Institutionalizing Community Health Conference

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ichc2017.org
Global Reference Guide for Community Health Worker Programs at Scale

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CHW Reference Guide has 16 chapters:

Section 1: Setting the Stage
- Intro
- History of CHWs
- National Level Planning
- Governance
- Financing
- Coordination and Partnerships

Section 2: Human Resources
- Roles & Tasks
- Recruitment
- Training
- Supervision
- Motivation

Section 3: CHW Programs in Context
- CHW Relationships with the Health System
- Community Participation

Section 4: Achieving Impact
- Maintaining CHW Programs at Scale
- Measurement and Data Use
- Wrap Up

Also includes: 12 country case studies & findings from key informant interviews about large-scale CHW programs; and annotated chapters and case studies
Case Studies (Appendix 1)

12 Large Scale CHW Programs
Why This Guide Now?

• To aid countries as they discuss, plan and implement activities to begin, expand, or strengthen large-scale CHW programs

• To provide a “sounding board” for issues that need to be considered

• To emphasize the need to tailor national programs to the national context and to tailor local implementation to the local context – there is no one size that fits all!
CHWs within the Health Sector
Who Are CHWs? (Chapter 1)

Auxiliary Health Workers
- Full-time
- Government-hired
- 1+ yr training
- Based at Peripheral health site or outreach site

Health Extension Workers
- More or less full-time
- Salaried + incentives
- Several months training
- Functions similar to AHW

Community Health Volunteers (Regular)
- Part-time duties
- Volunteer 5-20 hours / week with incentives
- Episodic short training
- From and live within community

Community Health Volunteers (Intermittent)
- Relatively light duties
- Volunteer
- Minimal training
- May be numerous
- Local
- Household visitation
Governance (Chapter 4)

In large-scale programs, formal governance structures, such as local government councils and/or community management committees may need to be relied on.
Financing (chapter 5)

CHW programs are not merely a stopgap solution. Investments in these CHW programs are, in fact, investments in strengthening the health system.

What is Needed?

- Careful planning
- Strong political support
- Documented early success
- Strong monitoring and evaluation program
- Strong linkages to local sources of revenue
Incentives: Direct and/or Indirect? (Chapter 11)

- Are there or has there ever been other CHW programs in the area? Are you in competition?
- What cultural or religious values sustain altruism?
- Is the CHW incentive package financially sustainable over the long-term?
- How are CHWs made visible in the health system and community?
- Are incentives fairly distributed among different types of CHWs?
- How many CHWs personally connect with the health issue?
- Do CHWs see training and experience as a stepping stone to professional development?
# Community Engagement (Chapter 13)

## Issues

<table>
<thead>
<tr>
<th>Issues</th>
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<tbody>
<tr>
<td>Power Dynamics</td>
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<td>Skills and Knowledge</td>
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<tr>
<td>Practices of Engagement</td>
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<tr>
<td>Transaction Costs</td>
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![Image of people waving hands]
Where to download

The following related documents are available at http://www.mchip.net/CHWresources:

• The CHW Reference Guide (in entirety)
• Annotated version of main chapters
• Annotated version of the country case studies

CHW Central blog posts by practitioners summarizing specific chapters:

http://www.chwcentral.org/article-archive/2017
(and in blog archives from 2016 and 2015)
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
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
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 Input:
Snippet of policy options screen

<table>
<thead>
<tr>
<th>Maternal Health</th>
<th>Included in CHW programme?</th>
<th>Coverage of interventions</th>
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<tbody>
<tr>
<td>ANC</td>
<td>yes</td>
<td>75</td>
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<tr>
<td>Labour &amp; Delivery</td>
<td>yes</td>
<td>75</td>
</tr>
<tr>
<td>Post-partum</td>
<td>yes</td>
<td>75</td>
</tr>
<tr>
<td>Newborn Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusive Breastfeeding</td>
<td>yes</td>
<td>75</td>
</tr>
<tr>
<td>Post-Delivery Checks</td>
<td>yes</td>
<td>75</td>
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<tr>
<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>
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</table>

- **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**
Illustrative C3 output: comparison of 2 scenarios

CHWs Available vs. CHWs Needed

Scenario 1: Full implementation of guidelines with part time CHWs
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
- Service Delivery, Community
- Referral visit
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?
### 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>
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<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>
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<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).</td>
<td>Current distribution may not match need.</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>
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<td>With addition of community-based and group-based strategies for promotion of preventive (not tested in the C3 model)</td>
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For more information, please visit www.mcsprogram.org

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