad hoc supportive or formative supervision could be done either as an individual or as a team to much lower levels especially at the onset of the programme. It is important to emphasize on this aspect as experience has shown that higher levels of supervisors do not go lower than the immediate level below them, whereas this is true in most cases, during supervision in the CDI process it is important for national and district levels to visit communities frequently in order to build confidence and trust.

## THE ROLE OF A SUPERVISOR

The role of a supervisor is to ensure quality training, good field experience and regular checks of those supervised. He/she at the planning stage identifies the performance indicators and ensures that simple



**Fig. 7: Supervisory organogram**

supervisory guides and budgeted work plans are developed for all the levels. It is his responsibility also to make sure that all those involved are trained and informed on the performance indicators. In addition to qualities and skills described under styles of supervision a supervisor should possess good managerial skills and strive at being a friend rather than a police or a dictator. These skills include planning skills, motivation and most of all good listening skills. He should know his subordinates and be caring and helping them to achieve better personal development and understanding of the CDI process. Flexibility, fairness to all is paramount. What the supervisor must inculcate during trainings and supervision is

that CDI is a community process and must be owned by the community which must be empowered by the health system.

### **SUPERVISION TOOLS FOR DIFFERENT LEVELS OF SUPERVISION**

During supervision it is important to use certain tools and look out for a certain number of documents that could indicate if the implementers are doing things correctly. Annex 2.7 indicates tools and documents to be used or checked at each level during supervision. There may be some slight variations depending on whether it is CDTI being run alone or other health interventions use

CDI as a vehicle. An example is the Tanzania Programme in which tools at all levels should show integrated NTDs control (Figure 8).

## THE SUPERVISION PROCESS

### Planning supervision

The planning session should also include training sessions using the established strategic plan for the programme to develop the plans for supervision activities with clear targets and indicators. The work plans should indicate the CDI package with programme activities i.e. HSAM, training of health workers and community implementers, distribution of drugs and health commodities, etc. All these activities need to be planned. Annex 2.8 is an example of a work plan matrix that could be used. Hold these discussions by insisting on the national strategy, mechanisms and the type of supervision recommended. In the CDI process supportive supervision is recommended.

The process of supervision is presented and all the relevant aspects of supervision discussed, including:

- Composition of the team of supervisors;
- The frequency intervals needed to measure particular information on performance (e.g. collecting routine stock reports to measure timely delivery of treatment drugs);

- Availability of a supervision form/card;
- Forms for the collection of data are presented and explained;
- Feedback mechanisms and report formats.

Finally, budgeted supervisory action plans are developed with SMART objectives.

What are the characteristics of a good action plan for supervision?

**Example of SMART objectives:** *The specific objective is to supervise training of Community implementers in 20 training sites in 4 districts in the Taraba CDTI Project area from March to April, 2011.*

A Specific Objective is one of the activities or actions that will lead to the realization of the goal of the programme. To implement this objective a whole lot of questions need to be answered. A few questions are stated below. These will enable you to finalise the budgeted action plan for supervision. Annex 2.9 is an example of a planning matrix that could be used to develop a budgeted action plan.

- **Specific:** how clear is this objective in terms of what has to be achieved or reached and how?
- **Measurable:** will it be possible to tell if this objective has been achieved? How? What are the indicators?
- **Appropriate:** how relevant is this objective for achieving the goals?

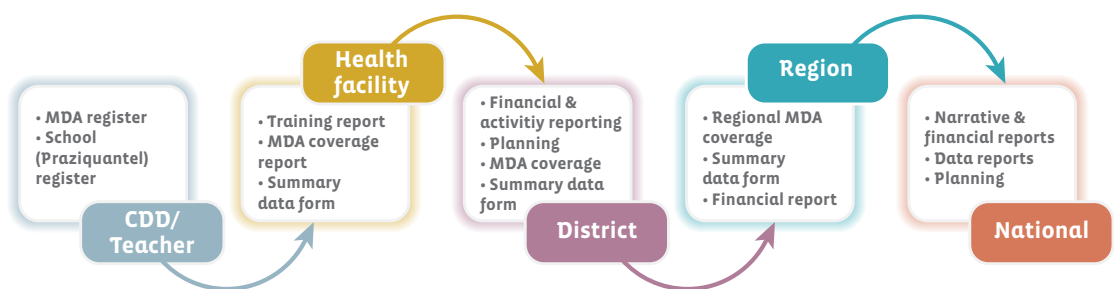


Fig. 8: Tools, reports & Data to be checked at different levels of supervision, NTDs Control Programme Tanzania



- **Realistic:** are there resources (financial and human)? Does the timeframe allow enough time for realization of the objective?
  - **Timeline:** what is the timeframe for realizing the activities that will enable us to achieve our objective?
- a) what activities are needed to achieve this objective?
  - b) what would be the success indicators?
  - c) who are the responsible persons for implementing each activity?
  - d) what resources are needed and from what sources?
  - e) a good plan is budgeted with clearly stated sources of funding.

Other important aspects that should be agreed upon beforehand in the CDI process are the supervisory checklists which should be based on the importance of items for achieving the CDI activity/strategy and programme targets. For example, a supervisory checklist should take into consideration the level of implementation and so the checklist should reflect skills at each level: national, provincial/regional, district, front-line health facility and community levels (see Annexes 5.1, 5.2, 5.3 & 5.4). It should reflect the importance of the indicators to the overall implementation process and success of the CDI intervention package (e.g. the number of people treated, the number of women CDDs, etc.). The checklist and tools should also reflect the fact that one or several programmes are co-implementing (see Annex 5.1)

### **Implementing supportive/ formative supervision**

The appropriate supervision guides and work plans should be used for the appropriate level. The supervision task/activity is indicated in each guide and should be followed as indicated. During supervision it

is necessary to verify the presence through observation and/or interview of the existence of medicines and commodities: availability, correct storage, usage of correct dose; presence of measuring poles etc. Again what is observed will depend on the level at which supervision is being done. For instance at community level it is important to make sure the community implementer has a measuring pole, a household register. In the CDI process activities are carried out in a certain chronological order during the year: Advocacy, Health Education, Mobilisation/Sensitization; training of health workers and community implementers; positioning of ivermectin and other relevant commodities; census taking and distribution, monitoring and supervision; data management and reporting; and finally evaluation.

The supervision action plan should take into account each of these steps of implementation in order to establish work plans that allow supervision at the appropriate time. This means a chronogram for supervision should be established (Annex 2.8). In implementing supervision it is important to:

- be knowledgeable on the CDI process;
- develop supervisor's visit plan and supervisor's schedule;
- inform those to be supervised;
- prepare and duplicate supervisory tools and other materials needed during supervision, ie supervision guide, checklist, supervision task, etc. (see Annex 4 - Supervision task Cameroon).

We have described above the different types and techniques of supervision which should be adapted depending on the different situations where supervision may be needed. In the CDI process techniques of supervision, field visits, direct observation (using a check list) or observing if a process is being carried out correctly by an individual and Group Meetings are very useful.

## Frequency of supervision and feedback

During supervision forms for registering data could also be collected for data entry in computers or reviewing performance later on. In the CDI process the following supervision frequency is recommended:

- **National:**  
2-4 per year and 1 review meeting.
- **Regional/Provincial:**  
3-4 per year and 1 review meeting.
- **District:**  
4 per year and 1 review meeting.
- **FLHF:**  
monthly and quarterly meeting.

## Reporting and feedback of supervision

The Oxford Advance Learner's dictionary describes Feedback as advice, criticism or information about how good or useful something or somebody's work is. The way we give feedback is important and can determine whether those receiving this feedback will act on our advice or not. It is necessary to be specific, direct and focus on the action that needs to be carried out or behaviour that needs to be changed. It should be related to something that could be realised and if realised could help the growth and performance of the one supervised. Above all, the feedback needs to be timely and should come not too long after the supervision.

### Feedback to Community

Feedback can be done at community meeting by the community leaders, CDD, community monitors and health staff. Usually done orally, the community is informed on the results of distribution, on results of community self CSM, refusals, absentees, etc. This enables the community to take appropriate action to increase coverage.

### Feedback to Health Staff

At this level two forms of feedback could be done:

*Direct Supervision:* Corrective measures are suggested during direct observation by supervisor during an activity (distribution of medicine and commodities).

*Indirect Supervision:* Written feedback is made to those supervised as soon as possible to enable them to take corrective measures to improve performance and achieve programme milestones and objectives. The supervision feedback could also be made during periodic review meetings at different levels. An example is the report of the community self-monitoring (CSM), which is reviewed during the district review meetings and this enables the health System to improve its performance at community level (see Annex 7.1 for an example of CSM report from Cameroon).

## TYPES OF PROBLEMS THAT CAN BE IDENTIFIED DURING SUPERVISION AND POSSIBLE SOLUTIONS/ACTIONS

It is important to verify during supervision that household registers are correctly filled. Poor record keeping is an indication that there will be need to train properly the community implementers (CDDs/Volunteers) and very often to give refresher training to the FLHF staff.

During supervision several problems could be identify and the ability of the supervisor to give advice and bring corrective measures will determine the improvement of implementation of the programme at all levels and the performance of the implementers (see Annex 2.10).

## CONCLUSION

All CDI activities must undergo regular Supportive supervision and adequate feedback should be given to all levels and persons supervised in a timely way.





# UNIT 8

## MONITORING AND EVALUATION



# UNIT 8:

## MONITORING AND EVALUATION

### SECTION A: TRAINING OUTLINE

**PURPOSE:** To provide information that will enable the tracking of progress in attaining the implementation of CDI interventions in countries.

**PREREQUISITE MODULES:** Units 2, 3, 4, 5, 6 and 7.

**MODULE TIME:** 2 hours.

**LEARNING OBJECTIVES:** At the end of the unit, participants should be able to:




- a) define general concepts in M&E;
- b) develop M&E tools;
- c) facilitate the process of CSM;
- d) collect and process data from a M&E exercise;
- e) conduct a feedback review;
- f) assemble a team for participatory research.

#### **PRESENTATION PLAN:**

This Unit covers:

- concept Definition;
- development, validation and use of M&E n tools;
- CSM;
- collection and analysis of monitoring and evaluation information;
- facilitation of review and feedback meetings;
- techniques for participatory research.

## OVERVIEW • UNIT EIGHT

Step	Time	Activity/ method 	Content 	Resources needed 
1	5 min	Introductory Presentation to Unit	Title, Learning Objectives and Content Outline (Presentation Plan) Discussions on objectives & expectations at the end of the Unit	Slides 1–3
2	20 min	Participatory presentation & Discussions	Concepts and Overview	Slides 4–7
3	30 min	Participatory presentation & Discussions	Development, Validation and use of M&E Tools <ul style="list-style-type: none"> <li>• M&amp;E Pathway and Framework</li> <li>• Sources of Data</li> <li>• M&amp;E Toolkit</li> </ul>	Slides 8–14
4	20 min	Participatory presentation & Discussions	CSM	Slides 15–17
5	15 min	Participatory presentation & Discussion	Review and Feedback Techniques	Slides 18–19
6	15 min	Participatory presentation & Discussion	Operational, Implementation and Participatory Research	Slide 20–21
7	5 min	Participatory presentation & Discussion	Data quality Assurance	Slide 22
9	5 min	Conclusion	Evaluation & summary of the Unit session	Slide 23

**Routine & Non Routine reporting, Data quality assurance, Evaluation and research****MATERIALS AND EQUIPMENT CHECKLIST:**

- Slides
- Computer with LCD projector and screen
- Flip chart paper
- Giant notepad
- Markers
- Blackboard.

**TEACHING GUIDE/ADVISORY NOTES TO TEACHERS:**

- For each of the following topics, ask participants to explain or to define in their proper meaning the following concepts: monitoring, evaluation, follow up, self- monitoring and feedback.
- M&E Process/Mechanisms.
- Self-Monitoring.
- Review and feedback techniques.

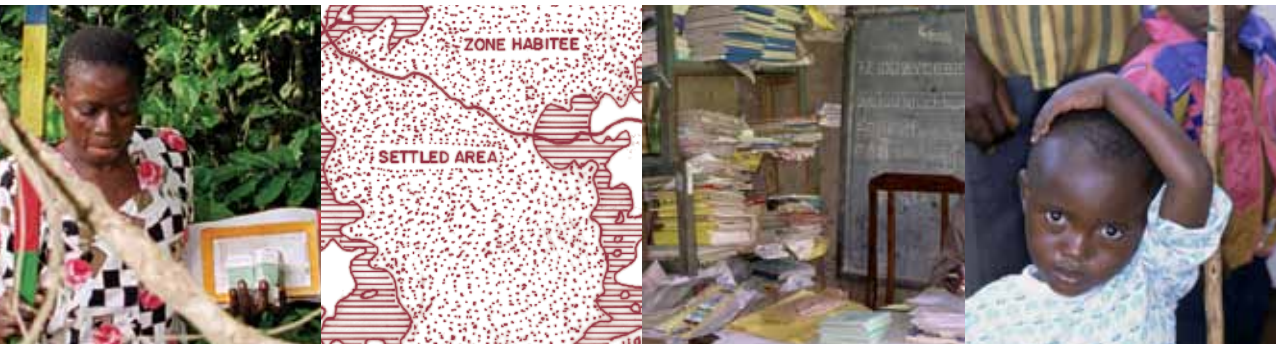
WRITE the points on the flipchart. Use the list to facilitate a discussion, allowing participants to show key elements of each definition or explanation.

**TEACHING METHODS AND TECHNIQUES:**

- Introductory presentation
- Brainstorming
- Questions & answers
- Group work/exercises
- Discovery method.



## SECTION B: NARRATIVE



### INTRODUCTION

M&E are among the basic principles of APOC's work. The Programme continuously assesses itself and the performance of its projects to identify areas that need strengthening or improvement.

Like any major public health intervention, CDI should be monitored and evaluated. In this Unit we will define and distinguish the concepts of M&E, present some of the tools that are used for M&E in CDI and related programs and discuss the role of the community in the M&E process. This unit also reviews feedback mechanisms by which program managers and communities alike can learn and improve interventions as well as explore implementation or operational research as a tool for discovering better ways of delivering health interventions through CDI.

## CONCEPTS AND OVERVIEW

Countries have different M&E needs, dictated in part by the state of their Disease burdens, Disease Programme Control and country health structure. Yet successful M&E systems will share common elements, as demonstrated by successful programs in several countries. As several stakeholders are involved in M&E activities at varying levels, it is important that all stakeholders have the same understanding and definition of basic M&E terms.

**Generic Definition:** Monitoring is the routine tracking and reporting of priority information about a program/project, its inputs and intended outputs, outcomes and impacts.

**Operational Definition:** Monitoring is the *routine* tracking of the key elements of program/project performance (usually inputs and outputs) through record-keeping, regular reporting and surveillance systems, as well as health facility observation and surveys.

Monitoring helps program or project managers determine which areas require greater effort and identify areas which might contribute to an improved response. In a well-designed M&E system, monitoring contributes greatly towards evaluation. Indicators selected for monitoring will be different depending on the reporting level within the health system. It is very important to select a limited number of indicators that will actually be used by program implementers and managers.

There is a tendency to collect information on many indicators and report this information to levels where it will not and cannot be used for effective decision-making. In addition, monitoring is used for measuring trends over time, thus the methods used need to be consistent and rigorous to ensure an appropriate comparison. More information is needed for project management than

is needed at national or international levels. The number of indicators reported should decrease substantially from the sub-national to the national and international levels.

**Evaluation** is the rigorous, scientifically-based collection and analysis of information about program/intervention activities, characteristics and outcomes that determine the merit or worth of the program/intervention. Process evaluation is a type of evaluation that focuses on program/intervention implementation including, but not limited to, access to services, whether services reached the intended population, how services are delivered and perceptions about needs, services and management practices.

Outcome evaluation is a type of evaluation that determines if, and by how much, intervention activities or services achieved their intended outcomes. An outcome evaluation attempts to attribute observed changes to the intervention tested. Impact evaluation is a type of evaluation that assesses the rise and fall of impacts, such as disease prevalence or incidence, as a function of Health programs/interventions.

In contrast, **evaluation is the *episodic* assessment of the change in targeted results related to the program or project intervention.** In other words, evaluation attempts to *link* a particular output or outcome directly to an intervention after a period of time has passed. Evaluation thus helps program or project managers determine the value or worth of a specific program or project. Cost-effectiveness and cost-benefit evaluations are useful in determining the added value of a particular program or project. In addition, evaluation should also relate the outputs of a project/program to wide national trends in behaviour and other outcomes, and the impact of diseases. This type of evaluation is important even if the project/program is only one part of a collective effort to impact the disease.

The objectives and the methodology used in M&E are different. In general, evaluations are more difficult in view of the methodological rigor needed: without such rigor, wrong conclusions on the value of a program or project can be drawn. They are also more costly, especially outcome and impact evaluations which often require population-based surveys or other rigorous research designs. However, evaluation should leverage data and surveys that are nationally available and regularly undertaken, e.g. DHS surveys, vital registration or sentinel site disease data.

A common, comprehensive and coherent M&E system has several advantages. It contributes to more efficient use of data and resources by ensuring, for example, that indicators and sampling methodologies are comparable over time and by reducing duplication of effort. As data collection resources are limited, this is an important asset as countries may pool donor funds in order to produce a limited number of large-scale, high quality studies rather than a myriad of ad hoc assessments that are not comparable. Data generated by a comprehensive M&E system ought to serve the needs of many constituents, including program or project managers, researchers and donors, eliminating the need for each to repeat baseline surveys or evaluation studies when they might easily use existing data. It is important that the basic data is made available as transparently as possible and placed in the public domain.

From the point of view of the national program, a coherent M&E system helps ensure that donor-funded M&E efforts best contribute to national needs. These needs go beyond disease-focused M&E, to strengthen the overall health information system. A further advantage is that it encourages coordination and communication between different groups involved in the national programme. Agreement among the major donors, technical and implementing agencies

on the basic core M&E framework will reduce the burden of requests for data from different agencies. Shared planning, execution, analysis and dissemination of data collection can reduce overlap in programming and increase cooperation between different groups, many of whom may work more efficiently together than in isolation.

A facility assessment as part of routine supervision serves to provide information on the quality of care or the availability and utilization of services. At all levels, both monitoring and evaluation are required.

Sub-national data is extremely relevant for national level M&E provided that national guidelines are followed to make aggregation possible. Information gathered from the sub-national level is helpful in guiding policy discussions and in validating results at higher levels. In some cases, data from the sub-national level provides a better indication of trends and issues of equity than from a country-level perspective.

Building or strengthening health information systems (HIS) is a pre-requisite for proper monitoring of diseases and the response to them. Increased funding in the disease areas creates an opportunity to strengthen not only program or project specific health information, but also the health information and surveillance systems.

An effective HIS provides a solid basis for evaluations of large-scale programs, ultimately leading to improved planning and decision-making. Based on these findings, urgent decisions such as how to allocate new resources to achieve the best overall results will become easier to make.

M&E includes many different components, methods and activities, but in general can be defined as acquiring, analyzing and making use of relevant, accurate, timely and affordable information from multiple sources for the purpose of program improvement. M&E is the cornerstone of an evidence-based

approach to the decision making required for designing and implementing CDI approach.

M&E activities are inextricably linked but differ in purpose and design. Monitoring provides information on where a policy, program or project is at any given time. It can provide a “snapshot” of the situation or program status. Evaluation provides information on whether or not specific programs or interventions are “working” (i.e., achieving intended objectives or targets) and why objectives or targets are or are not achieved. Evaluation complements monitoring: when a monitoring system observes that program efforts are off track, then good evaluative information can help clarify the realities and trends noted.

## DEVELOPMENT, VALIDATION, USE OF MONITORING AND EVALUATION TOOLS

We need a good record keeping strategy to be able to track program accomplishments, monitor and measure outputs and outcomes. Therefore, good record keeping system is a precursor to successful program implementation. This involves the process of documenting services provided over time using specific simple formats designed for the purpose. For this to be accomplished there is the need to understand the reasons why record keeping is important. It is important because we need to learn during program implementation activities:

- the number of people we will be providing with specific services over time;
- how the program is performing;
- information for planning and budgeting purposes
- Equipment, quantities of medicines and supplies required over a period of time;
- if the right people are receiving services;
- the continuity of care; and
- Progress on major health conditions.

We do not only record, we also need to ensure that information does not remain in the registers but is reported.

## M&E Pathway and Framework

M&E as a measurement process requires tools. These tools are built on an understanding of the normal pathway of program activities and results. An effective M&E system establishes a clear and logical pathway from the resources used to the achievement of the overall result. This pathway includes the following major components:

- i. **Inputs:** the financial, human, material, technological and information resources used in a program/intervention;
- ii. **Activities:** actions taken or work performed through which inputs, such as funds, technical assistance and other types of resources are mobilized to produce specific results;
- iii. **Interventions:** a specific activity or set of activities intended to bring about change in some aspect(s) of the status of the target population;
- iv. **Outputs:** the results of program/intervention activities; the direct products or deliverables of program/intervention activities;
- v. **Outcomes:** the short-term and medium-term effects of an intervention's outputs, such as change in knowledge, attitudes, beliefs, and behaviours;
- vi. **Impact:** the long-term, cumulative effect of programs/interventions over time on what they ultimately aim to change;
- vii. **Indicators:** quantitative or qualitative variables that allow the verification of changes produced by a program/intervention relative to what was planned;
- viii. **Target:** reference point or standard against which progress or achievements can be assessed. A target refers to the

performance that has been achieved in the recent past by other comparable organizations, or what can be reasonably inferred to have been achieved in similar circumstances. Indicators are best conceptualized within a M&E framework. There are varying frameworks applied to the selection of M&E indicators. Indicators are used at different levels to measure what goes into a program or project and what comes out of it. Over the past few years, one largely agreed upon framework has commonly been used, the input-process-output-outcome-impact framework. For a program or project to achieve its goals, **inputs** such as money and staff time must result in **outputs** such as new or improved services, trained staff, persons reached with services, etc. These outputs are the result of specific **processes**, such as training for staff that should be included as key **activities** aimed at achieving the outputs. If these outputs are well designed and reach the populations for which they were intended, the program or project is likely to have positive short-term **effects** or **outcomes**.

Impact monitoring is the tracking of health-related events, such as the prevalence or incidence of a particular disease; in the field of public health, impact monitoring is usually referred to as “surveillance”. Assessing the impact of a program requires extensive investment in M&E efforts, and it is often difficult to ascertain the extent to which individual programs, or individual program components, contribute to overall reduction in cases and increased survival. In order to establish a cause-effect relationship for a given intervention, studies with experimental or quasi-experimental designs may be necessary to demonstrate the impact. Monitoring of output or outcome indicators can also identify such relationships and give a general indication of programs progress according to agreed upon goals and targets.

National surveys and datasets should also be leveraged in evaluation.

## Sources of data

There are two main sources of data. These include routine and non-routine sources.

**Routine sources** include the use of registers to track on regular basis services provided to specific clients or patients. Such sources involve the use of community registers, monthly summary forms, tally sheets etc.

- Routine reporting of CHW activities:  
There is also a system of data collection linking the health facility to the community through the CHWs working at the village level.
- Routine reporting of community-based activities:  
The community-based information is collected primarily through program records from implementing organizations such as CDD, community-based civil society organizations. All CDD will provide monthly / quarterly activity reports to district level. It is important to note that many projects are collecting data for lower-level indicators that do not directly contribute to reporting on national indicators, as surveys were used whenever possible as the data source in order to reduce reporting burden at all levels.
- Routine Reporting at health facilities:  
In general, health facility information is collected through various registers which are used to record data on services on a daily basis at the time of service delivery. Each Health facility reports on monthly aggregate data using Monthly Reporting Form which is submitted to FLHF/MOH each month. Relevant data is subsequently recorded into the National HIS database where it is aggregated for national reporting.

Equally, M&E Officer and staff from District / Region routinely visit each health facility

in the country once per quarter as part of regular supervision and data quality assurance activities. For every visit, a supervisory feedback report highlighting the main findings and action plans is prepared and shared with the health facilities, the district and program managers. These reports also serve as primary data sources for monitoring some national indicators such as health centres with staff trained to perform male circumcision.

APOC will ensure that data collection on benchmarks and indicators to be reported as part of the national indicators are incorporated into all surveys and surveillance activities. Quality control measures will also be established to improve the data collection efforts and reliability of national surveys.

- **Non-routine sources** include survey, this involve periodic data collection usually when the need arises. The production of timely and high quality data through surveys and surveillance is critical to the effective M&E of CDI interventions. In addition, some national-level indicators can only be measured through surveillance activities and it is necessary to ensure that all surveys and surveillance activities capture the appropriate information needed by the M&E system. It is important to note that some indicators will also use routine reporting data as a secondary source for monitoring progress in the short-term. Results from these surveys that inform national indicators will be routinely updated into national databases as data becomes available in order to maintain an updated registry of all national results by indicator.

The major (non-routine) surveys are described below:

## M&E of CDTI projects

### Independent participatory monitoring

Every CDTI project undergoes an independent participatory monitoring exercise in the second year after its establishment. The purpose is to ensure that the project is functioning correctly and that all partners in the project are playing their respective roles.

The exercise is *independent* as the team leader and two members of the monitoring team are not involved in the project. It is *participatory* in that it involves one or two members of the project's supporting partners.

### CSM

Self-monitoring of CDTI encourages the community to take full charge of the CDTI process and make appropriate modifications as necessary.

Every year, each community involved in CDTI conducts a CSM exercise. This is usually carried out within three months of an ivermectin distribution session.

The community selects their own monitors and creates their own indicators to track their performance. Monitors' reports are given to the local health worker, who gives the community feedback on how to improve their CDTI process.

### External evaluation for sustainability

To eliminate onchocerciasis as a public health problem in Africa, the community-directed treatment approach must be sustainable. A method to evaluate the sustainability of CDTI projects was established in response to the first external evaluation of APOC, which expressed concern about the sustainability of activities once APOC funding comes to an end.

In its third year, every CDTI project undergoes an external evaluation to assess its ability to continue functioning after the withdrawal of APOC support.

The evaluation team includes members from another participating country, and members of another CDTI project in the same country. The Evaluation for sustainability of a project is based on the following criteria:

- **Integration:** projects that have become integrated into the routine running of the health care system are more likely to be sustainable.
- **Community ownership:** projects are more likely to be sustainable if the communities support the CDTI process and are willing to take responsibility for it.
- **Simplicity:** projects that use simple, uncomplicated routines and procedures are more likely to be sustainable.
- **Health staff acceptance:** projects are more likely to be sustainable if health staff have accepted CDTI as a routine activity, which they will continue even in the absence of material rewards.
- **Efficiency and effectiveness:** projects that are functioning efficiently and run cost-effectively are more likely to be sustainable.
- **Resources:** projects are more likely to be sustainable if they have enough human, financial and material resources to support what they are trying to do.

The evaluation team assesses the likelihood of the projects achieving sustainability and reports any weaknesses in a project that are likely to undermine its sustainability.

Following an evaluation, a sustainability plan is drawn up by local government health officials, health care staff, staff from NGOs, and members of the evaluation team. A sustainability plan commits the government to taking over the financial management of certain activities, previously funded by APOC. These activities include training of CDDs, training of health workers,

and project supervision. The sustainability plan marks a key stage in devolving APOC's financial support to the government. It helps all partners to prepare for the end of APOC's mandate in 2015.

## **Monitoring the implementation of sustainability plans**

One or two years after establishing a sustainability plan, each project undergoes a further monitoring exercise by a small team of independent experts. The aim is to verify how well the government is implementing the plan at district and community levels.

## **Epidemiological evaluation and disease surveillance**

### **Epidemiological evaluation**

Between 1999 and 2005, studies were carried out to assess the long-term impact of APOC's operations. The results showed a significant reduction in the prevalence of live microfilaria (larval forms of the *Onchocerca volvulus* parasite) in the skin. They also indicated that ivermectin treatment can prevent onchocercal blindness and severe itching.

In the coming years, APOC will establish sentinel villages in as many project sites as possible to evaluate CDTI project performance using epidemiological trend indicators.

### **Disease monitoring and surveillance**

APOC's role in disease surveillance is to encourage countries to integrate onchocerciasis control activities into their national disease surveillance systems. Between 2008 and 2012, APOC plans to provide financial support to the Multi-Disease Surveillance Centre (MDSC) in order to meet this objective. In collaboration with the MDSC, APOC also plans to encourage countries to increase the priority given to disease surveillance issues in their health sector strategies.

The Multi-Disease Surveillance Centre (MDSC) assists countries in planning and implementing an integrated disease surveillance system. This system includes active surveillance for onchocerciasis recrudescence. The MDSC was set up to monitor onchocerciasis in the countries covered by OCP. The same now needs to be done in APOC countries. MDSC will train epidemiologists, entomologists and technicians on all aspects of onchocerciasis epidemiological and entomological surveillance and evaluation. The MDSC will also analyze parasites and black flies using DNA probes and advise countries on transmission levels.

The role of countries is to plan for and execute monitoring and surveillance activities. They also analyse and apply the findings of these activities to decision-making. WHO assists countries in developing policies, guidelines and strategies for monitoring and surveillance of onchocerciasis.

### Assessing the health impact of APOC's operations

Between 1999 and 2010, epidemiological evaluations showed a significant reduction in the prevalence of live microfilaria (larval forms of the *Onchocerca volvulus* parasite) in the skin. They also indicated that ivermectin treatment can prevent onchocercal blindness and severe itching.

### Rapid health impact assessment

In 2007, a rapid health impact assessment of APOC was completed. The study aimed to assess the impact of APOC on skin and eye problems and on the burden of disease caused by onchocerciasis (measured in DALYs – disability adjusted life years lost due to the disease). A second objective was to predict the health impact of APOC by 2015.

The computer simulation model ONCHOSIM was used to simulate how the prevalence of infection and disease decline, depending on

the number of treatment rounds provided and the proportion of people treated per round.

### Reductions in symptoms and infection

By 2005, all symptoms had decreased (see Figure 9). The prevalence of infection had declined to about 73% of its level prior to Community-Directed Treatment with Ivermectin (CDTI). It is predicted to decline to 14% of the pre-CDTI level by 2015.

The prevalence of itching had halved by 2005 and is predicted to be almost eliminated by 2015. Reduction in blindness and low vision is slower because of the irreversibility of these symptoms. These were reduced to 77% and 88% of the pre-CDTI levels respectively in 2005, and are predicted to reduce to 32% and 49% by 2015.

### Reduction in burden of disease

In 2005, the annual number of DALYs lost had almost halved. By 2015, it is predicted that the reduction in DALY loss will be 86%.

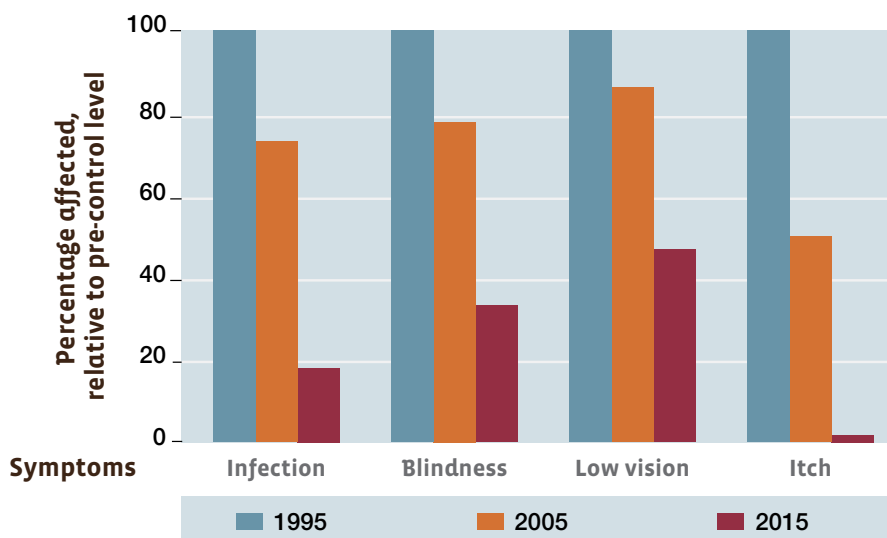
### Special studies

- Select priority outcome/evaluation studies.
- Include qualitative studies as needed.
- Include operational research studies.

### M&E toolkit

Different types of indicators are not equal but *linked* to each other to reach the intended goals and objectives of a specific program. Inputs such as money and staff time result in outputs such as delivery systems for drugs or other essential commodities, new or improved services, trained staff, informational materials, etc. If these outputs are well designed and reach the populations for which they were intended, the program is likely to have





**Fig. 9: Estimated prevalence of onchocerciasis infection and clinical manifestations in the APOC population in 2005 and 2015, compared to the pre-APOC level of 1995.**

positive outcomes – depending on the context in which it operates. These positive outcomes should lead to changes in the longer-term impact of programs on target populations or systems.

We have seen above that a common concern for stakeholders who want to join forces over an integrated community service delivery process is the need to secure data that shows they are successfully delivering the services to their target populations. Again starting at the community level one needs to include design and provision of community register books so that a page can be given to each household and its members and columns for services given. Reporting sheets must be locally appropriate so that they;

- Account for all health commodities provided.
- Enable recording of health education sessions.
- Be easy to mark for low literacy level CDDs.
- Be no longer than one page.

CDD training should include a session on how to keep records and submit monthly summary forms. In addition, health staff should review on a regular basis the records kept by the CDDs they supervise. One method for regular data collection is holding of monthly CDD review and supervisory meetings where CDDs bring their summary forms.

The assessment, a participatory workshop with key stakeholders, uses checklists to identify strengths and weaknesses and suggests key action steps for improvement at the national and sub-national levels.

### Data collection & analysis

- National level data collection and analysis plan & tools, including data quality assurance.
- Plan to collect data and periodically analyse indicators and associated data sets.

CDI requires that we put in place a good community-based information system (CBIS). CBIS is the process of collecting

information for services that are provided at the community level usually outside the health facilities. Then the health service integrates the community data into the facility to produce the overall facility output for the period under review. The CBIS system is made up of the following planning, collecting managing, reporting and using information. These activities should be carried out with the active community participation in fact the community should drive system. Therefore, it becomes paramount at the inception of program design to understand and agree on the information that would be collected at the community

level. Usually these will include such information as on community case management of diseases, for example Rwandan community malaria program could collect the following information:

1. Home management of uncomplicated malaria for children and adult.
2. Community parasitological diagnosis of malaria using RDTs kits.
3. Malaria in pregnancy –IPT.
4. Home based prevention of malaria – ownership and use of LLINs.
5. Referral for case management of complicated malaria and other illnesses.

### Tally Sheet for Literate Volunteers

MONTHLY SUMMARY TALLY SHEET

LSA: \_\_\_\_\_ Community \_\_\_\_\_ District \_\_\_\_\_

CDD Name: \_\_\_\_\_ Month: \_\_\_\_\_ Year \_\_\_\_\_

Service	Tally	Total
Pregnant women visited		
ITN	ITN pregnant women ITN-O	
IFIp	IFT1 IFT2	
RDT	Positive Negative Invalid	
ACT	ACT1 (2-11 months) ACT2 (1-5 years) ACT3 (6-13 years) ACT4 (>14 years)	
Parasitology treated		
Diarrhoea treated		
Referral		

### CDTI Tally Sheet for Low Literacy CDDs

FREE TREATMENT WITH NEUTRIN AGAINST BLOOD PARASITES

CDTI BY VOLUNTEER

100

50

0

Number of people 0-1000

Number of children 0-1000

## CSM

CSM is the process by which the community is empowered to oversee and monitor the performance of CDI (or any community-based health intervention programme), with a view to ensuring that the programme is being executed in the way intended. It encourages the community to take full charge and make appropriate modification as may be deemed necessary, on the basis of feedback from the reports of monitors. Community self-monitoring is community-driven activity and should be promoted as such.

Planning and adequate preparation is a key to effective CSM. Regular interaction between health staff and the community is an opportunity for providing solutions to unforeseen problems as soon as they arise.

### Characteristics of CSM

#### 1. When should it be done?

A CSM exercise should hold within 3 months of completion of ivermectin (Mectizan) treatment.

#### 2. What indicators should be included in the monitoring?

The indicators that should be included are those decided upon by the community at their meetings. Adjustments to these indicators would normally take place from time to time.

#### 3. Who should be the monitor?

Anyone may be selected as a monitor by the community provided that:

- i) There are on average four monitors per community of 500 persons ideally;
- ii) There is a fair, if not equal, representation of the sexes among those selected.

#### 4. Should there be a report?

Yes, there should be a written report from the monitors to be submitted to the Health

Office as soon as possible after all the necessary information has been collected. The report may be in the local language. Keep the reports in labelled files for ease of access and reference in future.

### 5. Getting monitoring reports in on time and using them to improve performance

Programmes depend on well kept CSM reports submitted on time for their effectiveness and should encourage all involved in CSM, especially the monitors, to keep and submit their reports on time for necessary actions to be taken based on these reports. Special commendation awards to the monitor who submits the best report and on time should be considered to serve as motivation for timely submission of reports.

### 6. Should there be a meeting after the monitors have collected and recorded the information?

Yes, there should be a meeting of the community to discuss the information collected by the monitors. This would provide an opportunity for a feedback and direct interaction with the community.

### What and how to prepare for CSM?

The 6 steps needed to prepare for CSM are as follows:

**Step 1:** Identify the community which will be facilitated and make sure that you have all the information needed on the community.

**Step 2:** Meet the community leaders and Representatives of CBOs. The success of CSM depends on adequate information exchange between monitors/facilitators and the populace.

**Step 3:** Facilitate a community meeting.

**Step 4:** Explain the need to review the treatment exercise, allow the community to discuss and decide the indicators of interest to them and take note of the indicators that have been selected by the community.

**Step 5:** Hold a brief meeting with the monitors before leaving the village. They should remember to keep a copy of the CSM report in the village.

**Step 6:** Attendance at the community (feedback) meeting. Encourage and commend good record keeping and performance by the monitors.

Annex 7.2 is an example of a community self-monitoring Form and Annex 7.3 contains a table with details on how to implement CSM.

### How to use the results of CSM exercise?

1. Every year discussion on CSM should be an agenda item of the Local Government/District health management Team and the State/Provincial/Regional Health management meetings after mass distribution of ivermectin.
2. At these meetings review the objectives set out for implementing CSM.
3. Were the objectives achieved in each District? If not, identify the causes and discuss possible solutions. Prepare a plan to address the problems and agree on deadlines of implementation.
4. For communities that carried out CSM, ask each LGA/District team to summarize the reports of monitors.
5. The presentation of the LGA/District team should include a table similar to that in the guide on CSM.

6. Compare treatment figures, absentee, refusals rates reported by monitors with that in the CDD registers.

7. Appraise your performance and those of the communities.

8. Collectively determine which districts need more attention in the next treatment cycles.

9. Discuss data management and presentation.

10. Report projects performance at NOTF review meetings. Collate data of all LGAs/Districts and prepare a summary for each project's Annual Technical Report to the Technical Consultative Committee (TCC) and other partners.

11. Use the CDTI CSM also for other health interventions such as vitamin A supplementation and Immunization programmes.

## COLLECTION AND ANALYSIS OF MONITORING AND EVALUATION INFORMATION

### Methods of data collection

Methods of data collection are provided in the disease specific sections, an overview is given here. The frequency of reporting will depend on the level of the indicators within the M&E conceptual framework – taking into account both a reasonable timeframe for an expected change and program capacity for M&E. It is particularly important to include routine data collection which is monitored regularly (quarterly, six months, annually) and plan at an early stage for longer term 1-3 year M&E surveys with clear baselines.

## **FACILITATION OF REVIEW AND FEEDBACK MEETINGS**

### **Feedback to Community**

Feedback can be done at community meeting by the leaders, CDD, community monitors and health staff. Usually done orally, the community is informed on the results of distribution, on self CSM, refusals, absentees. This enables the community to take appropriate action to increase coverage.

### **Feedback to health workers**

For feedback to health workers please see Unit 7.

## **DATA DISSEMINATION**

The use of data and other evidence to inform sound decision-making is the main goal of the M&E system. The M&E system needs to develop data dissemination mechanisms at all levels to ensure that all relevant stakeholders have access to most up-to-date information available that can influence their program decisions. Data dissemination strategies will be developed to assure that information is not only available, but disseminated to the appropriate stakeholders in a timely manner.

On receipt of the CDD forms, the health staffs need to incorporate all community data into their own monthly reporting formats. Ideally a monthly summary form for a health facility should have a place to enter both clinic-collected and community-submitted data for a particular service. Ultimately since the facility staff have trained and supervised the CDDs, they are rightly expected to summarize all services provided within their catchment areas for onward transmission to the district health office. This ensures that programs which require timely coverage data are able to see the impact of community-provided basic services.

Simple village summary forms with pictures may not be as simple as we believe. These forms have to be pre-tested to be sure that low literacy CDDs are able to 'see' the picture and understand what it means.

## **DATA QUALITY ASSURANCE SCHEDULING**

The implementation of the data quality assurance plan is structured according to the following schedules:

### **1. Daily routine basis**

### **2. Quarterly basis**

**Annual basis:** Annual data quality assessment is conducted on a sample of selected facilities by an external auditor and implementing partners. The exercise, based on selected indicators, will look at all the aspects and dimensions of data quality.



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# ANNEXES



# Annex 1

## CASE STUDIES ON COMMUNITY-DIRECTED INTERVENTIONS (CDI) CURRICULUM

### General and overall preamble

The series of case studies presented here-under are meant to enhance comprehension of the CDI strategy and are presented in a manner that meets the goal and objectives of the curriculum and training module on CDI as recounted under the curriculum units. The case studies should enable the trainers as well as the trainees to think through the various issues that best illustrate the various aspects of CDI.

Each training institution is expected to adapt the scenarios described to fit in with the real-life extant situation as occurs in the locality where its training is to be undertaken, and to fit the entire programme into the institution's training syllabus.

While each case study is meant, primarily to highlight the key issues in the relevant Training Unit that precedes it, it must be remembered that these Units are closely interrelated and the issues cut across Units and the case studies help to reinforce what each Unit sets out to teach.

Each institution is expected to develop its own set of appropriate case studies, using the examples in this Appendix as adaptable guidelines.

### Background

The setting is the District/Local Government Area (LGA) of OWANBE in the Region/State of EJANLA. Owanbe is in virtually all regards typical of most rural districts/LGAs in the Ejanla Region/State. Focus in the following set of case studies is on the

structure and activities of the Health Sector of Owanbe.

Owanbe is the main settlement town and the District derives its name from the town. It has a population of 13 556 and is the headquarters of the District. There are altogether 17 villages, not counting farmsteads, in Owanbe which has an elected local council consisting of 12 elected councilors. one of who, Mr. A.O. Oke, is the Supervisor for Health.

There is a District Hospital (DH) in the town of Owanbe, but which, on the basis of its limited facilities and scope of activities, is no more than a glorified Comprehensive Health Centre (CHC). By arrangement with the political leadership of the District/LGA, medical doctors, of the rank of Registrar from the Department of Community Medicine at the Teaching Hospital Medical School, located at PELEWURA, the Regional/State capital 86 km away from Owanbe, rotate on a half-yearly basis (January – June and July- December) to provide cover on a day-return basis to the DH, two days in the week (Mondays and Thursdays). Apart from his normal professional duties, the young doctor is in charge of 6 batches of medical students and 6 batches of nurses-in-training who each spend four weeks as part of their rural posting experience attached to the DH. Each medical student batch consists of 5-7 individuals, while there are 3-4 nurses per batch. The medical and nursing students' rural postings are synchronized between the authorities of both the Medical School and the School of Nursing. The postings last from October to May with one week's break

between postings. That leaves the months of June to September without any students (medical or nursing) at Owanbe DH.

The most senior non-medical District/LGA health personnel staff in charge at Owanbe is the 52 years – old Primary Health Care Coordinator (PHCC), Mrs. Aduke Kolapo who reports directly to Mr. Oke but is professionally responsible to the Senior Consultant in charge of the Regional/State Hospital at Pelewura, the capital city of Ejanla.

Mrs. Kolapo supervises a team of five trained and three ancillary staff who are based in the DH but operate outreach health activities covering the 24 villages of Owanbe district. The most senior of these is 58 year old Alhaji Ahmadu Musa who acts for Mrs. Kolapo when she is away from the district. The Alhaji is a trained Health Superintendent but with vast experience in running a Health Centre (HC) and regular in-service training. The other four staffers are Mrs. Opio (SRN SCM) an experienced 46 years old midwife; Mrs. Ojo a 34 years old trained nurse, Mrs. Okoro 36 years old auxiliary nurse and Mr. Odiata, 44 years old who is in charge of the medical records. Mrs. Kolapo takes direct responsibility for the drug store and the cold chain facility.

There are four Health Centres (HC) based in the villages of Odoona (+ 5 communities), Isaleodo (+4 communities), Olorunda (+ 5 communities) and Ebaona (+6 communities) which serve all of the 24 villages in the District/LGA. No village is more than 16km from the farthest HC. Each HC has two trained Health Workers who are supervised by health staff from the District HQ.

Because the district is only hypo-endemic for onchocerciasis it was excluded from the mass treatment with ivermectin, using the CDTI strategy, that was introduced in three neighbouring districts where onchocerciasis was found at baseline to be hyper- or meso-endemic. But a recent survey undertaken

by medical students under the supervision of a faculty member of the State university has established the presence of lymphatic filariasis in Owanbe district.

One Community-based organisation (CBO) with strong local political and social connections operates in Owanbe district, while a reputable International Non-governmental Development Organisation (NGDO) assists the CDTI programme in three of the neighbouring districts. The NGDO has a set of on-going vertical programmes on family planning and onchocerciasis and lymphatic filariasis control in three of the districts adjoining Owanbe. The local CBO struggles to assist with maintenance and repair of seven bore holes and nine deep well it has successfully mobilized resources for construction in 10 of the 24 villages/communities in Owanbe. The CBO has also sometimes been able to obtain anthelmintics from local donors for irregular de-worming activities in the local primary schools.

## **ANNEX 1.1: CASE STUDY FOR UNIT # 1: HEALTH CARE DELIVERY SYSTEM: SETTING UP OF CDI**

### **Preamble to UNIT ONE**

**This case study highlights important steps that should be taken in putting together a plan and a team of stakeholders and partners in the process of setting up CDI.**

The Medical School, after a brief telephone conversation with the Head of an international NGDO operating in the zone, has selected Owanbe as the District for the Introduction of CDI. The Dean of the Medical School after discussions with the Head of Department (HOD) of Community Medicine (ComMed) had approached the boss of the NGDO with CDTI experience in neighbouring districts, to help with

the establishment of a CDI programme in Owanbe. The representative of the NGDO in charge of the activities of the NGDO in five of the districts/LGAs of the State, including Owanbe, then paid an unannounced visit to Owanbe in the second week of June. This was on a day the PHC Coordinator Mrs. Kolapo was away on official visit to Ejanla, the Regional capital. Being a Monday the NGDO had met the medical Registrar and Alhaji Musa with both of whom he had discussions on “the Way Forward” for introducing CDI into Owanbe.

The NGDO representative reported back to his “boss” at Pelewura who arranged a meeting with the Dean of the Medical School to discuss ways of implementing the CDI ‘project’. The meeting duly took place on the Thursday of the following week in the office of the Dean. Present at the meeting were the Dean, the secretary to the medical school, the HOD of ComMed, the NGDO boss and his district representative. The medical Registrar, though invited to be ‘in attendance’ at the meeting was unable to attend because he was away on scheduled official duty to Owanbe. A decision was taken at the meeting in the Dean’s office, to go ahead with the proposal for setting up the CDI programme in Owanbe. The HOD of ComMed. was designated as Coordinator of the project and a small implementation committee was set up consisting of the HOD of ComMed., the NGDO district representative and the PHCC of Owanbe.

On the first day of July Alhaji Musa proceeded on his annual two months leave. In the second week of July, six weeks after the meeting in the Dean’s office, the ‘boss’ of the NGDO, the HOD ComMed and the District representative of the NGDO accompanied by the departmental medical registrar, visited Owanbe where they were warmly received by the PHCC. The medical registrar stayed behind at Owanbe to attend to pending professional matters, while the PHCC and

Mrs. Ojo then joined the three persons from Ejanla and proceeded to the villages of Isaleodo and Olorunda which had been selected by the NGDO representative for the initiating the CDI pilot in Owanbe district. The team arrived at Isaleodo at about 11.00 am, but was told that the village head had “gone to the farm” and was unlikely to be back before dusk. The more senior of the two HC staff was also away on official visits to neighbouring villages. The junior health staff in collaboration with the village headmaster, Mr. Chukwu, of the Primary School located in the village, hastily made arrangements to attend to the visitors who informed him of their mission. He listened attentively to the team and promised to pass the team’s message on to the village head and the village health committee of which he the headmaster is a member. The team spent about two and a half hours at Isaleodo, then moved on to village of Olorunda which it reached at about 3pm. There the members of the visiting team were able to interact directly with both the village head and two of his chiefs as well as the two HC staff. The visit coincided with the monthly meeting of the village development committee. The team was invited to join the meeting and took full advantage to explain its CDI mission. The team returned to Ejanla via Owanbe where it dropped the PHCC and Mrs. Ojo, and picked up the medical registrar who had just finished for the day. The HOD spent the journey back to base to brief the registrar about what had transpired in Isaleodo and Olorunda. He specifically directed that starting with the next set of medical students to undertake their rural posting in Owanbe adequate involvement with the CDI project should be embarked upon. The following morning the HOD tried to book an appointment with the Dean but was informed that the Dean had traveled overseas for an international conference. The Principal of the School of Nursing was listed to see him (the HOD) at 9.00am that morning.

### The unit #1 case study exercise:

1. Comment freely on the arrangements made for the introduction of CDI in Owanbe.
2. Identify gaps and errors (weaknesses) committed by the various institutions- medical school and NGDO in particular, in their approach to establishing CDI in Owanbe.

### Checklist for the trainer:

- Choice of Owanbe for CDI was by Medical School and NGDO without consultation with all stakeholders.
- The local CBO which had more intimate relationship with the communities in Owanbe was completely left out and kept in the dark of the proposed CDI initiative by both the medical school and the international NGDO.
- The School of Nursing, an important stakeholder and veritable partner in the project was also comprehensively sidelined and left out of all deliberations on the project.
- Initial contact with the District/LGA was done when the PHCC was away, and the subsequent follow up visit/contact was made when the Health staff with whom the initial contact was made was away on leave from his duty post= poor communication.
- A new medical registrar (other than the one with whom initial contact was made) had taken over at the beginning of July and knew little about the District= lack of continuity.
- Initial visits to the communities by the implementers of the CDI project were not well planned thereby making the communities, especially in Isaleodo, unprepared.
- All of the local health staff as well as the political and administrative leaders of Owanbe were not adequately briefed about the changes that would be expected

to follow the introduction of CDI in the District, and their opinions not sought.

- In particular the local political administration in Owanbe District/LGA that would be expected to provide support for and commitment towards CDI is left in the cold.

### Summary

Inadequate planning and incomplete inclusion of all stakeholders and potential partners in preparation for the introduction of CDI.

## ANNEX 1.2: CASE STUDY # 5: BEHAVIOURS AND ATTITUDES OF HEALTH WORKERS

### Preamble to UNIT 5

The unit deals exclusively with reinforcing characteristics that are expected in all health workers irrespective of the setting. In this unit which should be 'taught' in four modular sessions as outlined, a case study within a CDI setting is presented to reflect the positive and negative attributes of each characteristic.

### Case Study # 5.1 & 5.2 also suitable and adaptable for role play

Background on

#### 5.1 Compassion, Empathy and Friendly Disposition

AND

#### 5.2 Listening Attentively and Showing Patience

Scene I at the HC in Isaleodo community:

The time is 4.25 pm, on a Friday 5 minutes before the health centre is due to close for the day and weekend.

A pregnant woman, with two toddlers aged 3 years and 10 months (the infant is carried on the back in traditional African way) in

tow, arrives at the health centre where the following exchange takes place with the Senior Health Worker in charge,:

**Mother:** Nurse, my child has high fever and has not been feeding well

**HC staff:** Which child?

**Mother:** The baby on my back

**HC staff:** Why did you not bring him earlier? We are about to close for the day.

**Mother:** Today is market day in the district and I needed to get to the market early to get provisions for the family, otherwise I will have to wait for another five days before the next market day. Besides it is...

**HC staff** (*interrupting*):

So you value trading in the market more than the life of your child!

**Mother:** No nurse, I...

**HC Staff** (*interrupting again abruptly and in a rather aggressive tone*):

For your information, I am a sister not a nurse.

**Mother:** I am sorry sister.

**HC staff:** So you should be. Now what do you want me to do? You are already too late today and I must get home in time to prepare food for my family.

**Mother:** I was hoping you could treat my sick child who apart from fever is beginning to have loose stools frequently. As for being late there was not much I could do since the little amount of transport we have around here are not available for us to use until after the market has started properly because the transport operators make a lot more money with the commercial traders.

**HC staff** (*in a more conciliatory though very condescending tone but without examining the sick child*):

Okay I will give you some tablets and syrup for the baby. Bring him back tomorrow if he is not better.

She reaches for the drugs shelf and brings down a packet of antimalarials tablets and bottle of paracetamol syrup. As she is about to hand these over to the mother, the three year old girl starts to cough.

**Mother:** I wonder if you could give something for my little daughter. Her cough seems to be getting worse and keeps everybody awake at night.

HC staff ignores the mother's comments on the little girl and continues regardless to give instructions to the rather by now relatively distraught and inattentive mother on the use of the drugs for the infant. At the end the HC staff demands payment for the drugs (*amount to be stated in the local currency*)

**Mother:** I do not have that much money on me since I have to pay for the transport back home. Can I pay you tomorrow when I come for my antenatal care.

**HC staff:** No. You pay now or there will be no drugs. And don't tell me you are pregnant again for that useless husband of yours. Haven't you people heard about family planning? You can take this prescription (she begins to write one out as she returns the drugs to the shelf) to the local chemist in your village when you get back. I understand he gives out drugs on credit, we do not do so here.

Mother strongly resents her hardworking farmer husband being referred to as "useless" and is unhappy about the scornful allusion to her pregnancy, but she manages to keep her anger under control. Her next comment clearly reflects her frustration and disillusionment with her reception at the Health Centre.

**Mother:** But we are told that children will receive treatment free of charge and that the drugs are given free by government.

**HC staff:** Then go the government who told you that. You better go home before I get annoyed with you.



The HC staff shuts and locks the door, and walks away to her car without looking back, leaving the confused woman stranded and helpless outside the Health Centre.

### **Unit # 5 case study exercise for modules 5.1 And 5.2**

1. Comment freely on the general relationship between the HC staff and the mother
2. Identify the professional shortcomings in the attitude of the HC staff vis-à-vis the attitudes listed in unit 5 modules 1 & 2 viz. compassion, empathy, friendly disposition as well as ability to listen attentively and show patience

### **Checklist for the trainer:**

- Discuss the potential role of CDI in dealing with the issue of closing time and what to do in circumstances as described in the case study,
- Would a properly established CDI be able to handle the issue of payment for services rendered?
- Draw on local experiences to tackle, within the CDI philosophy, the potential problems that the family could face given an infant who is clearly on well, a three year old with a cough of unknown origin and a housewife who is not only pregnant AGAIN but has to look after her household, and juggle all of that with attending antenatal clinic in the prolonged absence of her bread-winner husband on the farm.
- Clearly dependence on an inadequate health service as illustrated in the case study is far from desirable and supplementary provision through CDI is a reasonable alternative.

### **Case Study # 5.3 & 5.4 also to be made suitable and adaptable for Role Play**

Background on

#### **5.3 Simplicity, Respect for Local Norms and Community Leaders and Cooperation**

AND

#### **5.4 Commitment to duty and Punctuality to Appointments**

Each institution is expected to device an appropriate Case Study that adequately reflects the HW attributes of Simplicity; Respect for Local Norms and Community leaders and Cooperation with the Community as well as a demonstration of Commitment to duty and Punctuality in respect of the community and the HW team and employers.

The case study that should be suitable for adaptation for role play by participants should include such characters as Community-Directed Health Care Providers, the broader and more multipurpose versions of the better known and established Community-Directed Distributors; community Heads and Leaders; Traditional Healers, Midwives; Drug peddlers etc; an interactive operational Health team as opposed and in preference to an individual health worker.

The case Study would be more meaningful and appropriate if it features pertinent local issues that the trainers perceive to be major socio-cultural constraints to CDI introduction and implementation, such as gender, clan or religious differences.

It is also strongly recommended that the bulk of the Case Study for modules 3 & 4 of Unit 5 be cast in a positive light than modules 1 & 2 so as to reinforce the helpful role of CDI without however overstating the case.

# Annex 2

## ANNEX 2.1: PARTNERS AND FACILITATORS OF COMMUNITY HEALTH CARE DELIVERY SERVICES

Community health care delivery	Partners	Facilitators
<b>Vertical Programmes (pre-colonial era and until Alma Ata Decl.)</b>	Medical Field Unit Les Equipes des Grandes Endémies	Colonial Governments
<b>Community-based health care delivery (Era following Alma Ata Declaration c)</b>	MOH/NIDs, NGOs, LF, Schistosomiasis, Deworming.	<b>ODA:</b> USAID, DIFID, GTZ, DANIDA, CIDA, Cooperation Francaise, Netherlands, Sweden, Switzerland etc. <b>Private:</b> Pharmaceuticals: GSK, Merck, Pfizer, Bayer, Johnson & Johnson. <b>Foundations:</b> Bill Gates, <b>Others:</b> Rotary, <b>International Agencies:</b> WHO, UNICEF, World Bank, UNDP, UNFPA.
<b>CDTI/CDI (Era of onchocerciasis control with ivermectin donation)</b>	FLHS, District Health Services NGDO (International & local) Health Research Institutions	MOH, <b>ODA:</b> USAID, DIFID, GTZ, DANIDA, CIDA, Cooperation Francaise, Netherlands, Sweden, Switzerland, etc. <b>Private:</b> <b>Pharmaceuticals:</b> Merck, GSK, Pfizer <b>Foundations:</b> Bill Gates, <b>International Agencies:</b> WHO, UNICEF, World Bank.

## ANNEX 2.2: CONTRAST BETWEEN STRATEGIES

	Vertical health delivery	Community-based health delivery	CDTI/CDI strategy of health delivery
<b>Advantages</b>	Not cost-effective not sustainable	Cost-effective for the HS and partners	Very cost-effective for HS as makes contribution
<b>Coverage</b>	Moderate	Moderate to high	High to very high
<b>Acceptance by the communities</b>	Doubtful	Short term acceptance	Highly accepted by the communities
<b>Empowerment</b>	No	No	yes

**ANNEX 2.3: A REVIEW OF COMMUNITY PARTICIPATION**

Interventions	Process	Axiom	Facilitating agency	Service Provider	Community	Review	Example
Health facility-based	Intervention is located in a health facility Individual with perceived problem goes to the facility	Health is a curative issue and the individual must seek the health professional out at the facility.	External to community, often Government	Trained health personnel	Community has very low participation index	Controlled, Recordkeeping, Lowest coverage, epidemic monitoring poor, very minimal impact on health problem	Hospitals and other government infrastructures. During the colonial era, the services of hospitals were extended to rural areas through the establishment of health posts, dispensaries etc. But this did not alter the situation appreciably since they were still health personnel-focus interventions
Pre-colonial community-based	Intervention is based in community, but community has no role, nor is it mobilized to take part in it	The community is too ignorant to resolve their own problem and must be forced to accept what has been professionally decided as best for its members health.	Government or some other authority over health of the people	Highly skilled personnel	Community members forced to take the service	May yield high coverage at the onset but gradually diminished coverage, misinterpretation of intervention objective, rumour and apathy may destroy programme. Non-sustainable	See Box 1 (Smallpox control in colonial Malawi)
Post colonial Community-based	Intervention is based in the community. Community is mobilized after sensitization. Community is directed to the venue (such as the Chief's house, health facility, school compound) and the time when the service will be made available and the duration of the caregivers in the community.	Health personnel have a duty to ensure the community health problem is solved to the best interest of the community and the community only needs to cooperate to get the best from what the health service gives and nothing more	Government	Highly skilled personnel who may sometimes co-opt the local health personnel from the health facility as guide or mobilizer	Community members is a passive recipient of service based within	This is common with campaigns. A lot more people are covered by the service. Community remains ignorant as a whole. Individuals take decision on the service. Little information is available. Health personnel carry out function as a duty with little regard to community perception or practices or opinion	See Box 2. Mass immunization campaigns take a form of campaign that shuts down the health system completely for one or two weeks and enforces all communities to take the service being offered at that time it is offered.

### ANNEX 2.3: A REVIEW OF COMMUNITY PARTICIPATION (CONTINUED)

Interventions	Process	Axiom	Facilitating agency	Service Provider	Community	Review	Example
Community-involved	Community has no input in planning, design or implementation but an extra-community agent allocates a role to someone in the community called community-based provider. Community-based provider reports to and takes instructions from the extra-community agency.	Health professional is trained and knows what is best for the community. Communities do not have the knowledge that can help improve their own health. Communities will be unable to select the type of person that can carry out the tasks that the external agent will assign to the community	The initiative and investment in the programme is wholly external to community, often Government	Externally selected community-based provider, no community input into selection, imposed community worker responsible to the external agency	Community is a passive recipient of the service and has no avenue for collectively enriching the delivery of the service but accepts the service.	Programme has high therapeutic coverage but geographic coverage does not reach 100% as agency may not reach some communities, intra-community structure ignored hence some segments of the community may not be served, Community based provider empowerment may alter the power structure when an unpopular but vocal individual is imposed on the community by outsider, Providers may work against the interest of the community for personal benefit thus jeopardizing programme goal. Motivation to serve is externally controlled	

**ANNEX 2.4: PARTNERSHIPS IN CDI**

Interventions	Process	Axiom	Facilitating agency	Service Provider	Community	Review	Example
Community Directed intervention	Community is facilitated by an external agent to take the central role in collaboration with the health system and other stakeholders in planning, designing, resource input and implementation of the intervention	Intervention is best sustained when communities understand, accept and make significant contribution to the process	Several partners have stakes including community	Community selects its member to be trained by health system	Community	High therapeutic and geographic coverage Community Ownership Equity Less burden on Health facility	

## ANNEX 2.5: TABLE FOR GROUP WORK ON ROLES OF PARTNERS IN CDI

CDI Partners and Stakeholders	Audience Segmentation	Key Messages	Appropriate Communications Media
Community members	Leaders or community and community based organizations (CBOs)	(to be completed during group exercises)	<ul style="list-style-type: none"> <li>• Face-to-face meetings</li> </ul>
	Community members		<ul style="list-style-type: none"> <li>• Face-to-face meetings</li> <li>• Use of radio at later point to inform about availability of interventions</li> </ul>
Program Managers of Interventions to be included in CDI	National level		(To be completed during group exercises)
	State/Regional level		
	District level		
Partner Organizations	International and bilateral donors		
	National non-government organizations (NGOs) and CBOs		
	Other related Ministries		
Other?	(to be completed during group exercises)		

## ANNEX 2.6: ROLES OF STAKEHOLDERS IN CDI

*If the Stakeholder's Position is ...*

*Then you would seek to ...*

- Supportive** → Involve them directly
- Opposed** → Defend your position
- Undecided** → Monitor for changes, encourage
- Mixed** → Collaborate with interested individuals

Stakeholder	Current Role Relevant to CDI	Characteristics Relevant to CDI				Advocacy Approach
		Interest	Influence	Position	Impact	
Malaria Control Program	Achieving high coverage of nets and medicines					
Integrated Management of Child Illnesses	Community case management of pneumonia, diarrhoea and other illnesses					
HIV/AIDS program	Testing and counselling; home based care					
TB/Leprosy Control Program	Directly Observed Therapy Short-course					
Onchocerciasis Control Program	CDTI					



## ANNEX 2.6: ROLES OF STAKEHOLDERS IN CDI (CONTINUED)

Stakeholder	Current Role Relevant to CDI	Characteristics Relevant to CDI			Advocacy Approach
		Interest	Influence	Position	
Neglected Tropical Diseases (NTDs) Program	Mass Drug Distribution				
Global Fund supported Principal and Sub- Recipients	Promoting high coverage targets for AIDS, TB and Malaria interventions including community strengthening approaches				
UNICEF	Technical and some commodity support for child nutrition and disease control				
WHO	Technical support for integrated management of childhood illnesses (IMCI)				
The United States Agency for International Development (USAID)	Financial and technical support for maternal and child health (MCH), Malaria, HIV, tuberculosis (TB) and NTDs				
World Bank	HSS and integrated disease control (e.g. Malaria Plus Package)				

(Continued)

**ANNEX 2.6: ROLES OF STAKEHOLDERS IN CDI (CONTINUED)**

Stakeholder	Current Role Relevant to CDI	Characteristics Relevant to CDI				Advocacy Approach
		Interest	Influence	Position	Impact	
International NGOs/PVOs*	Often serve as implementing partners for international donor programs					
National/Domestic NGOs/PVOs*	Public awareness and program implementation for specific health conditions					
Civil Society Groups such as people living with a certain condition*	Advocacy for increased service provision					
Research Organizations*	Discovering and testing new products and delivery mechanisms					
Others						

\*actual analysis would name these NGOs, PVOs and CBOs.

## ANNEX 2.7: TOOLS AND ROLES AT DIFFERENT LEVELS OF IMPLEMENTATION OF CDI

	Role	Tool
National (MoH, NGDO, Medical stores)/Regional	Supervise districts, FLHF and community levels	<ul style="list-style-type: none"> <li>• Guide for training and supervision District, Front line health facility staff and CDDs</li> <li>• Budgeted supervisory work plans</li> <li>• All monitoring forms</li> <li>• Annual reporting formats, training reports</li> <li>• Supervisory Checklist (integrated)</li> </ul>
District	Supervise Sub-District and Health Centres twice monthly	<ul style="list-style-type: none"> <li>• Guide for training and supervision District, Front line health facility staff and CDDs</li> <li>• Budgeted supervisory work plans</li> <li>• All monitoring forms</li> <li>• Annual reporting formats, training reports</li> <li>• Supervisory Checklist (integrated)</li> </ul>
Frontline Health Facility	Supervise community distributors twice monthly  Check CDD record	<ul style="list-style-type: none"> <li>• Guide for training and supervision of CD</li> <li>• Budgeted supervisory work plans</li> <li>• Summary sheet of health education sessions, Health Centre distribution form, Form to summarize distribution,</li> <li>• Merck form for reporting Severe Adverse Events,</li> <li>• Training report, Form to record health education sessions, Annual report format</li> <li>• Supervisory guide and check list(integrated)</li> </ul>
Community Implementers		<ul style="list-style-type: none"> <li>• household registers (integrated)</li> <li>• CDD summary forms, Form to record health education sessions</li> <li>• Supervisory guide and check list(integrated checklist</li> <li>• Mectizan logbook</li> </ul>

**ANNEX 2.8: MATRIX FOR DEVELOPING SUPERVISION WORK PLAN**

Ref. No	Supervision Task/ Activity	J	F	M	A	M	J	J	A	S	O	N	D	Observations
	Advocacy													
	Sensitization													
	Mobilization of communities													
	Training HW													
	Training CDDs													
	Training community Leaders													
	Census/Update													
	Drug distribution													
	Community self Monitoring													

### ANNEX 2.9: EXAMPLE OF BUDGETED ACTION PLAN MATRIX

Ref. number	Specific Objectives	Task/ Activity	Success indicator	Expected outcome	Responsible person	Cost estimates (Source of funding)		Time frame (date or period)	
						Source of funding	Source of funding	Planned date	Date realised

## ANNEX 2.10: COMMON PROBLEMS OBSERVED DURING SUPERVISION AND POSSIBLE SOLUTIONS/ACTIONS

No	Problem/Issue observed during supervision	Possible solution/action
1	No household register found.	National Coordination should assist in making household registers available.
2	House register not correctly filled: <ul style="list-style-type: none"> <li>• No census update of the household registers;</li> <li>• Everybody received the same Mectizan® dosage and was about the same height, despite the fact that they were a mixed group of men and women as well as youngsters and old people during distribution.</li> </ul>	Training of FLHF Staff and CDD should be redone
3	There is reason to believe that the patients take the Mectizan® pills to swallow at home.	Swallowing of the drugs should be observed directly during distribution by the CDDs.
4	Large numbers of persons are absent during distribution	Issues related to sensitization and mobilisation. Ensure that sensitization and mobilisation are carried out.
5	Number of CDDs selected in the village is low or CDDs come from another village; Some villages do not have community distributors <ul style="list-style-type: none"> <li>• According to training records, the number of community distributors is not sufficient.</li> </ul>	Organise and facilitate selection and training of CDDs in each community at a ratio of 1 CDD/100 people
6	The nurses have erroneous knowledge of onchocerciasis and Mectizan®. The nurses do not have the needed forms for correct monitoring of the project.	Training is needed here and positioning of all monitoring forms at all levels
7	The nurses say that they do not have medication to treat side effects.	Ensure timely delivery of drugs and other health commodities
8	Posters or other health education materials of the program are not on display. The nurses or CDDs do not carry out IEC activities	National coordination is to develop, produce and position at all levels IEC Materials and train the nurses and CDDs on their use
9	The population tells you that they were refused treatment because they had drunk alcohol two days before treatment took place.	It is usually advised not to take alcohol the night before nor the day of distribution.

# Annex 3

## EXAMPLE OF SUPERVISION TASKS (CAMEROON)

### 1. Visits in villages to supervise distribution:

Regularly conduct supervision visits in villages and check the following factors as indicated in the supervision guide. Send the completed supervision guide or a summary of the filled guides to the appropriate personnel:

- That the CDs conduct distribution activities as scheduled in advance.
- That the CDs verify that Mectizan® was taken.
- That the CDs effectively conduct IEC activities.
- That the CDs understand the key messages, the distribution protocol, and contra-indications.
- That the CDs have a measuring stick to measure the patients' height.
- That the CDs have the necessary Mectizan® stock.
- That the CDs correctly record Mectizan® distribution and IEC in their registers.
- That the CDs understand the monitoring protocol of side effects and inform each patient about the signs of severe reactions and what they need to do in case of severe reactions.

### 2. Using monitoring forms:

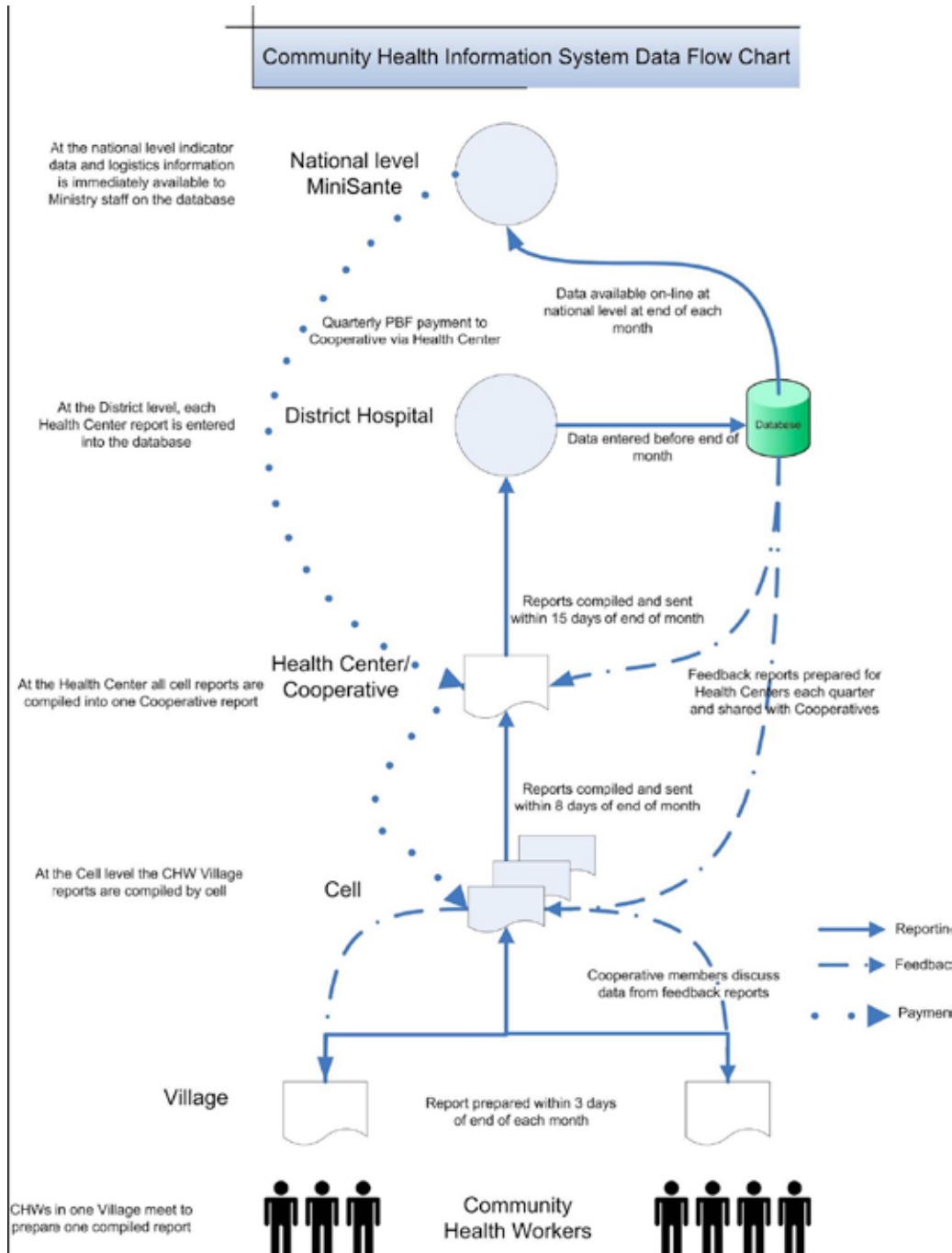
- Compile the information and statistics in the distribution forms at the health area level.
- Fill the required forms tracking their activities related to the NOCP and send them to the District.

### 3. Once the campaign is over:

- Collect the unused Mectizan® stock remaining after the distribution campaign and return it to the District.
- Organize a meeting of the CDD to remunerate them (the date is to be decided in advance and announced during training).

# Annex 4

## COMMUNITY HEALTH INFORMATION SYSTEM DATA FLOW CHART: RWANDA EXAMPLE





# Annex 5

## ANNEX 5.1: INTEGRATED SUPERVISION CHECKLIST FOR PHC PROGRAMMES

### Health post and community levels:

Number and names of communities supervised by health post .....

1. Names of communities
  - a .....
  - b .....
  - c .....
  - d .....
2. Name of health post .....
3. Name of officer in-charge .....
4. Designation and rank .....
5. Available records on health indices .....
6. Type of training attended during the year .....
7. Type of services provided in the health post .....
8. Facilities available and functionality .....

### Community level

#### Onchocerciasis

1. availability of Mectizan .....
2. number of people treated .....
3. availability of records on treatment .....
4. availability of Mectizan inventory record .....
5. type of incentives given to CDDs .....
6. number of CDDs .....
7. total population of community .....
8. visit 10 households and check for the following:
  - a. accuracy of dosing .....
  - b. dosing criteria .....
  - c. follow up on absentees and refusals .....

- d. treatment coverage .....
  - e. geographical coverage .....
- (ask for treatment in at least 5 communities)*

**Immunization**

- 1. check for BCG scars .....
  - 2. ask for immunization and Growth monitoring card .....
  - 3. types of immunization given to child .....
  - 4. percentage coverage .....
- (number of children seen with good immunization divide by number seen)*

**HIV/AIDS**

- 1. ask for knowledge of disease ( probe for KABP) .....
- 2. ask for nearest ARV centre and distance .....
- 3. ask for availability and accessibility to condoms .....

**Maternal Health**

- 1. ask for completion of immunizations for pregnant women .....
- 2. evidence of antenatal care and attendance .....
- 3. number of pregnant women .....
- 4. number that delivered in a health facility .....
- 5. number that delivered with TBA .....
- 6. number of mothers with treated nets

**Nutrition**

- 1. use growth monitoring chart to assess number of children thriving well
- 2. number malnourished and percentage .....

**Environmental sanitation**

- 1. assess the environment for cleanliness .....
- 2. availability of proper waste disposal .....
- 3. type of toilet used .....

**Other health issues of interest**

.....  
 .....

**Name of officer** ..... **Date** .....

## ANNEX 5.2: SUPERVISION CHECKLIST FOR CDTI

### LOCAL GOVERNMENT LEVEL

Name of LGA .....

Date .....

Name of SOCT .....

Name of LOCT leader in the LGA .....

1. Number of supervisory visits made to the communities by FLHF staff .....  
*Check for reports and filled checklists.*

2. What follow up was done about issues identified from supervision?.....  
 .....  
 .....

3. Number of trainings conducted for the period .....

4. Type of training .....

5. Number of persons trained .....

6. Availability of Mectizan inventory YES NO

7. Adequacy of Mectizan supply YES NO

8. Availability of treatment records YES NO

9. Availability of storage facility for Mectizan at LGA level YES NO

10. Availability of complete minimal list of indicators  
 for communities in the LGA YES NO

11. Availability of records on LGA counterpart funds released YES NO

12. Amount released N .....

13. Availability of reporting forms Adequate Not adequate

SOCT sign/date .....

LOCT sign/date .....



## ANNEX 5.4: MONITORING CHECKLIST FOR CDTI

Name of LGA .....

Date .....

Ward .....

Name of FLHF staff .....

Name of SOCT .....

- Community mobilization done YES NO
- CDD selection done YES NO
- CDD training done YES NO
- Number of CDDs available .....
- Names of CDDs available .....
- Availability of Mectizan Treatment Register .....
- Total population of community .....  
*Carry out Spot checks in houses to ensure complete enumeration*
- Measuring stick or wall correctly graduated for Mectizan dosage .....
- Correctness of format for treatment register .....
- Number of people treated for 2006 .....
- Number of Mectizan tablets received for 2006 .....
- Number of Mectizan tablets received for 2007 .....
- Adequacy of Mectizan tablets YES NO

**SOCT sign/date**

**Health facility staff sign/date**

# Annex 6

## ANNEX 6.1: COMMUNITY SUMMARY FORM

Year: .....

Months of distribution: ..... to .....

### Identification

District / LGA: ..... Sub-district / area: .....

Community: ..... Latitude: ..... Longitude: .....

Treatment cycle:    1   2   3   4   5   6   7   8   9   10   11   12   13   14   15

### Census

Number of male	
Number of females	
Total Population	

Children less than 5 years	
Persons 5 years and above	
Number of households	

### Treatment

Male treated	
Females treated	
Persons treated	

Children 5–15 yrs. treated	
Persons 15 yrs. and above treated	
Number of households treated	

**Therapeutic coverage** (Persons treated / Total Population) x 100 = .....

**Geographic coverage** (Number households treated / Total to number of households) x 100 = .....

### Not treated

Number of absentees	
Number of refusals	
Children less than years 5	
Pregnant women	
Breastfeeding women	
Sick	

**Opposite Number of events accommodate**    Minor: .....    Serious: .....

### Mectizan

Number of tablets received	
Number of tablets used	
Number of tablets lost / expired	
Number of tablets remaining	

**Number of households motivating FIXED-TERM CONTRACT:** .....

**Amount received:** .....

Name and Signature

Community Distributor(s)

Supervisor

## ANNEX 6.2: SUMMARY OF SUB-DISTRICT/FLHF ACTIVITIES

(Form to be filled by the chief of the Sub-district and sent to the chief of the District)

Name of CDTI Project: ..... Calendar year: ..... Month of distribution: ..... Number of years of distribution: .....

Level 1 (State/Region): ..... Level 2 (District): ..... Sub-district/FLHF: .....

Name of the Community /Village	CDDs who distributed			Census		Number of persons treated					Number of persons not treated					Therapeutic coverage (%)		Side events		Ivermectin tablets				
	Nb. of Male CDDs	Nb. of Female CDDs	Total nb. of CDDs	Nb of Males	Nb of Females	Total Population (Male + Females)	Nb of households	Nb of Males treated	Nb. of Females treated	Total nd. of persons treated	Nb. of children less than 5 years	Lactating others less than 7 days	Pregnant women	Sick	Absentees	Refusals		Nb. of minor cases	Nb. of cases referred	Nb. receives	Nb. distributed	Nb. Expired /lost	Nb. remaining	
<b>TOTAL for the sub-district in case of last page</b>																								

If last page, information on the sub-district: Nb. of communities/villages: (a) to be treated: ..... (b) treated: ..... Nb of persons treated at the FLHF: .....

Nb. of CDDs retrained: ..... Nb. of CDDs newly trained: ..... Total nb. of CDDs trained /retrained: .....

Nb. of supervisions planned: ..... Nb. of supervisions conducted: ..... Nb of SAE cases referred to health facility: ..... Annual Treatment Objective: .....

Community Self- Monitoring CSM: Nb of communities planned: ..... Nb of communities conducted CSM: .....

Date, name & signature

Chief of sub-district

Chief of District

**ANNEX 6.3: DISTRICT/ LGA SUMMARY FORM (LEVEL 2)**

*NB: Form to be filled by LOCT and send to SOCT for data entry in computer*

State / Region name: ..... District / LGA name: ..... Year: .....

Front Line Health Facilities names	Community involvement		Communities and Treatment				Training			Ivermectin											
	Nb communities with comm- nity members as supervisor	Nb communities with female CDD	Total Nb of CDTI communities	Total Nb of communities treated	Geographic coverage	ATO through CDTI	Nb passive treatment	CDDs newly trained	CDDs retrained	Total CDDs trained/retrained	Taba available begin.	Tablets ordered	Tablets received	Tablets sent for CDTI	Tablets used clinically	Tablets lost	Tablets expired	Tablets waste	Tablets remaining		

Nb.of health staff: a) available: ..... b) involved in CDTI: ..... c) to be trained: ..... d) newly trained: ..... e) re-trained: .....

Nb.of CDDs re-trained: ..... Nb.of CDDs trained: ..... Total CDDs: .....

Nb.of supervision planned: ..... Nb.of supervision carried out: ..... Nb of SAE: ..... ATO: .....

LOC name and signature

SOC name and signature





# Annex 7

## ANNEX 7.1: EXAMPLE OF CSM REPORT FROM CAMEROON

Problems identified	Solutions suggested	Structures involved	Persons in charge
Persistence of several cases of refusals due to fear of pruritus (frequent symptoms of adverse events)	Scale up Information, Education and Communication activities	COSA	Local chief
Lack of female CDDs in some communities	Conduct advocacy activities towards women associations	COSA	Local chief
Lack of incentive strategies for CDDs	Define incentive strategies for CDDs based on local possibilities	Village committee	Local chief
Distribution period not often favourable due to farming activities	Plan distribution during off-season, farming wise	COSA	Technical supervisor of health area
Inadequate quality of data due to intellectual inability of some CDDs	Support CDDs in taking census, distribution and report writing	Health staff	Technical supervisor of health area
Inadequate coverage of households	Reinforce community supervision	COSA	Community supervisor of health area

## ANNEX 7.2: COMMUNITY SELF-REPORTING FORM

Appendix 1

State/Region .....

Date .....

District/LGA .....

Name of Community .....

Name(s) of Monitor(s) .....

.....

Indicator	Number	$\% = \frac{\text{Number}}{\text{Population}} \times 100$
Population is number of people in the village (to know the population the community needs to count everybody in all the households)		Not applicable
Number of people who received Ivermectin and swallowed it (Treatment Coverage)		
Number of people who were absent during the distribution of Ivermectin (Absentees)		
Number of people who refused treatment (i.e. did not want to take the tablets) (Refusals)		
Number of people denied treatment because of illness, lactation, etc		
Number of CDDs		Not applicable

APOC COTI-CSM Guide

### Community Self-Reporting Form

Appendix 1

State/Region..... Date .....

District/LGA.....

Name of Community.....

**ANNEX 7.3: HOW TO IMPLEMENT COMMUNITY SELF MONITORING**

Steps	Activity	Who will be responsible for the task?	When will the task be completed?
1.	<ul style="list-style-type: none"> <li>Hold a planning meeting with district health management teams (DHMTs) and Oncho coordinators.</li> <li>Develop a plan of implementation of CSM for each approved project.</li> </ul>	Project Onchocerciasis managers (MoH & NGDO) including district Onchocerciasis coordinator	Three (3) months before the distribution of ivermectin (Mectizan).
2.	<ul style="list-style-type: none"> <li>Hold a planning meeting with frontline health facilities (FLHF)/sub district staff.</li> <li>Develop with HA staff a plan of implementation of CSM.</li> <li>Train FLHF/sub-district staff on facilitating behaviour.</li> <li>Determine proportion of communities in which CSM will be initiated each year (Optional: only for projects with many communities).</li> </ul>	DHMT and FLHF staff	Two months prior to distribution of ivermectin
3.	<ul style="list-style-type: none"> <li>Before you visit the community gather information about the community's last treatment coverage and performance.</li> <li>Arrange a visit to community.</li> <li>Hold a meeting with community leaders and representatives of CBOs.</li> <li>If any other groups (religious and/or social) express interest meet them and advise on their role in the CSM.</li> </ul>	FLHF/sub-district personnel. DHMT and FLHF personnel.	Within 2 months after completing of ivermectin treatment.
4.	<ul style="list-style-type: none"> <li>Facilitate a community meeting: <ul style="list-style-type: none"> <li>Always begin with commendations;</li> <li>Find out if community members know why CSM is important and what the community and individuals will gain;</li> <li>Allow community members to discuss and decide the indicators; Allow them to choose the monitors.</li> </ul> </li> </ul>	FLHF personnel. There should be spot supervision by district onchocerciasis coordinators. FLHF personnel should NOT direct the community meeting. They should take a back seat.	Within 2 months after completing of ivermectin treatment.
5.	Meeting with monitors	FLHF personnel (supervision by district oncho coordinators).	Within 2 months after completing of ivermectin treatment.

### ANNEX 7.3: HOW TO IMPLEMENT COMMUNITY SELF MONITORING (CONTINUED)

Steps	Activity	Who will be responsible for the task?	When will the task be completed?
6.	Find out the date the community will carry out the CSM. Before leaving the community arrange a meeting with monitors/moderators to discuss their findings. Explain to monitors how to write reports. Monitors/moderators should be asked to write simple reports and in a language easily understood by all.	FLHF personnel and community selected monitors  FLHF personnel	CSM should take place not later than 3 months after mass treatment. You should not wait for ALL absentees/refusals to receive treatment before initiating CSM.
7.	Request to be informed about the date the community will hold a feedback or stakeholders' meeting. Remind the monitors that they should collect the information and prepare a simple report before the date of the community's feedback or stakeholders' meeting.	FLHF personnel and monitors.	As soon as the monitors complete the work.
8.	Community holds CSM: <ul style="list-style-type: none"> <li>• Decide on what information monitors should collect;</li> <li>• Decides on the number of monitors to undertake the task;</li> <li>• Select monitors;</li> <li>• Agree on the date to hold the feedback or stakeholders' meeting.</li> </ul>	Community chief, community leaders and monitors.	Not later than 3 months after ivermectin distribution.
9.	Attend the community feedback or stakeholders' meeting.	FLHF personnel. Optional for district staff.	After CSM has been carried out by the community.
10.	Challenge: There are several communities; hence FLHF staff cannot be present at all the community feedback meetings. Determine what proportion the health staff should attend	FLHF personnel	NOTF to decide.

# Annex 8

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The African Programme for Onchocerciasis Control (APOC) has demonstrated that communities, in partnership with health professionals, can manage treatment of selected diseases prevalent in their environments using the strategy known as Community Directed Intervention (CDI). CDI is of proven effectiveness and efficiency as a means of bringing multiple health interventions to the poorest communities, especially in remote areas; can be used to strengthen Primary Health Care as it engages communities to manage and account for their own health where resources and infrastructure are insufficient; and is also a good means of involving community participation in health delivery systems. For these reasons, APOC initiated the development of a curriculum for medical and nursing schools as a means of propagating the CDI strategy in Africa and contribute to the production of future generations of health personnel trained and empowered to use the CDI strategy in health care delivery. This handbook is developed as a guide for the lecturers and other trainers that will be teaching students on CDI in the various collaborating faculties of medicine and health sciences across Africa. This trainers' handbook has followed the structure of the curriculum and training module document.

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