

2015

Somali Community Health Strategy



*Health Services at the
doorstep of Somali
Communities*

Approved by:
Health Advisory Board

15 APRIL 2015

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'Somali Community Health Strategy'
Health Services at the doorstep of Somali Communities

Produced by:
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Foreword

We are very pleased to present the Somali Community Health Strategy which was developed in consultation with all partners and stakeholders. This strategy provides clarity of vision and direction for the implementation of community based health services. The focus is on standardisation and scaling up of community based health services currently provided by numerous cadres of community health workers and ensuring quality of services delivered at the doorstep of Somali population in rural areas.

In the health sector of developing world, community health worker is recognized as one of the cost effective intervention to address barriers in access to primary health care, improving continuum of integrated care, delivering results and bridging the gap between health care delivery system and the communities. In addition, a well-designed community health workers' approach within primary health system is considered as an effective strategy for moving towards the Universal Health Coverage (UHC) and achieving the Sustainable Development Goals (SDGs).

The Alma Ata Declaration (1978) identified community based health workers as one of the cornerstones for provision of comprehensive primary health care at the grass root level. The movement which started from 'bare foot doctors' in China, witnessed a major development during the 1980s and 90s, when many developing countries trained large numbers of community health workers and those workers contributed significantly in improving health outcomes and are still providing care in the remote and disadvantaged parts of their country. Some examples include Aanganwadi workers in India, Lady Health Workers in Pakistan, Behvars in Iran, Raeda in Egypt, Community Health Agents in Ethiopia, Kader in Indonesia, Barangay Health Workers in Philippines, Activists in Mozambique and Brigadista in Nicaragua, etc. Somali 'Marwo Caafimaad' is an addition to the list. In addition, CHWs based in the Somali Primary Health Units (PHUs) also forms an integral part of the community health strategy.

The functioning of the overall health system is critical for the effectiveness of a community health system. The community health strategy adopts a twin track approach to strengthen health system by building on the existing health system particularly Health Centres and PHUs implementing the Essential Package of Health Services (EPHS); and adding an additional level to the health system at the household/ community level. The first phase in implementation of a community health strategy will be rationalisation and standardisation of two community health cadres including a slightly revised role for the Community Health Worker (CHW) at the PHU and a community based Female Health Worker (FHW) providing an integrated package of community health services (health, nutrition and WASH). The focus of the strategy is on promoting good health and preventing ill health through such issues as lack of good hygiene and hand washing with an emphasis on improving the reproductive health status of adolescents, women and addressing the most common causes of mortality in the under 5 children.

The Ministries of Health in Somaliland, Puntland and Central South Somalia are committed to the devolution and people centered approach - bringing decision making closer to the communities and facilitating their involvement in the process of health development - and integrating the different services so that primary health care is delivered coherently and with the best use of staff, material and resources. The level of delegation of decision-making will be greater than any other intervention in the Somali health sector. Moreover the strategy is in line with the commitments of

Somali authorities in moving towards Universal Health Coverage (UHC) endorsed during 60th session of the Regional Committee (EM/RC60/R.2).


We would like to acknowledge the support from the highest policy levels that this strategy has been able to get in a short period of time. We are thankful to JHNP donors especially Governments of United Kingdom (DFID), Sweden (SIDA), Finland, Switzerland (SDC), Australia (AusAID) and United States (USAID) who have provided generous funds for strengthening of Somali health systems at levels never before achieved. The decision of developing the strategy is an excellent example of the level of support from the donor community in Somalia.

We particularly acknowledge the leadership role of the United Nations Resident Coordinator and support & guidance provided by the three UN agencies i.e. World Health Organization (WHO), United Nations Children Fund (UNICEF) and United Nations Population Fund (UNFPA).


We would also like to express our appreciation to the staff of Ministries of Health from Somaliland, Puntland and Federal Government of Somalia for their support, without which we would not have been able to reach this milestone. We are also grateful to the contribution from NGOs and other stakeholders in the development of this strategy.

We are confident that the Community health strategy will help in provision of essential, cost-effective and integrated health and nutrition services at the doorsteps of the populations most in need and more and more partners would join hands in achieving our common goal of improving health status of Somali women and children, ensuring peace and ending poverty.

Dated: 15 April 2015



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LIST OF ACRONYMS

ABB Activity Based Budgeting	JD Job Description
ARI Acute Respiratory Infection	JHNP Joint Health and Nutrition Programme
ANC Ante-Natal Care	JPLG Joint Programme on Local Governance
C4D Communication for Development	LNGOs Local Non-governmental Organisations
CDC Community Development Committee	MCH Maternal and Child Health
CH Community Health	MDGs Millennium Development Goals
CHS Community Health Strategy	MICS Multi-indicator Cluster Survey
CHW Community Health worker	MOH Ministry of Health
CHWks Child Health Weeks	MOI Ministry of Information
CMs Community Mid-wives	NGO Non-governmental Organisation
CoC Continuum of Care	NIDs National Immunization Days
CSO Civil Society Organisation	PHU Primary Health Unit
CSS Community Systems Strengthening	PL Puntland
DFID Department for International Development	PNC Post-natal Care
DHB District Health Board	PSI Population Services International
EPHS Essential Package of Health Services	RHC Referral Health Centre
EPI Expanded Programme on Immunization	SCF Save the Children Fund
FHW Female Health Worker	SDGs Sustainable development Goals
FGM/C Female Genital Mutilation/Cutting	SL Somaliland
FGS Federal Government of Somalia	T4D Technology for Development
GAVI Global Alliance for Vaccines & Immunisation	TBA Traditional Birth Attendant
GBV Gender Based Violence	TFR Total Fertility Rate
HC Health Centre	THET Tropical Health & Education Trust
HCS Health Consortium for the Somali People	UNICEF United Nations Children's Fund
HIV & AIDS Human Immunodeficiency Virus & Acquired Immunodeficiency Syndrome	ToT Trainer of Trainers
HMIS Health Management Information System	VfM Value for Money
HPA Health Poverty Action	FHW Community based Female Health Worker
HRH Human Resources for Health	WASH Water, Sanitation and Hygiene
HSSP Health Sector Strategic Plan	WCBA Women of Child Bearing Age
iCCM Integrated Community Case Management	WHO World Health Organisation
IDP Internally Displaced Person	WHOSIS World Health Organisation Statistical Information Service
IYCF Infant & Young Child Feeding	

EXECUTIVE SUMMARY

Background

There is a high burden of mortality and morbidity in the country that can be prevented and treated at community level through a community cadre of health workers, supported through the health and local governance structures. However, the situation on the ground is fragmented as there are over 17 differently named community health cadres, with a huge variation in selection criteria, skills and services provided. This is an inefficient use of meagre resources.

There is a conducive environment for the implementation of Somali Community Health Strategy (CHS). The Somali Health Policy, 2014 and the three Health Sector Strategic Plans (2013-16) refer to the need to improve community based interventions particularly for health, nutrition and water, sanitation and hygiene (WASH), but nothing is stipulated. Stakeholders from all sections of society agree that a Somali community health strategy is important so as to reach women and children particularly in underserved areas and implement health care services with involvement of people and communities.

Community Health Strategy

The functioning of the overall health system is critical for the effectiveness of a community health system and the implementation of a community health strategy. Therefore it will be important to take a twin track approach to strength the health system by:

- Building on and strengthening the existing health system particularly Health Centres and Primary Health Units (PHUs) implementing the Essential Package of Health Services (EPHS); and
- Adding an additional level to the health system at the household/ community level.

The first phase in implementation of a community health strategy must be rationalisation and standardisation of community health cadres. In future, Somali community health workers should be standardised to 2 community health cadres;

- A slightly revised role for the Community Health Worker (CHW) at the PHU (static health facility) education level 6 ; and
- A community based Female Health Worker (FHW) providing an integrated package of community health services (health, nutrition and WASH), selection criteria ideally up to grade 6 but where women with this education level are not available assessment of basic literacy and life experience could be considered.

The CHS should build on what has be done by reviewing the numerous existing curricula comparing them to the education level needed for each community cadre so as to develop the most cost effective and appropriate curricula for the situation in Somalia.

The essential components of the Community Health Strategy are:

- Promoting good health in the community working through families, schools, community leaders, community health committees and women groups;

- Organising and strengthening communities to be able to take control of their own health;
- Providing essential information and preventive and promotive services to prevent ill health;
- Providing basic curative care for some common illnesses that can be treated at the community level; and
- A referral system providing a continuum of care for the people.

The focus of the CHS will be on promoting good health and preventing ill health through such issues as lack of good hygiene and hand washing with an emphasis on improving the reproductive health status of adolescents, women and addressing the most common causes of mortality in under five years children (ARI, diarrhoea, malnutrition). It is expected that volunteer members of the community will support the CHWs and FHWs in the broader prevention and promotion work such as: women groups (breast feeding promotion and optimal complementary feeding); pregnant mothers group promoting antenatal care, skilled deliveries, and early initiative of breastfeeding; mothers' group with children under five years for their health promotion and preventive activities); teachers with community worker providing health education in schools; Imams in the mosques; and other community members helping to improve the sanitation situation; etc.

Community Involvement

The evidence on good practice shows that the involvement of community in health activities and their inclusion in the selection and management of community health workers is critical to the success and sustainability. MoHs and regional medical officers will provide the criteria for selection of CHWs and FHWs with communities as this will help to ensure a standardised, open and transparent system that cannot be manipulated by local politics. The Community Development Committee (CDC)¹ will be requested to identify suitable candidates respected by members of their community, with empathy and good communication skills. Members of the CDC will form part of the interview panel with representatives of MoH/ regional medical officer.

Supportive Supervision

The international evidence shows that fundamental to the success of a CHS is sound supportive supervision, mentoring and on-going/ continuing training to the CHWs and FHWs.² To do this it is essential that a strong monitoring, supervision and support system is developed and implemented at different level of the health system including an effective system from the PHU to household level.

¹ Community Development Committees (CDCs) have been developed in many villages under a UN governance programme partly to help minimise the number of committees. However CDCs will not be established in all villages. In those cases, the most appropriate community committee structure should be used as long as it follows similar criteria of governance and accountability.

² Abbatt F (2005). Scaling up Health and Education Workers: Community Health Workers Literature Review. Health System Resource Centre, DFID.

http://collections.europarchive.org/tna/20100918075642/http://www.dfidhealthrc.org/publications/health_service_delivery/05HRSalingUp03.pdf

BACKGROUND

1. DISEASE BURDEN

The population of the country is estimated to be 12.3 million in 2014, with a growth rate of 2.9% per annum³. Seventy percent of Somalis are under the age of 30 and life expectancy is 53 years. The Somali population is classified into pastoralists, agro-pastoralists, coastal and riverine rural populations, with a third of these residing in urban settings. Poverty is widespread with around 45% of the population “surviving” on \$1 or less per day, and 73% on less than \$2 per day.⁴

The population density is low, just 25 people per square kilometre, making the provision of static health services difficult. Overall access to public health services in rural areas, and for nomadic populations in particular, is very limited; it is estimated that less than 15% of the rural population has access to any health provider⁵.

Table 1. Health and nutrition-related MDG indicators, 2009–2010 and 2013–2014⁶

Health and nutrition-related MDG indicators	Somalia		Sub-Saharan Africa	
	2009–2010	2013–2014	2009–2010	2013–2014
MDG 1: Poverty and hunger				
% under-5 children malnourished (underweight)*	32	32	30	21
% under-5 children chronically malnourished (stunting)*	42	42	41	38
% under-5 children acutely malnourished (wasting)*	13	13	10	9
MDG 4: Child mortality				
Under-5 mortality rate (per 1000 live births)	200	146**	144	98
Infant mortality rate (per 1000 live births)	119	91**	86	64
Measles immunization (% children 12–23 months)	24	46	72	72
MDG 5: Maternal mortality				
Maternal mortality ratio (per 100 000 live births)	1400	850***	900	500
% births attended by skilled health staff	33	33	39	50
MDG 6: HIV/AIDS, malaria and other diseases				
Prevalence of HIV (% adults aged 15–24)	0.5	0.2	5	1.9
Contraceptive prevalence rate (% of women ages 15-49)	15	15	23	24
Number of children orphaned by HIV/AIDS	–	110	10 200	15 100
% under-5 children sleeping under insecticide-treated bednets	11	11	–	36
% under-5 children with fever treated with antimalarials	8	8	42	37

³UNFPA State of the World Population: Demographic Indicators <http://countryoffice.unfpa.org/somalia/drive/SWOP2013-final.pdf>

⁴<http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/SOMALIAEXTN/0,,menuPK:367675~pagePK:141132~piPK:141107~theSitePK:367665,00.html>

⁵Health Sector Strategic Plan Puntland; Health Sector Strategic Plan Federal Republic of Somalia; Health Sector Strategic Plan Somaliland.

⁶ Sources for 2013–2014: UNICEF-The State of World Children 2014; UN Interagency estimates for child and maternal mortality, 2013; Population Estimation Study, Somalia 2014; World Bank Data Monitoring (2013).

* Indicators for undernutrition are cumulative for moderate and severe malnutrition. The latest Somalia Food Security and Nutrition Unit data for 2015 for severe undernutrition indicate underweight: 13.4%; stunting 12% and wasting: 13.6%.

** Recent under-5 mortality estimate for Somalia is **137 per 1000 live births**, whereas infant mortality rate is **85 per 1000 live births** as per UN interagency estimates for 2015.

*** Recent maternal mortality estimate for Somalia is **732 per 100 000 live births** as per UN interagency estimates for 2015.

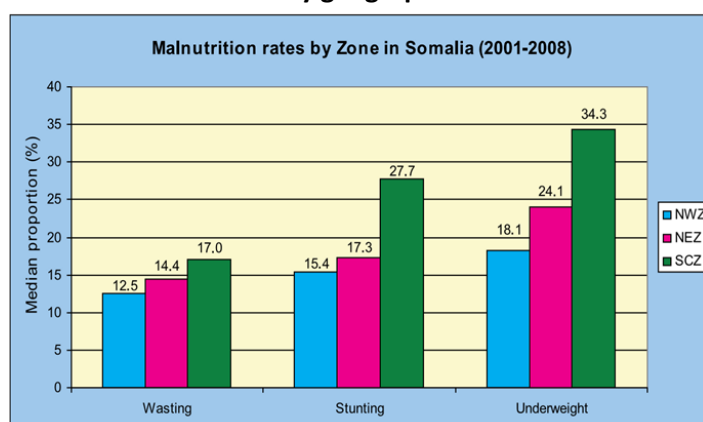
Incidence of tuberculosis (per 100 000 population/year)	–	285	343	290
Tuberculosis cases detection rate (all new cases) (%)	73	43	46	51
MDG 7: Environment				
Access to an improved water source (% of population)	35	30	58	63
Access to improved sanitation (% of population)	50	24	54	30

UNICEF reported in 2011 that the main causes of under-5 mortality in the country are:

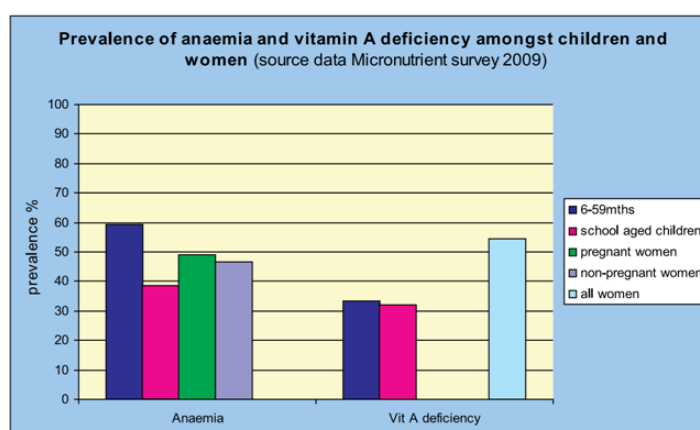
- Acute respiratory tract infection (including pneumonia) (24%);
- Diarrhoea (19%);
- Neonatal disorders (17%); and
- Measles (12%).

Malnutrition, micronutrient deficiency and open defecation are major underlying causes of under 5 mortality and morbidity in Somalia. Poor water and sanitation contribute to diarrhoea and malnutrition, UNICEF estimates that 30% of the population have access to clean water and 24% to sanitation. Both early and exclusive breast feeding for the first 6 months of life, and infant/young child feeding practices are very poor, contributing to the high malnutrition levels.

Levels of Malnutrition by geographical areas⁷



The prevalence of anaemia and vitamin A



Studies have found anaemia prevalence extremely high in all groups of the population but it found that 74% of children under 2yrs were anaemic and 52% for children over 2yrs⁸. The study identified this as iron deficiency anaemia. Anaemia in early childhood can have permanent cognitive consequences.

⁷ Source: Somali Nutrition Strategy 2010-2013

⁸ National Micronutrient & Anthropometric Nutrition Survey 2009 (FSNAU, UNICEF, WHO, WFP, FAO, UCL, SIDA)

2. ACCESS TO HEALTH SERVICES

Conflict and access to health services

The protracted Somali conflict has taken a huge toll on the healthcare system and overall health of the population. This has negatively affected the health sector development and displaced the few health professionals working in this sector. As a result, unregulated private hospitals, clinics and pharmacies emerged leading to current health seeking behaviour among vulnerable population and unequal access to basic health care services. There are unmet urgent healthcare needs in both urban and rural areas. In addition, conflicts and droughts have displaced large populations from their homes in both urban and rural areas leading to both humanitarian and health crises. It is estimated that there are 1.1 million internally displaced persons (IDPs) in Somalia who reside in IDP camps in a number of regions lacking access to proper shelters, safe drinking water, latrines, and health. IDPs are a vulnerable group in Somalia and they should to be targeted through community health activities.

The protracted conflict is negatively affecting women and girls' health. Due to the absence of state protection, women and girls have been subjected to various forms of sexual and gender based violence. The most common forms of Gender Based Violence (GBV) include rape, physical violence, intimate partner violence and harmful traditional practice such as early marriage and female genital mutilation/cutting (FGM/C). Under such environments where access to basic health services remains a challenge, women and girls affected find it extremely difficult to access the necessary services and support.

Maternal Health and Reproductive Health

Low levels of literacy, poor socio-economic status, high fertility rate and low access to birth spacing services affect women and men's reproductive health. Harmful traditional practices (including almost universal FGM/C) have severe and adverse effects on reproductive and maternal health. Women's health has not received sufficient resources and attention. As a result, the country has the highest pregnancy and childbirth related deaths in the world.⁹ A number of other factors hinder access to reproductive health services and they include: lack of awareness of the benefits of birth spacing¹⁰, lack of resources, no transportation, geographic distance, poor roads, lack of skilled and trained health staff and midwives.

Reproductive health services must be integrated into community health initiatives, including services such as: antenatal care, delivery services, post-partum care and new-born care.

Government is committed to ensure access to reproductive health in urban and rural areas through appropriate policies, strategies and implementation of reproductive health services. Consultative discussions undertaken during the process of this strategy development highlighted that women's groups wanted reproductive rights of women to be prioritized in the community health strategy and its programmes.

⁹ Save the Children (2014). State of the World's Mothers 2014: Saving Mothers and Children in Humanitarian Crises. See: http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/SOWM_2014.PDF

¹⁰ Family planning is a very contentious issue in Somalia and often discouraged by some religious leaders.

Status of women

The Somali literacy rate is 37.8 %¹¹ but the illiteracy rate of Somali women is thought to be as high as eighty percent¹². Although the country is a traditional and male-dominated society, women's mobility is not restricted and thus societal restrictions are not having a direct impact on their access to health services but other factors such as cost affect access to services. In addition, women's mobility to move around public spaces and the right to seek employment outside their homes are widely accepted and supported.

It is worth noting though that due to breakdown of political, economic and social institutions, women have shouldered more roles and responsibilities than they previously held. They are often the primary breadwinners of their families and this may affect, directly and indirectly, their available time to seek relevant information relating to their health and their family's health. With societal acceptance of women's work and mobility, Somali women can and will play critical roles in community health activities in their respective communities.

Additionally, there are a number of other barriers that affect both men and women's access to health services and they include:

- Existing healthcare services and facilities are heavily concentrated in the cities / towns;
- Financial obstacles including ability to pay user fees (both official and unofficial) and transportation costs;
- Lack of transportation to health service providers and facilities for rural and nomadic populations; and
- Poor services and unqualified health personnel leading to mistrust in the health system and reliance on / utilization of traditional healers due to access and lack of resources to visit professional health providers.

¹¹UNESCO (2011) EFA Global Monitoring Report: <http://www.efareport.unesco.org>

See also UNICEF: <http://www.unicef.org/infobycountry/>

¹²UNICEF. *Somalia Facts & Figures, The Situation of Women and Children* <http://www.unicef.org/somalia/factfig/chldwmen.html>

3. THE SOMALI HEALTH SECTOR

Policy Environment for community health

The Constitution guarantees the rights of access for all people to high quality health care services, to healthy and safe environments, access to safe and adequate water supply, sanitation and waste disposal and protection from all environmental dangers.

The policy environment is generally conducive for community health, but does not stipulate how to achieve it. The Somali Health Policy 2014 and the three Health Sector Strategic Plans (HSSPs)¹³ refer to the need to improve health and nutrition education, environmental health, strengthen community based interventions, and enhance community roles and ownership in the health system. The HSSPs recognize the need to greatly improve the human resource situation, especially to provide health services for people living in remote areas. The HSSPs objectives are focused on targeted training and equitable deployment of community health workers, especially female health workers to bridge urban-rural disparities. However there are no specific statements about community health staffing.

Revitalizing the regional/ district health system, through decentralizing decision making and services is recognized as a way of bringing services closer to communities and families. There are also calls for village advocates and influencers to provide information/ knowledge to specific population groups such as nomadic populations, to strengthen self-care for selected health problems.

Financial Resources

The analysis for the EPHS roll-out in 2013 indicates that the unit cost per beneficiary ranges from US\$ 12 to US\$ 17 per person per year - this includes contributions from the implementing partners which varies from 4.4 per cent to 34 per cent of the cash component. The unit cost to the programme is US\$ 8 to US\$ 11 for the cash component and US\$ 4 to US\$ 6 for the supply component. Variation in the unit cost depends upon the number and type of facilities covered under the project agreements. These are just an initial estimate and a more concrete unit cost analysis is required once the roll-out of EPHS is complete.¹⁴

Implementation of the HSSPs is expected to cost US\$350 million, 70 to 75 percent of which will be spent on health services delivery. Major donors include the Australia, Sweden, United Kingdom (UK), Finland, Switzerland and United States of America (US)¹⁵.

Human Resources for Health

There is a critical shortage of professional health workers in the country. Puntland's draft HRH policy highlights that there are currently 4 nurses per 10,000 population well below the WHO standard of 23 per 10,000 and Federal Government of Somalia has only 2.9 health professionals per 10,000 population. Most training institutes are private, although many are working closely with the health professionals' councils (nurses, midwives, medical practitioners) and government to jointly

¹³ HSSPs for Somaliland, Puntland and The Federal Government of Somalia, January 2013

¹⁴ Joint Health and Nutrition Programme. (May 2014). JHNP 2012-2016 Annual Progress Report 2013

¹⁵ IRIN news (2013). New plan to ensure universal healthcare in Somalia. <http://www.irinnews.org/report/97709/new-plan-to-ensure-universal-healthcare-in-somalia>

develop more professional courses, though some institutes are not yet accredited by the regulatory bodies.

This situation is aggravated by a maldistribution of the current workforce: in central and southern areas 83% of physicians and 62% of nurses are in 'Regional towns' which means that rural areas are badly underserved. Ongoing conflict in some areas, particularly in central and southern areas, impacts negatively on the provision of health services and the ability of health professionals to move safely between services to undertake supportive supervision. Gender disparity particularly within physicians is also highlighted as a problem in all zones.

The human resources for health (HRH) crisis affecting the health sector seriously impacts on the delivery of all services and will affect community services and justifies the urgent need to rationalize and use the existing workforce, including all the various community health cadres more efficiently. The draft HRH Policy makes this a priority "to immediately address this critical HRH shortage, the government will expedite local and partners' supported strategies to scale up the training and deployment of community based health workers and midwives."

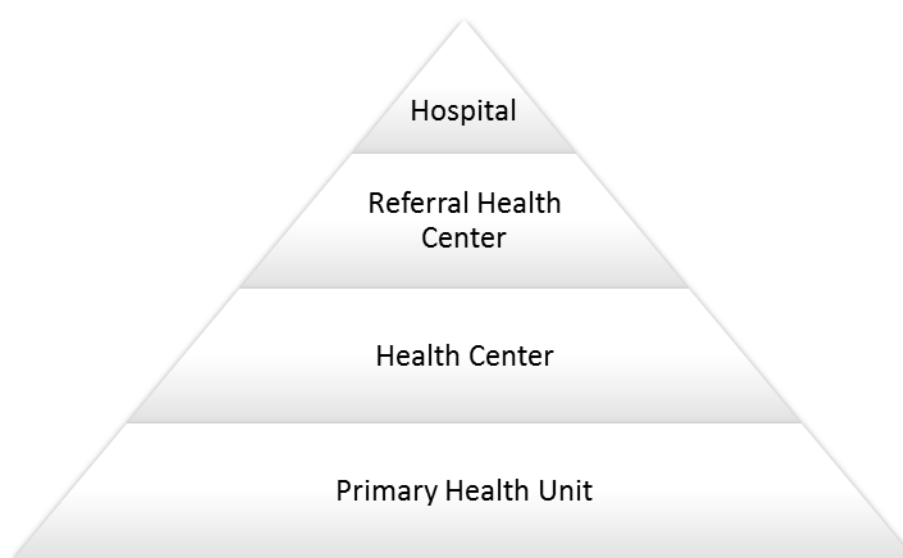
The Structure of the Somali Health System

The MOH management system flows from:

MoH → Regional Health Office → District Health Office.

The District level is responsible for the delivery of health services through the 4 levels of the health system (Diagram1). However, the war has affected the functioning of the district health level, leaving supervisory, managerial and oversight of health service delivery with the Regional Health Offices, which is the status to date. Central government is now beginning to rebuild this district level administrative structure across all sectors, including health.

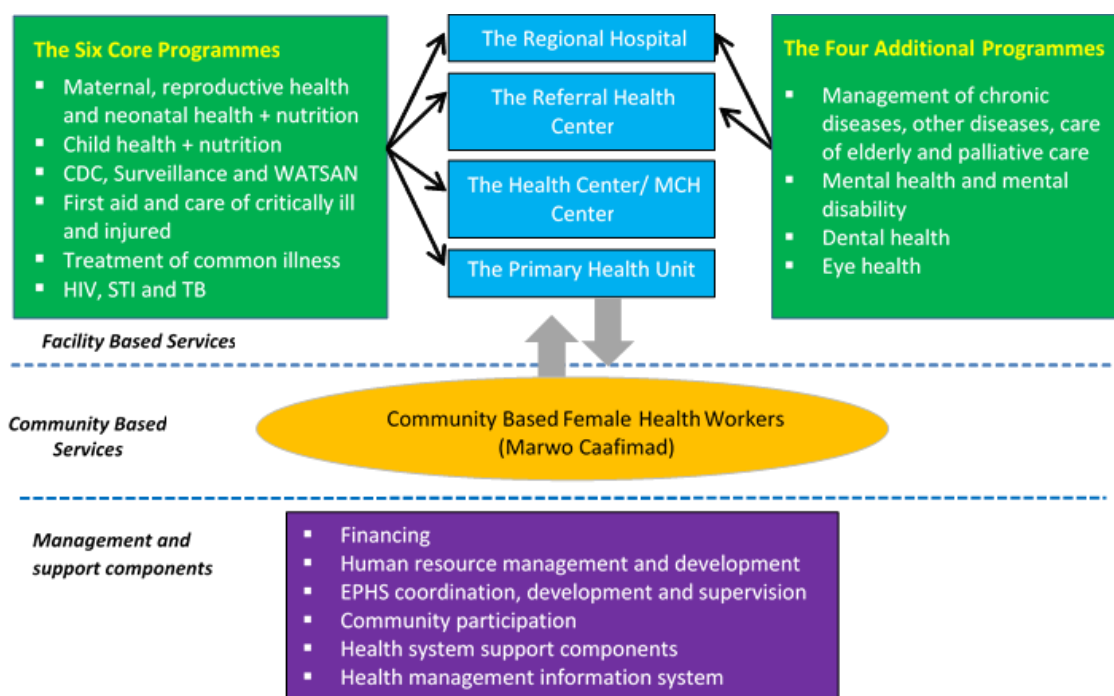
Diagram 1: The current health system



4. THE ESSENTIAL PACKAGE OF HEALTH SERVICES (EPHS)

The EPHS¹⁶ is the mechanism selected by Somalia to provide quality public health services and will help clarify health priorities and direct resource allocation. The EPHS strategy states clearly that the focus will be on quality. It comprises 6 core programmes that will be implemented to varying degrees at the different levels of the health system. The role out of the EPHS is critical to the effective implementation of a community health strategy due to the need for an effective referral system to provide a continuum of care (CoC) and support for health professionals at different levels of the health system.

The EPHS framework as explained in the Somali Health Policy 2014 is as following:



Status of EPHS roll-out

The EPHS is currently implemented in nine regions (Awdal, Togdheer, Sanaag, Bari, Nugaal, Mudug, Galgadud, Banadir and Lower Juba) under the Joint Health and Nutrition Programme whereas another three regions (Sahil, Karkar and Gedo) are covered under the Health Consortium for Somali people. The current funding for the two programmes ends in 2016 and successor programmes are likely to replace the same with prioritization to EPHS implementation.

At present, the EPHS concentrates its community level work through CHWs at PHU level. It assumes the CHW will be both a PHU worker and also a community mobiliser/ health promoter. The EPHS also identifies community health promoters who, as volunteers should have a purely promotional and mobilising role within communities. These volunteers would be very much part-time unpaid roles which they would undertake in conjunction with the CHW. The activities expected of both of these roles are vital for effective primary and community health and will be incorporated into the roles envisaged of the CHW and FHW, which should however, be broader than currently described to meet the needs identified.

¹⁶ UNICEF (2009). Essential Package of Health Services.

5. CURRENT SITUATION OF COMMUNITY HEALTH SERVICES

To date there has been no national plan or strategy for Somali community health which means that activities are often uncoordinated which has resulted in a fragmented approach with overlaps and glaring gaps in service provision. One of the worst incidences of this fragmentation was noted where two agencies are supporting a single rural health facility, each providing separate services – separate reports for each service provided were demanded, overburdening the facility staff.

Health Related Community Cadres

The mapping of community health cadres was carried out by aggregating the responses of agencies (12 agencies responded) working in the country but this is not the full picture as responses were patchy. The mapping found 17 different community cadres and the number of people undertaking community health activities was in excess of 2,000 (Table 2). The largest named category, is the 'Community Health Worker', based in PHU and the training period ranges from 2 days to 2 years. Clearly the job descriptions, knowledge and skills are very different for each of these differently trained CHWs. Educational selection criteria ranged from basic literacy and numeracy to class 8 primary education/ intermediate school level (though the community and personal attributes were similar).

Some cadres provide a range of services/ support, others are single-issue focused (nutrition, or HIV & AIDS), whilst some are providing information to peer groups (e.g. mother-to-mother). Many provide information/ knowledge on improving health status either as stand-alone or as part of a comprehensive package of services.

Table 2: Summary - Community Health Cadres

Title	Number	Number of Agencies responded
FHWs	231	3
CHWs	273	8
Trained TBA	396	5
Hygiene Promoters	226	2
Maternal Volunteers	13	2
Health Volunteers	7	1
Community Development Mobilizers	7	2
Community Health Promoters	80	2
Community Educators	197	2
Village Health Workers (iCCM)	68	2
Infant & Young Child Feeding Counsellors	340	5
Community Nutrition Workers	194	5
Mother-to-Mother Support Groups[6]	52	2
Midwives	34	4
TOTAL	2118	

OTHERS

Female Health Promoters	42	2
W2W	25	1
TOTAL	67	

OTHERS INDIRECTLY INVOLVED

Community health committee	187	1
Actors	22	1
Training of Trainers for community's Own resource persons On Community Reproductive Health in Puntland (target)	117	1

Traditional Birth Attendants (TBAs) do not work formally in the health system, but are very active in their community, providing ante-natal, intrapartum and post-natal services, which are not otherwise available by more skilled staff to many. Several programmes are bringing TBAs into the regular health system by giving monetary incentives to TBAs for each referral to a health facility, while also training them to undertake additional tasks (birthing supporter, and other aspects of safe motherhood promotion).

All zones are currently increasing the numbers of midwives through training and deployment in MCH/ health centres. The PL HSSP specifically states that 30 midwives will be trained per year for 3 years and will be assigned to work in rural health facilities. Somaliland has trained 375 midwives, with 100 midwives graduating each year but it estimates it needs a total of 4000 to offer adequate services. All zones state that CHWs and skilled health workers will be deployed to rural health facilities. None of these travel into the villages to provide services beyond health facilities.

Although there are over 17 different community health cadres, there are only few with more developed systems, training curricula, job descriptions and supervision systems and therefore offer the greatest potential to build on to deliver future community health services. These are:

- the CHW programme designed by THET, with 9 months supportive training currently underway in Burao Health training institute (with HCS funding);
- the Female Health Worker programme supported by GAVI Alliance funding with a 9 months training and supervised practice;
- the integrated Community Case Management (iCCM) volunteers managed by SCF and funded by HCS; and

Also UNICEF is developing training for a Community Based Worker who will provide health, nutrition and WASH services based on 1,000 critical days.

Linkages to the health system

All current community health initiatives work with the existing health system to a greater or lesser extent, from close linkage in a well-managed system to a much looser linkage. CHWs, FHWs, TBAs are usually linked closely with the health system. Single-issue community based workers, such as: nutrition promoters; HIV & AIDS volunteer workers; IYCF workers (Infant and Young Child Feeding); and Nutrition Promoters, all work through the health sector but the level of data reporting is

variable. The HSSPs speak of the need to include WASH activities under environmental health and/or health promotion, however, support from generalist NGOs which provide WASH interventions, do not necessarily link formally with the existing health system.

Challenges

The HSSPs and EPHS identify the PHU as the level of the health system closest to the community staffed by CHWs. The PHU is based in a village covering a catchment population of approximately 1,000-4000 people. The HSSPs stated that the PHU should be staffed by a trained CHW who has had a minimum of a 6 months approved training. However, in many cases, the PHU is staffed by CHW with much less training, or by auxiliary nurses, who have only had on -the-job training (often ad hoc) and who are supervised intermittently from the nearest MCH centre/Health Centre. This means that in many cases they cannot provide support to FHWs based in villages and therefore a standardised training for CHWs is required.

The current wide range of community health cadres with different skills clearly cannot continue. It is critical that this situation is rationalised and replaced by a standardised approach which will provide cost effective services for women and children particularly in rural underserved areas.

Stakeholder views

Consultations were held with the Health Authorities in July and August 2014 to discuss their vision and ideas for a community health strategy. A full list and description of stakeholder meetings can be found in Annex 1.

The main issues that emerged from these meetings were:

- That a community health strategy is urgently required but in-country stakeholders put forward very few suggestions on what that might look like;
- The need to rationalise the current fragmentation by building on what exists under an ‘umbrella plan’ that all stakeholders could work under;
- All wanted remote communities to have health services, while stating that it would be difficult to achieve as too many locations did not currently have health care which needed to be corrected;
- The importance of understanding and accommodating the inherent socio-cultural/religious context;
- The need to improve the skills/ knowledge of CHWs so they can do more; TBAs’ skills and knowledge should be improved so they can help their communities more because they are well respected;
- More could be done through public and private media (radio and TV), including social media, and through dramas, song, poetry on dissemination of messages;
- The need for people to better understand how to prevent disease, change habits so they can be more healthy, and to be more empowered to effect change in their own health; and
- The need to increase comprehensive service delivery on the back of single issue interventions which are often well funded.

Discussions were also held with service providers and the overriding conclusion was that they appreciated the consultation process and considered that a community health strategy was urgently required. Other issues raised were:

- Service providers at MCH/Health centre level felt they were managed and supported by both the MoH regional office and the community health committee (CHCs) and that this combination worked well and was very important for maintaining motivation for good quality work;
- With CHC (or CDC) support, health service staff felt empowered and supported in their work – both at HC level (qualified and auxiliary staff);
- All felt that people themselves were not only able but wished to be involved in determining their own health, and that they would welcome opportunities to be more knowledgeable and empowered; and
- Village-based health workers are well respected by their community, and have enough knowledge to prevent, manage and treat common health problems.

Civil Society

At the community level, there are various community actors that directly and indirectly contribute to promoting community health in urban and rural areas. These include: professional groups, local NGOs led by men, women & youth, community leaders, members of IDPs, and pastoralists & agro-pastoralists. Thus, it was critical to consult with this diverse group of actors that in one way or another are involved in various activities that lead to good health in their respective communities. These local actors are potential partners in support of community health strategy.

These are the main findings from the local stakeholders' consultations:

- Women's organizations were critical of outreach initiatives particularly the National Immunization Days, as these solely focus on polio immunization. They argued that such initiatives are 'lost opportunities' to provide wider care to women and children. They want NIDS to provide additional activities such as immunization to mothers and children;
- The health needs in rural areas are neglected and receive inadequate resources and attention from the health authorities. Thus, the health needs of rural and IDP populations must be given specific consideration by all levels of authorities;
- Factors that contribute to ill health/poor health at the community level must be addressed;
- Poor men and women in urban areas face certain constraints in accessing clean drinking water, adequate nutrition, basic health services that are affordable and this profoundly affects their health;
- Equal representation of both genders in community health committees and opportunities for both genders to access skill development trainings were said to be critical to the success of any community health programmes;
- Coordination mechanisms remain weak at all levels (at CSO and government levels);

- The inclusion of both men and women in community conversations on health issues including child spacing, FGM, early marriage and HIV & AIDs was noted to be critical to prevention and response of these issues.
- Radios and television are said to be important tools to both reach out to wider population and provide valuable information relating to health;
- Islam can play an important role in promoting the protection and health of vulnerable groups. Women's groups recommended the use of Islam as a tool to reach out to different members of the community to support anti-FGM initiative and early marriage;
- Informal networks of solidarity existing at the village level that provide critical support to individuals and families must be nurtured and supported. Such networks have the potential to provide wider assistance to a given community; and
- Donors' support to community health strategy is recognized and they must work together to sponsor joint programs. It is stated that competition between UN agencies creates unhealthy competition and thus affects the work on the ground.

6. INTERNATIONAL EVIDENCE

The experience over the last 30 years of implementing community health worker programmes is that they cannot substitute or compensate for a weak health system and will only be effective if they are part of the health system and supported by the system¹⁷. This is very important when considering a community health strategy in the Somali context where the health systems are weak and vary considerably by zone.

A Cochrane Review¹⁸ found encouraging evidence that where community health worker programmes were well designed and focused with good support to the community health workers they could contribute to reducing maternal, neonatal and infant mortality. Studies from South Africa¹⁹, and Kenya²⁰ found that the critical design features were:

- CHWs should be resident in the community and selected by the community;
- CHWs should be respected by the community;
- less educated women who are part of their local society often provided better care;
- a clear accountability framework with CHWs accountable to their communities; and
- supervision and support is essential.

The current Somali situation is that all the different cadres are paid some form of incentive by the MoH or a partner. The in some literature shows that places volunteerism can work but for a reliable and sustainable system some form of regularly payment is necessary.^{21, 22} Furthermore, in Somalia where the cadres are now accustomed to being paid an incentive it would be difficult to move to a volunteer system for CHWs. The international evidence shows that a salaried paid position is more effective and provides the opportunity to set up an accountability structure.

Although several reviews have documented the positive impact of CHWs on health outcomes, CHW program costs have barely been examined, probably because cost data are much less widely available than data on program outcomes²³.

To date, the official costs of national CHW programs in pioneering countries such as Ethiopia, Malawi or Rwanda have not been estimated, partly because tracking unit costs is difficult and because methods for isolating the CHW subsystem from an integrated primary-health-care system have been elusive²⁴.

¹⁷ Abbatt F. (2005). Scaling up Health and Education Workers: CHWs Literature Review. Health System Resource Centre, DFID.

http://collections.europarchive.org/tna/20100918075642/http://www.dfidhealthrc.org/publications/health_service_delivery/05HRSscalingUp03.pdf

¹⁸ Lassi Z. S., Haider B. A. and Bhutta Z. A. (2010). Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes. Cochrane Review

<http://onlinelibrary.wiley.com/enhanced/doi/10.1002/14651858.CD007754.pub2#Survey>

¹⁹ Friedman et al (2007). Moving Towards Best Practice: Documenting and Learning from Existing Community Health/Care Worker Programmes. Durban: Health Systems Trust. <http://chwcentral.org/moving-towards-best-practice-documenting-and-learning-existing-community-healthcare-worker>

²⁰ United Nations Children Education Fund (2010). Evaluation Report of the Community Health Strategy Implementation in Kenya. UNICEF. http://www.unicef.org/evaldatabase/files/14_2010_HE_002_Community_Strategy_Evaluation_report_October_2010.pdf

²¹ Oxford Policy Management (2009). External Evaluation of the National Programme for Family Planning and Primary Health Care: Lady Health Worker Programme." Management Review: Oxford Policy Management.

http://www.opml.co.uk/sites/opml/files/LHW_%20Management%20Review_1.pdf

²² Haines A, Sanders D, Lehmann U and Rowe AK et al (2007). Achieving child survival goals: potential contribution of community health workers. The Lancet, 368: 2121-2131.

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)60325-0/fulltext?_eventId=login](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)60325-0/fulltext?_eventId=login)

²³ McCord G C, Liu A and Singh P (2013). Deployment of community health workers across rural sub-Saharan Africa: financial considerations and operational assumptions. Bulletin of the World Health Organization.

<http://www.who.int/bulletin/volumes/91/4/12-109660/en/>

²⁴ McCord G C, Liu A and Singh P (2013). Deployment of community health workers across rural sub-Saharan Africa: financial considerations and operational assumptions. Bulletin of the World Health Organization. <http://www.who.int/bulletin/volumes/91/4/12-109660/en/>

7. Analysis of Main Somali Community Health Programmes

The mapping showed that there are over 17 types of Community Health Cadres working in the country, with different training and skills and this should be rationalised for a more efficient use of the limited resources. However this pool of trained CH cadres offer an opportunity to build a skilled human resource to deliver community health services. In reviewing what exists it became evident there were three main schemes: Female Health Worker (FHWs); Community Health Workers (CHWs); and Integrated Community Case Management (iCCM) that offer the foundation upon which to develop future community health services. The three schemes were analysed against the international evidence of good practice and the specific Somali situation.

Table 3: Main Community Health Cadres in Somalia

Type	Location	Supporting Agency
Female Health Workers based in a village/ community	Puntland, Somaliland and South-Central Somalia	WHO/ GAVI- JHNP
CHWs based in PHU	Somaliland, Puntland	THET/ DFID
iCCM based in PHU and village	Puntland	SCF/ DFID

Community Health Worker (CHW) Programmes/ Integrated Community Case Management

As explained there are numerous variations in CHW training programmes many at the pilot stages of implementation with little documentation. The CHW programme implemented by THET funded under the IHP programme is relatively well established in all 3 Health Authorities. This programme has broader curricula than the ICCM focusing on health promotion and prevention which is more aligned to the CHW envisaged in the EPHS. The selection criteria and the eligibility criteria of literacy level 6 is appropriate to the Somali literacy levels and would mean that CHWs could be selected from a larger range of rural underserved settings. The duration of training is realistic with a good mix of knowledge and practice and supportive supervision using the existing health system an essential factor for a successful CHW programme. The CHW programme (THET funded) provides a sound foundation to build on and would be relatively easy to modify reducing time and cost and therefore the most appropriate model to review and modify and then use as the standard for CHWs based in PHUs.

Marwo Caafimaad (Female Health Worker) Programme

The FHW programme is often referred to as the Marwo Caafimaad Programme and is built and adapted from the successful LHW programme in Pakistan and conforms to good international practice and experience. It has extensive training covering the provision of integrated community health, nutrition and WASH services. It conforms to international good practice in selection criteria, community involvement and supportive supervision. The duration of training is long for rural women to attend with 3 months class room-based followed by on the job training for one week over 9 months. Due to the weakness of the current health system the programme has designed a vertical training and supervision system which is expensive. However, the main concern with this programme is the selection criteria which require an education level of 8 years (minimum 6). With an overall literacy level of 25 percent in women, and even lower in rural and underserved areas, a high coverage of FHWs may not be possible in the near future. Whilst some places are relaxing this

rule, a standard approach is required that is appropriate for Somali by not excluding the vital involvement of women because they have not had the opportunity of a formal education.

The conclusion reached is that an alternative to training FHWs is required which has a more relaxed education selection criteria and is simpler and more focused on the main causes of ill health. The review by Abbatt²⁵ is clear that where CHWs have limited education they should only be expected to perform limited tasks and supported by health professionals. However, Abbatt is also clear that CHWs with a lower education level can carry out curative care, the critical factor is the training methodology.

UNICEF is also developing curricula for another type of community based health worker to provide integrated health, nutrition and WASH preventive and curative services based on the 1,000 critical days²⁶. The selection criteria is appropriate for Somali basic literacy and life experience and could result in higher coverage. Three weeks training is planned. A supportive supervision system has not yet been developed, which will be critical. Whilst much can be learnt from the existing FHW programme, any supportive system should eventually be part of the existing health system.

TBAs are part of the current community health system whether formally or informally. The international evidence has for many years questioned the effectiveness of TBAs to carry out safe deliveries²⁷ in the home. Therefore, in most countries their roles are changing and they are being used to identify pregnant women, encourage pregnant women to go to ante natal care and use a skilled birth attendant for her delivery.

However, the large burden of maternal and neonatal morbidity and mortality is of great concern. Women continue to prefer to use TBAs to assist their deliveries rather than use a skilled birth attendant. Midwives could do much more to reduce the fear and strangeness if they were to carry out community visits to provide basic ANC and PNC services and discuss with community the importance of ANC and skilled assistance for delivery. Midwives could use these community visits to also discuss with the FHWs and CHWs, their concerns, provide support and encouragement to them to strengthen their role in supporting the community towards ANC and safe delivery. The priority of the community health strategy should be to rationalise the current situation as it relates to the community health cadres but serious consideration should be given to expanding the roles of midwives to support to the FHW and provide safe deliveries in the community but the feasibility of this depends on the overall the human resource situation.

²⁵ Abbatt F (2005).Scaling up Health and Education Workers: Community Health Workers Literature Review". Health System Resource Centre, DFID.
http://collections.europarchive.org/tna/20100918075642/http://www.dfidhealthrc.org/publications/health_service_delivery/05HRSalingUp03.pdf

²⁶
²⁷ Sibley L M, Sipe TA, Barry D (2012).Traditional birth attendant training for improving health behaviours and pregnancy outcomes. The Cochrane Database of Systematic Reviews. <http://www.ncbi.nlm.nih.gov/pubmed/22895949>

8. CONCLUSION

In conclusion there is a high burden of morbidity in Somalia that could be prevented and treated at community level through community health workers providing integrated services supported through the health and local governance structures. Major stakeholders support the development of a community health strategy.

It is recommended that rolling out the EPHS continues particularly strengthening the MCH/HCs and PHUs whilst adding a new level to the health system called the “Household Level” recognising that the FHW must be an integral part of the health system.

The mapping of community health cadres shows that there are over 17 different community health workers which represents a fragmented and inefficient system that should be rationalised and standardised as soon as possible into 2 community health cadres;

- a slightly revised role for the CHW at the PHU; and
- A community based FHW at household level.

The main active CHW schemes were reviewed against the international evidence on good practice and the Somali situation. The CHW programme implemented by THET provides a foundation to build on and would be relatively easy to modify, therefore the most appropriate model to review and then use as the standard for the CHW based in the PHU.

The FHW programme conforms to good international practice but the entry criteria are ambitious for the current situation and the training is extensive. It is important that the education criteria for selecting CHWs and FHWs is appropriate to the Somali situation and the literature supports the fact that high education levels are not required for a good village health worker.²⁸ Therefore it is suggested that the selection criteria for FHWs should be flexible ideally up to grade 6 but where women with this education level are not available assessment of basic literacy and life experience could be considered. However this means the curricula will need to be revised and focused on the main causes of ill health and the teaching methodology will be critical to the successful training of FHWs. UNICEF is developing curricula for a community based health worker to provide integrated health, nutrition and WASH services with entry criteria of basic education and life experience. These curricula along with the existing FHW curriculum developed with support from GAVI could provide the basis for the community based FHW whilst reviewing all similar curricula.

Finally the community health strategy should build on what has been done by all the partners reviewing all the existing curricula and training systems to develop the most cost effective and appropriate community health strategy for the current Somali situation.

²⁸ Abbatt F (2005). Scaling up Health and Education Workers: Community Health Workers Literature Review”. Health System Resource Centre, DFID.
http://collections.europarchive.org/tna/20100918075642/http://www.dfidhealthrc.org/publications/health_service_delivery/05HRSali ngUp03.pdf

SOMALI COMMUNITY HEALTH STRATEGY

1. PRINCIPLES OF A COMMUNITY HEALTH STRATEGY

- Use a multi-sectoral and integrated approach ensuring all relevant players and partners are fully involved in improving health status.
- It should build and strengthening the existing health system and avoid the development of parallel systems.
- Review and build on what exists rather than designing new systems.
- Ensure communities are involved in all stages of design, selection and implementation of the community health strategy.
- Provide community health that is appropriate and culturally sensitive to all the citizens of Somalia.
- Emphasize a rights-based approach to improve reproductive health and maternal health.²⁹
- Focus on the underserved areas and marginalized communities particularly nomadic & IDP populations.

Definition of community health service

A Community Health Service provides effective health promotion, illness prevention and curative service delivery to their local communities, through a combination of service delivery, educational and social efforts designed to help people take greater control of, and improve their health.

2. STRATEGIC FRAMEWORK

The strategic framework for the community health strategy uses the same as the HSSPs, thereby broadening the HSSPs to include community aspects. The community health strategy and strategic objectives provide a framework which should then be adapted by Health Authorities to develop work plans for zones or district based on the prevailing situation, budgets and local priorities.

Vision

Ensure all Somali citizens attain their full health potential and play an active role in their own health and health care.

Strategic Objectives

Health services: To provide an integrated community-based package of health³⁰, nutrition and hygiene/sanitation services, with a focus on poor women and children.

²⁹ Through a rights-based approach, government as well as health authorities are challenged to reduce maternal mortality and overall address social, cultural, economic, legal and policy factors that affect both women's & men's reproductive health in Somalia.

³⁰ Definition of this package will need to be agreed by the Health Authorities.

Human Resources for Health: To standardize the current human resource situation to build a skilled, equitably distributed and motivated workforce to provide integrated community health services.

Leadership and governance: To strengthen the leadership and governance of the health sector to manage community health services responsive to the needs of the community.

Health Financing: To develop a health financing strategy that includes costing for community health care with incremental increases in financial allocation to the community health strategy.

Medicines and consumables: To ensure the availability, safety and rational use of essential health products particularly at the PHU and household level.

Health information: To plan and manage the community health system based on quality up-to-date information, analysis, reporting and use of the data to inform future policy and practice.

Human Resources

A key element of this strategy includes building a standardised human resource system to implement the CHS. The aim will be to rationalise the HR system to only two community health cadres:

- Community Health Workers at the PHU, with education level 6; and
- A Community – based Female Health Worker at the household level ideally up to grade 6 but where women with this education level are not available, assessment of basic literacy and life experience could be considered.

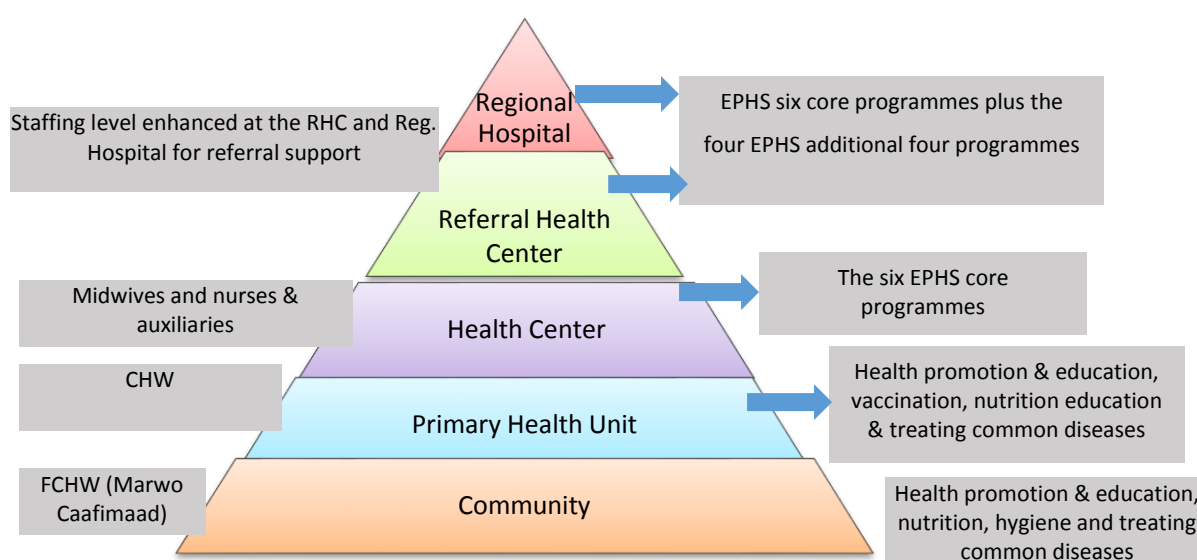
3. THE COMMUNITY HEALTH SYSTEM

The functioning of the overall health system is critical for the effectiveness of a community health system and the implementation of a community health strategy. Therefore the approach to the community health strategy will be to:

- Build on and strengthen the existing health system particularly MCH/HCs and PHUs implementing the EPHS; and
- Add an additional level to the health system at the household level.

There will now be a 5 tier health system which includes a new level at the household (see Diagram 2).

Diagram 2: The Regional Health System Organization, Staffing and Performance functions



The MCH/ Health Centres (HCs) will need to be strengthened to form an effective referral system that can provide a Continuum of Care to the Somali people from Household to Hospital and a life cycle approach. The MCH/ HCs are responsible for organising the coverage of essential services not currently provided by the PHU, this would include immunization. Feedback from the community has highlighted how they see the National Immunization Days (polio) as a wasted opportunity to deliver other services. Child Health Weeks (CHWs) have been found to be effective at providing a small selection of services³¹ such as EPI, Vitamin A and deworming particularly where there are weak delivery systems as in Somalia. If CHWs are implemented to increase coverage of key services they should be seen as an interim strategy until routine essential services can be delivered by the appropriate level of the health system otherwise they can undermine routine services.³²

In addition to increasing the clinical skills of staff at PHUs it will be important to increase the MCH/ HC staff skills to provide support and supervision. Once community midwives are included in the system they should undertake field visits to their catchment locations to visit pregnant women in their homes and to work with the FHWs in undertaking promotion of skilled birthing in reliable facilities. Developing this linkage at village level should increase women's interest in health facility delivery.

The Primary Health Unit (PHU)

The role of the CHWs in the PHUs will be revised and expanded so they are able to provide an increased range of basic services (part of EPHS) and provide support to the FHW. It is acknowledged however that expanding the role of the CHW will take time whilst rationalisation of the existing pool of CHWs takes place and so the current system of training FHW will need to

³¹ Doherty, T. et al. Moving Forward from Vertical to Integrated Child Health Programmes: Experience from a Multi-Country Assessment of the Child Health Days Approach in Africa. Tropical Medicine and International Health, Volume 13, April 2010, http://www.hki.org/research/nna_en_april10.pdf.

³² Bryce, J. et al. (2008). Maternal and Child Under nutrition: Effective Action at National Level, The Lancet, 371:9611. [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61694-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61694-8/fulltext)

continue until CHWs have the necessary skills (see Annex 5). Clearly this will happen at a different pace depending on the capacity of the CHWs.

Household Level

A Marwo Caafimad (FHW) will be selected and paid a stipend to work in her defined catchment area with a focus on prevention and care of basic illnesses. Her job description has been deliberately kept simple and focused. Due to the difference in population density it is recommended that one FHW look after no more than 150 households. She will be supported by a local health committee to help her particularly with the wider health promotion and sanitation work.

There is no prescription on how this committee should operate but each village should decide on the arrangements that best suit their circumstances.

4. APPROACH

The essential components of the Community Health Strategy will be:

- Promoting good health in the community working through families, schools, community leaders, community health committees and women's groups;
- Organising and strengthening communities to be able to take control of their own health;
- Providing essential information and prevent and promotive services to prevent ill health;
- Providing basic care for some common illnesses; and
- A referral system providing a continuum of care for the Somali people.

The overall focus of the community health strategy will provide integrated services promoting good health with an emphasis on addressing the key underlying causes of morbidity and mortality, improving the reproductive health status of adolescents, women and addressing the most common causes of mortality in the under-five years children (ARI, diarrhoea, malnutrition, and vaccine preventable disease).

Promoting good health and strengthening control of their own health

It is expected that volunteer members of the community will support the CHWs and FHWs in the broader prevention and promotion work such as: women groups (on breast feeding promotion; pregnant mothers group promoting antenatal care and skilled deliveries; and mothers' group with children under 5 years for their health promotion and preventive activities); and teachers with community worker providing health education in schools; Imams in the Mosques; and other community members helping to improve the sanitation situation.

It is also important to raise community's awareness of the negative effects of FGM, early marriages, the dangers of open defecation and such awareness can be done through house-to-house, school, market and mosque visits. Men have significant roles to play in reproductive health and reducing preventable mortality and morbidity. Thus, it is critical that they are mobilized at the household level, community level and national level to champion for safe maternal health, reproductive health and other important prevention services. Advocacy and child spacing initiatives must involve men to receive the required education and information to make informed choices.

Essential information to prevent ill health

Expanding and building on the work of the CHWs and FHWs particularly through the use of radio is an important feature of the CHS. There are huge opportunities to transmit health messages through radio, E-Health, and the various emerging social platforms thereby reaching a high coverage of important health messages. The Health Authorities with support from partners should take the lead in the broader communication aspects of the CHS by agreeing on what messages should be aired, how they should be presented and frequency. E-Health can also play an important role in both supporting and updating the CHWs/ FHWs and transmitting messages to individuals. In addition, interpersonal communications skills will be enhanced for both CHWs and FHWs to use IEC materials for health education and raising awareness about key health issues.

Providing care for some common illnesses

The focus of all training should be on the main causes of ill health in the country: diarrhoea, pneumonia and under-nutrition. The Lancet highlights two effective interventions³³ that are relevant for the situation and we noted were not being currently delivered: ferrous for children (no, or very little, malaria transmission); and the routine delivery of zinc to children. Promoting birth spacing services, and utilisation of evidence based antenatal care, skilled deliveries and neonatal care will contribute to reducing maternal and neonatal mortality.

A referral system providing a CoC for the Somali people

The health system particularly the MCH/HCs and PHUs will need to be strengthened to form an effective referral system that can provide a CoC from household to hospital for the Somali people. Part of this will be rolling out the EPHS.

5. INSTITUTIONAL FRAMEWORK

The Ministry of Health (MOH)

In relation to the governance and leadership of the community health strategy, the MOH cannot function in isolation and requires sound multi-sectoral and community collaboration at all levels for effective community services. Both the MoH and the community have leadership and governance responsibilities. See Annex 3 for more detail on MoH and community responsibilities.

The health structure works from MoH to Regional Health Offices, to District where the District Health Office has responsibility for implementing and management of local health services. Each level of the institutional structure (regional, district, health facility and communities) have level-specific assigned roles and responsibilities to uphold the access of citizens to quality health services (as seen in Annexe 3). Ideally, the Regional Health Office should have one representative from each district so that the senior MOH regional management team (the regional health office - RHO) ensures fair management and service distribution across the region.

The MOH is responsible for developing a conducive policy and regulatory framework to guide the

³³ Bhutta Z et al (2013) Evidence – based interventions for improvement of maternal and child nutrition: what can be done at what cost. The Lancet Special addition

work of the regions and districts. This should cover policy, strategy, regulation, standardization and accreditation. Specifically for the community health strategy it will be important that Central MOH ensures agreement on revised JDs and curricula and lays out an agreed legal framework for the CHWs and FHWs. CHWs and FHWs will be paid health workers and therefore ultimately are accountable to the MOH for performance and behaviour but the community has a very important role to play in accountability and local management.

The MoH works at each level with community representation:

MoH ➔ Regional HO ➔ District HO ➔ PHU ➔ Village

- MoH and the parliamentary committee on health (policy, regulatory, standards setting, national oversight)
- Regional Health Office with the regional health board (planning, local strategy, management, regional oversight)
- District Health Office with the district health board (district planning, implementation, service delivery, district oversight)
- Hospital Management Committee with the Hospital Board (hospital management, hospital oversight)

Community Involvement through Community Development Committees (CDC)³⁴

The evidence on good practice shows that the involvement of the community in the selection and management of community health workers is critical to the success and sustainability. It is important to build on what exists and to avoid developing additional overlapping committees.

Community involvement at each level is required to ensure the concerns of the people reflected in service delivery: the parliamentary committee on health at national level holds the Ministry to account, and likewise regional health boards, district health boards and community committees hold the MoH at these levels to account.

It is therefore proposed that the community development committee (CDC), as developed through the Joint Programme for Local Governance, takes on the responsibility for management and governance of the CHWs and FHWs. The CDC may designate smaller community health committees (CHCs) to take on specific activities such as selection of CHWs and FHWs jointly with the MOH and as support to the CHW and FHW in their work.

The communities' governance and leadership roles include:

- Responsibility for expressing their local health priorities to the MOH;
- Responsibility for selecting CHWs and FHWs³⁵, jointly with the health authorities, as well as electing members of CDC / CHC with mandates to represent, exercise oversight to promote community ownership and support CHWs and FHWs;

³⁴ Community Development Committees (CDCs) have been developed in many villages under a UN governance programme partly to help minimise the number of committees. However CDCs will not be established in all villages in those case the most appropriate community committee should be used as long as it follows similar criteria of governance and accountability.

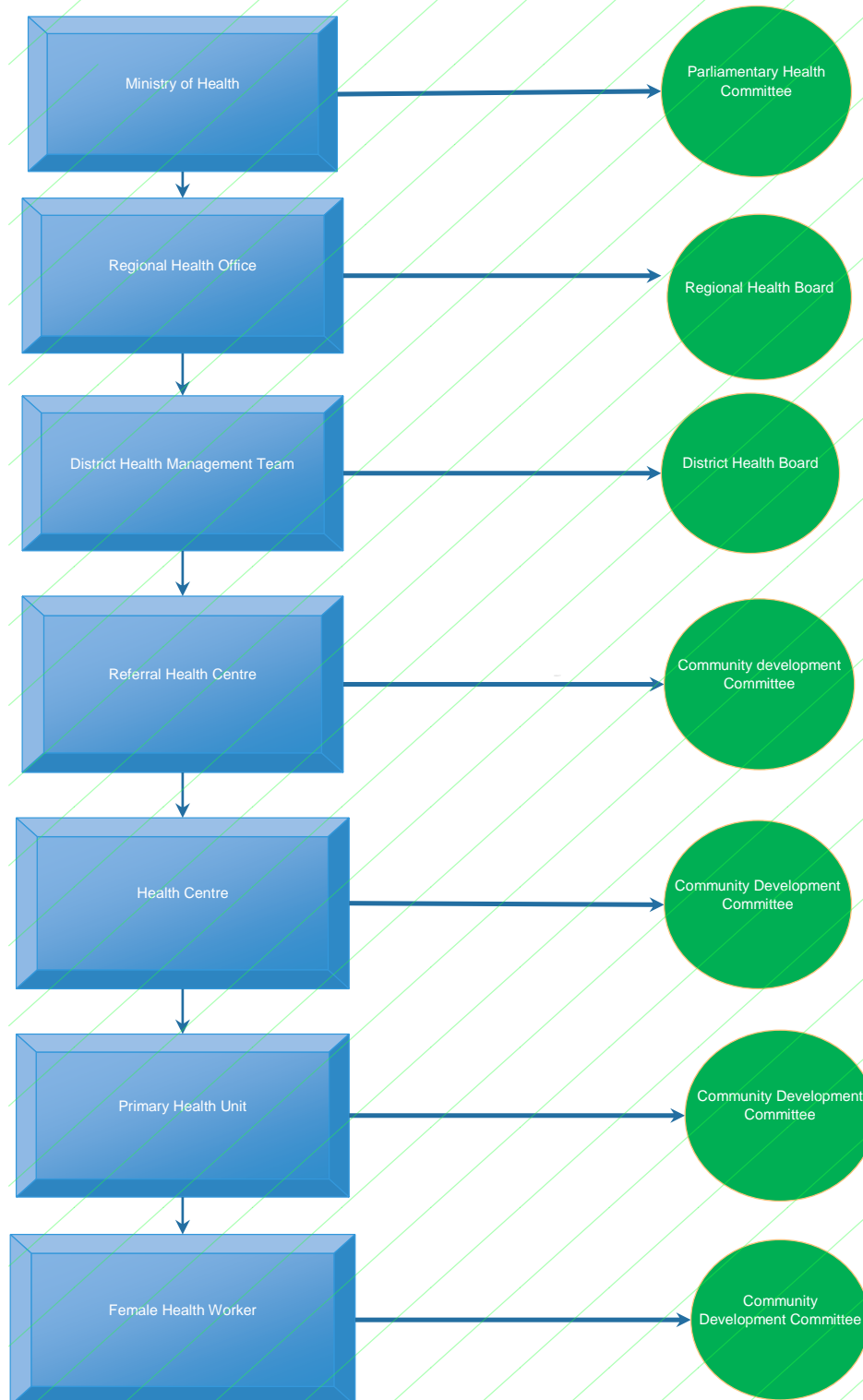
³⁵ Community health workers and village health workers – national minimal selection criteria is provided by MoH, which may be add to by joint agreement by the MoH and community

- Sending representation to DHB and RHB, with responsibility for ensuring the health needs, resource management and service delivery issues of their communities are transmitted to, and addressed by, DHMTs and RHBs;
- Holding CHWs and FHWs accountable for delivering quality services; and
- Supporting and supervising the work of CHWs and FHWs, and the health facilities in their communities.

The structure and arrangements of CDCs must be inclusive and participatory. The composition of the CDC / CHC must be gender and clan/sub-clan balanced to be reflective of the community. A 50/50 representation of women and men is recommended. Marginalized communities may need additional support to enable them to have access to decision-making processes relating to community health.

The criteria for selection of CHWs and FHWs will be provided by MoH after discussions with communities as this will help to ensure a standardised, open and transparent system that cannot be manipulated by local politics. The CDC will be requested to identify suitable candidates respected by members of their community, outgoing and warm, patient, non-judgemental, possessing some leadership and communication skills. Members of the CDC will form part of the interview panel with MOH.

Diagram 3: Diagrammatic Representation of institutional framework



Development Partners

Development partners such as UN agencies, Donors, international NGOs, CSOs have been filling the funding gaps and have been working closely with MoH and communities in all areas. Through their activities including WASH, health, nutrition, livelihoods in various Somali communities, they have provided much needed services to vulnerable populations. These development partners possess both the resources and the technical skills thus forming partnership with them is vital to the implementation of community health strategy.

However it is important that these contributions are better coordinated to make more effective use of the limited resources. The main coordinating body that brings the health authorities and major partners together is called “The Health Sector Coordination” group. There are “Zonal Health & Nutrition Coordination Forum” supported by thematic technical working groups. It is recommended that a CHS thematic technical working group be nominated to prepare a work plan to guide harmonization and the implementation.

Private Sector

Due to the public health sector disintegration in 1990s and the absence of fully functioning public health services, the private sector has been a dominant provider of health services to the Somali population. Through this sector, private hospitals, health clinics, pharmacies are run and supported by those with purchasing power to seek basic healthcare services. The private sector will continue to exist in parallel with the public health sector. Thus, it is critical to explore opportunities where they can contribute to the implementation of community health in Somalia as they can play crucial roles in supporting community strategy initiatives including solid waste management, water and environmental sanitation.

6. IMPLEMENTATION

The community health strategy will use a systematic twin track approach which will simultaneously strengthens the health system rolling out the EPHS to deliver community health services whilst rationalising the fragmented community health situation. However it is expected that there will be different rates in implementing the strategy due to the weakness and differences in the existing health systems particularly at the health centres and PHUs. Some critical activities that will be required are discussed below but again the pace of implementation is expected to be different per region and district (See Annex 4, a work plan highlighting the important activities needed to implement the strategy).

Harmonization

The first step in implementing the strategy should be to rationalise and harmonize the current fragmented situation as it relates to the community health cadres. A Memorandum of Understanding should be signed at minimum laying out clearly that:

- Any new training of community health workers will comply with the strategy and the 2 cadres; and

- Partners will agree to the retraining and certification of all existing community health cadres.

Job Descriptions and revision of curricula

In the Job Description (JD) of the CHWs (Annex 5), the role has been expanded to provide an increased range of basic health services envisioned in the EPHS and to ultimately train and provide supervision and support to the FHWs. As previously mentioned it is acknowledged that expanding the role of the CHW will take time whilst rationalisation of the existing pool of CHWs takes place and so the current system of training FHW will need to continue until CHWs have the necessary skills. It is recommended that the existing CHW curricula, training and supervision system should be the basis for the future training of CHWs with some modifications and revisions to cover the expanded JDs and other issues that might arise.

The JD for the FHW (Annex 5) is focused on prevention, health, nutrition, water and sanitation.³⁶ In many countries the effectiveness of FHWs has been undermined by the continual adding of additional tasks. Therefore it is recommended that the responsibilities of the FHWs should be strictly enforced and no additional tasks be added until a review has taken place.

Once the JD of the FHW is agreed the curriculum can be finalized that has reviewed and builds upon existing curricula including the current FHW curriculum and the new curriculum being developed by UNICEF for a community based worker. The focus will be on promoting good health and preventing ill health with an emphasis on improving the reproductive health status of adolescents, women and addressing the most common causes of mortality in the under 5s (ARI, diarrhoea, malnutrition). Using the 1,000 critical days approach to address nutrition issues will contribute to reducing both infant mortality and malnutrition including evidence based interventions such as ferrous for children and zinc supplementation. In addition, the curriculum should include interpersonal communication skills, health education, community organization and a chapter on record keeping and reporting.

Accreditation and Legal Framework

The MoH should approve the finally agreed new training for CHWs and FHWs, and accredit training institutes which will undertake these trainings, and then formally recognise these cadres of health workers on successful completion of their training. Sufficient supervised practice (amount, quality and frequency) should play a very significant role in assessing these cadres for graduation. Current health professional bodies should review how they can incorporate these cadres into their ranks, perhaps as associate members.

Assessment and Mapping of existing community health cadres

There is a large pool of trained health cadres (CHWS, FHWs, ICCM) but at the moment no one knows exactly how many, the exact skill base, and where they are operating. This is an inefficient use of limited human and financial resources. It will be important to capitalise on this pool and use it to develop the future community health system. Therefore, the first step should be to map the

³⁶ Bhutta Z et al (2008). What works? Interventions for maternal and child under-nutrition and survival. Lancet, 371. [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61693-6/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61693-6/fulltext)

current situation by district based on agreed JDs looking at: selection criteria; skills, knowledge, and location. The mapping will help to identify where all the health cadres are working now, and then, after retraining to identify the gaps and possible overlaps. It will then be possible to identify priority areas where new CHWs and FHWs are needed to cover underserved areas.

The majority of the CHWs working at the moment have not been trained to provide support to FHWs and some have not been officially trained and therefore the current CHWs would also need to be assessed and mapped against the new criteria. By comparison other cadres such as GAVI supported FHWs have had a good training and might be eligible to be CHWs. Accurate mapping is needed to guide retraining and the rational allocation of CHWs and FHWs.

Traditional Birth Attendants (TBAs)

TBAs play an important role in providing care to women in pregnancy and are respected within their communities. Work by Pivone et al ³⁷ shows that TBAs can be successfully assimilated into the health system and should be considered for the position of CHWs/ FHWs if they wish, and meet the selection criteria. Otherwise they are a useful resource that could possibly be members of health committees and support the work of the CHWs and FHWs.

Retraining

The mapping should be analysed against the agreed selection criteria to then identify capacity gaps and which cadres can continue working and where others would like to be retrained as either CHWs or FHWs. A rational plan of retraining will help to ensure that the existing human resource is used effectively with a more equitable distribution of health workers.

Training of Trainers

In most cases the CHWs will not initially be in a position to train FHWs, in the interim it is recommended that the Regional/Zonal Human Resource Training Centres established to train the FHWs and funded under JHNP continue the training using the agreed revised curricula until a new system has been established. These centres will identify CHWs who can be trained as Trainer of Trainers (ToT) and provide support to FHWs but this will take time and will not be uniform but based on the capacity of individual CHWs.

Training

Any new training should conform to the new standards of either a CHW or FHW. The mapping of existing community health cadres should inform where new CHWs and FHWs are required to increase the coverage in underserved areas and avoid duplication.

Communication Strategy

Each Health Authority should develop a broad communication strategy for the CHS based on the local priorities and using the broad range of communication opportunities available such as: radio, play and drama, E-health (mobile phone, texting), and public places. It is essential this strategy uses proven communications techniques to ensure messages are clear and unambiguous. This would be

³⁷ Thidar P. et al (2013) .Changing the role of traditional birth attendants in Somaliland. International Journal of Gynaecology and Obstetrics. [http://www.ijgo.org/article/S0020-7292\(14\)00292-6/pdf](http://www.ijgo.org/article/S0020-7292(14)00292-6/pdf)

a cost effective way to get high coverage of the important messages and complement the work by the health professionals, CHWs, and FHWs.

7. MONITORING, SUPERVISION AND EVALUATION

The international evidence shows that fundamental to the success of a community health strategy is sound supportive supervision, mentoring and on- going training to the CHWs and FHWs.³⁸ To do this it is essential that a strong monitoring, supervision and support system is implemented between the different levels of the health system.

Monitoring

The first step in operationalising this CHS will be to develop a Monitoring and Evaluation (M&E) Framework with measurable indicators linked to the agreed milestones/targets. It will be the responsibility of the MoH to maintain this M&E Framework to ensure progress is effectively charted. South Central Somalia, Puntland and Somaliland have a common Health Information Management System (HMIS) which is under revision. A new level is being added to the health system and therefore based on the roles and responsibilities of the FHW a two way reporting system will need to be established that provides data on mortality, morbidity, prevention and promotive activities to the PHU which will then feed into the existing HMIS data flow up to the district MoH. To encourage evidence-based decision making and a strong data use culture, there should be an effective mechanism to ensure data is fed back to the FHW. The current FHW programme has systems in place which provide a good foundation for any revised monitoring system. These should be reviewed and revised based on the finally agreed JD, roles and responsibilities of the FHW.

Supportive Supervision

Distance, bad roads, insufficient funding and insecurity in many areas are major constraints to a good quality supportive supervision system which is vital for an effective community health system.

The larger CHW programmes (CHW, FHW, iCCM) already have established systems of supervision and support but they are small in scale. A review of each of the main systems should be carried out to help develop an appropriate and realistic system that strengthens the existing health system.

A new system of supervision and support will need to be developed between the PHU and the new household level. The new curriculum UNICEF is developing for the community based worker does not include a supervision system and so lessons from other programmes such as the FHW programmes should be drawn on to develop the new system. Any new systems of supervision and support must be standardised between partners, and aligned with and strengthening the existing health system to avoid developing parallel systems and further fragmentation or overlap.

³⁸ Abbatt F (2005). Scaling up Health and Education Workers: Community Health Workers Literature Review. Health System Resource Centre, DFID.
http://collections.europarchive.org/tna/20100918075642/http://www.dfidhealthrc.org/publications/health_service_delivery/05HRSalingUp03.pdf

The EPHS proposes that the MCH/HC staff should visit the PHU and provide support to the CHWs monthly, this should be possible if combined with the delivery of outreach services and would provide value for money. At a minimum quarterly visits should be made to FHWs, looking for opportunities for bringing FHWs together at the PHU as part of ongoing mentoring and training.

Evaluation

It is recommended that an evaluation of the implementation of the CHS should take place after 3 years to monitor progress in coverage, the work and impact of CHWs and FHWs and benefits to the communities. Lessons learned can then be used to review and revise the CHS.

8. RISKS

- Partners do not agree to rationalize their existing community health cadres in accordance with the CHS and may not have the capacity to implement the transition phase.
- Partners continue to fund different community health cadres.
- The health system is too weak to provide the support and supervision required for an effective community health system.
- The Health Authorities will need to take leadership and ownership of the CHS by developing CHS work-plans.
- Persistent and infrequent insecurity affects the implementation of the CHS.
- Inadequate financial resources are available to support the implementation.

9. COSTING

Introduction

The budget for the Somali Community Health Strategy has made reference to the implementation framework (Section 6 and Annex 4 of this document). It has addressed issues related to harmonization, job descriptions and revision of curricula, accreditation and the legal framework, assessment and mapping of existing community health cadres, retraining, training of trainers, new training, a communication strategy, monitoring, supervision and evaluation.

Methodology

The budget was developed in consultation with WHO. Partners were also consulted in order to gain sense of the extent of and costs associated with their community based work. These provided estimates for base unit costs per year.

Assumptions

The budget uses the same base assumptions as:

- The THET training budget for WHO for 20 CHW in Somaliland, Puntland and South Central Somalia

- The third of three deliverables defined under the consultancy commissioned by the Accelerated Child Survival Development (ACSD) section of UNICEF Somalia - **“Harmonization of a Public Health Community Strategy for UNICEF Somalia”**
- Identified by the stakeholders meeting (Annex 1) that FHWs will receive stipend and not incentives. This will give them a stake in the system and also enable the government to set up control mechanisms.

Limitations

These are

- Limited bottom up budgeting of community-based work. Some partners acknowledged that they have approached this inconsistently, both over time and across locations

Table 4: Budget

BUDGET FOR SOMALI COMMUNITY HEALTH STRATEGY				
ACTIVITY AND TASK	NOTES	DESCRIPTION	UNIT COSTS YEAR ONE (\$)	RECURRENT UNIT COSTS IN SUBSEQUENT YEARS (\$)
SALARIES (CHW, FHW and TBA)				
CHW (Part of Existing structure, Paid by MOH)		Unit cost/personnel/year	2400	2400
FHW (They will receive salaries from first day of training)		Unit cost/personnel/year	1200	1584
TBA	1	Unit cost/personnel/year	-	-
ESTABLISHMENT COSTS				
Community Health Worker (CHW)		Unit cost/CHW/year	16897	6825
Female Health Worker (FHW)		Unit cost/FHW/year	7998	3601
MAPPING		Unit cost/zone/year	65000	-
PLANING		Unit cost/zone/year	7500	8250
BCC ACTIVITIES AND MATERIALS		Unit cost/zone/year	315000	346500
SUPPLIES (together with freight and logistics costs)-UNICEF Kits	2	Unit cost/HC kit /year	5728	6301
HMIS		Unit cost/zone/year	29000	31900
REVIEW AND EVALUATION (after 2 years)				
Conduct final evaluation		Unit cost/year	-	60000
Complete, analyse and disseminate reports on CHS activities		Unit cost/year	-	14000
Document and disseminate case studies of good practice		Unit cost/year	-	21000
NOTES				
1. No salaries are required for TBAs as there are links with CHWs and FHWs				
2.This does not include one-time supplies for health facilities like hospital beds, delivery beds etc.				

ANNEXES: SOMALI COMMUNITY HEALTH STRATEGY

ANNEX 1: STAKEHOLDER CONSULTED

Date	Agency	Name	Title
July 1, 2014	WHO and JHNP	Dr. Rizwan Humayun Dr. Raza Zaidi Dr. Samar Elfeky	Technical Officer (WHO) Senior Program Manager (JHNP) Technical Officer Health System Programme Monitoring and RMNH (WHO)
July 3, 2014	Somaliland Ministry of Health	Osman Hussein Warsame Ahmed Omar Askar	Director General Health, Somaliland Head of Health Policy & Reform – Directorate of Planning, Policy and Strategic Information
July 3, 2014	Somali Red Crescent Somaliland (SRCS)	Kaltun Hussein Dahir	SL SRCS National Health Officer
July 3, 2014	NAGAAD (SL)	Nafisa Yusuf Mohamed	Executive Director
July 3, 2014	Somaliland Family Health Association	Amal Ahmed Mohamed Abdifatah Mahad Kasim	Executive Director Program Officer
July 4, 2014	Somaliland Medical Association	Dr. Abdirashid Hashi Abdi	Chair
July 4, 2014	Regional Medical Officer-Sanaag Region	Dr. Ahmed Mohamed Jama	RMO, Sanaag Region, SL
July 4, 2014	Hargeisa Group Hospital (SL)	Dr. Ahmed Askar	Hospital Director, Medical doctor
July 5, 2014	Ministry of Labour and Social Affairs (SL)	Shukri Harir Ismail Lul Adan Gedi	Vice Minister Head of Gender Office, Ministry of Labour & Social Affairs
July 5, 2014	Somaliland National HIV/AIDS Commission	Prof. Abdi Ali Jama	Executive Director
July 5, 2014	Horn of Africa Voluntary Youth Committee (HAYOYOCO) (SL)	Omer Abdullahi Isse	Executive Director
July 5, 2014	Somaliland Nursing and Midwifery Association	Fouzia Mohamed Ismail Filsan Hamda Khadra Ali Egal	Executive Director Professional Development (CPD) Officer CPD Coordinator Associate Dean Nursing & Coordinator MSc nursing programme
July 5, 2014	Taakulo Somaliland Community (SL)	Omer Jama Farah	Chair person
July 5, 2014	Women's organizations: Waapo Somaliland Women's Research and Action Group (SOWRAG) NAFIS WAAPO Barwaaqo Voluntary Organization	Amina Hamud Asmahan Abdulsalaam Amira M. Rodel Khaltuun Sh. Hassan Khadra Omer Hassan	Executive directors of their respective groups
July 7, 2014	Sahil region team (Berbera)	Dr. Abdirahim Abdullahi Dualeh Abdirizak Mohamed Abdi Abdikhadir Mohamed Barre	Regional Medical Officer Nurse / Primary Healthcare worker Public Health Management Information (PHMI)
July 7, 2014	Community Health & Nutrition Committee in	Hinda Ibrahim Mohamed Faduma Farah Hashi	TBA & member

	Jambalaaye - Berbera	Bashir Diriye Abdi Muse Ismail Ebyan	Member of Community Nutrition Committee Member of Community Health Committee
July 7, 2014	IDPs / pastoralists in Waraabe-u-taag, Sahil region	Nasra Diriye Dahir Kinsi (Filfilo) Hirsi Mohamud	IDP / pastoralist woman IDP / Pastoralist woman
July 7, 2014	Jambalaaye Health Centre Staff –Berbera	Saado Jama Adan Abdikadir Mohamed Shire Weris Ahmed Jama Naqiiba Ege Abdi Faduma Yusuf Awad	Nurse in Charge/ Team leader Qualified Nurse Qualified Midwife Qualified Midwife TBA
July 7, 2014	Lafo-Rug village, Sahil Region	Aidid Ali Adan Abdirahman Hawadle Jama Abdi Gofle	Health Post Manager/Supervisor in Lafarug village Agro-pastoralist in Lafarug village Agro-pastoralist in Lafarug village
July 7, 2014	WHO (SL)	Abdi Hassan (Gure)	Liaison Officer, CHS, WHO SL (also facilitator LHW training)
July 8, 2014	Puntland Medical Association (PMA)	Dr. Idil Mohamud	Member of PMA
July 9, 2014	Ministry of Health in Garowe, Puntland	Abdirizak Hassan Isse Hodan Mire Idiris Hassan Shukri Ahmed Samad Mohamed Jihan Mohamed Salad Salma Osman Mohamed Jama Said Abdi	Director of Planning UNICEF Save the Children UNFPA Health Promotion, MoH, PL WHO office in Garowe, PL Child health Unit, MoH, PL
July 9, 2014	Ministry of Women Development and Family Affairs (MOWFSA) (PL)	Abdirahman Mohamoud Hassan	Director General
July 9, 2014	The Red Crescent Puntland Office	Sirad Adan	National Health Officer
July 9, 2014	Puntland Medical Association (PL)	Dr. Abdi Artan Dr. Farah Abdulahi Dr. Ibrahim Obsiye Dr. Idil Mohamud Dr. Habiba Nuh Ismail	Chair, Puntland Medical Association (PMA) Member of PMA Member of PMA Member of PMA Member of PMA
July 10, 2014	RMO Nugaal region, Puntland	Mohamed Jama Hirsi Ubah Yusuf Ali	RMO – Nugaal Region, PL PHC Coordinator Nugaal (qualified nurse), PL
July 10, 2014	IDP men in Jilab village, Garowe, Puntland	Mohamed Sheikh Abdi Mohamed Mohamed Mohamud Hirse Ugas Mohamed Isse Salat Omar Weli Garad Hassan Jelle Mohamed Must Abdi Abdifatah Ali Farhia Jama	IDP man IDP man IDP man IDP man IDP man IDP man Camp leader Camp leader Camp leader
July 10, 2014	IDP women in Jilab Village, Garowe, Puntland	Halima Kheyre Gambol Lin Adan Abdi Ayan Abdulahi Ahmed Halima Hassan Ali Mako Suge Sahra Abdisalan Sharifa Farah	IDP women

		Barni Hirsi Nimo Ali Isse Anab Gurhan	
July 10 2014	Non-State Actors / Local NGOs, PL	Abshir Mohamed Hirsi Fadumo Diriye Noor Abdulahi Askar, Maymun Salad Zeinab Ismail Mohamed	Puntland Non-State Actors (PUNSA) Executive Director of Samofal Development Organization Kaalo Aid & Development – program officer Kaalo Aid & Development – HIV/AIDs Focal Person Executive Director of DAWO organization
July 10 2014	Puntland Midwives Association	Shukri Ahmed Mohamud	President of Puntland Midwives Association
July 12, 2014	MoH in Puntland	Abdirizak Hassan Isse Idris Abdullahi Mohamed Sharmarke	Director of Planning, MoH RH Unit manager, MoH, PL HMIS Officer, MoH PL
July 12, 2014	Save the Children	Mohamed Takoy	
July 13, 2014	Community leaders	Said Khalif Adan Keyse Jama Omar Abdikadir Noor Adan	Religious & Traditional Leader, Eyn Youth leader in Eyn, Buhodle (Sool region) Local Councillor (Garowe)
July 17, 2014	HCS	Saba Khan	Coordinator for Health Consortium Somalia
July 22, 2014	SL MoH	Faisa Ibrahim (Ousman Warsame – for a short time)	Director of Planning, MoH, SL Director General, MoH, Somaliland
July 22, 2014	SL WHO	Abdi Dualeh (Gure)	Liaison Officer, CHS, WHO SL (also facilitator LHW training)
July 23, 2014	UNICEF SL	Awil Haji Ali Mahdi Dahir Bohdoon Mohamed Sheikh Abdillahi Dr Shahid Awan	Health Specialist & Acting Head of Office, Hargeisa C4D Officer Nutrition Officer Nutrition Specialist
July 24, 2014	UNFPA	Adam Farah	Reproductive & Maternal Health Specialist, SL
July 24, 2014	MoH SL	Faisa Ibrahim	Director of Planning
July 25, 2014	UNICEF Somalia (Nairobi)	Bonkoungu Boukare Dara Johnston Junianne Birungi Erin McCloskey Daisy Nyagah	Maternal & Child Health specialist WASH C4D Nutrition HIV/AIDS
July 30, 2014	UNICEF	Erin McCloskey Daisy Ruguru Nyagah	Nutrition section, UNICEF
July 30, 2014	WHO	Dr H Rizwan	
July 31, 2014	MoH Mogadishu	Dr Mohamed Farah	DG MoH, Somalia
August 1, 2014	Somali Health Sector Partners – Consultative meeting - Nairobi	Hussein Ahmed Jaime Carrillo Grace Muema Betty Oloo Christy Forster Wafula Ayub	CCS Medair SCC Health Information Liaison Office – WHO International Medical Corps Somali Rehabilitation Development Agency (SORDA) Galkacyo Medical Foundation - GMF

		Risto Harma Gwen Callaway Dr. Lula Sanscieno Abdi Moge Mohamed Zivai Murira Erin McCloskey-Rebelo Gabrielle Appleford Juliana Nzau Hassan A. Shariff Tadesse Kassaye Mohamed Ahmed Hussein Habiba Bishar Hannah Huser	Intersos Intersos ARDI UNICEF UNICEF UNICEF UNFPA Swisso-Kalmo Health Poverty Action International Medical Corps ACF IOM Somalia
Aug 16, 2014	MoH SCS	Abdihamid Ibrahim Ahmed	Director of Planning, MoH Mogadishu
August 23, 2014	Somali Midwifery Association	Halima Abdi Sheikh Hawa Abdullahi Ali	The Chairlady The Vice Chair lady
August 23, 2014	SAACID	Liban Abukar Osman Yahiya Hassan Osman	Health & Nutrition Manager Program Officer
August 23, 2014	Professional Nurse Association	Omar Mohamud Ibrahim	The Chairman
August 23, 2014	Community Leader	Mukhtar Isak Abdi	Leader
August 24, 2014	Ministry of Health - Somalia	Abdihamid Ibrahim Ibrahim Mohamed Nur	Director of Planning National Health Information Management System Coordinator
August 24, 2014	Somali Medical Association	Dr. Mohamed Hussein Mumin	Secretary General
August 24, 2014	Hamarweyne Health Centre / MCH health workers	Asha Abdi Dini Biyod Mire Ali Maandeeq Abukar Safia Ahmed Ugas Khadija Hassan Ali	Supervisor Head Nurse Midwife Nurse Nurse
August 24, 2014	Humanitarian Action for Relief and Development Organization (HARDO)	Abdulahi Mohamed Mustafa Farhiyo Diriye Osman	Senior Program Officer IYCF Coordinator
August 24, 2014	Sahil Internal Humanitarian Organization (SIHO)	Abdirahman Hussein Elmi	Internal Auditor
August 25, 2015	WARDI	Ahmed Ali Osman	Health Coordinator
August 25, 2014	ZAMZAM Foundation	Abdirahman Hussein Amir	Health Supervisor
August 25, 2014	HIJRA	Daud Ali Rahoy	Officer in Charge
August 25, 2014	South, Central Somali Aids Commission	Ahmed Mohamed Jimale	Executive Director
August 25, 2014	Somali Women Care and Development Organization (SOWCADO)	Muno Ahmed Abdule Ruun AbdiAziz Sidow	Executive Director M& E
August 25, 2014	Coalition for Grassroots for Women (COGWO)	Khadija Abdulahi	Chairlady
Aug 29, 2014	Reproductive Health Working Group	Karen Stephenson (chair) Ombretta Tattaroni	DfID Trocaire

		Grace Muena Fatuma Muhumed Agnes Ekano Ruth Mbugua Raza Zaidi Dr Naidu Achu Lordfred Risto Harma Engwarfa	SCC UNFPA UNFPA IOM UNICEF/JHNP SCI UNFPA Galkhayo Medical SWRDA
Sept 8, 2014	3 zonal MoH	Dr Abdirizaak Ousman Hussein Warsame Dr Abdi Wahad Abdirisak Hassan Isse Faiza Ibrahim Abdihamid Ibrahim Ahmed	DG MoH PL DG MoH SL Advisor to MoH, Somalia Dir Planning MoH, PL Dir Planning MoH, SL Dir Planning, Somalia

Observations on Female Health Workers

July 23, 2014	WHO-GAVI in Gabiley	Abdillahi Barre Amale Abdillahi Omar Faisal Ismail Abdi Zuhur Mohamed Abdi Khadan Yusuf Ahmed Khadra Jamac Farax	WHO-GAVI HSS Master trainer Master trainer FHW supervisor FHW supervisor FHW supervisor
July 23, 2014	Gabiley District	Saado Mohamed Jama	FHW, Aburiin location, Gabiley District
July 23, 2014	Gabiley District	Nimco Abdi Omar	FHW, Gadkha Yogul location, Gabiley District
August 24, 2014	Female health workers	Zeinab Yusuf Abdinoor Marian Ismail Abdi Khadijo Sharif Munye Nasra Mohamud Awale Fatuma Araye Mohamud Shukri Barre Mohamud	Supervisor for Hamarweyne, HamarJajab & Waaberi Supervisor for Hodan, Wadajir and Wart-Nabada districts

ANNEX 2: LITERATURE REVIEW OF COMMUNITY HEALTH PROGRAMMES

SECTION A: DESIGN FEATURES

Pakistan: Lady Health Worker Programme

Global Health Workforce Alliance World Health Organization (2008). "Country Case Study Pakistan's lady health worker programme." GHWA Task Force on Scaling Up Education and Training. Available online at http://www.who.int/workforcealliance/knowledge/case_studies/CS_Pakistan_web_en.pdf

Programme Features

- Each Lady Health Worker (LHW) is attached to a government health facility, from which they receive training, a small allowance and medical supplies.
- Candidates must be recommended by the community and meet a set of criteria, including a minimum of eight years of education.
- LHWs act as a liaison between the formal health system and the community and disseminate health education messages on hygiene and sanitation.
- Trained for 15 months in the prevention and treatment of common illnesses: three months in the classroom, followed by 12 months of practical on-the-job training.
- After training, provincial and district coordinators monitor and supervise this cadre.

Wazir, M. S. , Shaikh, B. T. and Ahmed, A. (2013). "National program for family planning and primary health care Pakistan: a SWOT analysis". *Reproductive Health* 10:60, BioMed Central. Available online at <http://www.reproductive-health-journal.com/content/10/1/60>

The SWOT analysis undertaken identified the following strengths; political commitment, recruitment and selection procedures, integrations with healthcare system at upper levels and defined management and supervisory structures. Weaknesses identified include; problems in salaries payment and job insecurity, weak supplies and equipment provision, weak referral system, poor integration of MIS with health system, poor supervision and linkages with peripheral health facilities and non- acceptance by medical profession. Opportunities that arose from the analysis of the program include the wide coverage and social acceptability of the program and training capacity that can be used by others.

Oxford Policy Management (2009). "External Evaluation of the National Programme for Family Planning and Primary Health Care: Lady Health Worker Programme." *Management Review*: Oxford Policy Management. Available online at http://www.opml.co.uk/sites/opml/files/LHW_%20Management%20Review_1.pdf

In an examination of the general evidence on motivations and incentives to work among community health workers, the paper finds that a large number of community health programmes rely on volunteers. In the cases where CHWs are paid, remuneration is often limited to a stipend owing to the fact that they will not have received continuous formal health training and quite often even fully qualified members of staff do not receive adequate payment. Despite this, **financial incentives are often the main motivating factor** for CHWs to take on the role and for preventing them from dropping out of the programme. However, the examination underlines the significance of **non-monetary incentives** such as the importance of the relationship between the CHWs and the community, community recognition and appreciation of their work. Various motivations include the ability to expand their own knowledge and inform their family and community on issues relating to health and hygiene, social prestige, the impact of performance management (supervision, training, performance appraisal, and career development), positive community feedback from the community and the value of their work. In the case of the Lady Health Worker Programme, conclusions on the relative empowerment of LHWs compared to other working women suggest that the programme is having a positive effect on the well-being and empowerment of women employed.

Douthwaite, M. and Ward, P. (2005). "Increasing contraceptive use in rural Pakistan: an evaluation of the Lady Health Worker Programme" *Health and Policy Planning*: 20 (2), pp. 117-123. Oxford Policy Management. Available online at <http://chwcentral.org/sites/default/files/Increasing%20contraceptive%20use%20in%20rural%20Pakistan-%20an%20evaluation%20of%20the%20Lady%20Health%20Worker%20Programme.pdf>

This paper highlights the impact of the programme in increasing access to contraceptive services in rural areas of Pakistan. The evaluation found women's mobility in Pakistan to be severely limited and female modesty highly valued, consequently the provision of doorstep services through community-based female workers appears appropriate as a model of service delivery. The evaluation also underscores the importance of understanding what social factors determine women's mobility so as to better know when using the LHW model as the most cost-effective method of providing services, and where fixed site services could be used. It is important for sustainability that the mix of service delivery mechanisms is reviewed and evolves.

Ethiopia: Health Extension Programme

Global Health Workforce Alliance World Health Organization (2008). "Country Case Study Ethiopia's human resources for health programme." GHWA Task Force on Scaling Up Education and Training. Available online at http://www.who.int/workforcealliance/knowledge/case_studies/Ethiopia.pdf

Programme Features

- Female high school graduates are recruited and trained for one year (candidates must have completed grade 10 in school, need to be from the local community, and speak the local language.
- Trained to deliver a package of 16 preventive and basic curative services that fall under four main components: hygiene and environmental sanitation; family health services; disease prevention and control; and health education and communication.
- Graduates of the programme are deployed to health posts, and employed at the government scale for HEWs. The HEWs are accountable to and supervised by environmental health professionals and public health nurses.

Hailay D Teklehaimanot, H. D. and Teklehaimanot, A. (2013). "Human resource development for a community-based health extension program: a case study from Ethiopia". *Human Resources for Health*, 11:39. Available online at <http://www.human-resources-health.com/content/11/1/39>

Additional Programme Features

- Initially, community participated in infrastructure development and recruitment of health workers.
- Two female Health Extension Workers (HEWSs) are stationed in each health post.
- The HEWs are formally employed and salaried by the respective districts with the aim of preventing attrition and ensure sustainability.
- Supported by Voluntary health promoters, although they are not considered as staff of the health posts.
- Key design principles in the design of Health Extension Programme (HEP) is to ensure ownership and empower the poor to have a more central role in the program.
- The community participates in planning, implementation, and monitoring of the HEP, ensuring that people are active partners in decision making about resources, defining priorities, and ensuring accountability.
- The HEP packages was also adapted to pastoralists' special needs. The Ministry of Health designed modified health units appropriate for pastoralist communities that focused on outreach health services. Due to a shortage of female candidates (as well as cultural issues) and high school graduates, sixth grade males were recruited and received 6 months of training to serve as HEWs.

Banteyerga H. (2011) "Ethiopia's Health Extension Program: Improving Health through Community Involvement" *MEDICC Review*, 13:3. Available online at: www.medicc.org/mediccreview/pdf.php?lang=&id=210

Rationale behind programme

Community-based health service delivery program whose educational approach is based on the **diffusion model**, which holds that community behaviour is changed step by step: training early adopters first, then moving to the next group that is ready to change. Those resistant to change would gradually be conditioned to change because of changes in their environment.

Additional Programme features

- Every village with 5000 residents builds a health post.
- HEWs' major task is increasing knowledge and skills of communities and households to deal with preventable diseases and be able to access services available at clinics and hospitals.
- HEWs give special attention to family health. In addition to conducting preventive family health education and sanitation, they can supervise intake of community Directly Observable Treatment-Short Course (DOTS) for TB and antiretroviral treatment for HIV/AIDS; conduct rapid diagnostic tests for malaria and administer malaria drugs; attend uncomplicated childbirth; refer patients to nearby health centres; and collect vital statistics. HEWs are not allowed to administer antibiotics.
- Use of model families. The first families to be trained are selected by the local government (*kebele*) administration, HEWs, CHWs and community leaders based on criteria related to their earlier participation in community health activities and readiness to enrol in the training.
- Women in the selected families take the lead role in the training, recognizing that women take more responsibility in family care.
- Each group receives 96 hours of training, involving face-to face teaching and household visits in four modules corresponding to the four HEP subprograms: prevention of communicable diseases, family health, environmental and household sanitation, and health education.
- Formal training continues until all households graduate. HEWs and CHWs follow up with households regularly.

According to the review, the HEP demonstrates that instead of sticking to traditional health provider and medication-oriented models, context-sensitive and affordable functional models and approaches could be developed to expand primary health care services.

Medhanyie A. et al (2012) "The role of health extension workers in improving utilization of maternal health services in rural areas in Ethiopia: a cross sectional study". *BMC HEALTH SERVICES RESEARCH*, 12:352. Available online at <http://www.biomedcentral.com/1472-6963/12/352>

The study found that Health Extension workers (HEWs) have improved access to family planning, similar to findings from other studies. It also found that the proportion of women who had at least one Ante-natal care visit has increased considerably. However, the study showed the proportion of women who had 4 and more Ante-natal care visits as recommended by WHO was still low (48%), indicated a need for a concerted effort by HEWs and to educate women about the importance of having four and more visits.

Contrastingly, deployment and work of HEWs has not showed any improvement in birth assistance. The study revealed the proportion of women who were assisted for birth by trained traditional birth attendants (TBAs) is much higher than those assisted by HEWs. This might be due to the fact that TBAs are tried and tested by women and seen to be experienced in conducting deliveries, or also potentially due to easier access to village women. On the other hand low competency and confidence of HEWs in assisting births, less favourable working conditions at the health posts, workload and walking long distances at night to assist births at home might also be attributed to this low performance of HEWs in assisting births. Cultural beliefs supporting home birth may also be a factor impacting this as women's preference for having birth at home is

a deeply embedded cultural belief. Women may believe that it is appropriate to go to a health facility for birth assistance and check-up only if there are visible complications during birth. Other determinants like women's age, education, income, number of children and health seeking behaviour could also influence women's preference on health facility delivery and birth assistance by skilled birth attendant.

South Africa: Community Health Workers

Friedman et al (2007). "Moving Towards Best Practice: Documenting and Learning from Existing Community Health/Care Worker Programmes". Durban: Health Systems Trust. Available online at <http://chwcentral.org/moving-towards-best-practice-documenting-and-learning-existing-community-healthcare-worker>

The review found that the large range of CHW models in place is matched by an equivalent assortment of training programmes and support mechanisms, with only a few representing effective and well-thought through programmes. This result in a medley of initiatives, some effective, some being of questionable value. Reports that this inconsistency has threatened to discredit the national programme as a whole.

Best Practice

- **Innovations in CHW projects** such as low cost solutions have the potential for large-scale impact. Examples include the use of imaginative ways to communicate health messages e.g. the use of songs and drama to trigger debate and discussion.
- **Successful attributes of CHW may vary** e.g. the review found that slightly older, less educated women seemed to provide better care, whereas younger more educated workers seemed to provide information better, particularly to their peers, similarly, lesser educated nursing assistants can often be better motivators than more skilled professionals, with often a better understanding of and ability to work with local people. It is also important to consider the role of traditional birth attendants or traditional healers.
- **Good CHWs know their communities well.** They should care about and enjoy working with people, whilst also be willing to commit and work hard. Good practice for organisational purposes is that they would have a map, even if hand drawn as well as a file with the records of the clients that they visit.
- **Practices introduced by respected local people are often adopted more readily.** Accounting for traditional views can often lead to more effective approaches. Accommodating time for local people to absorb messages, ask questions, argue and discuss until there is broader community understanding often leads to more profound diffusion of innovations in the longer run.
- **Good governance** should allow for the process to be fully accountable to the beneficiary community, as CHWs are by definition supposed to be accountable to the communities they serve. Full accountability to democratic community-based management structures, which act as a liaison between health personnel and community based workers, can do a great deal to promote this.

The need to rationalise

- **Selection and recruitment** is often haphazard with self-selection being dominant, commonly resulting in individuals with inappropriate personalities, backgrounds and skills attempting to provide a service, often ineffectively.
- **Training discrepancies.** Much of the existing training, where it is offered, often varies in length, content and methodology. More often than not there is no formal assessment of competence and no recognition of training given or proper certification.
- **Remuneration.** The policy of offering stipends has led to a proliferation of pseudo voluntarism, some participants hoping for jobs in the community, others aiming to simply get training that they hope will increase the likelihood of finding formal employment elsewhere.
- Career prospects hardly exist for CHWs

- Many excellent CHWs' lack of literacy or formal education has been a barrier to them becoming more highly effective.
- Mentoring, supervision, and other support mechanisms are frequently absent or very weak. Accountability is consequently poor.

GENERAL EVIDENCE ON PROGRAM FEATURES

Shakir, F. K. (2010). "Community Health Worker Programs: A Review of Recent Literature". USAID. Available online at https://www.usaidassist.org/sites/assist/files/chw_literature_review_jan2010.pdf

Review identifies key components as central to the design and implementation of functional and sustainable CHW programs:

- Defined job description with specific tasks or responsibilities for volunteers
- Recognition and involvement by local and national government
- Community involvement (especially in recruitment and selection, by making use of existing social structures, consider cultural appropriateness, address needs of community, etc.)
- Resource availability (funding, equipment, supplies, job aids, etc.)
- Monitoring and evaluation of programs
- Linkages with formal health care system
- Training (including refresher trainings)
- Supervision and feedback
- Incentives or motivational component
- Advancement opportunities

Common challenges and weakening characteristics that influence the functionality and sustainability of CHW programs

- Poor initial planning (disconnect between program developers, program managers and volunteers, failure to consider true costs of program – training, supervision, etc.)
- Unrealistic expectations or undefined job descriptions
- Lack of community involvement in design, recruitment and implementation
- Inadequate training (too complex, not tailored to volunteers' educational level, lack of refresher training, etc.)
- Difficult to scale up due to tailoring required for CHW programs
- Lack of resources or inconsistency of resources (funding, supplies, etc.)
- Problems with sustainability
- Lack of incentives (monetary or others)
- Poor supervision and support (by MOH, supervisors, local community)

These factors, combined with a weak management and organizational structure, contribute to high rates of attrition, absenteeism, low work morale, and poor quality of work for community health volunteers.

Haines A, Sanders D, Lehmann U and Rowe A K et al (2007). "Achieving child survival goals: potential contribution of community health workers". The Lancet, 368: 2121-2131. Available online from [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)60325-0/fulltext?_eventId=login](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)60325-0/fulltext?_eventId=login)

The paper argues that community health workers are not a panacea for weak health systems and will need focussed tasks, adequate remuneration, training, supervision, and the active involvement of the communities in which they work. The paper maintains that tasks performed by CHWs need to be focused as community workers cannot provide comprehensive care for all community health needs. It highlights national and socioeconomic factors, community factors, health system factors, financial incentives and remuneration, performance management, supportive management, including appropriate supervision and availability of infrastructural support as critical issues for programme success. It further suggests that the implementation of large-scale programmes should be accompanied by research to show that the anticipated effect and value for money are achieved and to document the reasons behind successes and failures. Nevertheless, the

evidence suggests that CHWs can have an important role in increasing coverage of essential interventions for child survival and other health priorities.

Abbatt F. (2005). "Scaling up Health and Education Workers: Community Health Workers Literature Review". Health System Resource Centre, DFID, London UK. Available online at http://collections.europarchive.org/tna/20100918075642/http://www.dfidhealthrc.org/publications/health_service_delivery/05HRScalingUp03.pdf

This review examines the evidence to support or reject the hypothesis that investment in 'community workers' can only impact on health outcomes with parallel investments in trained health workers and health systems.

The papers reviewed demonstrated that it is possible to train CHWs – even those with limited formal schooling – to a standard where they are capable of providing a good quality care for a limited number of conditions. The literature review highlighted the following success factors in relation to training design and implementation:

- Clear job description for the CHWs, defining a limited number of tasks that the CHWs will be expected to perform
- Competency-based training that is closely linked to the job description
- Large allowance in training for the practice of skills
- Initial training supplemented by opportunities for further education. The papers quoted above demonstrate that it is possible to train CHWs – even those with limited formal schooling – to a standard where they are capable of providing a good quality care for a limited number of conditions. However, the more important question is whether CHW's can have an impact on health under normal working conditions. This issue is considered in the following section.

The literature review also found CHWs can and do have a positive impact on health outcomes even in national scale health programmes. However quite often the scale of the impact is less than had been hoped for. Reports that CHWs have had a positive impact when they are employed to: enable people to look after their own health better; encourage increased utilisation of health facilities; support preventive health programmes; diagnose and treat a limited range of common diseases. The literature also shows that CHWs may have advantages over health care professional in that they are members of the communities in which they work and hence are more likely to continue to work in that community, and are more likely to be able to communicate effectively with members of the community. In the cases where outcomes have been less positive, the principal reason seems to have been the failure of the health system -and the health professionals within that system - to provide the necessary support for the CHWs.

The literature review emphasises however that CHWs limited educational background and limited period of training in health care mean that each CHW can only be expected to perform a limited number of specific tasks that complement the work of health professionals. Consequently training of CHWs is not enough to ensure they have a positive impact on health, investment of time and expertise is required to analyse and define the work to be done by CHWs and the context in which they will work. CHWs need to work within a health system that provides supervision, supplies, equipment and, communication with health professionals. The literature highlights that the effectiveness of CHWs has been limited by failure to define tasks in detail or by the tendency to change the work expected of CHWs. Key issues with regards to the context include where work will be done, question of financial remuneration and how much, type of incentives, management and supervision, continuing education, link with work of health care professionals, supply of resources. This analysis will give important information on the investment required for initial and continuing education of CHWs as well as on the investment required in the health system where they work. The nature and amount of the investment will vary from country to country depending on the work to be done by the CHWs and on the effectiveness of the country's health care system. According to the review, without this investment in analysis and in the health care system, CHWs are unlikely to achieve substantial health benefits.

Darmstadt et al (2013) "A strategy for reducing maternal and new-born deaths by 2015 and beyond". BMC Pregnancy and Childbirth, 13:216. Available online at <http://www.biomedcentral.com/1471-2393/13/216>

Incorporating community health into MNCH

- Trained frontline workers, including qualified or unqualified medical practitioners, private drug sellers, community health workers (CHWs), traditional birth attendants, and trained midwives and other skilled birth attendants (e.g., nurses) together provide a critical link to address the problem of low coverage of interventions.
- In linking cadres of frontline workers who are primarily community-based with those who work in primary health facilities, a larger number of families can be supported through combined counselling, health education and negotiation at home, pregnancy care, skilled care at birth, and postnatal healthcare in communities and primary health facilities.
- By connecting communities with the health system, for example by mobilizing and empowering families to seek health care with birth preparedness planning or through communication and referral systems, life-saving interventions can be brought closer to those who need them, particularly the poorest, who continue to experience the highest burden of mortality

Nomadic and Pastoralist Groups

Katharine Downie (2012). "A Review of Good Practice and Lessons Learned in Programming for ASAL Populations in the Horn of Africa." UNICEF ESARO. Available online at [http://www.fao.org/fileadmin/user_upload/drought/docs/Pastoralism%20Good%20Practice%20and%20Lessons%20Learnt%20in%20Pastoralist%20Programming%20-%20DRAFT 2 27 09 2011.pdf](http://www.fao.org/fileadmin/user_upload/drought/docs/Pastoralism%20Good%20Practice%20and%20Lessons%20Learnt%20in%20Pastoralist%20Programming%20-%20DRAFT%2027%2009%202011.pdf)

This review of UNICEF good practice and lessons learnt was taken from six countries in the Horn of Africa (HOA); Djibouti, Eritrea, Ethiopia, Kenya, Somalia and Uganda and the external agency review of good practice and lessons learnt employed examples from pastoralist and ASAL communities around the world.

Why focus on pastoralists in the quest for equity of service provision?

- **Lack of Access to Basic Services:** these communities tend to fall behind in in basic indicators of well-being.
- **Health of Pastoralists:** Pastoralists tend suffer higher Infant MR, Maternal MR, and higher U5MR, may be more frequently affected by water-borne diseases (parasitic or bacteriologic) as they consume surface water more often than settled groups, and can be susceptible to zoonotic diseases such as brucellosis, Q-fever, bovine tuberculosis and botulism due to their association with and consumption of raw, unpasteurized milk. In addition, mobility and dispersion can influence the spread of disease and therefore enhance risk for mobile populations.
- **Education and Pastoralists:** Barriers to accessing quality and relevant programmes remain high.
- **Marginalisation of Pastoralists in Government Policy and Practice:** Pastoralists have traditionally suffered from a lack of representation in governments in the HoA, a situation which has led to development of policies that have adversely affected their lifestyles and access to public services.
- **Contribution of Pastoralist Livelihoods to Regional (HoA) Economies:** Some governments and policy makers have now understood that the livestock that pastoralists depend on can contribute significantly to their countries' economies, if all elements are properly managed. In economic terms, pastoralism contributes significantly to the HoA's agricultural Gross Domestic Product (GDP), including 35% of agricultural GDP in Kenya, Ethiopia and Sudan

Good practice

- **Adopt an innovative and adaptive approach:** With a focus on **community-based services**, such as community health workers and traditional birth attendants, but with close attention to the quality of services and to ensuring their continuation beyond the duration of project support

(sustainability). Innovations such as combining **mobile and static health services and provision of dual animal and human interventions** are a proven way to link pastoralists with formal service provision. Projects also need the capability and space for flexibility, for example with regard to health centres to consider by-passing pastoralists. Flexibility should also be exercised in identifying alternative solutions, and inter-sectoral collaboration should be pursued where relevant.

- **Ensure cost effectiveness and impact:** A cost/benefit analysis of intervention ensures they are cost-effective in improving delivery of service to ASAL populations. While cost effectiveness should remain a priority for long-term sustainability of building resilience and capacity into populations, in the bid to achieve equity with other sedentary populations, initially, given the current gap in spending of development funds on pastoralist populations versus other more sedentary groups, more funds overall could be devoted to ASAL interventions

Community Animal Health Workers (CAHWs), Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs)

Experience in Marsabit District in Northern Kenya has shown that employing already practicing traditional healers as CHWs and TBAs can reduce the risk of posts being abandoned due to lack of remuneration. The best choice of community health workers for pastoral communities is the traditional health practitioners, who are already offering health care at this level. Once they are given a basic training as that required for conventional community health workers, and once they are formally recognised as ‘community doctors’, they could be more productive and deliver a better quality of care. In addition, most of them perform a dual role in both human and animal health care. They could therefore be used for both purposes as long as they are willing to be trained. Experience so far shows that the traditional birth attendants are willing to be trained and the other groups (herbalists, bonesetters) are likely to support such an initiative. These personnel can serve as a link between the health system and the community in which they work.

EVIDENCE OF COMMUNITY BASED STRATEGIES DELIVERING IMPROVED HEALTH OUTCOMES

Perry H et al (2009). “How effective is Community-Based Primary Health Care in Improving the Health of Children? A Review of the Evidence”. Summary Findings. Report to the Expert Review Panel. Community-Based Primary Health Care Working Group, International Health Section. American Public Health Association. Available online at http://pdf.usaid.gov/pdf_docs/PNADQ109.pdf

This report attempts to summarize the current research findings concerning the effectiveness of Community Based Primary Health Care (CBPHC) in improving the health of children in high-mortality, resource-poor settings. The review reaffirms that the following interventions and approaches are effective and should receive priority in programming of community-based interventions:

- BCG, polio, diphtheria, pertussis, tetanus, measles, Haemophilus Influenza Type b (Hib), pneumococcus, and rotavirus immunizations for children and tetanus immunization for mothers and women of reproductive age
- Provision of supplemental vitamin A to children 6-59 months of age and to post-partum mothers
- Provision of preventive zinc supplements to all children 6-59 months of age
- Promotion of breastfeeding immediately after birth, exclusive breastfeeding during the first 6 months of life, and continued breastfeeding after 6 months of age
- Promotion of appropriate complementary feeding beginning at 6 months of age
- Promotion of hygiene (including hand washing), safe water, and sanitation
- Promotion of oral rehydration therapy (ORT) and zinc supplementation for children with diarrhoea
- Promotion of clean delivery, especially in settings in which most births occur at home and hygiene is poor
- Community-based treatment of childhood pneumonia
- Home-based neonatal care, which includes promotion of immediate and exclusive breastfeeding, promotion of cleanliness, prevention of hypothermia, and diagnosis and treatment of neonatal sepsis by Community Health Workers (CHWs)

- Community-based rehabilitation of children with protein-calorie malnutrition through provision of food supplementation (including rehabilitation of children with severe acute malnutrition through the provision of ready-to-use dry therapeutic foods)
- Insecticide-treated bednets (ITNs) in malaria-endemic areas
- Indoor residual spraying in malaria-endemic areas
- Community-based treatment of malaria Intermittent preventive treatment during pregnancy (IPTp) of malaria in malaria-endemic areas
- Intermittent preventive treatment during infancy (IPTi) of malaria in malaria-endemic areas
- Detection and treatment of syphilis in pregnant women in areas of high prevalence
- Prevention of mother-to-child transmission (PMTCT) of HIV infection
- Iodine supplementation in iodine-deficient areas where fortified salt is not consumed

The review notes that all of these interventions cannot be immediately implemented in high-mortality, resource-constrained settings. Policy makers, program managers, and donors will have to make judgments regarding which interventions have the most promise for mortality reduction given the epidemiological, health system, and socio-cultural factors in a given setting.

There is some evidence that the following community-based interventions can be effective in improving child health, but further evidence is needed in a greater variety of field settings:

- Community-based rehabilitation of children with protein-calorie malnutrition through the Positive Deviance/Hearth approach
- Provision of prenatal calcium in calcium-deficient populations for prevention of pre-eclampsia and eclampsia
- Detection and treatment of asymptomatic bacteriuria
- Application of a topical antiseptic to the umbilical cord of neonates
- Skin cleansing of newborns with a topical antiseptic soon after birth
- Improved airway management and resuscitation in neonates by appropriately trained CHWs
- Reduction of household smoke by placement of improved cooking stoves (to reduce childhood pneumonia)

The following interventions have evidence of effectiveness in improving child health along with evidence of having other important benefits beyond child health:

- Participatory women's groups for empowerment and education about maternal and neonatal health issues
- Micro-credit programs for women, conditional cash transfers to women (in which poor women receive cash transfers with the condition that they obtain certain health services), and education of girls

With respect to integrated programs (defined as those with at least three child survival interventions), the review confirms that they can be effective in improving child health. These programs have strong community outreach components including: home visits to all households, use of community-based health workers, and strong partnerships with the community and community mobilization.

The review found numerous examples of programs that had a sustained impact of 10 years or longer when the following conditions were met:

- The program addressed epidemiological priorities of children
- Proven and affordable interventions existed to address these priorities
- The programs were carefully designed at the outset
- Adequate long-term funding was assured

Overall, the findings of this review provide strong scientific support for the following three conclusions:

- When proven interventions are implemented at the community level by locally trained and well-supervised health workers, coverage, impact, and equity can be favourably affected.
- Under the right conditions, communities can become strong partners with established health delivery systems in improving the health of children.

- Health programs can more effectively and sustainably improve the health of children by mobilizing the energy of local people for their own benefit.

The impact which CBPHC has shown in such extremely poor and diverse countries such as Haiti, Cambodia, Afghanistan, and western Africa suggests that CBPHC should be a fundamental building block of health improvement in severely impoverished and fragile states. Many aspects of CBPHC can be sustained when a fragile health system breaks down, especially those around behaviour change. Once a community-based outreach system is in place, it can continue to function with minimal additional inputs from the formal health system, and further interventions can be added with relative ease.

Common Strategies for Successful Community-based Programs

Within the formal health system (through outreach services provided by staff based at peripheral health facilities)

- Outreach activities arising from facilities can provide essential education messages and key services for a high percentage of families with women of reproductive age, pregnant women, and young children. Holding “satellite clinics” where basic services such as immunizations, family planning, and prenatal care can be provided intermittently, usually monthly, at locations convenient to all households is one common approach for outreach. Routine systematic home visitation (i.e., to all homes periodically) is another common strategy. Such approaches promote equity by giving the poorest and most geographically isolated children and their mothers’ access to basic services.
- Many successful community-based programs have been able to provide referral care as part of a systematic approach to health improvement. Such systems usually are built up slowly with long-term financial and technical support. Integration of CBPHC services with facility-based care, including hospital referral care, is a long-term priority which will also give legitimacy to CBPHC activities from the perspective of local people.

Within the community at the household level

- Community-based health workers – either volunteer or paid – are needed to provide direct services, to build community capacity, and also to link the community with the health system. There is a wide variety of types of workers among programs which have demonstrated success.
- Interventions to promote healthy behaviours must achieve high levels of coverage if they are going to be effective in reducing under-5 mortality in the population.
- Priority needs to be given to community-case management of pneumonia, diarrhea, malaria, and neonatal sepsis and to promotion of exclusive breastfeeding and appropriate complementary feeding.

Linking top-down and bottom-up approaches

- Program effectiveness requires careful attention to the selection of lower-level staff, their training and supervision, and logistical support. These issues become critically important in scaling up program activities to larger populations, and they require a well-designed, ongoing stable support structure of professional leadership, long-term planning, and financial support.

There needs to be continued efforts to strengthen the above-mentioned program elements through public-private collaboration and to test the cost-effectiveness of improvements to these program elements while at the same time adding new program elements, especially in the area of building community partnerships and promoting community and women’s empowerment.

Lassi Z. S., Haider B. A. and Bhutta Z. A. (2010) “Community-based intervention packages for reducing maternal and neonatal morbidity and mortality and improving neonatal outcomes” Cochrane Review. Available online at: <http://onlinelibrary.wiley.com/enhanced/doi/10.1002/14651858.CD007754.pub2#Survey>

The review offers encouraging evidence of the value of integrating maternal and new-born care in community settings through a range of strategies, many of which can be packaged effectively for delivery through a range of community health workers (CHWs). Concludes that the most successful packages were those that emphasised involving family members through community support and advocacy groups and

community mobilisation and education strategies, provision of care through trained CHWs via home visitation, and strengthened proper referrals for sick mothers and new-borns.

Key Findings

Women in areas assigned to receive a community-based intervention package with health workers receiving additional training had decreased illnesses and complications during pregnancy and birth associated with decreased stillbirths, perinatal and neonatal deaths. Referrals rates to health facilities for pregnancy related complications, and initiation of breastfeeding within an hour of birth were also improved.

- Significant reduction in maternal morbidity (by 25%) observed as a consequence of implementation of community-based interventional care packages.
- Referrals to health facilities for pregnancy-related complications increased by 40%.
- Evidence for reduction in neonatal deaths: observed a 24% reduction in overall neonatal deaths from the studies reviewed.
- The findings also demonstrated an impact of community interventions on reducing stillbirths by 16% and perinatal mortality by 20%.
- Found that community-based packages that disseminated education and promoted awareness related to birth and new-born care preparedness based on building community support groups/women's groups were best for reducing total and early neonatal deaths.
- Packages that comprised community mobilisation and education strategies and home visitation by CHWs managed to reduce neonatal, perinatal deaths and stillbirths, possibly with the reason that these strategies focused on women in the antenatal period and on early new-born care, management and referrals of sick new-borns.

The review notes that most of the reviewed studies, when implemented, lacked the complete description and characteristics of CHWs deployed, especially the level and amount of supervision provided to those workers, which could have helped the review in identifying the importance of this factor and its association with other outcomes. Additional information on the initial level of education of CHWs, provision of refresher training, mode of training (balance of practical/theoretical sessions) would have provided greater assistance in understanding the threshold effect, if any, of these factors on CHW performance in community settings. They also add that importantly, community ownership and supervision of CHWs is a key characteristic which is insufficiently described and analysed in available literature.

Sibley L. M., Sipe T.A., Barry D. (2012) "Traditional birth attendant training for improving health behaviours and pregnancy outcomes". The Cochrane Database of Systematic Reviews:8. Available online at <http://www.ncbi.nlm.nih.gov/pubmed/22895949>

This paper reviewed six studies and examined the effect of TBA training, or additional training, on TBA behaviour and on pregnancy outcomes. It concludes that while there are a few more studies meeting the inclusion criteria and the results are promising for some outcomes, more evidence is needed to establish the potential of TBA training to improve peri-neonatal mortality. In settings where there is an insufficient number of skilled birth attendants or limited access to health facilities and women prefer TBAs, TBA training may be the only means to optimise the use of community-level health workers for maternal and new-born health. Where skilled birth attendants and health facilities exist and are accessible, and women prefer TBAs, TBA training coupled with strategies to effectively engage them with the health system may be considered. The remaining five studies comparing additionally trained TBAs and trained TBAs show no clear advantage of additional or advanced training. However, this finding may be due to an insufficient number of studies and the methodological issues in the included studies (risk of bias, lack of contrast in the intervention between the comparison groups).

Brenner J. L., Kabakyenga J., Kyomuhangi T., Wotton K.A., Pim C., et al. (2011) "Can Volunteer Community Health Workers Decrease Child Morbidity and Mortality in Southwestern Uganda?" An Impact Evaluation. PLoS ONE 6:12. Available online at http://chwcentral.org/sites/default/files/Brenner-CHW_ChildMortality.pdf

The study concluded that a low-cost child health promotion model using volunteer community health workers demonstrated decreased child morbidity, dramatic mortality trend declines and high volunteer retention. It proposes that this sustainable model could be scaled-up to sub-Saharan African communities with limited resources and high child health needs.

Key findings

A community-based intervention using volunteer community health workers to promote health for children under five years old in rural Uganda successfully **improved child health outcomes and decreased mortality**. Household survey findings of **reduced malnutrition and morbidity** (from household surveys compared to controls and from focus group reports) were complemented by evidence of improved child health practices and reductions in reported deaths (from focus group reports and from community health worker monthly death reports), suggesting that health improvements went beyond illness reduction, perhaps dramatically decreasing the mortality rate within a short time. Specific success features include:

- Attention to local needs and priorities
- Alignment with local health systems
- An established and consistent selection process for community health workers
- Training appropriate to the setting
- Regular supervision

The evaluation found that during the three years of the intervention, volunteer community health worker retention was notably high at 86%. It speculates that model may facilitate volunteer retention through:

- Careful selection process
- Community choice of volunteers
- Clear volunteer expectations
- Ongoing, participatory training in teams with supportive supervision and regular meetings.

However, the authors recognize that the high retention over the short to medium term may represent enthusiasm and commitment which could be harder to sustain over time in a volunteer system. They conclude by suggesting that the successful national or regional programs need to account for the importance of community engagement and community health worker selection, training, and supervision cannot be underestimated or compromised. Flexibility must be built into programs in order to accommodate modifications based upon ongoing critical evaluations, local needs and resources.

United Nations Children Education Fund (2010). "Evaluation Report of the Community Health Strategy Implementation in Kenya". UNICEF. Available online at http://www.unicef.org/evaldatabase/files/14_2010_HE_002_Community_Strategy_Evaluation_report_October_2010.pdf

This evaluation found that there was improved community access to health care in intervention sites, as evidenced by improved childhood immunization coverage, uptake of ante-natal care and HIV related stigma reduction among others. The results indicate improved linkages between the health facilities and the community, as the health facilities register higher numbers of people seeking health services as compared to before the implementation of the strategy. It also found that regular monitoring and evaluation activities undertaken by the ministry ensured that the strategy structures continued accessing Govt. support.

Challenges identified

- **Limited resources.** The evaluation found that the implementation of the community strategy had been constrained by inadequate resource allocation from the national level, consequently having a significant implication on sustainability.

- **Training discrepancies.** There were discrepancies between the content of training for Community Health Workers (CHWs) and the tasks they were required to perform after training by different partners. The CHWs underwent different types of training modules by partners based on their particular project needs (i.e. Nutrition, HIV&AIDS, or MCH). This was particularly evident between partners and the GAVI sponsored sites. Indicates a need to standardise the training provided.
- **Remuneration.** Found the current policy of non-remuneration of CHWs to be lacking. With certain programmes implemented by partners having a structured remuneration package for their CHWs, government CHWs who are not remunerated become disillusioned. Despite the fact that the CHWs undertook their responsibilities on a voluntary basis, they had their own expectations regarding rewards and incentives, resulting in lower motivation and retention rates.

Lessons Learnt

- **Participation of community members** in strengthening health systems elicited grass root acceptance, support and sense of ownership, translating into increased demand for health services.
- **Creating community demand** for health services by government and partners must be matched with the availability of improved services within health facilities. The paper concludes that a **comprehensive and integrated approach** to a multidimensional health programme helps ensure that communities ultimately access the services they need.

Recommendations for policy and practice

- The evaluation highlighted the need for government and partners to explore **standard and sustainable financial incentives** for CHWs: allowances, reimbursements among others, as seen in successful cases such as that of Ethiopia
- It also highlighted the need to explore **non-financial incentives** for CHWs that are performance based e.g. when there is increased condom use in their communities, financial incentives are considered, with this approach seen to have well in some countries e.g. India. Suggested incentives include exchange tours, badges, recommendations letters, and certificates of attendance.
- **A focus on training delivery** with the suggestion that the training of CHWs could be designed and delivered in phases in order to cover more content. Such multi-phased training in turn increases retention rates as CHWs will anticipate further training and possibly develop career paths. The approach has been seen to work very well in Malawi.

Banteyerga H. (2011) "Ethiopia's Health Extension Program: Improving Health through Community Involvement" *MEDICC Review*, 13:3. Available online at: www.medicc.org/mediccreview/pdf.php?lang=&id=210

Main findings

- HEP has created greater awareness of how to prevent communicable diseases such as malaria, tuberculosis, HIV/AIDS and waterborne disease
- Community and household attitudes toward HIV/AIDS and those living with HIV/AIDS are changing, as have practices related to prevention of infectious diseases in general
- Beneficiaries reported changed attitudes and behavioural practices in preventive aspects of maternal and child health. Community informants and district and regional program coordinators say that mothers and children are regularly monitored by HEWs. Access to family planning, antenatal and postnatal care services has improved, and maternal and childhood disease incidences have decreased as a result. Community informants reported improvements in infant feeding habits such as breast feeding and use of supplements; increase in the number of children and mothers immunized, and practices in reporting sick children to HEWs have shown improvement.
- HEP has improved sanitation and increased access to safe and clean drinking water from 35.9% in 2004–2005 to 66.2% in 2009–2010 nationally,[2] when access to safe excreta disposal reached 60%.

- The diffusion model as an approach to health behavioural change is working. HEP's impact is visible in the way people live in their communities and from local stakeholder feedback.
- HEP has created synergy among public sector, community, and development partners. Local leaders, religious leaders, and associations of youth, women and farmers actively participate during construction of pit latrines, vaccination, and community meetings. Development partners are assisting in the training of HEWs and by supplying health posts with essential drugs and supplies.

Gallo M. F. , Walldorf J. , Kolesar R. , Agarwal A. , Kourtis A. P. , Jamieson D. J. and Finlay, A. (2013) "Evaluation of a volunteer community-based health worker program for providing contraceptive services in Madagascar". Contraception, 88:5 Available online at <http://www.sciencedirect.com.ezp2.bath.ac.uk/science/article/pii/S001078241300454X#>

This evaluation demonstrates that community-based family planning services offered by CHWs in Madagascar provide high-quality contraception services. Results of this research have been used to modify existing programs and design future CHW programs in Madagascar. Suggests that the use of CHWs to provide contraceptive services should be considered to increase access to services especially in other resource-limited settings with inadequate coverage of health care professionals. The evaluation revealed that many CHWs proved capable of providing high-quality contraception services. This finding is consistent with other evaluations that have identified benefits in delivering contraceptive services associated with CHW programs or the use of remunerated lay counsellors.

Lehmann U and Sanders D (2007). "Community health workers: what do we know about them? The state of the evidence and programmes, activities, costs and impact on health outcomes of using community health workers". World Health Organisation, Geneva. Available online at http://www.who.int/hrh/documents/community_health_workers.pdf

This review examines questions regarding the feasibility and effectiveness of community health worker programmes. It finds that there are a number of common issues that arise from the literature such as the positive impact of CHWs in improving access to and coverage of communities with basic health services. Particular success has been seen the field of child health. However, it also emerges that CHWs do not consistently provide services likely to have substantial health impact, and the quality of services they provide is sometimes poor. Other common issues include the impact of appropriate and adequate selection, training and supervision. Overall the literature shows that CHW programmes are neither the panacea for weak health systems nor a cheap option to provide access to health care for underserved populations. It reports that past programme failures have been due to unrealistic expectations, poor planning and an underestimation of the effort and input required to make them work, consequently undermining and damaging the credibility of the CHW concept.

Community ownership is also emphasised as a key issue to ensure sustainability. The review argues that the concept of community ownership and participation is often ill-conceived and poorly understood as a by-product of programmes initiated from the centre. Evidence suggests that CHW programmes thrive in mobilized communities but struggle where they are given the responsibility of galvanizing and mobilizing communities. The question of remuneration is also in focus, with little or no evidence that volunteerism can be sustained for long periods: as a rule, community health workers are poor and expect and require an income. Most of the evidence reflects failures of community financing schemes, leading to high drop-out rates and the ultimate collapse of programmes. Appropriate selection, continuing education, involvement and reorientation of health service staff and curricula, improvement supervision and support are emphasised as key components of a good community health programme.

Perry H and Zulliger R (2012). "Literature Review Summary: How effective are community health workers?" The John Hopkins Bloomberg School of Public Health. Available online at http://www.chwcentral.org/sites/default/files/How%20effective%20are%20community%20health%20workers%20-%20Johns%20Hopkins%20University_0.pdf

The purpose of this review is to assess the effectiveness of CHW programs, with particular emphasis on how they have or how they might assist countries in achieving the health-related MDGs. The paper concludes by arguing that CHWs provide the most promising health workforce resource for accelerating progress in achieving the health-related MDGs and for enabling health systems in resource- constrained settings to reduce the burden of disease from serious, readily preventable or treatable conditions and, thereby, to improve the health of population. Their effectiveness has been demonstrated, they can be trained in a relatively short period of time, and their cost-effectiveness is almost always substantially better than the cost-effectiveness of similar services provided by higher- level staff based at facilities. Furthermore, they are living with the people who need services, in contrast to higher-level health professionals who often do not come from areas where services are needed or who do not want to live in such settings.

Case for Financial Incentives

Brunie A. et al (2014). "Keeping community health workers in Uganda motivated: key challenges, facilitators, and preferred program inputs." *Global Health: Science and Practice*, 2:1. Available online at <http://chwcentral.org/sites/default/files/Keeping%20CHWs%20in%20Uganda%20motivated.pdf>

This study assessed influencing factors of the motivation and level of activity of CHWs providing family planning services in a public-sector program and two programs supported by NGOs in Uganda. It specifically examined key challenges as well as what enables CHWs to be active and stay in service. The study found that regardless of the awareness of the volunteer nature of the CHW role, aspirations for a regular salary existed. The importance of income was found to be a core theme, consistent with previous studies highlighting that despite being volunteers, CHWs may view their role as income generating. The study also highlights that previous research has shown that CHWs often feel disgruntled at the lack of material benefits, with the findings adding to the evidence base emphasizing the complex processes underlying CHW motivation for wanting better compensation. Overall the study provides important insights for sub-Saharan Africa with regards to the underlying dynamics affecting CHW performance and retention, and on the relative importance of program inputs from CHWs' perspectives.

Greenspan J. A. et al (2013). "Sources of community health worker motivation: a qualitative study in Morogoro Region, Tanzania". *Human Resources for Health*, 11:52. Available online at <http://chwcentral.org/sites/default/files/Greenspan-CHW%20motivation%20Tanzania.pdf>

This study explored sources of CHW motivation to inform programs in Tanzania and similar contexts. Found that inadequate remuneration can prove to be a discouraging factor to becoming a CHW and can cause CHWs to drop out or devote less time to their work. In reviewing the literature, the study shows that proponents of regular compensation argue that remuneration can help build financial capital and foster economic and social equity in impoverished areas. The evidence in the findings suggests that monetary or in-kind external rewards would 'crowd in' intrinsic motivation by making CHWs feel more supported and less restricted in their work. The study argues that policy-makers and program managers should be cognizant of the burden that a lack of remuneration imposes on the families of CHWs, who were found to be an important source of motivation for the CHWs. It also argues that CHWs' intrinsic desire to volunteer does not preclude a desire for external rewards. Adequate and formal financial incentives and in-kind alternatives would reinforce existing motivation at the individual level and increase CHWs commitment to their work.

Alam K, Tasmin S, Oliveras E (2011). "Retention of female volunteer community health workers in Dhaka urban slums: a case-control study." *Health Policy and Planning*, 1-10 Available online at <http://chwcentral.org/sites/default/files/Alam-Retention%20Female%20CHWs%20Dhaka.pdf>

The study found that financial incentives were the main factor linked to CHW retention. The findings showed that CHWs who joined with the expectation of income were almost twice as likely to remain in the role, with the poorest CHWs significantly more likely to stay in the programme than those who were most well off. The

findings also highlight other non-financial incentives such as social prestige, community approval and household responsibilities as having an impact on retention. The study recommends that the restructuring and expansion of existing financial incentives can strengthen the commitment and participation of volunteer CHWs, therefore improving retention.

Bhattacharyya K, Winch P, LeBan K, Tien M (2001). "Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability". Published by the Basic Support for Institutionalizing Child Survival Project (BASICS II) for the United States Agency for International Development. Available online at https://www.ghdonline.org/uploads/Community_Health_Workers_-_how_they_affect_motivation_retention_and_sustainability.pdf.

This reviews the types of incentives needed to motivate and retain CHWs once they have been trained, as well those needed to sustain their performance at acceptable levels. High attrition rates represent one of the most critical problems for CHW programs, with higher rates generally associated with volunteers. Remuneration of CHWs for their services is a recurrent issue in many programs. CHWs often work long hours, possibly full time, alongside salaried employees, which inevitably leads to demands by CHWs for regular compensation. While full-time salaried CHWs are relatively rare, many CHWs receive some form of cash incentive. The paper argues that monetary incentives can increase retention with some success stories of programs paying CHWs. Highlights that from the CHW perspective, appropriate respectful, and regular compensation is a sign of acknowledgment and approval that allows them to earn a living or supplement other income. Cash incentives may come in several forms; CHWs may be part of the civil service and be paid a salary, they may also be given a small stipend. Inconsistent remuneration, a change in tangible incentives and inequitable distribution of incentives among different types of community workers are represented as disincentives. It also recognises that non-monetary incentives are critical to the success of any CHW program; CHWs need to feel that they are a part of the health system through supportive supervision and appropriate training. The paper is cognizant of the fact that CHWs are generally unpaid, owing to the fact that the relevant Ministry of Health or donors do not consider salaries to be sustainable. However it recommends that even if recognized as volunteers, the use of both intrinsic incentives and extrinsic incentives such as salary should be considered.

Strachan D.L., (2012). "Interventions to Improve Motivation and Retention of Community Health Workers Delivering Integrated Community Case Management (iCCM): Stakeholder Perceptions and Priorities". American Journal of Tropical Medicine and Hygiene, 87:5. Available online at http://chwcentral.org/sites/default/files/Strachan_Interventions%20to%20improve%20motivation%20and%20retention%20of%20CHWs%20delivering%20iCCM.pdf

International stakeholders interviewed proposed a range of financial and non-financial incentives for retaining and motivating CHWs, whilst stressing the importance of understanding CHW expectations and warning of the durability of perceptions that specific rewards will follow effort even despite contrary information. They emphasised that a failure of programs to deliver on CHW expectations would be viewed as a breach of trust and almost certainly have adverse consequences for retention. A range of financial incentives were also explored however, as with all incentives described, stakeholders warned that if introduced programs must be sure to consistently and reliably deliver them. Recommended that a package of incentives be tailored to match CHW expectations and program priorities and that once established they be reliably delivered.

Cherrington A. et al (2010). "Recognizing the Diverse Roles of Community Health Workers in the Elimination of Health Disparities: From Paid Staff to Volunteers". 20:2. Available online at <http://chwcentral.org/sites/default/files/Cherrington-CHW%20health%20disparities.pdf>

This paper argues that there are legitimate arguments for utilizing both the paid and the volunteer models. Emphasises that selection must depend on context, community needs and program goals.

ANNEX 3: TABLE OF GOVERNANCE & LEADERSHIP IN THE HEALTH SECTOR

Stakeholders	Key Roles and Responsibilities
Zonal level	
Ministry of Health	<ul style="list-style-type: none"> Policy/strategy setting; regulation; standardization; accreditation and approval of health cadre training
Parliamentary Health (or Welfare) Committee	<ul style="list-style-type: none"> Drafting legislation, oversight, advice; keeping government accountable to the people for services
Regional level	
Regional Health Office (RHO)	<ul style="list-style-type: none"> Health planning, supervisory, personnel and technical support services for all health services in the region; Ensures disease outbreak/emergency preparedness and response Guides, directs, monitors, supports and supervises health staff in region, Ensures quality health services, in-service training & appraisal of staff in region Manages and responds to the HMIS data in the region <p><i>Qualified staff appointed by MoH; ancillary staff locally appointed</i></p>
Regional Health Board (RHB)	<ul style="list-style-type: none"> Represents communities regional health concerns/issues to the RHO Oversight of regional health from consumers point of view <p><i>Members of RHB are selected by members of the community;</i></p>
District level	
District Health Management Team (DHMT)	<ul style="list-style-type: none"> Management of district health services & facilities, direct supervision of district hospital and referral health centres and/or health centres Ensures disease outbreak/emergency preparedness & response Guides, directs, monitors, supports and supervises health staff in region Manages and responds to the HMIS data in the region <p><i>Qualified staff appointed by RHO; ancillary staff locally appointed</i></p>
District Health Board (DHB)	<ul style="list-style-type: none"> Oversight of district health & services from consumers point of view Works with DHMT in response to, or to mitigate, emergencies (outbreaks, famine, potential seasonal disease trend increase, war), supports campaigns <p><i>Members of DHB are selected by members of the community;</i></p>
Town or village level	
Referral Health Centre (RHC) - clinical officer (CO), qualified nurse, nurse/midwife and/or midwife	<ul style="list-style-type: none"> Provides care & management of diseases (common, chronic, and complicated), refers more complicated cases Alerts seniors (DHMT/RHO) on potential threats Devolved management, supervision & support of health centres (+ oversees PHUs) Coordinates disease outbreak response in catchment area <p><i>Qualified staff appointed by DHMT; ancillary staff locally appointed</i></p>
Community development (or health) committee (CDC)	<ul style="list-style-type: none"> Oversight of RHC services, staff, premises; supports referral health centre staff Oversight of Health Centres in catchment area <p><i>Members of CDC are selected by members of the community;</i></p>

Health Centre (HC) (town or village location)	
Health centre staff (qualified nurse and/or midwife)	<ul style="list-style-type: none"> • Provides care & management of common diseases, care for chronic conditions managed from the RHC, refers more complicated cases • Alerts seniors (RHC/DHMT) on potential threats • Devolved Supervisory / Management of Primary Health Units in catchment area <i>Qualified staff appointed by DHMT; ancillary staff locally appointed</i>
Community development (or health) committee	<ul style="list-style-type: none"> • Oversee health services, staff and facilities; • Involved in the selection of the community health workers; • Community representation, oversight, ownership & support; <i>Members of CDC are selected by members of the community;</i>
Primary Health Unit (PHU)	
Community health worker (CHW)	<ul style="list-style-type: none"> • Provides basic curative, preventive and health promotive care to the community in catchment area • Alerts seniors (HC/RHC/DHMT) on potential health threats • Member of the CDC • WATSAN/hygiene/nutrition promotion; • Treatment of common illnesses & provides first aid; • Maternal & neonatal, child health & nutrition; <i>CHWs are jointly selected by community members and district medical officer and PHC coordinator (regional medical officer or PHC officer or regionally appointed proxy) using mutually agreed selection criteria based on agreed minimal criteria.</i>
Community development (or health) committee	<ul style="list-style-type: none"> • Oversees and supports health services and staff; • Helps in selection of the CHWs; • Community representation, oversight, ownership & support • Facilitates community understanding of, and follow guidance on health, hygiene, watsan & nutrition advice <i>Members of CDC are selected by members of the community;</i>
Village Health (where there is no health facility)	
Female Health Workers (VHW)	<ul style="list-style-type: none"> • WATSAN/hygiene/nutrition promotion; • Treatment of common illnesses & provides first aid; • Maternal & neonatal, child health & nutrition; • Alerts (PHU/HC/RHC) on potential health threats <i>FHWs are jointly selected by community members and district medical officer, PHC coordinator (regional medical officer and PHC officer or regional appointed proxy) using mutually agreed selection criteria based on agreed minimal criteria.</i>
Community Development Committee (CDC)	<ul style="list-style-type: none"> • Oversees and supports health services and staff; • Helps in selection of the Female health workers; • Community representation, oversight, ownership & support • Facilitates community understanding of, and follow guidance on health, hygiene, watsan & nutrition advice <i>Members of CDC are selected by members of the community;</i>

ANNEX 4: WORK-PLAN FOR COMMUNITY HEALTH STRATEGY

Harmonization	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Establish a CHS thematic technical working group	X	X	X	X	X	X	X	X	X	X	X	X
Agree Job Descriptions for CHWs in PHU		X										
Agree Job Descriptions for FHWs		X										
Review THET and WHO CHW curricula and revise as standard curricula for CHWs			X									
Review WHO and UNICEF curricula for community based female health workers to develop a standard curricula for FHWs				X	X							
Mapping and assessment of all trained community health cadres compared to the new JDs			X	X	X							
Retraining of existing CHWs and other community health cadres						X	X	X	X	X	X	X
New Training based on standardised curricula									X	X	X	X
Review existing supervision systems and agree on a standardised system.		X	X									
Other work												
Communication strategies developed by each Zone						X	X	X				
Implementation of communication strategy phased depending on resources											X	X

ANNEX 5: JOB DESCRIPTIONS

COMMUNITY HEALTH WORKER (CHW)

Objective

To provide basic health services at the PHU according to the package defined in EPHS and promote good health in the community. To refer and link patients to the Health Centre or hospital as required. To provide support and mentoring to x FHWs at the household level. However it is expected that as the health system develops the CHWs will take on more responsibility for training FHWs.

Main duties and responsibilities

1. To deliver an agreed package of health, nutrition services at the PHU and through outreach as defined in the EPHS.
2. Provide basic first aid for minor injuries and emergencies referring to the Health Centre or hospital as necessary.
3. Provide advice on identification of danger signs in pregnancy and for common childhood illnesses.
4. Maintain accurate and regular reporting system (HMIS reports).
5. To support community members to adopt healthy attitudes, practices and behaviour and take responsibility for their own health.
6. Mobilize the CDC and health committee to identify and select FHWs and then participate in the selection.
7. To provide ongoing support to x FHWs in their work.
8. Mobilize the CDC and health committees to support the FHWs to increase demand for utilization of health, nutrition and WASH services by families.
9. To review the HMIS data provided by the x FHWs they support, ensuring appropriate action taken as necessary.
10. Maintain a healthy, hygienic facility and be a role model for the community in his/her personal life.

Management

The CHW will be a salaried post on MOH terms and conditions and based in the PHU. He/ she will be managed and report to the CDC and the Nurse at the nearest Health Centre. Similarly, the CHW will support the VHWs in the catchment area.

- CHWs will provide services for the catchment area.

- CHWS will work in an active manner, working at the PHU 6 days per week for a minimum of 6 hours per day, visit households where required on a regular basis. They will also facilitate group sessions as appropriate.
- CHWs should maintain links with referral health centres/PHUs to ensure clarity in referral points.
- The CHW will report on a monthly basis to the Community Development Committee as well as the relevant supervisor at the HC.
- Supportive supervision is provided by the District and Regional health offices and by MOH as per agreed schedule.

Qualifications

Male or Female with grade 6 education selected by the community and should be well respected in the community.

Key qualities include but not limited to the following:

- ✓ Must be able to read and write Somali at a basic level;
- ✓ Must be over 18 years of age;
- ✓ Must have good communication skills;
- ✓ Must be a resident in the village to be covered/catchment area and locally respected and trusted;
- ✓ Should not be engaged in other full time activities/employment; and
- ✓ Must be selected by the Community Development Committee and MOH in conjunction with the supporting NGO.

FEMALE HEALTH WORKER (FHWs)

Objective

To promote good health in her community and provide essential information and care for common illnesses at the household level. To refer and link patients to the PHU or Health Centre as required.

Main duties and responsibilities

- To deliver an agreed package of health, nutrition and WASH information and services within the community.
- To support community members to adopt healthy attitudes, practices and behaviour.
- Mobilize the health committee to help the FHW increase demand for utilization of health, nutrition and WASH services by families.
- To facilitate community action to assess the health, nutrition and WASH situation of children and women and support the planning of appropriate actions.

- To register population in her catchment area and maintain records of pregnant women, births, deaths and other children under 5 years and follow up to ensure they get necessary services from the nearest health/referral centre.
- To work with and support outreach, campaigns and any other public health events occurring in the community.
- To work with the community in supporting referral of anyone requiring a higher level of care.
- To help report any relevant outbreaks to the nearest health facility.
- To keep record of her activities and report monthly and to adequately account for usage of all materials.
- To participate in Community Development Committee meetings.
- To perform similar other duties as required by the community, CDC or MOH.
- To be a role model for the community in her personal life, including maintaining a healthy, hygienic home life.

Management and organization

The FHW will be provided incentives/salary on a scale agreed by MOH and based in the community working from her house. She will be managed and report to the CDC and the relevant supervisors as per agreed supervision system.

- FHWs will provide services for around 100-150 households (600-1,000 persons).
- FHWs will work in an active manner, visiting each household under their care on monthly basis and more frequently if needed. They can also facilitate group sessions as appropriate.
- FHWs should maintain links with referral health centres/PHUs to ensure clarity in referral points.
- The FHW will report on a monthly basis to the Community Development Committee as well as the relevant supervisor.
- Supportive supervision is provided according to the agreed supervision structure and mechanism.

Qualifications

Selected candidate must come from the community in which she will work ideally she should have attained an education level of grade 6 but in areas where this is not possible consideration could be given to basic literacy and life experience. Key qualities include but not limited to the following:-

- ✓ Must be female over 18 years of age, preferably married;
- ✓ Must have good communication skills;

- ✓ Must be a resident in the village to be covered/catchment area and locally respected and trusted;
- ✓ Should not be engaged in other full time activities/employment ; and
- ✓ Must be selected by the Community Development Committee in conjunction with health authorities at the district and regional level.