Introduction to the C3 tool
(CHW Coverage and Capacity) to strengthen CHW policy and programming

Institutionalizing Community Health Conference March 28, 2017

Presented by Melanie Morrow
Challenges for CHWs

Endless need; finite resources
What is the C3 Tool?

- An Excel-based tool for examining options of CHW allocation and engagement

C3

CHW
Coverage
(and)
Capacity

- A step toward rational planning for CHW programming
Illustrative Input: Snippet of policy options screen

<table>
<thead>
<tr>
<th>Maternal Health</th>
<th>Coverage of interventions</th>
<th>CHW 1 (Full-time, Paid)</th>
<th>CHW 2 (Full-time, Volunteer)</th>
<th>CHW 3 (Part-time, Paid)</th>
<th>CHW 4 (Part-time, Volunteer)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>yes</td>
<td>75</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Labour &amp; Delivery</td>
<td>yes</td>
<td>75</td>
<td>50</td>
<td>50</td>
<td>30</td>
</tr>
<tr>
<td>Post-partum</td>
<td>yes</td>
<td>75</td>
<td>50</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

| Newborn Health          |                           |                         |                             |                         |                             |
| Exclusive Breastfeeding | yes                       | 75                      | 75                          | 25                      |
| Post-Delivery Checks   | yes                       | 75                      | 100                         | 25                      |

Decision to include intervention in CHW program

Proportion of needed services that would be delivered by CHWs

Decision about distribution of workload among various CHW types
Potential uses of C3 Tool

- Planning at district (primary target), regional and/or national levels with support from MCSP staff experienced with the tool.
- Scenario building: “what if we ask X of CHW type Y?”
- Reality check: can our plan really work? If not, what modifications would make expectations
- *Not* a costing tool
Illustrative policy questions

• How many CHWs are needed to implement the draft CHW policy in Country X?
• How would “full” and “partial” implementation of the policy differ?
• What health services delivered by CHWs have the biggest impact on time use?
C3: Assumptions

- To make the model, we incorporate:
  - Population
  - Available days/hours of work
  - Time for travel
  - Time for each activity in scope of work as related to disease burden.
General disclaimer

- C3 results are based on *assumptions* for different *scenarios* of use of community health human resources:
  - Not actual evidence unless data available
  - But ‘reasonable guesses’
- C3 serves to identify potential significant policy-to-program gaps (not small variation)
- C3 is meant to open discussions for the MOH and partners
- Some important assumptions may require studies to establish actual benchmarks – we advise against seeking absolute certainty on all assumptions if they are “good enough” to compare scenarios
Illustrative C3 output: comparison of 2 scenarios

CHWs Available vs. CHWs Needed

Scenario 1: Full implementation of guidelines with part time CHW
- CHWs available
- CHWs needed for planned coverage
- CHWs needed for full coverage

Scenario 2: Partial implementation of guidelines with part time CHWs
- CHWs available
- CHWs needed for planned coverage
- CHWs needed for full coverage
Illustrative C3 output: CHW time use

Across functions
- Non-health sector work
- Travel
- Other non-service delivery
- Reporting and administrative tasks
- Direct service delivery

Across technical areas
- Maternal Health
- Child Health
- Infectious Disease/Communicable Diseases
- Newborn Health
- Sexual and Reproductive Health
- Water, Sanitation & Hygiene

Across activity types
- Health Communication, Home Visit
- Service Delivery, Home Visit
- Service Delivery, Facility/Health Post
- Health Communication, Community
- Service Delivery, Community
- Referral visit
## Sample policy options for discussion of hypothetical scenario short 10,000 CHWs

<table>
<thead>
<tr>
<th>Option</th>
<th>Pros</th>
<th>Cons</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediately recruit and train 10,000 more CHWs</td>
<td>Allows coverage of 1 CHW/21 HHs</td>
<td>Cost and challenges of scale</td>
<td>Is it realistic?</td>
</tr>
<tr>
<td>Take away iCCM from CHW role in accessible areas</td>
<td>Gives time for more preventive outreach and coverage (1 CHW/42HH)</td>
<td>Is access to treatment of malaria, pneumonia, diarrhea (high burden of disease) in health facilities satisfactory?</td>
<td>Responsiveness to drivers of mortality in accessible areas?</td>
</tr>
<tr>
<td>Geographic targeting: Concentrate CHWs in hard to reach areas, and provide full set of services (not tested in the C3 model)</td>
<td>Likely areas of maximum need (equity and impact). Better fit between targets and human resources available.</td>
<td>Current distribution may not match need. Unit cost of CHW support system higher in hard to reach areas. Political feasibility of incomplete national coverage.</td>
<td>Maximum targeting, but responsiveness to drivers of mortality in accessible areas further challenged. (How accessible are accessible areas?)</td>
</tr>
<tr>
<td>Household targeting: Limit home visits to ANC-PNC period + sick child.</td>
<td>Very strategic: maximizes potential for impact from trained and professionalized CHWs</td>
<td>Requires partnerships and active community-outreach and SBC strategy</td>
<td>Rebalancing roles and strategy</td>
</tr>
<tr>
<td>With addition of community-based and group-based strategies for promotion of preventive (not tested in the C3 model)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
For more information, please visit www.mcsprogram.org

This presentation was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.