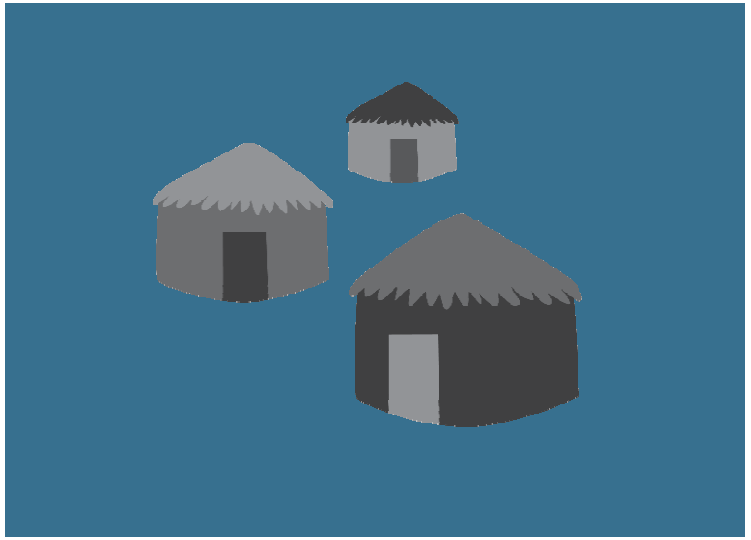
Institutionalizing Community Health Conference

27-30 March 2017 | Johannesburg, South Africa



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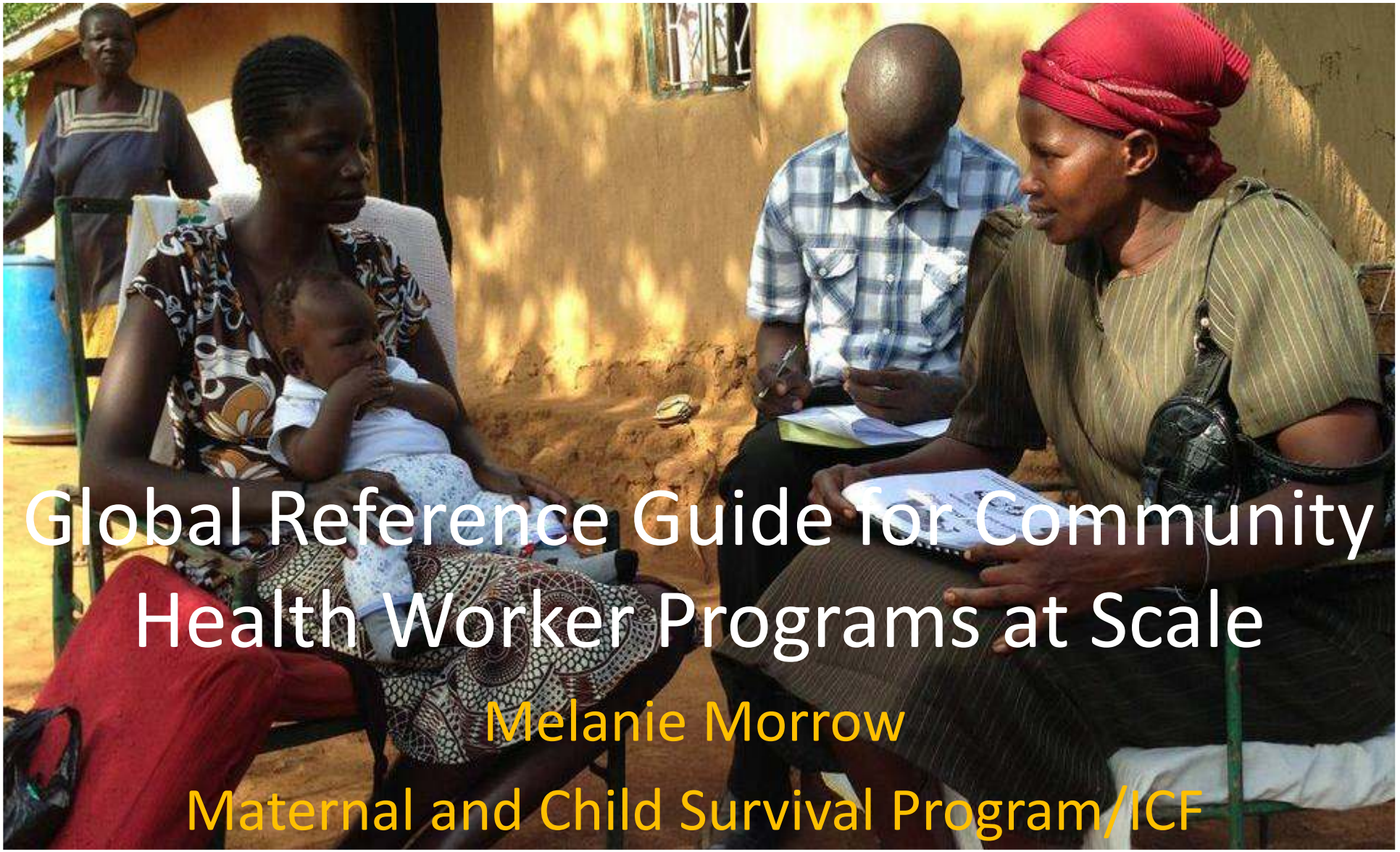


Global Reference Guide for Community Health Worker Programs at Scale

Melanie Morrow

Maternal and Child Survival Program/ICF

Senior Writers & Authors

SENIOR WRITING TEAM

- Lauren Crigler
- Claire Glenton
- Steve Hodgins
- Karen LeBan
- Simon Lewin
- Henry Perry

OTHER SENIOR AUTHORS

- Muhammad Mahmood Afzal
- Iain W. Aitken
- Christopher Colvin
- Jessica Gergen
- Wanda Jaskiewicz
- Sharon Tsui

COLLABORATING AUTHORS

- Novia Afdhila
- Shelly Amieva
- Said Habib Arwal
- Peter Berman
- Zaynah Chowdhury
- Rachel Deussom
- Dena Javadi
- Uta Lehman
- Jon Rohde
- Elizabeth Salisbury-Afsar
- Kerry Scott
- Katharine Shelley
- Francisco Sierra-Esteban
- Yekoyesew Worku
- Rose Zulliger

Peer Review

- Bill Brieger, JHU
- John Rhode, BRAC
- David Sanders, University of Western Cape

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

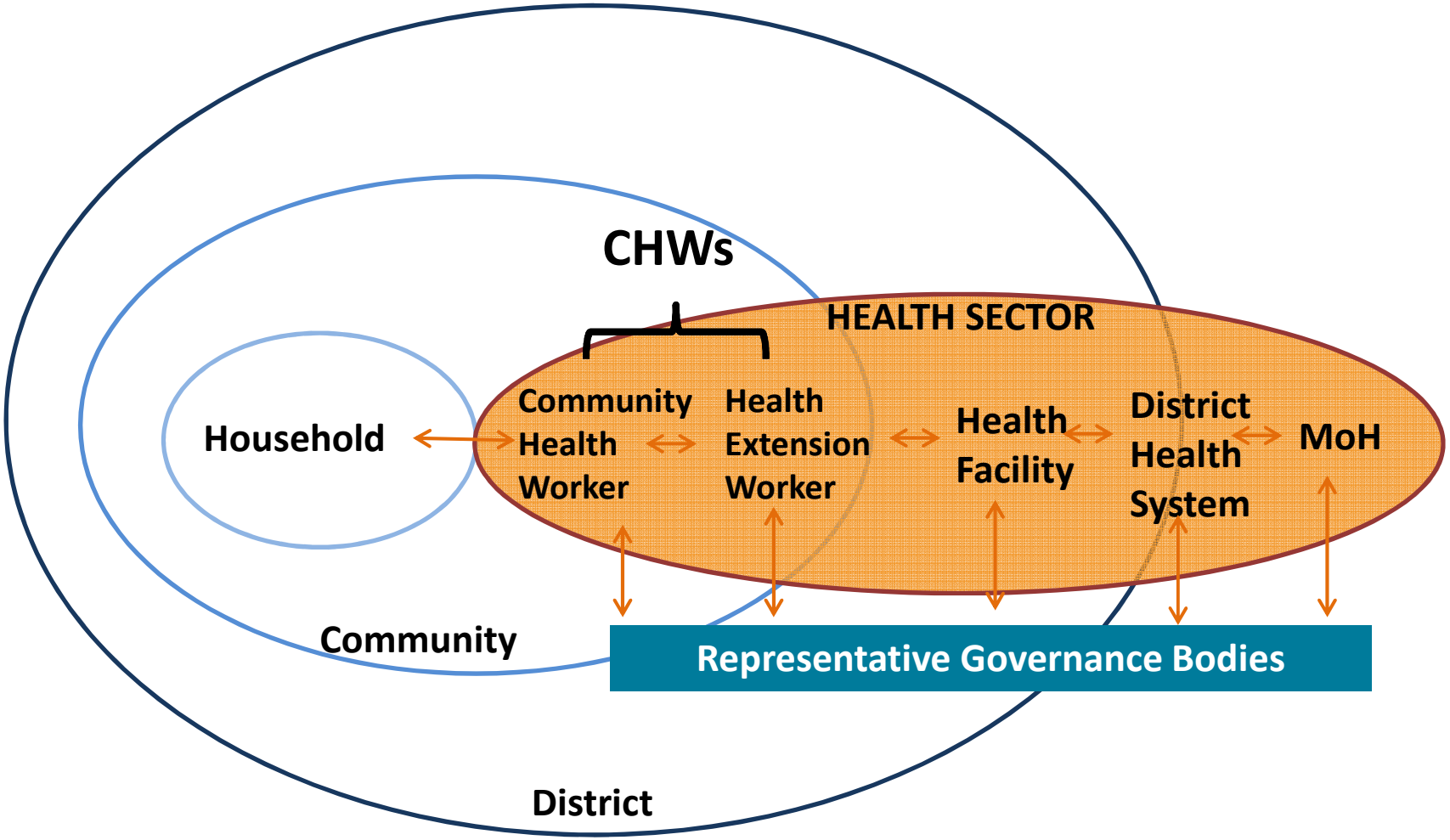
Case Studies (Appendix 1)

12 Large Scale CHW Programs

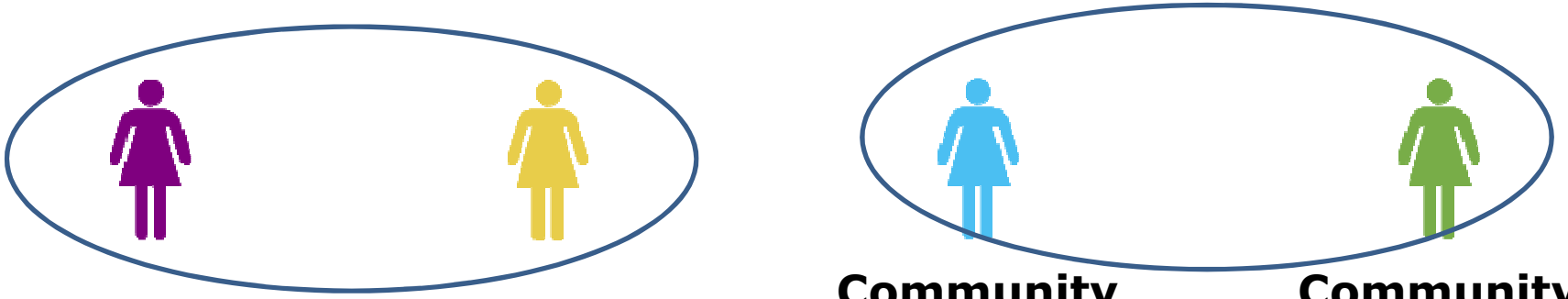
Why This Guide Now?

- 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	Health Extension Workers	Community Health Volunteers (Regular)	Community Health Volunteers (Intermittent)
• Full-time • Government -hired • 1+ yr training • Based at Peripheral health site or outreach site	• More or less full-time • Salaried + incentives • Several months training • Functions similar to AHW	• Part-time duties • Volunteer 5-20 hours / week with incentives • Episodic short training • From and live within community	• 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
Power Dynamics
Skills and Knowledge
Practices of Engagement
Transaction Costs

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)

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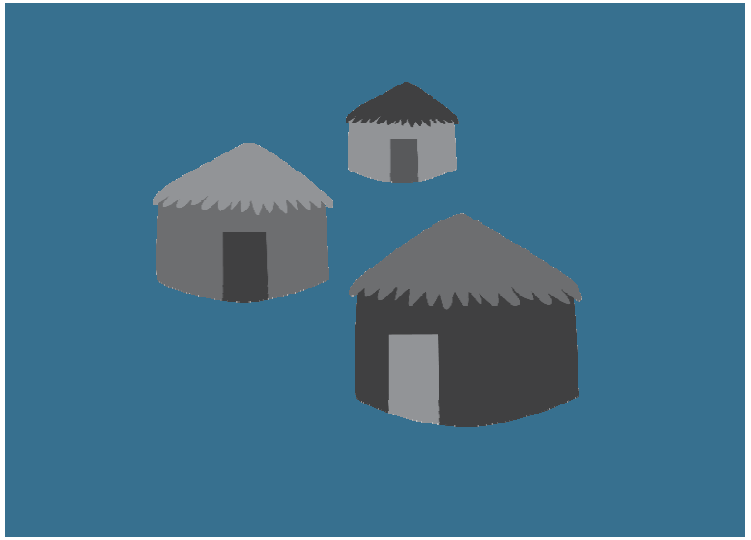

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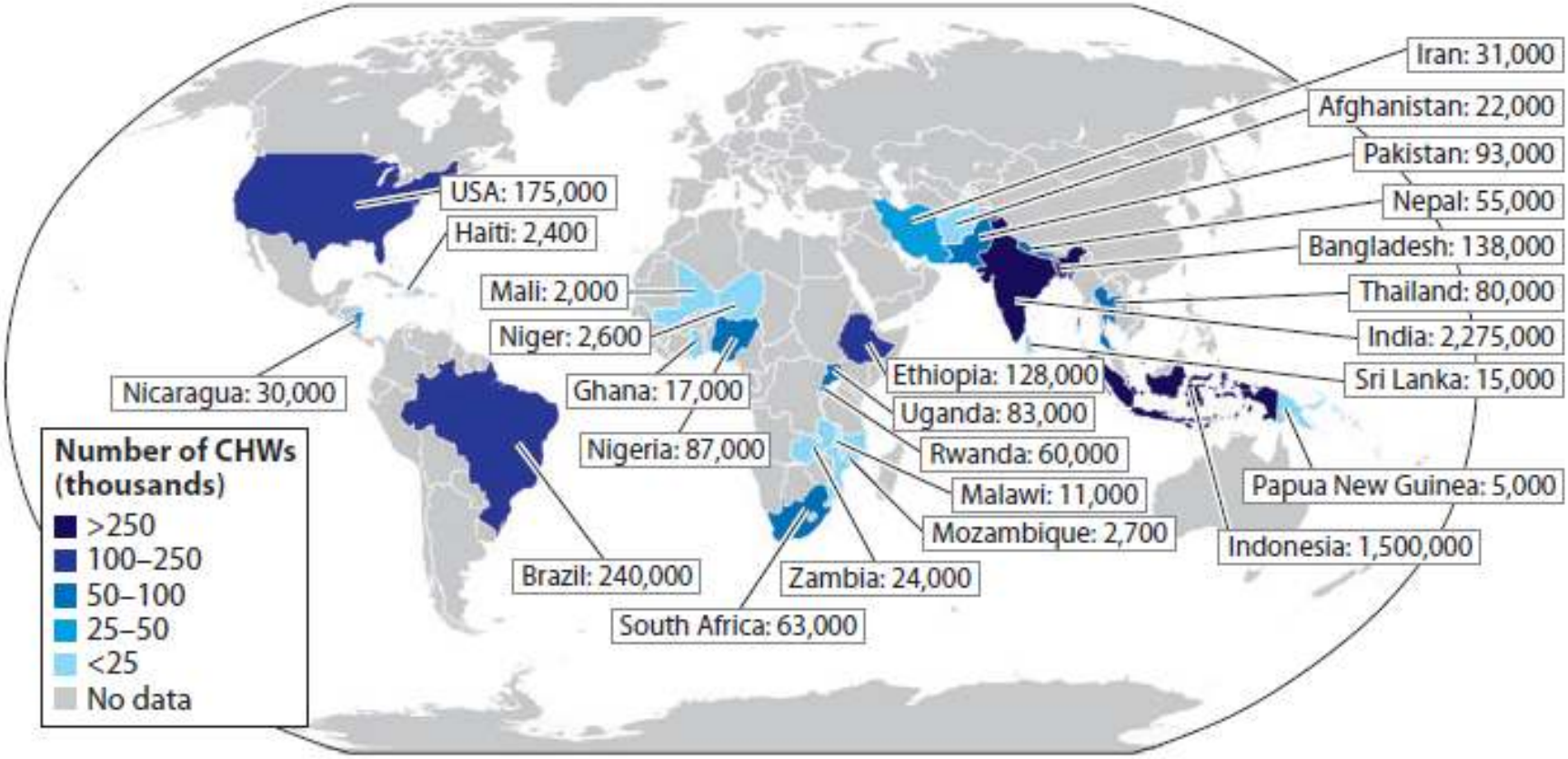
Maternal and Child Survival Program

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) **C**apacity

- 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

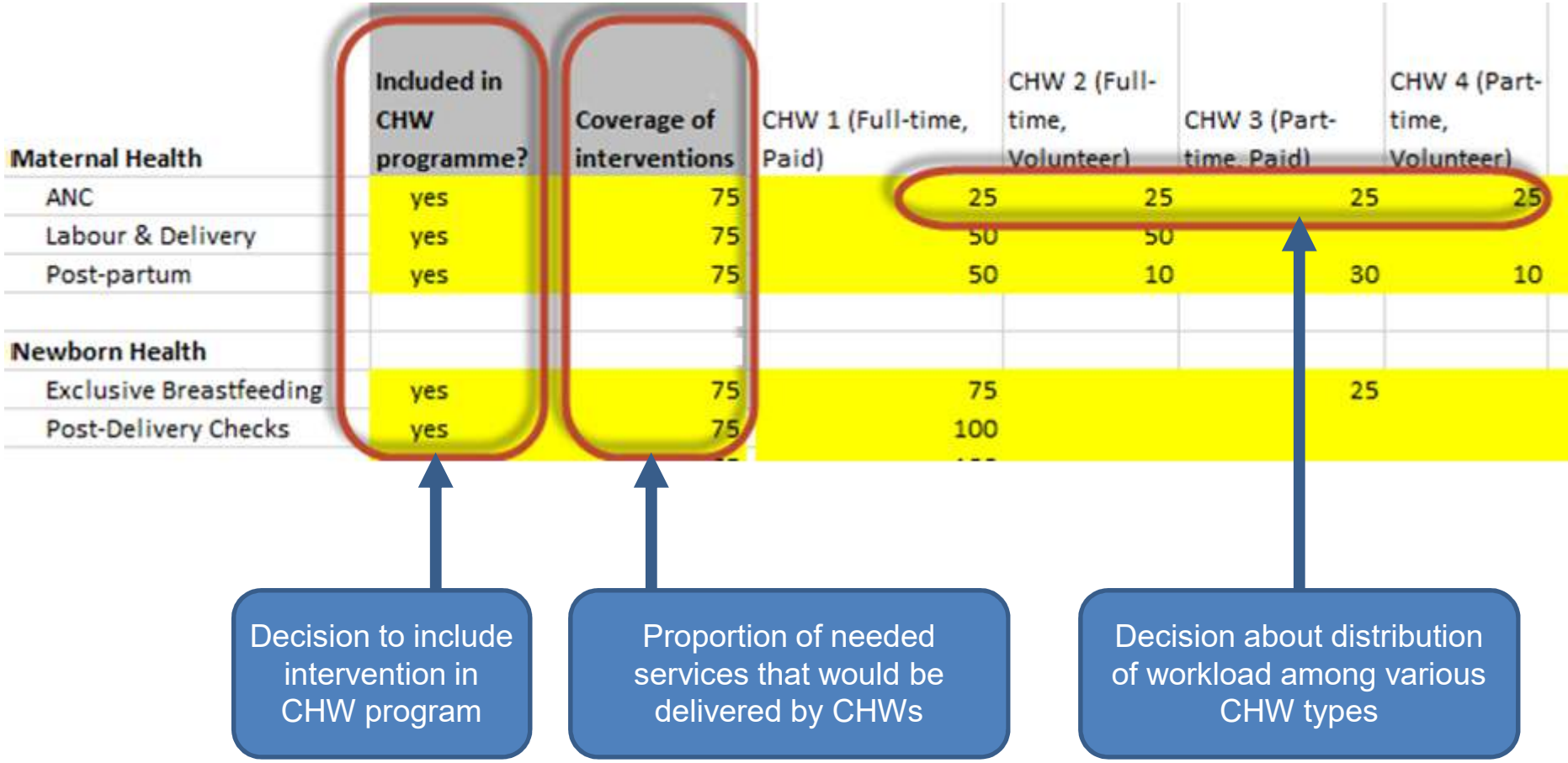
C3: Assumptions

- 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

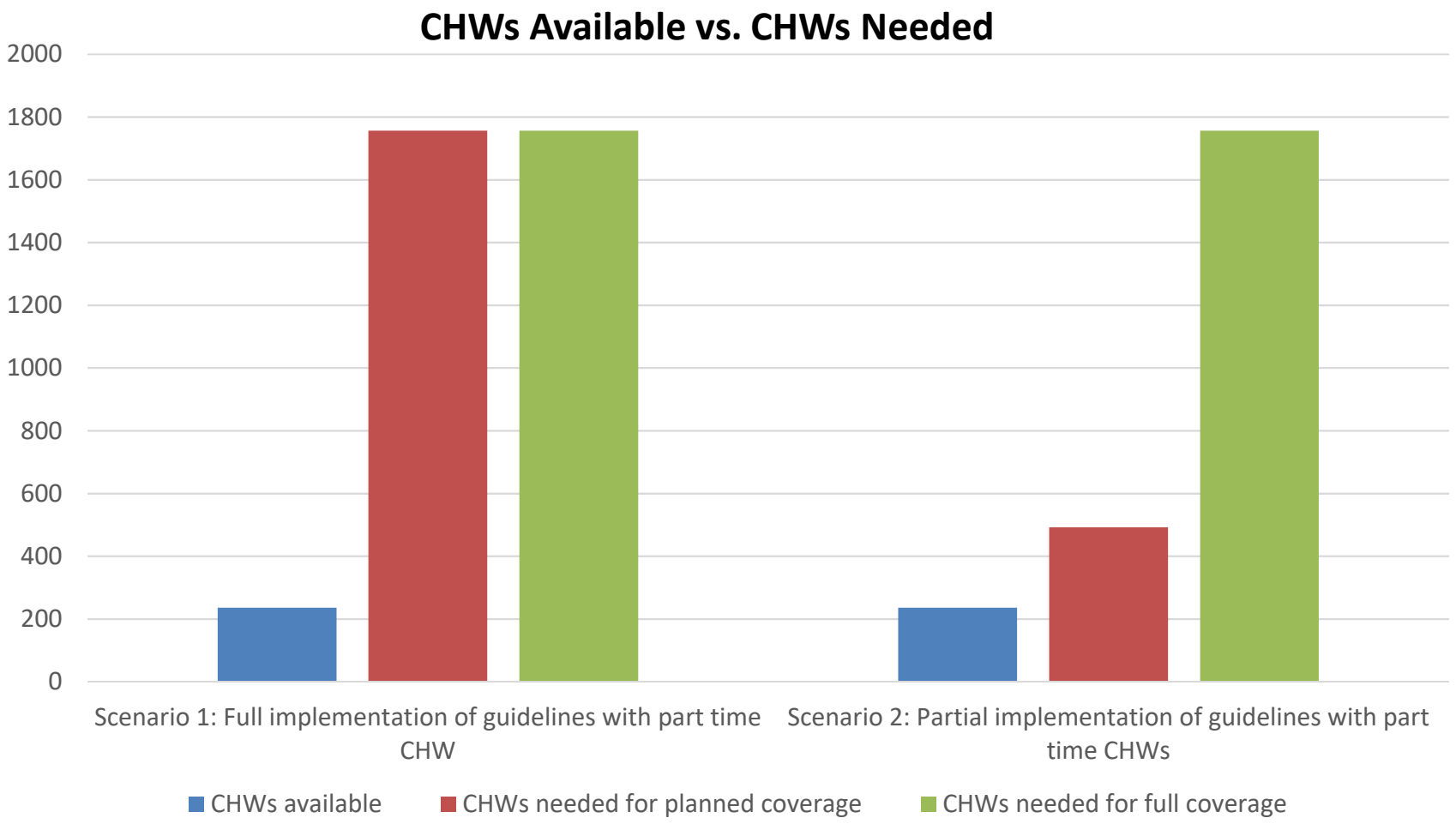
- C3 results are based on *assumptions* for different *scenarios* of use of community health human resources:
  - Not actual evidence unless data available
  - But 'reasonable guesses'
- C3 serves to identify potential significant policy-to-program gaps (not small variation)
- C3 is meant to open discussions 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



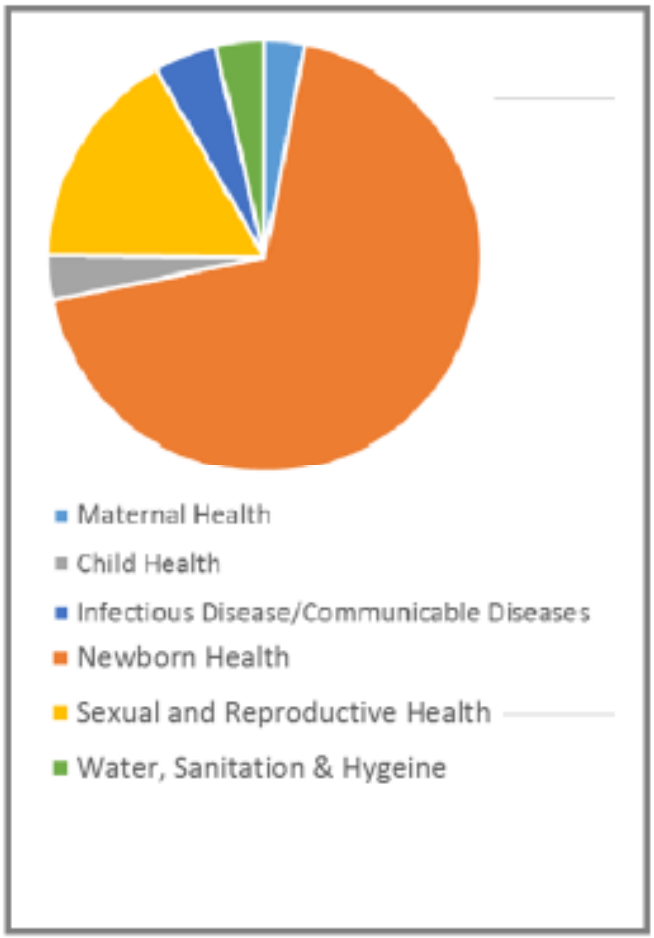
	Included in CHW programme?	Coverage of interventions	CHW 1 (Full-time, Paid)	CHW 2 (Full-time, Volunteer)	CHW 3 (Part-time, Paid)	CHW 4 (Part-time, Volunteer)
Maternal Health						
ANC	yes	75	25	25	25	25
Labour & Delivery	yes	75	50	50		
Post-partum	yes	75	50	10	30	10
Newborn Health						
Exclusive Breastfeeding	yes	75	75		25	
Post-Delivery Checks	yes	75	100			

Illustrative C3 output: comparison of 2 scenarios

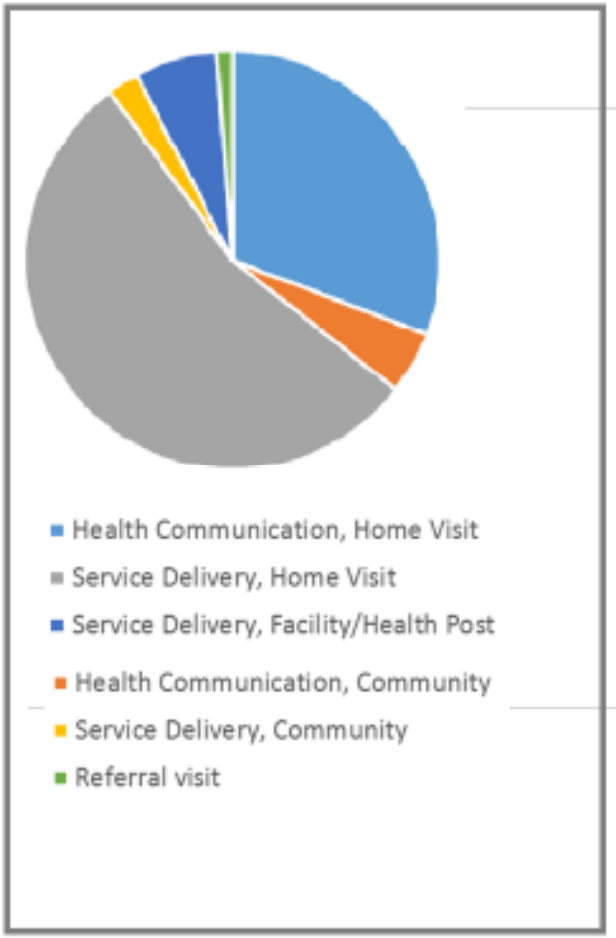


Illustrative C3 output: CHW time use

Across functions



Across technical areas



Across activity types

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

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

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.

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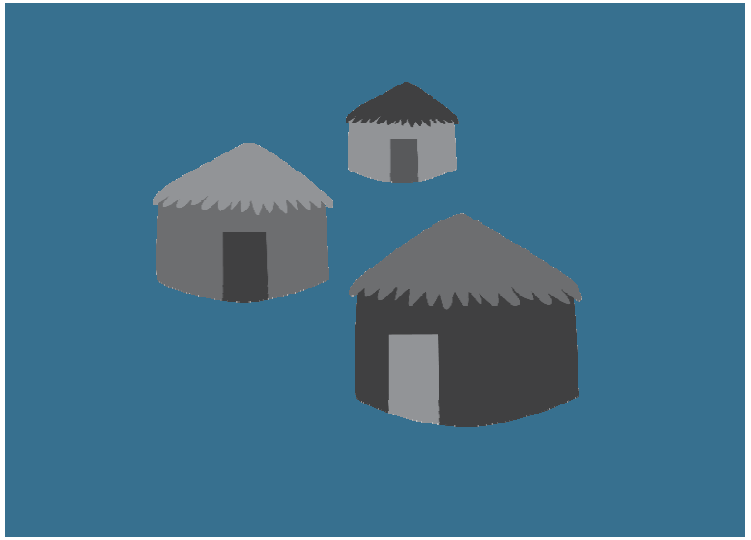

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