Advancing Primary Health Care at the Community Level: Integration, Quality, & Accountability

November 21, 2019 | 9am – 5pm
Side Meeting of the CHW 2019 Symposium | Dhaka, Bangladesh

Convening representatives from Afghanistan, Bangladesh, the Democratic Republic of the Congo, Ethiopia, Haiti, India, Kenya, Liberia, Nepal, Pakistan, and Uganda
WELCOME

Prof. Dr. Abul Hashem Khan
Line Director, CBHC
MOHFW, Government of Bangladesh
Agenda Overview

Morning
- High-level Introductions
- Tools to Improve Community Health System Design, Implementation & Measurement
- Country Exchange for CHW Program Optimization

Afternoon
- Community Health Worker Coverage and Capacity (C3) Tool
- Evidence, Learning & Data for Decision-Making for CHW Programs: Highlights from ICH Collaboration
- “Start, Stop, Continue” Activity
- Sharing of actions/takeaways toward fulfilling milestones in the journey towards ICHC 2020
- Next steps & closing
HIGH-LEVEL INTRODUCTIONS

Rory Nefdt
Senior Advisor Health,
Child and Community Health
UNICEF, New York

Luula Mariano
UNICEF, South Asia
Operationalizing PHC at community level

A common approach to:
- the health-related SDGs
- health and wellbeing
- UHC, and
- Expanding health access to primary care

David Hipgrave
Senior Health Advisor (Health Systems)
UNICEF, New York

Rory Nefdt
Senior Health Advisor (Child and Community Health)
UNICEF, New York
Pre-Astana: Global and country coordination on PHC... Now ongoing thru SDG3+GAP

Agreement to establish a PHC Partners WG
- Variety of int., bilateral & other agencies, foundations: WHO / UNICEF co-leads
- Replicated at each level

Convenings
- Meetings, Astana, WHA, UNGA, PMAC etc.
- SDG3+ Global Action Plan

Community of practice on PHC implementation
- Leveraging existing ones such as the Joint Learning Network, Community Health Roadmap, Health Harmonization in Africa etc.

Political advocacy
- G20 and G7, regional bodies (ASEAN, AU...), grps of nations, regional PH authorities

Country govt leadership & coordination
UHC, Health and Wellbeing through PHC

- Nutrition
- WASH
- Education
- Housing...

Multisectoral policy & action

Empowered people & communities

Primary care & essential public health functions as the core of integrated health services

Engage communities and youth
Social accountability
Empower women

Access AND Quality. Affordable for All!
SDG3+ Global Action Plan

Launched on 24 September during the 2019 UNGA

A joint initiative of 12 global health and development agencies committed to advance collective action and accelerate progress towards the health-related SDGs
ACCELERATE

7 cross-cutting areas where more innovative, synergistic efforts can significantly accelerate progress towards the health-related SDGs.

1. Primary health care
2. Sustainable financing
3. Community and civil society engagement
4. Determinants of health
5. R&D, innovation and access
6. Data and digital health
7. Innovative programming in fragile and vulnerable states and for disease outbreak response
Modalities - the ideal PHC “hows”

• Country level coordination through existing national and sub-national mechanisms led by government, inclusive of private sector and civil society

• Joint situation analysis and prioritisation, only as needed. Ideally prompted by the national health planning cycle

• A single framework of PHC metrics and measurements based on global standards

• Streamlined programmatic policies, operational rules and technical assistance to ↑ efficiency and ↓ fragmentation

• Aligned resources / ↑ domestic resources

• Aligned investment cases and more coherent financing plans for funding from government and all contributing agencies

• = full alignment with the seven key behaviours of the former IHP+

• A SWAp for PHC?
Accelerating PHC progress depends on its operationalization — HOW

Governance, policy and finance levers

1. Political commitment and leadership
2. Governance and policy frameworks
3. Adequate funding and equitable allocation of resources

Operational Levers

4. Engagement of community and other stakeholders across sectors
5. Models of care that prioritize both primary care/public health functions
6. Ensuring the delivery of high-quality and safe health care services
7. Engage private sector providers
8. The PHC workforce / HRH
9. Physical infrastructure,
10. Medicines, products & technologies
11. Digital technologies
12. Purchasing and payment systems
13. PHC-oriented research
14. Monitoring and evaluation

Blue = action aligned with other accelerators of progress on SDG3
Black = unique contribution of PHC
Agency/Partnership/Country Office approaches to PHC at country level

- Q’s to be asked at national health sector working group

1. What is govt’s strategic approach to PHC strengthening?
2. What are the gaps in PHC? What guides PHC planning, implementation, monitoring & evaluation?
3. What is the structure of agency support in-country? Led by govt or fragmented?
4. How will govt and partners operationalize PHC at community level?
5. What is the approximate level of support in each country? – $, HR, etc. By agency? In total?
UNICEF’s approach to universal health coverage, health & well-being through primary health care and health systems strengthening

**HEALTH & WELL-BEING**

*Primary care & essential public health functions as the core of integrated health services*

- **Multi-sectoral policy & action**
- **Empowered people & communities**

**Food Systems**

- Child Protection
- WASH

**Education System**

**Supply Chain Management**

- Quality of Care
- Data and Digital Health
- Governance and Partnerships (CSO, Pvt. Sector)
- Decentralized management
- National planning and financing
- Health Workforce

*Primary health care, as defined for Astana, 2018*

*Integrated Health, Nutrition, HIV and ECD services*

Supported by actions in the areas below to strengthen health systems
In order to **ensure healthy lives and promote wellbeing for all ages**...

...and achieve **UHC** viz. access to quality, affordable health care for everyone, everywhere...

...we need **PHC**, which is effective, efficient and equitable...

...and **community level action** that is cost-effective & high-impact; as the foundation for the supply of and demand for health and well-being

- Health promotion and service delivery, mostly **not in health facilities**
- Both **supply** of basic health care & **demand** for wellbeing, including activities by individuals for their own and their community’s H & WB
- **Community health workers** as one, but not the only, delivery channel
- Service delivery through **public, private** and non-govt sectors
- Linkages to **broader, multi-sectoral community approaches to the determinants of H & WB**
They thank you
HIGH-LEVEL INTRODUCTIONS

Catherine Kane
WHO, Geneva
WHO guideline on health policy and system support to optimize community health worker programmes

Catherine Kane
Accelerating Primary Health Care at the Community Level
21 November 2019
Introduction

Background
• Growing body of evidence supports CHW effectiveness for a range of services.

Challenges
• Inadequate health systems and community integration.
• Lack of best practices replication.
• Uneven adoption of evidence-based policies.

Rationale
• Identify management systems and strategies for CHW programmes.
• Provide recommendations to scale up, integrate, optimise design and performance, and sustain effective CHW programmes.
• Address normative gap on policy and system support.
Evolving roles & career pathways

• Guideline lays foundation for CHW programmes embedded in health systems.
• Multisectoral approach with health, education, labour, youth and finance ministries creates shared objectives.
• Supervision underscores health system links and mentoring.
• Emphasis on CHW rights and dignity envisions career pathways.
• Community engagement and integration.
Objectives & audiences

Objectives
• Provide gender-sensitive recommendations on CHW selection, training, management and integration.
• Identify implementation and evaluation considerations at policy and system levels.
• Suggest tools to support national uptake of recommendations in planning and operations.
• Identify priority evidence gaps.

Target audiences
• Policy-makers, planners and managers responsible for health workforce policy.
• Development partners, donors, global health initiatives, researchers, activists and civil society organizations.
• CHW organizations and community health workers themselves.
Methodology

- Overview of reviews
- 15 systematic reviews
- Stakeholder perception survey

Steering Group

Collaborative guideline development process

Guideline Development Group

External Review Group

WHO Guidelines Review Committee review and approval
Evidence sources

Geographical distribution of included studies across the 15 systematic reviews on the PICO questions

PRISMA diagram of studies assessed by the systematic reviews
Selecting, training & certifying CHWs

<table>
<thead>
<tr>
<th>Selection</th>
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<tr>
<td>• Specify minimum educational levels.</td>
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<td>• Require community membership and acceptance.</td>
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<tr>
<td>• Consider personal capacities and skills and apply appropriate gender equity to context.</td>
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<thead>
<tr>
<th>Pre-service training duration</th>
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<tr>
<td>• Base on CHW roles and responsibilities.</td>
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<tr>
<td>• Consider pre-existing knowledge.</td>
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<tr>
<td>• Factor in institutional and operational requirements.</td>
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<thead>
<tr>
<th>Curriculum to develop competencies</th>
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<tr>
<td>• Train on expected preventive, promotive, diagnostic, treatment and care services.</td>
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<tr>
<td>• Emphasize role and link with health system.</td>
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<td>• Include cross-cutting and interpersonal skills.</td>
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<tr>
<th>Training modalities</th>
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<tr>
<td>• Balance theory and practice.</td>
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<td>• Use face-to-face and e-learning, and conduct training in or near the community.</td>
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</tbody>
</table>

| Offer competency-based formal certification upon successful completion of training |
Managing & supervising CHWs

**Supportive supervision**
- Establish appropriate supervisor-CHW ratios.
- Train and resource supervisors to provide meaningful, regular performance evaluation and feedback.
- Use supervision tools, data and feedback to improve quality.

**Remuneration**
- Provide a financial package commensurate with the job demands, complexity, number of hours, training and roles that CHWs undertake.
- Include financial resources for CHW programmes in health system resource planning.

**Contracting agreements**
- For paid CHWs, establish agreements specifying roles, responsibilities, working conditions, remuneration and workers’ rights.

**Career ladder**
- Create pathways to other health qualifications or CHW role progression.
- Retain and motivate CHWs by linking performance with opportunities.
- Address regulatory and legal barriers.
Community embeddedness & system support (1/2)

**Target population size**
- Consider population size, epidemiology, and geographical and access barriers.
- Chart expected CHW workloads, including nature and time requirements of services provided.

**Collection & use of data**
- Enable CHWs to collect, collate and use health data on routine activities.
- Train CHWs and provide performance feedback based on data.
- Minimize reporting burden, harmonize requirements, and ensure data confidentiality and security.

**Types of CHWs**
- Adopt service delivery models comprising CHWs with general tasks.
- Consider complementary role for CHWs with more selective and specific roles, based on policy objectives and population health needs.
Community embeddedness & system support (2/2)

Community engagement

- Involve communities in selecting CHWs and promoting programme use.
- Engage community representatives in planning, prioritising, monitoring and evaluation.

Community resource mobilization

- Identify community needs and develop required responses through CHWs.
- Engage and mobilise local resources through CHW involvement.
- Encourage CHWs to support community participation and linking to health system.

Supply chain

- Ensure health system supply chain includes adequate, quality commodities for CHWs.
- Develop health system staff supply chain management capacities, including reporting, supervision, team management and mHealth.
Enablers of successful implementation

• Tailor CHW policy options to context.
• Consider rights and perspectives of CHWs.
• Embed CHW programmes in the health system, as part of a **diverse, sustainable skills mix**.
• Harness demographic dividends by increasing employment for young people, especially women.
• Resource and invest in CHW programmes as part of overall health strategy.

*The role of CHWs should be defined and supported with the overarching objective of constantly improving equity, quality of care and patient safety.*
Future of CHWs in Primary Health Care Agenda

• **1978:** Declaration of Alma-Ata
  • Recognised CHWs as a vital component of primary care.

• **2018:** [WHO Guideline on health policy and system support to optimize community health worker programmes](https://www.who.int/health-topics/community-health-workers#tab=tab-2) launched to support governments and partners:
  • To address immediate and pressing needs.
  • Based on evidence and considering CHW labour rights.

• **2019:** 72\textsuperscript{nd} World Health Assembly passes a resolution recognising the role of CHWs delivering quality primary health care services.
  • [Community health workers delivering primary health care: opportunities and challenges](https://www.who.int/health-topics/community-health-workers#tab=tab-2)

• **Future:** Evolution of health systems and epidemiological profiles:
  • CHW education, certification and career ladder support employability of CHWs.
“Improving the way WHO communicates is one of my priorities. We can produce the best guidelines in the world but there’s no point if nobody knows they exist.”

– Dr Tedros Adhanom Ghebreyesus
HIGH-LEVEL INTRODUCTIONS

Nazo Kureshy
Senior Community Systems Advisor, Office of Health Systems
Bureau for Global Health
USAID/Washington
Community Health Roadmap: Announcements, September 2019

1. Fully optimized community health platforms in the 15 roadmap countries could meaningfully bridge three gaps, including the potential to close the gap to reaching SDG 3 by 50%.

2. 14 COUNTRIES have established their national community health priorities that require action.

3. There are 6 CROSS-COUNTRY INVESTMENT PRIORITIES.

4. A CATALYTIC FUND will be ready to support national priorities.

5. There will be another institutionalizing community health conference in March 2020 (ICH C2020).

6. The Roadmap process will be on-going and led through a SECRETARIAT; it will also share progress across the 15 countries.

Source: Press Release and Webinar Recording (Sept 10, 2019)
Community Health Roadmap:
Cross-cutting Investment Priorities

1. Financing:
   Mobilize funding for CH/PHC, including sustainable domestic financing

2. Fragmentation:
   Reduce fragmentation by integrating community health into national system in particular in areas of human resources, supply chain, and information systems

3. Optimization:
   Optimize the quality of design and implementation of CH programs

4. Future fit:
   Identify design options for future CH/PHC systems

5. Performance management:
   Enhance performance management systems for CH

6. High-level commitment:
   Foster high-level political commitment to community health, in line with existing movements to achieve SDG 3
Focus of the Roadmap

Support government-led efforts to scale and optimize CH platforms, by:

- Collaborating with countries to highlight national priorities (current bottleneck addressed: unclear or misaligned understanding of priorities within government and among partners)
- Channeling more and aligned investments to countries toward executing national priorities (current bottleneck addressed: insufficient and fragmented support from funders/partners to countries)
- Accelerating cross-cutting investments in support of country progress (current bottleneck addressed: fragmented investments and not reflecting actual country needs)

Theory of Change for building high-functioning community health platforms at the country level

CH system levers
- Strengthened national-level inputs for CH:
  - Greater political prioritization
  - Better designed system and policies
  - Increased and more sustainable funding
  - Stronger management, leadership and stakeholder alignment

Program delivery in communities
- Higher performing community health platform integrated into the country’s primary healthcare system
  - Performance indicators used by countries

Outcomes
- Increased coverage of high quality health interventions

Triple impact
- Bridging the gaps on:
  - Survival
  - Equity
  - Thriving

Country 1
Country 2
Country ...
Country X
National Investment Priorities

- Afghanistan
- Burkina Faso
- Central African Republic
- Democratic Republic of Congo
- Cote D’Ivoire
- Ethiopia
- Haiti
- Kenya
- Liberia
- Malawi
- Mali
- Mozambique
- Niger
- Uganda
- Zambia
HIGH-LEVEL INTRODUCTIONS

**Bill & Melinda Gates Foundation**

Nicholas Leydon
Health Manager
BMGF, Seattle
Memorandum of Understanding (2016)
collaborate on a set of jointly defined investment priorities that advance frontline delivery of primary health care and community engagement in health systems
Integrating Community Health Collaboration: Elevating & Supporting Country Leadership
Facilitating Global Learning & Coordination

- USAID investment of in 7 countries – CHW entry point into health and community systems
- UNICEF contribution (global and national levels)
- BMGF investment in Last Mile Health

- BMGF investment in Population Council

- Community Health Community of Practice (UNICEF/USAID

- Government, ICH NGO, USAID Mission, UNICEF Country Office
- BMGF investment in Last Mile Health

- USAID investment of in 7 countries – CHW entry point into health and community systems
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- BMGF investment in Last Mile Health

- BMGF investment in Population Council

- Community Health Community of Practice (UNICEF/USAID

- Government, ICH NGO, USAID Mission, UNICEF Country Office
- BMGF investment in Last Mile Health
Institutionalizing Community Health Conference (ICHC): Convening Health Systems Leaders to Define the Way Forward

• **ICHC 2017 (USAID and UNICEF, in collaboration with BMGF, WHO, MCSP):**
  - 22 country delegations made commitments to advancing community health and supported these with action and learning plans.
  - Approximately 400 champions of community health endorsed [10 Critical Principles for Institutionalizing Community Health](#)

• **ICHC 2020 (TBD):**
  - Planning underway; stronger focus on country leadership & progress on priorities and cross-country dialogue on synergies, solutions
Tools to Improve Community Health System
Design, Implementation & Measurement
WHO guideline on health policy and system support to optimize community health worker programmes

Catherine Kane
Presentation to Advancing Primary Health Care at the Community Level
November 2019
Monitoring & accountability mechanism

• Background: Requested by Member States at World Health Assembly by Resolution A72/13: Community health workers delivering primary health care: opportunities and challenges

• Aims:
  – Quantify current state of CHW programmes globally
  – Provide a starting point for governments to assess their programmes against CHW Guideline recommendations
  – Support reporting progress against national and global indicators and goals
  – Align with current human resources for health and health systems tools
  – Minimise government reporting burdens
How it will work

- **Invite inputs**
- **Collect data**
- **Review & reconcile**
- **Incorporate in NHWA**
- **Validate**
- **Release**

**Other HRH data sources**
- Professional organizations: Non-governmental organizations, Educational institutions

**HRH data collection mechanisms**
- HRH registry
- Administrative data
- Health surveys
- Labour force surveys

**CHW data collection**
- WHO, UNICEF, CHW Hub, Technical/Implementing partners

**CHW Repository**
- National Health Workforce Accounts (NHWA)

**Validated by NHWA focal point**

**Validated national HRH data feeds into HRH policy**

**CHW Resolution reporting**

**Other HRH & CHW reporting & research**

**SDG 3c reporting**

**Global Health Observatory** (publicly available)
## M&A: Framework

### Indicators

<table>
<thead>
<tr>
<th>Number/density of community health workers</th>
<th>Reference/source</th>
<th>Yes</th>
<th>No</th>
<th>Partial Value</th>
<th>Guideline recommendation number</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>Strategy</strong></td>
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<tr>
<td>1. Community health worker programmes institutionalized within human resources for health strategies and policies, particularly for PHC and UHC, and in health sector investment plans.</td>
<td>CHWR</td>
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<td>2. Human resources for health information systems can generate data to track community health worker stock, education, distribution, flows, demand, capacity and remuneration.</td>
<td>NHWA 10-06</td>
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<td>3. Percentage of female community health workers in active workforce.</td>
<td>NHWA 1-04</td>
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<td><strong>Selection &amp; skills.</strong></td>
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<td>4. Existence of selection criteria that:</td>
<td>CHWR</td>
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<td>a. Specify minimum educational competency &amp; skill levels;</td>
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<td>b. Require community membership and acceptance;</td>
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<td>c. Consider personal capacities and skills; and</td>
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<td>d. Apply appropriate gender equity to context, favouring equal or greater female-to-male ratios.</td>
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<td>5. Existence of a national and/or subnational standard on the duration, delivery methodologies and content of CHW pre-service training and education.</td>
<td>NHWA 2-02, 3-01</td>
<td></td>
<td></td>
<td></td>
<td>2, 3, 4</td>
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<tr>
<td>a. Ratio of students enrolled in CHW education and training programmes to qualified educators in a given year.</td>
<td>NHWA 2-05</td>
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<td>b. Ratio of students completing a CHW education and training programme to students initially enrolled.</td>
<td>NHWA 2-06</td>
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<td>c. Existence of national systems for continuing professional development for CHWs</td>
<td>NHWA 3-08</td>
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<td>6. Issuance of competency-based certification to CHWs who have successfully completed pre-service training.</td>
<td>CHWR</td>
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<td>5</td>
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<td>a. Existence of an up-to-date master list of accredited CHW education and training entities that is publicly available.</td>
<td>NHWA 2-01</td>
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<tr>
<td>b. National and/or subnational mechanisms exist for accreditation of CHW education and training institutions and their programmes.</td>
<td>NHWA 3-02</td>
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**CHWR** = CHW Repository  
**NHWA** = National Health Workforce Accounts
## M&A: Framework

### Supervision

7. Presence of a strategy to provide regular supportive supervision to CHWs.  
   - CHWR

   a. Presence of a training system for supervisors that addresses technical content and supervision skills.  
   - CHWR

### Salary/remuneration strategy

8. Presence of a remuneration strategy with a financial package commensurate with the job demands, complexity, number of hours, training and roles that CHWs undertake.  
   - CHWR

   a. Average entry level wage and salary (in US dollars equivalent), excluding social contributions  
   - NHWA 7-05

   b. Presence of written contracting agreements for paid CHWs, specifying roles, responsibilities, working conditions, remuneration and workers’ rights  
   - CHWR

   c. Existence of a career pathway envisioned for CHWs, including other health qualifications or CHW role progression.  
   - CHWR

### System support

9. CHWs collect, collate and use data in routine activities.  
   - CHWR

   a. CHWs use mHealth tools  
   - CHWR

10. Service delivery models include CHWs with general tasks as part of integrated care teams.  
    - CHWR

   a. Service delivery models include CHWs with selective and specific tasks, based on population health needs, cultural context and workforce configuration.  
    - CHWR

11. Community representatives are formally and regularly engaged in planning, selection, priority setting, monitoring, evaluation and problem-solving of the CHW programme and its activities.  
    - CHWR

### Supply

12. Presence of a health supply chain that includes adequate, quality-assured commodities and consumables for CHWs.  
    - CHWR

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CHWR = CHW Repository  
NHWA = National Health Workforce Accounts
“We all share the belief that the key to universal health coverage is to involve and grow the health care team. Community health workers should stand side-by-side with nurses and doctors to extend primary health care to every last child and family on earth.”
– Jim Campbell, WHO Health Workforce Director

who.int/hrh/community
Workforce2030@who.int
#workforce2030
Frontline Health Project Objectives

1. Measurement
   Develop consolidated measurement framework and metrics to measure effectiveness of community health worker programs

2. Monitoring
   Work with in-country implementing partners to support the adoption of the measurement framework and metrics

3. Research
   Conduct operations research in several countries to address gaps in knowledge on approaches to implementing effective community health worker (CHW) programs
Frontline Health Project

- November 2017 - April 2021
- Supported by the Bill and Melinda Gates Foundation
- Development Partners: USAID, UNICEF
- Advocacy Partner: Last Mile Health
- In-country implementing partners:
  - Mali – Aga Khan Foundation
  - Liberia – Last Mile Health
  - DRC – Humana People to People
  - Bangladesh – Save the Children
  - Kenya – Liverpool School of Tropical Medicine
  - Uganda – Pathfinder International
  - Haiti – Zanmi Lasante
Community Health Performance Measurement Framework

Inputs
- Policies
  - CHW selection
  - CHW tasks/workload
- Governance/Stakeholders
- Logistics
  - Transportation
  - Commodities
- Funding
- Information/Management Systems

Programmatic Processes
- Supportive Systems
  - Supervision & performance appraisal
  - Data use
- CHW Development
  - Recruitment
  - Training
  - Incentives
- Support from Community-Based Groups

Community Health Systems Performance Outputs
- CHW-Level Outputs
  - CHW Competency
    - CHW knowledge
    - Service delivery
    - Service quality
    - Data reporting
    - Absenteeism
  - CHW Well-Being
    - Motivation
    - Job satisfaction
    - Attrition/retention

Community-Level Outputs
- Community Access
  - Use of services
  - Knowledge of service availability
  - Referral/counter referral
- Community-Centered Care
  - Empowerment
  - Experience of care
  - Credibility/trust of CHW

Outcomes
- Improved Health Outcomes

Economic Evaluation
- Equity, Gender, Accountability
Why standardize metrics?

1. Shared understanding of “value” - what outcomes are meaningful measures of program success

2. Provide generalized guidance for programs and effective resource use

3. Standardize data at a national level to support interoperable systems

4. Identify programs and countries that are performing well and conversely programs and countries that need additional attention

5. Supporting global knowledge on best practices
Community Health Performance Measurement Framework - Goal

• Guide the development of standardized metrics for measuring the performance of community health programs

• Provide groundwork:
  • to guide CHW programs at various stages of scale in measuring program performance
  • for standardizing global metrics for monitoring CHW programs
Community Health Performance Measurement Framework - Approach

• We built our framework within a health system approach - broad lens on community health programs that support CHWs.

• Metrics development works from an interest in CHW performance. Not on measures around the impact of services in a specific health/disease area (e.g. HIV, maternal health etc.)

• Focus on aspects that are amenable to, and critical for, the purposes of measurement of CHW performance.

• Balance between:
  - short-term demand for data to inform programmatic activities and longer-term data needs to understand effectiveness of the program.
  - Routinely collected data and data collected through special surveys
## Community Health Performance Measurement Framework - Process

### Reviewing the literature
- **Key sources include:** CHW-AIM, CHW logic model, USAID Community Health Framework, PHCPI's conceptual framework, WHO National Health Workforce Accounts, DHS, SPA, SDI, Countdown to 2030, WHO European Health for All, OECD Health Care Quality Indicators, SDG Goal 3 Indicators, WHO Global Reference List of Core Health Indicators, and iCCM indicators

### Developing the Measurement Framework
- 7 ICH partners and country MoH representatives met in Johannesburg, South Africa in May 2018
- Stakeholders established priority domains, identified a minimum set of indicators, and noted measurement challenges from implementer & policymaker perspectives

### Refining and Establishing Consensus
- A Technical Advisory Group (TAG) of global stakeholders, community health systems advocates and measurement experts was convened in May 2018.
- TAG completed a survey ranking the importance and value of domains and indicators identified at the ICH partners meeting.

### Finalizing the metrics
- Researchers, program implementers, and policy stakeholders met during the Health Systems Research Symposium in Liverpool, UK in October 2018.
- Participants confirmed the priority areas for measurement and relevant metrics through a nominal group technique process.
Community Health Performance Measurement Framework

**Inputs**
- Policies
  - CHW selection
  - CHW tasks/workload
- Governance/Stakeholders
- Logistics
  - Transportation
  - Commodities
- Funding
- Information Management Systems
- Supportive Systems
  - Supervision & performance appraisal
  - Data use
- CHW Development
  - Recruitment
  - Training
  - Incentives
- Support from Community-Based Groups

**Programmatic Processes**

**Community Health Systems Performance Outputs**
- CHW Competency
  - CHW knowledge
  - Service delivery
  - Service quality
  - Data reporting
  - Absenteeism
- CHW Well-Being
  - Motivation
  - Job satisfaction
  - Attrition/retention
- Community-Level Outputs
  - Community Access
    - Use of services
    - Knowledge of service availability
    - Referral/counter referral
  - Community-Centered Care
    - Empowerment
    - Experience of care
    - Credibility/trust of CHW

**Outcomes**
- Improved Health Outcomes
- Economic Evaluation
- Equity, Gender, Accountability
<table>
<thead>
<tr>
<th>Indicator domains</th>
<th>Definition/explanation</th>
<th>Example measurement areas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. CHW Competency</strong></td>
<td>Degree to which CHW has the knowledge and skills necessary to carry out the assigned tasks</td>
<td></td>
</tr>
<tr>
<td>CHW knowledge</td>
<td>Degree to which CHWs have theoretical knowledge of counselling, preventative and curative and other tasks they are responsible for</td>
<td>1. Knowledge around different health areas</td>
</tr>
<tr>
<td>Service delivery</td>
<td>Quantity of promotional, preventive and curative services CHWs provide to community members</td>
<td>1. # of home visits per CHW by health area Populations level coverage</td>
</tr>
<tr>
<td>Quality of services provided</td>
<td>Adherence to standards and procedures (Treatment accuracy)</td>
<td>1. CHW adherence to recommended protocols/procedures</td>
</tr>
<tr>
<td>Data reporting</td>
<td>Regularity with which CHWs report on the services they provide at the community-level</td>
<td>1. Regularity of data reported 2. Quality of data reported</td>
</tr>
<tr>
<td>CHW Absenteeism</td>
<td>Frequency with which CHWs do not carry out their tasks (days absent?)</td>
<td>1. Days (in the last month), CHW worked a CHW</td>
</tr>
<tr>
<td><strong>2. CHW well-being</strong></td>
<td>The overall well-being of the CHW may be seen as a measure of effectiveness of the system that supports the CHW program</td>
<td></td>
</tr>
<tr>
<td>CHW motivation</td>
<td>An individual’s degree of willingness to exert and maintain effort on assigned tasks; A CHW’s confidence, belief in his/her ability to produce a desired result</td>
<td>Measured through a series of questions that make a motivation scale. Includes self-esteem.</td>
</tr>
<tr>
<td>CHW Job-satisfaction</td>
<td>Degree to which CHWs derive personal satisfaction from serving the community and providing services</td>
<td>1. Satisfaction with community support/health facility staff support 2. Confidence in education</td>
</tr>
</tbody>
</table>
# Community Health Worker Performance Indicators

## Domain 1: Supportive Systems

### Sub-Domain A: Supervision and performance appraisal

1. 
   - % of supervisors trained in management and supervision of CHWs
2. 
   - Ratio of CHWs to supervisors
3. 
   - % of supervisory visits that met the quality criterion
4. 
   - Average # of visits per supervisor to monitor/support CHW activities in the last month
5. 
   - % of CHWs who received a supervisory visit in the last 1-3 months that includes review of reports and data collected
6. 
   - Average # of supervisory contacts (in-person visits, phone calls, text messages, etc.) per CHW

### Sub-Domain B: Data use

7. 
   - % of health workers (CHWs/supervisors/health facility staff) who have access to client data AND who report using the data to make decisions about their provision of services
8. 
   - % of national/sub-national/facility/community meetings in which data (from standardized reporting platforms etc.) are discussed/reviewed
9. 
   - % of CHWs who have access to the client data they have collected (for follow-up) in the last 6 months
## Community Health Worker Performance Indicators

### Domain 2: CHW Development

**Sub-Domain A: Recruitment**

10. \% of CHWs who have been selected in alignment with selection criteria
11. \# of CHWs who have been selected/recruited
12. \% of target communities/populations that have an assigned CHW

**Sub-Domain B: Training**

13. \% of CHWs who have received initial training
14. \% of CHWs who have received follow-up training in the last two years
15. \% of CHWs who have completed the certification program

**Sub-Domain C: Incentives**

16. \% of CHWs who have received their stipend in the last month
17. \% of CHWs who have received a specific non-financial incentive

### Domain 3: Support from Community-based Groups

18. \# of planning/review meetings held at the level of the local government to discuss CHW program performance
## Community Health Worker Performance Indicators

<table>
<thead>
<tr>
<th>Domain 4: CHW Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-Domain A: CHW knowledge</strong></td>
</tr>
<tr>
<td>19. #/ of CHWs who have passed knowledge/competency tests (following training)</td>
</tr>
<tr>
<td>20. #/ of CHWs who express that they feel confidence in their abilities to provide health education</td>
</tr>
<tr>
<td>21. #/ of CHWs who express confidence in their abilities to deliver basic healthcare services</td>
</tr>
<tr>
<td><strong>Sub-Domain B: Service delivery</strong></td>
</tr>
<tr>
<td>22. Average # of home visits made by CHWs in the last month (indicator to be disaggregated by type of home visit - i.e. sick child visit, antenatal care, etc.)</td>
</tr>
<tr>
<td><strong>Sub-Domain C: Service quality</strong></td>
</tr>
<tr>
<td>23. #/ of CHWs who correctly identified the case/health problem (as per items in a checklist)</td>
</tr>
<tr>
<td>24. #/ of CHWs who correctly addressed (treated) the identified health problem (as per items in a checklist)</td>
</tr>
<tr>
<td>25. #/ of CHWs with all the key stock commodities in the last reporting period</td>
</tr>
<tr>
<td>26. Average time from onset of symptom to first contact with CHW</td>
</tr>
<tr>
<td><strong>Sub-Domain D: Data reporting</strong></td>
</tr>
<tr>
<td>27. #/ of CHWs who submitted reports in the last month</td>
</tr>
<tr>
<td>28. #/ of CHW reports submitted that were complete/did not have missing information</td>
</tr>
<tr>
<td><strong>Sub-Domain E: Absenteeism</strong></td>
</tr>
<tr>
<td>29. #/ of CHWs who reported on their activities in the last month</td>
</tr>
<tr>
<td>30. # of days CHW has performed at least one CHW responsibility in the last month</td>
</tr>
</tbody>
</table>
## Community Health Worker Performance Indicators

### Domain 5: CHW Well-Being

<table>
<thead>
<tr>
<th>Sub-Domain A: Motivation</th>
</tr>
</thead>
<tbody>
<tr>
<td>31. Composite metric</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-Domain B: Job satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>32. % of CHWs who expressed satisfaction with the community support they receive</td>
</tr>
<tr>
<td>33. % of CHWs who expressed satisfaction with the support they receive from health facility staff</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-Domain C: Attrition/ Retention</th>
</tr>
</thead>
<tbody>
<tr>
<td>34. In the last 3 months, % of CHWs who have reported on their activities</td>
</tr>
</tbody>
</table>
### Community Health Worker Performance Indicators

#### Domain 6: Community Access

<table>
<thead>
<tr>
<th>Sub-Domain A: Use of services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>35. #/% of households who received at least one visit by a CHW in the last 3 months</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-Domain B: Knowledge of service availability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>36. #/% of community members that know the name of the community CHWs</td>
<td></td>
</tr>
<tr>
<td>37. #/% of community members who can name at least 3 services that the CHW provides</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-Domain C: Referral/counter-referral</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>38. % of individuals referred by CHW to the health facility per 100 clients seen (and subset by reasons for referral)</td>
<td></td>
</tr>
<tr>
<td>39. #/% of clients that completed the referral at the health facility (referral completion)</td>
<td></td>
</tr>
<tr>
<td>40. #/% of referred clients seen at receiving service (health facility) that is seen back at referring service (CHW) with complete counter-referral information (counter-referral)</td>
<td></td>
</tr>
<tr>
<td>41. Average # of referrals made per CHW in the last month</td>
<td></td>
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</tbody>
</table>

#### Domain 7: Community-Centered Care

<table>
<thead>
<tr>
<th>Sub-Domain A: Empowerment</th>
<th></th>
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<tbody>
<tr>
<td>42. Composite metric</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-Domain B: Experience of care</th>
<th></th>
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<tbody>
<tr>
<td>43. #/% of women/households who express satisfaction with services they received from the CHW in the last 3 months</td>
<td></td>
</tr>
<tr>
<td>44. #/% of women who report that in their interaction with the CHW they felt humiliated or disrespected (scale 1-5)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Sub-Domain D: Credibility/trust of CHW</th>
<th></th>
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<tbody>
<tr>
<td>45. #/% of women/clients who report they trust the health information provided by the CHW</td>
<td></td>
</tr>
<tr>
<td>46. #/% of women/clients who report they trust the treatment services provided by the CHW</td>
<td></td>
</tr>
</tbody>
</table>
Next steps

• Dissemination of framework and 46 metrics
• Conducting DCE (remuneration), metrics validation (perceived supportive supervision, referral, CHW & client empowerment, client trust, CHW motivation), and operations research studies in Bangladesh, Haiti, Kenya, Mali, & Uganda
• Look for alignment with other tools, e.g. AIM toolkit
The Population Council conducts research and delivers solutions that improve lives around the world. Big ideas supported by evidence: It’s our model for global change.
State-of-the-Art Tools & Resources to Optimize CHW Programs

Rachel Deussom, MSc
Technical Director
Human Resources for Health in 2030 (HRH2030) Program
Chemonics International
WHO Community Health Worker Guideline Recommendations Using Lifecycle Approach

1. CHW Selected
   - Based on educational level, gender equity, motivation, community membership and trust

2. CHW Trained
   - Content builds on responsibilities and baseline knowledge, and promotes quality services
   - Competency-based curriculum includes service package, health system links, interpersonal skills
   - Training is practical, blended and close to community

3. CHW Certified
   - Formal, competency-based certification

4. CHW Contracted
   - Adequate remuneration
   - Formal agreement

5. CHW Retained
   - Supported through routine supervision, mentoring and performance feedback
   - Career path opportunities

6. CHW Integrated in Health System
   - Appropriate workload and population size
   - Data generation and use, including mHealth
   - CHW tasks integrated in primary health care
   - Community engagement to use and inform services
   - Community health resource mobilization and solutions
   - Contributions to “last-mile” supply chain management

7. Community Health Needs Inform New Skills | Enhanced Scope

8. High-performing health system that is accessible, accountable, affordable and reliable

9. Optimizing

10. EDUCATION/HEALTH SECTOR
11. COMMUNITY HEALTH LABOR MARKET

CHW POLICY IMPLEMENTATION ENABLERS: Tailoring CHW policy options to context | Considering CHW rights & perspectives | Embedding CHW program in health system | Investing in CHW programs
Recommandations des directives de l'OMS sur les agents de santé communautaires en utilisant une approche de cycle de vie

**Construction**

- **Construire**
  - Les besoins en santé des communautés informe de nouvelles compétences / une portée accrue
  - ASC sélectionné
    - Base sur le niveau d'éducation, l'égalité des sexes, la motivation, l'appartenance à la communauté, et la confiance
  - ASC formé
    - Le contenu s'appuie sur les responsabilités et les connaissances de base et promeut des services de qualité
    - Le programme d'études basé sur les compétences comprend un ensemble de services, des liens avec le système de santé et des compétences interpersonnelles
  - ASC certifié
    - Certification fondée sur les compétences
  - ASC sous contrat
    - Remunération adéquate
      - ASC maintenu
        - Soutenu par la expansion de rotation, le mentorat et les retours d'informations
        - Opportunités de parcours de carrière
          - ASC intégré au système de santé
            - Charge de travail et taille de la population appropriées
            - Génération et utilisation de données, y compris Santé
            - Tâches des ASC intégrées dans les soins de santé primaires
            - Engagement de la communauté à utiliser et à informer les services
            - Mobilisation des ressources en santé communautaire et solutions communautaires
            - Contributions à la gestion de la chaîne d'approvisionnement du dernier kilomètre

**Gérer**

**Marché du travail en santé communautaire**

**Santé pour tous**

Un système de santé performant, accessible, responsable, abordable et fiable

**FACILITATEURS DE MISE EN ŒUVRE DE LA POLITIQUE DES ASC**

- Adapte les options de politique des ASC au contexte
- Prise en compte des droits et perspectives des ASC
- Intégration du programme ASC dans le système de santé
- Investir dans les programmes ASC
WHO CHW Guideline
Integrate global recommendations into national policy/strategy and subnational implementation

Community health systems catalog
Access national CHW policies and supporting documents

= Community Health Roadmap resource
Strengthening PHC through CHWs: 
Investment Case & Financing Recommendations

Powerful economic and impact case for investing in community health, outlined principles for building strong community health platforms, and presented a pathway to sustainably financing those platforms.

Closing the $2 Billion Gap

Strengthens the knowledge base on community health financing and draws lessons from Zambia and Ethiopia on financing pathways to secure additional resources.
BUILDING the Community Health Workforce

Global CHW Training Packages (for adaptation)

Example: Comprehensive training & implementation materials
→ English & French
→ Implementation Guide
→ Job aids
→ Training manuals
→ Guidance for M&E, advocacy, scale up

Example: Clearly defined gender competency framework, domains & competencies
MANAGING the Community Health Workforce

WHO CHW Monitoring and accountability framework (in progress)

Community Health Performance Measurement Framework

CHW AIM Tool: Updated Program Functionality Matrix

= Community Health Roadmap resource
MANAGING the Community Health Workforce

Open-source, interoperable, customizable human resources information systems

- **iHRIS Manage** track and manage health workers actively engaged in service delivery
- **iHRIS Qualify** enables professional councils and associations to register, license, and regulate health workers to support increased quality of care
- **iHRIS Plan** projects the likely changes in the health workforce under different scenarios and compares them with projected needs
- **iHRIS Retain** developed in collaboration with the WHO, helps countries plan and cost recruitment and retention interventions
- **iHRIS Train** assists in tracking and managing health worker preservice education pipelines and in-service training.

**Rapid retention survey toolkit**
Evidence-based method to develop job packages (financial & other incentives) to attract and retain CHWs

**Human Resources Management Assessment Approach**
Guidance for policy-makers, managers, and HR practitioners toward better understanding and responding to HRM challenges facing their health systems

- Community Health COP
- CHW Central Resources
- HRH Global Resource Center
- Resources from ICHC 2017
OPTIMIZING the Community Health Workforce

**DHIS2 Community Health Information Systems Guidelines**
Practical guidance to strengthen design, development and use of CHIS. Generic curriculum, toolkit and SOPs

**CHW Coverage and Capacity (C3) Tool**
Excel-based modeling for CHW allocation and engagement to support planners to (1) estimate number of CHWs required or (2) define, rationalize, and optimize CHW coverage
**HRH Optimization Tools**


→ Forthcoming:
  - HRH Optimization Tool for Family Planning: “HOT4FP”
  - HRH Optimization Tool for Primary Health Care: “HOT4PHC”

Developing and Strengthening CHW Programs at Scale: A Reference Guide for Program Managers and Policy Makers

Comprehensive review of (pre-WHO Guideline) evidence, country cases, and best practices for CHW programs
WHO Community Health Worker Guideline Recommendations Using Lifecycle Approach

BUILDING

CHW Selected
1. Based on educational level, gender equity, motivation, community membership, and trust

CHW Trained
2. Content builds on responsibilities and baseline knowledge, and promotes quality services
3. Competency-based curriculum includes service package, health system links, interpersonal skills
4. Training is practical, blended, and close to community

CHW Certified
5. Formal, competency-based certification

COMMUNITY HEALTH NEEDS

CHW Contracted
6. Adequate remuneration
7. Formal agreement

CHW Retained
8. Supported through routine supervision, mentoring, and performance feedback
9. Career path opportunities

INFORM NEW SKILLS | ENHANCED SCOPE

HEALTH FOR ALL
High-performing health system that is accessible, accountable, affordable and reliable

OPTIMIZING

CHW Integrated in Health System
10. Appropriate workload and population size
11. Data generation and use, including mHealth
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14. Community health resources mobilization and solutions
15. Contributions to “last-mile” supply chain management

MANAGING

COMMUNITY HEALTH LABOR MARKET

EDUCATION/HEALTH SECTOR
Country Exchange for CHW Program Optimization
Optimizing Community Health Programs for Impact

Institutionalizing Quality w/the CHW AIM Tool

CHW PROGRAMS CAN:

Improve access to healthcare
   Reach the unreached

Reduce morbidity and mortality
   Save 2M lives annually

Reduce the risk of pandemics
   Identify the next Ebola early

Lower costs/Improve growth
   Create an ROI of $10:1

Byrne (2014); Chou (2017); Dahn (2015); Kruk (2015)
THE KEY THREE

Political Will

Financing

System Design & Implementation
THE KEY THREE

Political Will  Financing  System Design & Implementation
WHO guideline on health policy and system support to optimize community health worker programmes
Community Health Worker Assessment and Improvement Matrix (CHW AIM)

Updated Program Functionality Matrix for Optimizing Community Health Programs
1. Role & Recruitment
2. Training
3. Accreditation
4. Equipment & Supplies
5. Supervision
6. Incentives
7. Community Involvement
8. Opportunity for Advancement
9. Data
10. Linkages to Health System
Accreditation

How health knowledge and competencies are assessed and certified prior to practicing and recertified at regular intervals while practicing.

- Health knowledge and competencies are tested and CHWs must meet a minimum standard prior to practicing.
- Provisions for CHWs to re-test are in place in the case of failure.
- CHWs are accredited by a national body based on clear documented standards.

- CHWs do pre-/post-tests but no minimum standard of achievement has been set.
- Provisions for CHWs to re-test are in place.

1. Non functional
2. Partially Functional
3. Functional
4. Highly Functional
2K+ unique views from 100 countries
Devolution in Kenya makes county-level policy imperative

Landscape of county-level community health policy relies on volunteer cadres & conflicts with national-level ambitions for UHC

AIM Tool & the proof point of its local implementation, leveraged to inform Community Health Service Bill

Bill codifies key pieces of design principles into law: payment of CHWs, dedicated supervisors, & centrality of community structures

AIM Tool provided a framework to assess current practice & structure new policy

Alignment with USAID & UNICEF brought legitimacy to design principles
CHW AIM FOR RAPID ASSESSMENT

Project
- Global Fund Prospective Country Evaluation in Guatemala

Context
- Rapid assessment of malaria community volunteer program (ColVols) in Alta Verapaz and Escuintla—two high burden districts of Guatemala that account for 74% of malaria cases
- Identify bottlenecks to better performance

Utility
- Adapted tool to Spanish and developed scoring sheet for malaria field technicians and “ladder” scoring sheet for ColVols
- Led focus group discussions about each of the 10 topic areas
- Reviewed and explained scoring matrix to focus group participants
- Participants marked their individual self assessment in scoring sheets (field technicians = 43; ColVols = 47)
- Comparison of mean scores across districts and triangulation with other data (interviews, focus groups, observation, document review)
- Assess what’s working and areas that need improvement

NEXT STEPS!

Individual Assessment on CHW AIM Components

Please reflect on the following 10 programmatic components, and indicate which (if any) you feel are particularly successful or unsuccessful in your country’s programs, and why.

20 minutes

Complete the 1-page assessment individually
Tea Break
GROUP A: Go to a table for a Component *you want to improve*

GROUP B: Go to a table for a Component *you do well*
ROUND TABLE DISCUSSION QUESTIONS

30 minutes

• Describe how you approach this component in your country?

• What do you think makes this component highly functional?

• What about your context might require some of these strategies to be adapted?
GROUP A: Go to a table for a Component you do well

GROUP B: Go to a table for a Component you want to improve
ROUND TABLE DISCUSSION QUESTIONS

30 minutes

• Describe how you approach this component in your country?

• What do you think makes this component highly functional?

• What about your context might require some of these strategies to be adapted?
COUNTRY TEAM CONVENING

40 minutes

Fill out the canvas in country teams

### Country Team Reflection

1. Which areas do we need to prioritize for improvement?

2. What strategies that we heard today could help us improve these areas?

3. What steps can we take to adapt and implement these strategies?

5. What can each member of our delegation bring to this effort?

Today, we commit to:

4. What resources and support will we need?
SPEED RECAP - 2 MINUTES!

Country Team Reflection

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2. What strategies that we heard today could help us improve these areas?

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Today, we commit to:

What resources and support will we need?
Lunch
Overview of the CHW Coverage and Capacity (C3) Tool

Side Meeting of the International CHW Symposium in Dhaka
November 21, 2019

Presented by Melanie Morrow, Maternal and Child Survival Program/ICF
with Eric Sarriot (MCSP/Save the Children) and Allyson Nelson (D-Tree International)
Background: CHW Program Fit in Health Systems

Developing and Strengthening Community Health Worker Programs at Scale

WHO guideline on health policy and system support to optimize community health worker programmes

Beyond the building blocks: integrating community roles into health systems frameworks to achieve health for all

Emma Sacks, Melanie Morrow, William T Story, Katharine D Shelley, D Shanklin, Minal Rahimtoola, Alfonso Rosales, Ochiawunna Ibe, Eric Sarriot
Many Factors Affect CHW Program Impact

C3 Tool uses Excel to model different scenarios for expected implementation coverage vs. human capability (numbers * time)
Tool + Decision-making Process

An Excel-based tool for examining options of CHW time allocation, workload and estimated coverage.
C3 Tool Uses

• Inform new CHW policy and strategy design
• Analyze existing policy and/or modifications
• Adapt central plans to local reality
• Inform costing
• Advocate for CHW programming
The C3 Modeling Process

CHW Program Questions

QUANTIFY NEED
• What is the number of CHWs needed to reach:
  • Full coverage for selected services?
  • Targeted coverage?

QUANTIFY EFFECTIVE CAPACITY
• What maximum service coverage can be achieved with a fixed number of CHW workforce?

OPTIMIZATION
• How can coverage be improved (minimum, maximum) in different “what if” scenarios for use of CHW cadres (task distribution, administration choices, prioritization of roles, etc.)?

C3 Model Inputs

CONTEXT
- Population & Geography
- Typologies (urban/rural…)
- Burden of disease
- Health policies & priority community health services
- Available resources
- Known future trends

CHW CADRES
- Status & roles
- Number & geographic distribution
- Time use
  - Service Activities
  - Travel time
  - Administrative time
  - Training time
- Known future trends

Actionable Analysis

Best case scenarios
Options to rule out
Options for optimizing
Possible research needs
Broad cost questions
Example: Zanzibar 2018-2019

- Revision of Community Health Strategy
- New nationally-standardized community health volunteer (CHV)
- Key question for MOH: “How many CHVs do we need to reach all communities in Zanzibar?”
- D-Tree International worked with MOH to apply the C3 Tool

Map source: BBC
http://news.bbc.co.uk/2/hi/africa/4167807.stm

Zanzibar Example courtesy of Allyson Nelson; More info at https://chwcentral.org/blog/chw-coverage-and-capacity-c3-tool
Model Building Process with Zanzibar MOH

• Reviewed intended service package
• Estimated number of visits, time/visit, travel time, etc.
• Agreed on target levels of service coverage and feasible CHV workload (18 hours/week)
• Reviewed assumptions with broader stakeholder group from MOH and President’s Office*

*PORALGSD: President’s Office Regional Administration, Local Government and Special Departments
## 1. Program Information

<table>
<thead>
<tr>
<th>Name of subpopulation</th>
<th>Zanzibar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country</td>
<td>United Republic of Tanzania</td>
</tr>
<tr>
<td>Policy analysis mode</td>
<td>Population per CHW</td>
</tr>
<tr>
<td>Year of analysis</td>
<td>2018</td>
</tr>
<tr>
<td>Total Population (2018) Zanzibar</td>
<td>1,579,849</td>
</tr>
<tr>
<td>Population per community</td>
<td>720</td>
</tr>
<tr>
<td>What is the average household size?</td>
<td>5.4</td>
</tr>
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</table>
## Inputs: Community Health Sub-programs

<table>
<thead>
<tr>
<th>RMNCH incl Nutrition &amp; ECD</th>
<th>RMNCH+N+ECD</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/TB/NCD</td>
<td>HIV/TB/NCD</td>
</tr>
<tr>
<td>Surveillance and response</td>
<td>Surveillance</td>
</tr>
<tr>
<td>Adolescent</td>
<td>ASRH</td>
</tr>
<tr>
<td>Community engagement and events</td>
<td>Engagement</td>
</tr>
<tr>
<td>Administrative + HIS</td>
<td>Admin</td>
</tr>
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</table>
Inputs for up to Six Cadres of CHWVs

<table>
<thead>
<tr>
<th>CHW 1 title:</th>
<th>CHV</th>
<th>CHV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbreviation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel time (Minutes per service)</td>
<td>25.0</td>
<td></td>
</tr>
<tr>
<td>Administrative tasks (Hours per week)</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>Campaigns (Days per year)</td>
<td>6.0</td>
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</tr>
<tr>
<td>Training (Days per year)</td>
<td>4.0</td>
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<td>Meetings (Days per month)</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Service / Intervention</td>
<td>Program</td>
<td>Target population</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Pregnancy Visit 2</td>
<td>RMNCH incl Nutrition &amp; ECD</td>
<td>Pregnant Women</td>
</tr>
<tr>
<td>Pregnancy Visit 3</td>
<td>RMNCH incl Nutrition &amp; ECD</td>
<td>Pregnant Women</td>
</tr>
<tr>
<td>FU-referral (preg,PP,new RMNCH incl Nutrition &amp; ECD)</td>
<td>Pregnant Women</td>
<td>5.00%</td>
</tr>
<tr>
<td>FU visit - problem (preg,</td>
<td>RMNCH incl Nutrition &amp; ECD</td>
<td>Pregnant Women</td>
</tr>
<tr>
<td>Emergency support</td>
<td>RMNCH incl Nutrition &amp; ECD</td>
<td>Pregnant Women</td>
</tr>
<tr>
<td>Postnatal Visit 1 (normal</td>
<td>RMNCH incl Nutrition &amp; ECD</td>
<td>Children &lt;1</td>
</tr>
<tr>
<td>Postnatal Visit 2 (normal</td>
<td>RMNCH incl Nutrition &amp; ECD</td>
<td>Children &lt;1</td>
</tr>
<tr>
<td>Postnatal Visits (3) (smal</td>
<td>RMNCH incl Nutrition &amp; ECD</td>
<td>Children &lt;1</td>
</tr>
<tr>
<td>Infant Visit 1</td>
<td>RMNCH incl Nutrition &amp; ECD</td>
<td>Children &lt;1</td>
</tr>
<tr>
<td>Infant Visit 2</td>
<td>RMNCH incl Nutrition &amp; ECD</td>
<td>Children &lt;1</td>
</tr>
<tr>
<td>Infant Visit 3</td>
<td>RMNCH incl Nutrition &amp; ECD</td>
<td>Children &lt;1</td>
</tr>
</tbody>
</table>
### Three Scenarios Defined for Analysis

<table>
<thead>
<tr>
<th></th>
<th>Best package</th>
<th>Less work time/CHV</th>
<th>Smaller catchment/CHV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pop, Hours per week, total # CHVs fixed.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Weeks worked per year</strong></td>
<td>Population per CHW</td>
<td>Hours worked per week</td>
<td>Population per CHW</td>
</tr>
<tr>
<td>CHV</td>
<td>720</td>
<td>48</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>720</td>
<td>48</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>500</td>
<td>48</td>
<td>18</td>
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</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>Best package</th>
<th>CHV</th>
<th>Provider</th>
<th>Less work time/CHV</th>
<th>Provider</th>
<th>Smaller catchment/CHV</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy Visit 1</td>
<td>95</td>
<td></td>
<td>CHV</td>
<td>95</td>
<td>CHV</td>
<td>95</td>
<td>CHV</td>
</tr>
<tr>
<td>Pregnancy Visit 2</td>
<td>80</td>
<td></td>
<td>CHV</td>
<td>80</td>
<td>CHV</td>
<td>80</td>
<td>CHV</td>
</tr>
<tr>
<td>Pregnancy Visit 3</td>
<td>90</td>
<td></td>
<td>CHV</td>
<td>90</td>
<td>CHV</td>
<td>90</td>
<td>CHV</td>
</tr>
<tr>
<td>FU-referral (preg, PP, newborn)</td>
<td>90</td>
<td></td>
<td>CHV</td>
<td>90</td>
<td>CHV</td>
<td>90</td>
<td>CHV</td>
</tr>
<tr>
<td>FU visit - problem (preg, PP, newborn)</td>
<td>90</td>
<td></td>
<td>CHV</td>
<td>90</td>
<td>CHV</td>
<td>90</td>
<td>CHV</td>
</tr>
<tr>
<td>Emergency support</td>
<td>90</td>
<td></td>
<td>CHV</td>
<td>90</td>
<td>CHV</td>
<td>90</td>
<td>CHV</td>
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</table>
## C3 Tool Outputs for Zanzibar

<table>
<thead>
<tr>
<th>CHW Cadre:</th>
<th>CHV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario:</td>
<td>Best package</td>
</tr>
</tbody>
</table>

Top 10 interventions, ranked by total time needed to deliver services:

1. Health promotion: Average meeting (education)
2. Child Visit 1
3. Child Visit 2
4. Child Visit 3
5. Identify and coach, threats to development
6. Postnatal Visit 1 (normal)
7. Pregnancy Visit 1
8. Child Visit 4
9. Infant Visit 1
10. Child Visit 6
Percent of planned activities that can be implemented with available/planned CHWs

- **Best package**: CHV = 99%
- **Less work time/CHV**: CHV = 84%
- **Smaller catchment/CHV**: CHV = 137%
Theoretically ideal number of CHWs

- **Best package**: 2207
- **Less work time/CHV**: 2614
- **Smaller catchment/CHV**: 2298

![Bar chart showing the number of CHWs needed for different scenarios]
C3 Tool Influence in Zanzibar

• New Zanzibar Community Health Strategy* incorporated estimates based on C3 analysis:
  Specifically, an estimated 2,200 CHVs could reach approximately 90% coverage of all services, working 18 hours per week, with a catchment population of 725 persons/CHW.

*While not yet signed, signature is imminent and training of CHVs based on the strategy is already underway in 2 of 11 districts.
• Workload analysis from C3 was used to determine an acceptable monthly performance-based incentive for CHVs.

• C3 Tool results were translated into the Community Health Planning and Costing Tool, where the entire CHS and CHV program were costed.
Bonus Feature:
Current version of C3 Tool includes a graph showing time needed by activity vs. time available.

Data shown here are not from Zanzibar.
Links to C3 Tool, User Guide and Blogpost

• **C3 Tool** ([Link to landing page for blank tool & pre-populated example](#))

• **Blogpost** on CHW Central with Zanzibar example ([Link](#))

• **User Guide** ([Link](#)).
Evidence, Learning & Data for Decision-Making for CHW Programs: Highlights from Integrating Community Health Collaboration
Mixed methods approach to real-time implementation feedback for Liberia’s National Community Health Assistant Program

Presenters: J. Mike Mulbah, Liberia Ministry of Health
William E. Walker Jr., Last Mile Health
Liberia National Community Health Assistant Program

- Revised in 2016 to reflect standardized approach to addressing equity gaps in health outcomes for 1.2 million people in communities >5km from a health facility in Liberia.
- Integrated lessons learned from Liberia’s tragic Ebola experience and need for community engagement
- Designed to provide promotive and selected package of curative services; mainly integrated community case management
Liberia NCHAP Package of Services

**MODULE 1**
- Community Entry
- Mapping/Registration
- Community Event-Based Surveillance

**MODULE 2**
- Care for the Pregnant Woman
- Mother and Newborn Care
- Family Planning

**MODULE 3**
- Sick Child Management (iCCM)
- Nutrition

**MODULE 4**
- HIV
- TB
- Leprosy
- NTDs
- Mental Health
- First Aid
Rationale for adopting a Mixed methods approach to NCHAP evaluation

Implementation Fidelity component measured commodities, supervision, incentives and service delivery with data collected at community and facility levels quarterly in all 14 CHW program-implementing counties.

PP semi-structured interviews measured:
1. perceived benefits and root causes of challenges at community, facility and county levels,
METHODOLOGY

Development of mixed methods approach

- Routinely evaluate CHW program fidelity and stakeholder perception
- Tool development through Iterative review and consensus building to ensure tool relevance and buy-in
- Implementation began in the last quarter of 2017
- Data used to inform quarterly national and sub-national discussions around program successes and improvement
IFI Supervision Tool Workflow

Community Tool Workflow

**SECTION A**
- Community Engagement
- Supply Chain
- Supervision
- Incentives
- Monitoring & Evaluation
- Service Delivery
- Recruitment

**SECTION B**
- Start with the CHA
- Health Education & Outreach
- Continue with community member

**SECTION C**
- Go back to the CHA
- Vector Control
- Sanitation & Waste Management
- Water Quality
- Food Safety
- Continue to 3 cook shops

**SECTION D**
- Go back to the CHA
- Building Rapport
- Relevance to Target Audience
- Message Delivery
- Functional Performance

*Section C can be done with either the CHA or a community leader.*

Integrated CUSD / DEOH / NHPD Supervision Tool
Program Perceptions Methods

- Purposive sampling to interview community members, CHWs, their supervisors, facility staff, County Health Teams, Program Managers, etc.
- Done once, in each of the fourteen (14) implementing counties
- Data integrated with IFI into quarterly review meetings
Data management and analysis

- **IFI**: Data extracted and analyzed in STATA for basic descriptive data analysis
- **PP**: Interviews transcribed and reviewed for thematic content
- Triangulation of IFI and PP data using an explanatory mixed methods approach
- Data aggregated nationally, stratified by county, and showing change over time as appropriate
Data use at Quarterly Review Meetings

- Held at the county level and national level ~4 times per year
- Attendees include central MOH, County Health Team, and donor & partner representatives
Outcomes of process

- Successfully developed mixed methods approach to program real time monitoring and evaluation
- Facilitated iterative identification of program challenges
- Supported data-driven changes to the program
- Highlighted the value of community perspective and stakeholders feedback
RESULTS

Specific data-driven findings

- Commodity security; a major quality driver for effective community case management and motivation
- More than access to services; quality matters – providers perception is key to informing quality improvement initiatives
- Gap in providers skills for service delivery CHAs identified;
- Enhanced management understanding of challenges and successes associated with different CHA payment methods
"The drugs issue... the villages I have is very big. So, the drugs that can come it can not able.... Because, sometimes you give um 2, or 3, 4, 5, 6 urm children, ahann. **Before the month can end... I ... have gone out of drugs** to cover the whole area. Because the population here." - CHA
Example: Incentives

“Waiting after two three months, it give us problem, because where we are the living condition is very costly; so, if you wait before the three months you give one or two cent then I have gone into debt ... it will not be ok will me as a professional person to be going around crediting.”
RESULTS

Examples: Data-driven change

- Challenge of allocating supplies for CHAs in Supply Chain System
  
  **20-25% of drugs are allocated in each county as of present**

- Gap in service delivery CHAs identified;

  **Refresher training conducted in selected counties (Bong< Lofa Nimba)**

- Understand challenges and successes of different CHA payment methods.

  **Mobile money vs On the counter payment**
CHALLENGES & LIMITATIONS

Meaningful data quality & sampling issues

- Data entry quality assurance processes not universally followed
- Not all enumerator visits were conducted as reported; incentives are tied to visits
- Representation of CHAs - harder to reach CHAs selected less frequently
Limitations of data use process

- Quarterly review meetings are not sufficient to address all identified issues (e.g., supply chain)
Next steps

- Data storage ownership shift
- Transition to eJISS / digital data collection
- Data quality improvement measures
  - Spot checks
  - Improved QA during data entry
Development of innovative, locally developed mixed methods tools can capture fidelity and perceptions.

MOH-led development process and institutionalization of data review supported collaborative problem solving and increased public-sector ownership.

Goes beyond traditional CHW process evaluation to inform learning and management decisions.

Conclusion
POLICY & ADVOCACY TO SCALE
FRONTLINE DELIVERY

INTEGRATING COMMUNITY HEALTH (ICH)
UGANDA

UGANDA COUNTRY CASE STUDY
TABLE OF CONTENTS

1 Community Health in Uganda
2 The CHEW Policy Journey
3 Learning and Improvement Initiative
4 Discussion
TABLE OF CONTENTS

1 Community Health in Uganda

2 The CHEW Policy Journey

3 Learning and Improvement Initiative

4 Discussion
Olive’s Story

➢ Olive lives in a small village in Eastern Uganda. She is 42 years old and married with five children. Olive has served her community for over ten years.

➢ She is proud of the role she has played on the Village Health Team (VHT) but would like to receive adequate support for the time that she dedicates to this work.

“I would like government to recognize the work of us - the VHTs and other community health workers - by being compensated for the time spent mobilizing and sensitizing communities for health services.”

➢ In 2016, CHEW policy introduced and Mayuge among one of the thirteen pilot districts.

“...I really wanted to be part of the CHEW program to continue serving my community.. [while this has not happened yet]...I will continue mobilizing my community and making home visits to follow up with pregnant mothers and children.”
WHERE WE ARE TODAY

The CHEW Policy was developed, strategy and guidelines in place, pre-training preparation completed, pending cabinet approval. Olive continues to work on her VHT while the policy is being amended waiting final approval.

This presentation outlines the story of how this policy came to be, the challenges it has faced and how a consortium of organizations are spearheading an effort to strengthen the community health system.
COMMUNITY HEALTH IN UGANDA:
AN UNFINISHED AGENDA

Significant progress has been made...

➢ From 2011 to 2016, the maternal mortality rate dropped from 438 to 336 deaths per 100,000 live births (25%).
➢ Child mortality rates have also dropped from 38 to 22 child deaths for every 1,000 children (20%)
➢ Contraceptive prevalence has nearly doubled from 18% to 35% from 2006 to 2016

…but challenges remain

➢ Only 0.4 health providers—well below the WHO recommended minimum of 2.5 for every 1,000 people
➢ 75% of the disease burden in Uganda is attributed to preventable diseases – the focus of CH, political commitment to health promotion
➢ 60% of Ugandans in some regions, report that distance to a health facility limits their ability to seek care when ill
➢ While 79% of people have access to a latrine, only 37% use soap when washing their hands
➢ PHC funding remains sub-optimal. Growing population with reducing non-wage funds.
COMMUNITY HEALTH IN UGANDA: THE CURRENT SYSTEM

- Two levels: facility and community
- Decentralized
- Main cadre = VHTs (2001)
- Health promotion and disease prevention services at the village level
- Referrals
- Mobilization
- Other CHWs, TBAs, other traditional providers

Uganda: Community health system structure and delivery channels

- One Health Center III at the sub-county level per 20,000 people
- Four Health Center IIIIs, each at the parish level, employs one nurse, two nursing assistants, and a health assistant. Each Health Center II provides care for 5000 people.
- Five Health Center IIs at the village level per Health Center II, employing two to four VHTs each covering 25-30 households

Alternate delivery channels

- Private (for profit): Traditional and complementary medicine practitioners, including traditional birth assistants, tend to have no functional relationship with public and private health providers
- Individual private health professionals (e.g., doctors, nurses, midwives) and facilities (e.g., pharmacies, clinics, drug shops) tend to offer curative, rather than preventative, services
- Private (nonprofit): Non-facility-based nonprofits (comprised of hundreds of NGOs) mainly provide preventative health services (e.g., health education, health promotion, and some disease-specific interventions (e.g., HIV, TB)
- Lay community: Community leaders (e.g., local council leaders, parish chiefs, religious leaders, teachers, youth groups) liaisons (e.g., Community Development Officers) and organizations (e.g., mother peer groups, youth groups), conduct health promotion activities, primarily for family care
<table>
<thead>
<tr>
<th>Section</th>
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<tbody>
<tr>
<td>1</td>
<td>Community Health in Uganda</td>
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<tr>
<td>2</td>
<td>The CHEW Policy Journey</td>
</tr>
<tr>
<td>3</td>
<td>Learning and Improvement Initiative</td>
</tr>
<tr>
<td>4</td>
<td>Discussion</td>
</tr>
</tbody>
</table>
USAID ISS-CHW PROGRAMMING PROJECT

The USAID Integrated Systems Strengthening for CHW Programming Project

**Goal**: To support Ministry of Health (MoH) integrate its new CHEW cadre into health system to achieve and sustain effective coverage of high impact health and nutrition interventions at scale, to contribute to ending child and maternal deaths, creating an AIDS free generation and realizing other health goals.

**Objectives:**
1. Institutionalization of CHWs through effective & efficient linkages of community health programs: *Support in the development of tools and guidelines*
2. Measurement to influence systems & policies to operationalize the CHEW strategy: *Learning agenda for community health*
3. Inclusive & effective partnerships to sustain the CHEW strategy: *District capacity development to implement effective programs*
THE CHEW POLICY JOURNEY

2015

VHT assessment

Ethiopia learning exchange

2016

MOH introduces CHEW policy

ICH and CHW conferences in South Africa and Uganda

2017

NCCC and MOH develop strategy guidelines, training curriculum, monitoring plan, readiness assessment

2018

Districts selected, begin piloting CHEW policy in 13 districts: Selection, training, CHW registry

2019

NCC, MOH and donor collaboration to secure year 1 resources

Presentation to cabinet; initial approval/withdrawal; continued refinement throughout 2019, including CH Roadmap

Global: WHO guidelines, Astana PHC, WHA resolution, Aceng award, etc.
**EARLY WINS OF THE CHEW POLICY PROCESS**

- The 2017 ICHC Conference, political commitment, learning from global experience: training was addressed.
- Regional consultations, with political, CSOs and District health teams. Total buy-in from districts. *other ministries were critical*
- Advocated for and obtained a financial clearance letter, to have the policy presented in cabinet
- National coordination of partners: Implementing partners, MOH and donors, monthly meetings led to policy monitoring, information sharing and accountability mechanisms.
- Readiness of districts: assessment in 13 pilot districts: focus on understanding policy shifts, selection, training, supervision and ownership.
- **Tested selection:** what are the cost effective selection approaches that optimizes community participation at scale. Selected and validated 1,640 CHEW trainees.
- **Training:** a policy position for training wasn’t clear, on who to train, where to train. Regional training centers and building capacity of professional trainers.
- Supported the development of Community Health Roadmap. Providing a broader framework to implement the CHEW Program.
- Worked with Population Council to research in CHW incentives, report to inform MOH guidelines
- Led to the establishment of the National Community Health Learning and Implementation initiative (NaCHLII). The Health Minister has invited us to present the initiative to the MOH Top leadership.
2019: FALSE START WITH A NEW POLICY

Dr. Jane Ruth Aceng @JaneRuth_Aceng

Cabinet has approved the Community Health Extension workers (CHEWs) policy that will see @MinofHealthUG and Development partners enroll & train over 15,000 selected persons from all parishes in 🇺🇬 for purposes of intensifying efforts on prevention of communicable diseases & NCDs

1:55 AM - 15 Jan 2019
81 Retweets 176 Likes

15,000 recruits left jobless as government cancels new health extension workers policy

by ZAHRA NAMULI — 8 months ago in Health, News

Cabinet has rescinded the Community Health Extension Workers (CHEWS) policy barely two weeks after the policy was passed.
WHY HAS THE POLICY STALLED?

- Negative backlash in replacing VHTs with a paid cadre

- Last mile: 2 CHEWs per parish vs 5 VHTs per village, what would happen to investments such as ICCM?

- Cost of new cadre yet VHTs are volunteers, why pay for what can be got free?

- Sustainability of the program: CHEW allowances

- Lack of clarity on how existing structures will work with CHEWs

*Please note: elections are in 2021*
## COMMUNITY HEALTH ROADMAP PRIORITIES

1. **Develop a comprehensive, costed, evidence-based community health strategy** that includes all community health cadres and other system components.

2. **Strengthen community health leadership, governance, and multi-sectoral collaboration throughout the entire health system** (national to community level).

3. **Strengthen and sustain (time and financial) investment in supervision and motivation** of community health cadres to improve community health outcomes.

4. **Strengthen and improve the community health supply chain across all levels** to increase the availability of critical quality supplies and commodities at community level.

5. **Invest in the scale up of appropriate technology** for community health implementation and supervision (real time and long-term, care coordination and active monitoring and analytics).

6. **Invest in the active engagement of communities** to increase participation, ownership, and their capacity to be agents of their own health starting with the household.
1 Community Health in Uganda
2 The CHEW Policy Journey
3 Learning and Improvement Initiative
4 Discussion
The Challenge: Uganda has a strong platform for community health - platform of VHTs and PHC - but many strategies, policies and plans have fallen short in implementation. Why is this?

- Coordination, governance and challenges of accountability
- History of promising program pilots, but few are scaled or integrated into national policy
- Learning is scattered and rarely focused on how to scale practices
- Community health policy is developed in a siloed fashion - focused on specific cadres, disease areas with insufficient costing or integration into the health care system

Vision: The National Community Health Learning and Improvement Initiative (NaCHLII) is a Government of Uganda led consortium of implementers, donors, and researchers dedicated to strengthening the community health system, shaping national policies, and informing global best practice.
The above activities include continuous engagement with the Ministry of Health and partners.
Objective 1: Operational Foundation for NaCHLII

Objective 2: Research and Learning

Objective 3: National Policy Process

Objective 4: Strengthen District Capacity
LINKING LEARNING WITH POLICY REFORM

District Coordination Group

1. IDENTIFY

2. LEARN & MODEL

3. INFORM & INFLUENCE

National Community Health Strategy

Community Health Learning Agenda

National Community Health Steering Committee

Learning Initiative Core Group
# TABLE OF CONTENTS

1. Community Health in Uganda
2. The CHEW Policy Journey
3. Learning and Improvement Initiative
4. Discussion
CONCLUSION

➢ Despite uncertainty related to where the CHEW Policy is headed, there is now a national focus on the community health system, with a broad, multi-sectoral approach to community health.

➢ The MOH has expressed a strong commitment to community health and has elaborated the Community Health Roadmap, which illustrates the importance of community health toward universal health coverage, approved the establishment of a national steering committee for CH. MOH is ready to operationalize the roadmap.

➢ Through NaCHLII, the MOH and partners are testing promising approaches such as the “Model Household” sought after by the government to scale up health promotion in the country, multisectoral district coordination to improve leadership at the district level, generating evidence to standardize incentives for CHWs.

➢ The initiative, is currently engaged with USAID and UNICEF on transitioning some of the strategic activities into the HSS bilateral and also supporting MOH to move forward the CH Roadmap, and working closely with MOH and partners to move the CHSS advocacy agenda.
**WHAT IS A LEARNING AND IMPROVEMENT INITIATIVE?**

An approach to generate learning that informs and influences policy and program implementation to achieve a high performing and institutionalized community health system

**Effective learning initiatives often incorporate the following elements:**

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
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<tbody>
<tr>
<td>A shared learning agenda</td>
<td></td>
</tr>
<tr>
<td>Regular engagement from a diverse range of organizations/stakeholders</td>
<td>(under government leadership), positioned to influence policy</td>
</tr>
<tr>
<td>Processes and structures for these organizations</td>
<td>to generate, share, and translate learning into policy</td>
</tr>
<tr>
<td>Opportunities to disseminate learning widely</td>
<td></td>
</tr>
<tr>
<td>Processes to test and adapt learning to local context</td>
<td>(e.g., district sites)</td>
</tr>
</tbody>
</table>
THE COMMUNITY HEALTH EXTENSION WORKER: OVERVIEW OF ROLES

Service delivery: Promote good individual and family health practices through mobilizing communities, providing information, conducting home visits and referring to clinics.

Supplies: Ensure the availability of necessary equipment, drugs, and supplies at CHEW stations.

Local engagement
- Identify, train, and collaborate with volunteer community groups and local government.
- Participate with other sectors’ development workers in community-based development.

Training and Supervision
- Train and graduate model households.
- Supervise and collaborate with VHTs.

Data/Learning
- Participate in review meetings and present best practices and challenges to activities.
- Collect, analyze, compile, and report progress on the health extension package to HCIII and local government.
COMMUNITY HEALTH IN UGANDA: VILLAGE HEALTH TEAMS

➢ Working in teams of five individuals per village, the 180,000 VHTs are expected to reach 25 to 30 households each

➢ Creating the VHTs filled a human resource gap, extended health services to households, and mobilized and empowered communities to take part in the health system

➢ Gaps found in the 2014/15 National assessment: almost 1 in 3 with no basic training, supervision, standardized incentives, referral issues, no career path, documentation and the use of information systems, coordination both at national and district. CHEW policy was designed to address these issues.
Improving CHW Program Performance through Harmonization and Community Engagement to Sustain Effective Coverage at Scale in Bangladesh

District Learning Laboratory (DLL)

21 November 2019
Presentation Outline

- ICHW Implementation Strategy
- District Learning Laboratory (DLL)
- Key component /activities of DLL
- Pilot: Community Clinic Centered Health Service Model
- Outcome
Implementation Strategy

**National Steering Committee**
- Policy and Strategic guideline, oversight, review/endorse best practice and facilitate to incorporate those in the OPs
- Members: MOHFW, MOLGRDC, USAID, Unicef, SCI

**National Stakeholder Forum (Technical Working Group)**
- Technical guideline
- Proposed Members: DGHS, DGFP, NIPORT, LGD, BRAC, UNICEF, USAID, SCI, INGOs, Professionals

**District Coordination Committee**
- District Learning Laboratory (DLL)
- Implementation at 6 Upazillas (CC centered community health programming model)
District Learning Laboratory (DLL)

• The purpose of DLL is to define and demonstrate the health system changes required to strengthen comprehensive community and local government engagement

• Several conceptual and system propositions to enhance CHW program efficiency will be tested to adjust methodologies and refine ideas before national level scale-up

• The DLL will exist within ongoing initiatives, and complement the program’s strong learning agenda
Key component /activities of DLL

- CHW Profile development and updating
- Identified CHW capacity building needs and provide training
- Capacity building of Trained managers and supervisors
- Technical assistance to activate community group (CG) and Community support group (CSG)
- Revitalization and technical assistance to activate union Education health and Family Planning standing committee
- Pilot Community Clinic Centered Health Service Model
Harmonization among CHWs
Effective Community Engagement
Strengthen Local Government support
Accountability mechanism
Strengthened referral system
Outcomes

• Data\(^1\) indicates that community microplanning meetings are being held regularly with participation from community members and their supervisors in majority (99%) of intervention areas. There were no meetings being held at baseline.

• 64% of newborns and mothers referred, attended higher level facility (at referral point) for treatment in intervention area.

• Community Health Care Provider (CHCP), Health Assistant (HA), and Family Welfare Assistant (FWA) are now working together so that everyone can do their respective work properly.

\(^1\)Community Clinic Centered Health Service Model, endline survey
ANC1 coverage: CC Control vs Intervention area

ANC1 coverage increased 78% in intervention area

Source: DGHS, DHIS2
All referred cases: CC Control vs Intervention area

Referred cases increased 42% in intervention area

Oct'17-Sep'18
Oct'18-Sep'19

Control

1,555
1,571

Intervention

2,280
3,243

Source: DGHS, DHIS2
Total patients treated by CHWs: CC Control vs Intervention area

Patient coverage increased 15% in intervention area

Source: DGHS, DHIS2
Revitalization of CG and CSG members

Before Reformation

- 40 % CC area covered by CG & CSGs
- CSGs confined to nearby CC areas

After Reformation

- 100 % area covered
- CSGs represent all villages
Community Contribution:

Construction of approach road to community clinic

Repair of CC floor with tiles fitting
Local Government Support:
Social Accountability
THANK YOU

Save the Children
Impact of a community QI intervention on MNCH outcomes

Otiso, L., Ochieng C., Kumar, M.B., Doyle, V., Okoth, L., Muturi, N., Karuga, R., Taegtmeyer, M

Presented by Dr Lilian Otiso
LVCT Health

21st November 2019
ICH Partner’s meeting
Dhaka, Bangladesh
Community health in Kenya

Policy

Structure

National & County referrals (Tiers 3 & 4)

Primary health care (Tier 2)

Community health care (Tier 1)
5 CHEWs
10 CHVs

5,000 people
The SQALE project (2016-19)

• **Goal:**
  *Reduce maternal and child deaths in Kenyan communities using a Quality Improvement (QI) approach*

• SQALE model - QI in the Kenyan community health system: a mechanism to drive local innovations to overcome local challenges

• Effective data for decision making at community level
Adapting QI principles to community health

1. Alignment with existing MoH standards, models and tools
2. Data quality for data use
3. Small set of quality indicators
4. Simple, jargon-free materials
5. Clearly defined roles and responsibilities using a team approach
6. Recognising good practice, celebrating success
7. Incorporating the voice of the community – community engagement
8. Strengthening community – facility linkage
SQALE cascade – Work Improvement teams (WITs)

Established WITs
- 27 at community and 9 at subcounty level
- Members: CHWs, CHEWs, facility manager, community members

WIT functions
- Collect and use data for QI
- Use Community WIT data for QI

Quality Improvement approach - PDSA
## SQALE three-phase QI capacity-building program

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
</tr>
</thead>
</table>
| • Establishing QI Teams (WITs)  
• QI concepts  
• Client perceptions  
• **Data quality** for decision making  
• Monitoring performance & quality of CHS | • Presentation and analysis of data  
• Problem identification and root cause analysis  
• QI Change plans | • Evaluation of change plans  
• Sharing and Learning  
• Identification of best practice  
• QI Awards  
• Action planning & embedding QI |

[Image of SQALE logo]
Learning events: learning and sharing platforms

• Teams presented their QI project results to each other after 6 months
• Learnt how to present their data
• Involved MOH, WITs and county health management teams
• Competed for awards
Research Methods/Learning agenda

Qualitative – baseline & endline qual interviews
  • Feasibility and Acceptability of community QI approach

Data Quality Audits – Quantitative and Qualitative
  • Quality of community health data
  • Factors that influence quality of community health

Quantitative: Household survey using Lot Quality Assurance Sampling (LQAS)
  • Baseline and endline
**Research Methods – Household survey**

Lot Quality Assurance Sampling (LQAS):

- Rapid method for conducting household surveys using small, random samples at a decentralized level
- 3 intervention sub-counties (9 intervention CHUs) and 3 matched control sub-counties (9 matched control CHUs)
- Total sample size in Migori is 1,293 households
  - N = 645 households (intervention); n = 648 households (control)
- Three target groups of mothers surveyed
  - Children 0-5 months (ANC, delivery, PNC, breastfeeding)
  - Children 12-23 months (complete immunization)
  - Children 6-59 months (nutrition, growth monitoring)
Mother discussing her use of community health services during the household survey
Data Quality Assessment (DQA) – improvements in data quality

“The difference was one; data. We used to cook, you know the previous paper was so complicated but at least now….We know what we are filling”

Community health volunteer
### Household survey - MNCH results

<table>
<thead>
<tr>
<th></th>
<th>Intervention</th>
<th>Control</th>
<th>Diff-in-diff</th>
<th>Significance p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers of children 0 - 5 months (n=)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% mothers who attended 4 or more ANC visits during last pregnancy (card)</td>
<td>32.6% (n=215)</td>
<td>56.0% (n=216)</td>
<td>6.3%</td>
<td>p&lt;0.0001</td>
</tr>
<tr>
<td>% mothers whose first ANC visit was during 1st trimester during last pregnancy</td>
<td>44.2%</td>
<td>45.8%</td>
<td>-7.6%</td>
<td>p&lt;0.0001</td>
</tr>
<tr>
<td>% mothers whose most recent birth was attended by a skilled provider</td>
<td>80.0%</td>
<td>92.1%</td>
<td>8.4%</td>
<td>p&lt;0.0001</td>
</tr>
</tbody>
</table>
Household survey - Child health outcomes

Difference in differences in Vitamin A, immunization and growth monitoring of children aged 5-69 months between 2018 and 2019

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Intervention</th>
<th>Control</th>
<th>Diff in diff</th>
<th>Sig</th>
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<tbody>
<tr>
<td></td>
<td>2018</td>
<td>2019</td>
<td>2018</td>
<td>2019</td>
</tr>
<tr>
<td>Mothers of children 6-59 months (n=)</td>
<td>% (n=215)</td>
<td>% (n=216)</td>
<td>% (n=216)</td>
<td>% (n=216)</td>
</tr>
<tr>
<td>1 dose Vitamin A in past 6 months</td>
<td>46</td>
<td>52.8</td>
<td>44.9</td>
<td>43.4</td>
</tr>
<tr>
<td>Growth monitoring (CHV or health facility) in past 6 months</td>
<td>55.0</td>
<td>66.2</td>
<td>48.1</td>
<td>49.8</td>
</tr>
</tbody>
</table>
What do the LQAS/Household survey data tell us?

- Similarities and differences between the average program coverage and KDHS coverage
- Similarities and differences between sub-county coverage of key MNCH indicators
- Variation in the MNCH indicators – which shows generally stronger or weaker coverage
Policy impact and sustainability

- Outputs from SQALE adopted by national government
  - The facilitators manual for training teams on QI for community
  - Revisions of standards for community health services (with input from WIT members)

- Sustainability of QI in community health
  - Counties have included QI in their annual workplans and budgets
  - Counties have created health bills to pay CHWs
Challenges of QI implementation

• High staff transfer rate
• Lack of basic resources – e.g. tools
• Lack of CHV stipend – attrition, motivation
• High start up costs – training
• Maintaining effective coaching

*M- health solutions can help address some barriers e.g tools and training/continuous updates*
Research challenges

• Challenges researching complex adaptive systems
• Distal benefits of intervention
• Reliance on QI at facility,
• Reliance on functionality of health system
• Possible ‘spillover effects’ of county uptake
• QI teams implement different interventions – affects ‘effect size’
Lessons learned

• Quality improvement is achievable at community level by using a phased and simple approach to capacity building
• QI at community level achieves health outcomes
• Effectiveness depends on simplicity, few indicators and clear roles and responsibilities.
• Use of participatory approaches ensures effective QI functioning and locally-relevant problem identification and prioritization and community facility linkage
• Inclusion of supervisors as team members improves advocacy and utilization of local/decentralized resources
• Leadership! Leadership! Leadership!
  (county, sub-county, CHEW level, QI champions)
Conclusion / key messages

• Guided, structured QI is possible in community-led approaches
• Communities can use QI resulting in innovation and implementation of ‘what works’ in users’ micro-context.
• QI capacity can lead to creativity of community teams to design and drive meaningful change in their priority health issues.
• QI can work in all health contexts
Acknowledgements

• Community and sub-county WITs
• Counties – Nairobi, Migori, Kitui
• Community Health Development Unit - MOH Kenya
• Department of Standards, Quality Assurance and Regulation – MOH Kenya
• USAID
• USAID SQALE team – LVCT Health, LSTM
Resources

• SQALE brief: How can we achieve Universal Health Coverage with quality? A quality improvement model for community health from Kenya

• Data quality in community health brief: http://reachoutconsortium.org/media/12820/reachout-data-quality.pdf

• Blog - Stimulating, cascading and sustaining quality: The role of Champions for community health

• Read all about the USAID SQALE Learning Event.

• Poster: Creating a forum for shared learning and advocacy in strengthening community health systems
Thank you!

http://usaidsqale.reachoutconsortium.org
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Lilian.otiso@lvcthealth.org
Twitter: @lilianotiso @lvct_ke
Questions & Discussion
Start, Stop, Continue Activity

Based on learnings of the day, write down at least one thing that you want to:

1. START
   - New ways to accomplish goals
   - New ideas introduced
   - Things worth trying for better results

2. STOP
   - Anything that is not working
   - New ideas that have been introduced
   - Things worth trying for better results

3. CONTINUE
   - Things that are working
MOH & country delegation reflections

Share an action or learning takeaway toward developing and fulfilling their milestones in the journey towards ICHC 2020:

1. Group brainstorm
2. Report out
Closing remarks
CLOSING REMARKS

Ms. Ariella Camera
Deputy Director, Health Systems Strengthening Pillar
Office of Population, Health, Nutrition, and Education
USAID/Bangladesh
Thank you!  ধন্যবাদ  Merci!
Shukran!  Asante!
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<tr>
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<th><strong>Advancing Primary Health Care at the Community Level: Integration, Quality, &amp; Accountability</strong></th>
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