National Planning for Community Health Worker Programs

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22 August 2013

Key Points

- The planning process defines many of the other topics in this manual (e.g., supervision, training, roles and responsibilities of community health workers [CHWs]) using an informed and methodical process.
- The most effective planning mechanism is a feedback loop, where community-level information is fed through the multiple sub-levels (e.g., district, regional) to the national level, where policy, funding, and evaluation can be continually revised.
- Careful planning during the design and implementation of a national CHW program results in a context-appropriate program that successfully trains, supervises, and retains CHWs, while simultaneously improving the health service delivery on the community level.

INTRODUCTION

Expansion or development of a community health worker (CHW) program on a national level requires a planning strategy that coordinates many of the topics covered in the other chapters, such as supervision, training, and community relations. Further, incorporating or expanding use of CHWs into existing health system infrastructures—which are often complex and operate differently across countries—is a difficult task that requires careful planning. Planning for such an expansion demands the involvement of multiple stakeholders from the national to the village level. The direct result of careful planning during the design and implementation of a national CHW program is a context-appropriate program that successfully trains, supervises, and retains CHWs, while simultaneously improving the health service delivery in the community level.

PHASES OF THE COMMUNITY HEALTH WORKER PROGRAM PLANNING PROCESS

A national-level plan should coordinate planning committees and stakeholders from multiple governmental and community levels, as well as nongovernmental organizations (NGOs) and relevant implementing actors, to create an informed strategic plan for the CHW program that includes:

- A situational analysis
- An operational model
- Integration of the program with policy
- CHW training
- CHW supervision
- A deployment strategy
- Routine and systematic monitoring and evaluation (M&E)

Clear and carefully chosen strategies across each of these areas, taking into account their inter-relationships, contribute to the success and sustainability of the program at scale. The group charged with planning and developing this effort must give careful attention to ensure that the program will continue to be adequately supported by the multiple levels of government involved, national level down to community level, and that this support includes appropriate provision for long-term financial sustainability (see Chapter 5 for more detail on financing). Table 1 summarizes the key considerations for planning CHW-delivered services, phase by phase. These key steps were informed by the One Million Health Workers document and developed using best practices shared across international organizations and national governments.[1]

Table 1. Phases of planning a CHW program*

PHASE 1	POLICY-LEVEL PLANNING	
	Situational analysis	Documents the current state of the local health system, informing planners on the overlap or differing needs of communities.
	Development of an operational model	Provides a framework illustrating how all of the working parts of the health system are expected to function.
	Coordinated planning	Decision-makers meet with stakeholders to determine timeline, indicators, objectives, evaluation tools and internal communication strategy, and to establish regular planning meetings.

	Policy planning and formalization	Decision-makers communicate a draft of these policies to all stakeholders and then, once feedback has been obtained, formalize the policies.
PHASE 2	**TRANSLATION OF POLICIES INTO A PLAN**	
	Development of the key ideas for the program	Planners translate the CHW program policies into an operational national-level plan.
PHASE 3	**PREPARATION OF A DETAILED IMPLEMENTATION PLAN**	
	Development of details for the specific sub-systems of the program	Program implementers develop detailed plans for governance/management, selection, training, supervision, engagement with communities, relationship with the health system, scaling up, and monitoring and evaluation (covered in other chapters).
*Adapted from: [1]		

CHW cadres should be selected, trained, and deployed in accordance with local norms and context-specific constraints in mind. This chapter helps to define clear processes to develop and implement a national plan for community health services. Such a plan must be responsive to local norms, context-specific constraints, and the results of the situational analysis, and the planning process needs to be a continuous, ongoing process. BRAC's Shasthya Shebika CHW Program (Box 1) provides an example of a stable and sustainable national CHW program.

In this chapter, we provide suggestions for how a country might plan a large-scale community health services program. What we propose here is a rather top-down approach, quite different from the BRAC example from Bangladesh. But linking top-down strategies with frequent interactions at the grassroots level is certainly an option to be considered. Our intention is not to prescribe a unilateral way of planning, but to provide a useful starting point for developing an appropriate planning process.

Box 1. A sustainable large-scale CHW program in Bangladesh[2, 3]

BRAC (formerly the Bangladesh Rural Advancement Committee and now sometimes known as Building Resources Across Communities) has recently become the largest NGO in the world. Throughout Bangladesh, BRAC has trained and actively supports 100,000 CHWs known as Shasthya Shebikas.

Key Features: This is a public-private partnership successfully deploying a sustainable CHW program at scale without financial support from the government. Over the past two decades, BRAC has scaled up its Shasthya Shebika Program using a sustainable, local financing model whereby Shasthya Shebikas earn a modest income by selling medicines and commodities at a competitive market price through a highly efficient supply system managed by BRAC. Shasthya Shebikas are responsible for 150–250 households that they visit on a regular basis (every 1–2 months). They provide general health education and promotion about nutrition, family planning (FP), immunizations, and other priority topics. They treat common diseases, such as fever, cold, scabies, and diarrhea. They also provide community case management for childhood pneumonia and collect sputum specimens for patients with chronic cough and; for those diagnosed with tuberculosis, they dispense directly observed therapy for them. Notably, there are no literacy requirements for Shasthya Shebikas.
Shasthya Shebikas are supervised by Shasthya Kormis, who are also recruited from their communities. Shasthya Kormis are paid a sum equivalent to about US$40 per month to supervise the Shasthya Shebikas and perform antenatal care in villages. The Shasthya Kormis, all of whom are women, have a minimum of 10 years of schooling and work between four and five hours per

day. They accompany each of the Shasthya Shebikas in their charge on community visits at least twice per month and meet monthly with their group of Shasthya Shebikas to discuss problems, gather information, and provide supplies and medicines.

Shasthya Shebikas earn an income by selling supplies, such as oral contraceptives, birthing kits, iodized salt, condoms, essential medications, sanitary napkins, and vegetable seeds, at cost plus a small profit margin. They receive incentives for good performance that are based on achieving specific objectives during that month, such as identifying pregnant women during their first trimester. Supervisors verify and monitor performance during their visits to communities, where they have the chance to talk with village women.

The development of Shasthya Shebikas Program is an example of a planning process that was deliberate but slow and organic. There was no preconceived national blueprint that was scaled up rapidly. Rather, a viable role was established for these CHWs, appropriate for the Bangladesh context, and a way was found to provide sufficient locally generated financing to motivate these women to carry out their responsibilities. Then, as BRAC was able to provide appropriate training and supervision, the program began to grow over the following two decades.

BRAC is one of the most business-like NGOs in the world, because the profits generated by their various social enterprises are fed back to support program operations—making BRAC nearly 80% self-funded.

PHASE ONE: POLICY-LEVEL PLANNING

Situational Analysis

To ensure effectiveness when designing community health services, it is necessary to begin with a clear understanding of the local environment. A situational analysis can both identify context-specific needs and challenges and guide design decisions about key program elements. To ensure meeting the needs of a diverse population, a national program may use a variety of implementation strategies depending on the local situation. In BRAC's case, it was already operating community development programs and had a "built-in" situational analysis based on its own programmatic experience, since it had been functioning for a decade before beginning to plan and scale up its CHW program.

A situational analysis also documents the current state of the health system and may include information on health services offered by the formal and informal sectors, care-seeking behaviors by priority groups such as women and young children, supply chain management, utilization and coverage of care provided by the health system, and human resources challenges.

Sources of information for a situational analysis can include:

- A review of the peer-reviewed and gray literature (e.g., programmatic publications and reports) and NGO projects
- Documentation from meetings with stakeholders (i.e., local leaders, women's groups, church leaders, representatives of the Ministry of Health [MOH], local NGOs, etc.)
- Documentation from visits to local communities by small teams to gain a better understanding of the environment, the social and economic context, and the needs expressed by the people living there

- Identification of gaps and existing assets on which to build (e.g., collaborating with current NGO programs, using existing human resources in the health and non-health sectors, and engaging with the existing health system infrastructure)
- Formative research on issues that the program is to address and on the communities the program is meant to serve

To expand on the third point listed above, some countries have diverse geographic and socio-cultural populations. Oftentimes, a situational analysis needs to be completed at the provincial or regional levels, as well as on a national level. A good example is India, where rural people, lower-caste people, religious minorities, tribal ethnic groups, women, and the poor in particular suffer gross health inequalities and lack access to good-quality care because of social, geographic, and economic barriers.[4–6] This is one reason why it is important that district and regional authorities play a strong role in the planning and design processes. Regional and district leadership involvement in the planning is just the beginning, since their participation is needed across all the areas discussed in this manual—supervision, training, support, supplies, and incentives.

Specific questions to address in the situational analysis include:

- What are the main health problems and who experiences them? Which of these persons can be identified and referred or directly managed by the types of CHWs you expect to deploy? What are the direct, indirect, and underlying causes of these health problems? (This latter question will help frame the operational model as well.)
- Are there specific subgroup(s) of the population that will be a particular focus for the type(s) of CHWs deployed? Who are those most affected by the priority health problems? Who will be the easiest to reach and who will be the hardest? What strategies will be used to reach them?

Development of an Operational Model of the Current Health System

An operational model, as we use the term here, is a representation of how the current health system operates. Development of an operational model provides an opportunity to visualize how the health system functions, including service provision, human resources, technology and information management systems, and the supply and distribution of commodities. Specifically, using an operational model to map the dynamics of the current health system helps those involved in planning to characterize where further development of community health services fits into the broader health system. For example, if a health system currently has only one clinic for every 10,000 people that offers voluntary HIV counseling and testing (VCT) along with anti-retroviral drug treatment for patients with HIV/AIDS, then an outreach program may need CHWs to provide VCT services and help ensure follow-up appointments for patients who test positive. Further, an operational model can be used to define CHW roles in order to address identified gaps in the local health care system, such as defining who CHWs are, what they do, how they get their supplies, how the system intends to retain them, and what training and supervision will be required.

During the design or scale-up of new community health services, CHW interaction with providers of the health system and their potential impact on the health system itself must also be carefully considered and planned. To aid this endeavor, the World Health Organization (WHO) has produced useful tools for examining the interaction and impact of CHWs on the formal health system, including the WHO Health Systems Building Block Framework, which highlights the inter-relationships of the six major components of a health system (i.e., service delivery, human health workforce, health information system, access to commodities, financing, and governance) and offers a conceptual model of how CHWs may interact with the health system.[7] Additionally, WHO has developed monitoring tools and indicators to assess these

health system building blocks. These tools can be used to examine the impact of CHWs on the health system. Using these measurement strategies to track progress of health system indicators ensures that continued improvement in health care and accountability at country and global levels is sustained. (See Chapter 14 on monitoring and evaluation).

Coordination of Planning

National-scale implementation of community health services has implications for health care governance from the MOH down to village leaders. Before any implementation of program development or expansion, determining how the multiple levels of government will communicate and interact during the planning, funding, and implementation stages will ease the tensions and challenges that often accompany systematic program scale-up (See Chapter 13 on scale-up, for a more detailed description of these challenges). The level of coordination will depend on the country, the current degree of decentralization, and what responsibilities have been delegated. However, many countries have not succeeded in decentralizing health care, and in these cases, the mechanisms that exist to support health programs at the local and regional levels should be utilized. Depending on the situation, it may be appropriate to consider, and, if necessary, incorporate NGOs and/or the private sector as part of a national CHW program. Regardless of who will be included in the planning process, coordinated communication is key. For example, in Zambia where multiple NGOs cover the country, it may not be possible for the government to take that over all at once, so coordination with and among the NGOs is an important first step.

Health system planning and ongoing monitoring of performance must begin at the community level and provide feedback through various levels to the national level, where policy, funding, and evaluation can be periodically revised. The most effective planning mechanism is a feedback loop, where the community level feeds back information about their program through the multiple levels (e.g., district, regional) to the national level. Additionally, each level should have a defined set of responsibilities during each stage of program development (i.e., planning, implementation, activity coordination, resource security and dispersion, continual monitoring, and program improvements). The establishment of responsible bodies at each level, with oversight from central level, helps to ensure clear roles and responsibilities are determined through the process of conducting the situational analysis and building the operational model (two stages of Phase 1).

National-Level Roles and Responsibilities

A planning body at the national level should be established, and this body may comprise high-level leaders, such as members of the relevant government ministries and departments, as well as leaders of NGOs and private partners. The national-level planning body is responsible for providing leadership for the development of community health services. Support and engagement from the finance ministry, national planning commissions, and other sector leaders are useful, if not essential, since the MOH in many countries may not have sufficient political influence on decisions involving significant commitment of new resources. A national committee can provide high-level leadership, make decisions on resource allocation, oversee the development of implementation guidance, monitor implementation, oversee national monitoring and evaluation (M&E), and adapt the program based on M&E findings.

Some questions to consider when forming the CHW national-level planning committee are:

- What national governing bodies need to be on the committee?
- Who are the high-level leaders and advocates for CHW programming?
- How often does the committee need to meet?

- What specific planning documents will be needed, and when will they be needed in order to guide the regional- and district-level planning committees?
- How and how often will the national and sub-national committees communicate?
- How will the national-level committee document its meetings and share this information with sub-committees?
- What policy changes are needed to support or integrate a CHW program with the national health sector policy?
- How will data from the district and regional levels be collected and managed?
- How will the M&E data be used to revise the program? How will this data be shared?

Regional-Level Roles and Responsibilities

Regional leaders may include regional or district supervisors, program implementers, NGO managers, and private sector representatives. Their responsibilities may include planning for the engagement and coordination of key partners in training and for the oversight of supervision activities and the supply chain.

District-Level Roles and Responsibilities

District health committees, when they are present, can help coordination among health facilities, CHW program supervisors, and local NGO partners within the district. District- and municipal-level stakeholders, health care providers and their professional organizations, local NGO leaders, and community-led groups are examples of district-level actors who can be involved in developing and overseeing community health services. Potential responsibilities of a district-level planning committee include ensuring supervisor support and evaluation, overseeing the supply chain, and supporting CHWs from facility-based providers and communities. Relevant questions for district committees include: Are there particular sub-group(s) of the population who will be a particular focus for the type(s) of CHWs deployed? Who are those most affected by the priority health problems? Who will be the easiest to reach and who will be the hardest? What strategies will be used to reach them?

Health Center Roles and Responsibilities

Further development or expansion of community health services, if not adequately planned and resourced, can over-burden an already over-stretched health facility staff due to new supervisory and mentoring responsibilities and additional paperwork, meetings, and field visits. (See Chapter 11 on relationship with health systems.) Therefore, effectiveness of any new services will depend, in part, on appropriately engaging health facility staff early in the planning process. As part of the situational analysis, the typical functional state and human resources capacity of health facilities that are expected to be involved in the provision of community health services will be documented. This documentation will help planners determine what additional resources are needed to ensure that health facility staff can take on the functions associated with these new community health services.

The capacity of facility-based staff to take on new supervisory or support roles for community-based cadres will vary by setting. Brazil has mandated that community health agents (CHAs) be supervised by nurses and physicians from the local clinics. In many settings in Brazil, nurses have half of their work time reserved to serve as CHA supervisors. In Ethiopia, by contrast, the supervision of health extension workers (HEWs) falls to a designated supervisory team comprised of a health officer, a public health nurse, an environmental/hygiene specialist, and a health education specialist.[8]

Community-Level Roles and Responsibilities

A community-based health committee can assume a planning function as well. It may include members from village-level government (e.g., a village development committee), traditional or other local leaders, and representatives from other committees concerned with community development. These committees potentially have the ability to take certain responsibilities for CHW oversight. (See Chapter 12 on community participation.) They can coordinate with the CHW's supervisor, assist the CHW in mobilizing the community, and generate support for CHWs by advocating their importance for the community's improved health. A strong community commitment helps ensure more effective community health services and can mitigate stress points on the system. Planning for this from the outset is important.

PHASE TWO: TRANSLATION OF POLICIES INTO A GENERAL PLAN

The principle ideas that emerge from the planning process need to be converted into CHW program policies, and these, in turn, need to be translated into an operational national-level plan. In response to political pressures, political leaders often promise to devote resources and enact legislation that will improve coverage, access, and service provision within their country's health system. Yet, too often these promises are inadequately funded, lack proper legislative authorization, and are not integrated with the existing health system. For example, national and regional initiatives and goals are adopted and supported by political figures throughout sub-Saharan Africa, to end preventable maternal and child death by 2030. A critical component of ending preventable maternal and child death is to deliver health services at the household level and ensure referral networks begin at the household. CHWs could aid in achieving this goal. However, without proper legislation to define the role of CHWs within the health system and adequate financing to support this cadre of workers, such a system cannot be developed.

PHASE THREE: PREPARATION OF A DETAILED IMPLEMENTATION PLAN

Once an operational national plan has been created, the next step is to prepare a detailed implementation plan. Among other things, this preparation requires development of details for the specific sub-systems of the program, including governance, financing, selection and recruitment, training, supervision, relationship with the health system engagement with communities, scaling up, and M&E. These implementation components are covered in detail in other chapters. Here, we will briefly focus on planning for training and deployment, supervision, and M&E. (See Chapters 4 and 5, 7–9, and 11–14 for further discussion on these and other issues.)

Training and Deployment

The information collected by the situational analysis, the operational model developed, and the analysis arising from formative research will inform the design of new community health services. Specifically, this information can help direct decisions about selection criteria for CHWs and their training needs. Further, information arising from the situational analysis on spatial distribution of facility-based services can inform the deployment strategy of CHWs.

Supervision, Monitoring, and Evaluation

Countries vary considerably in their approaches to supervision. For instance in Brazil, as previously mentioned, national policy mandates that nurses who are selected to supervise CHAs spend 50% of their paid time providing clinical care and the other 50% of time fulfilling their role as supervisors of CHAs. However, this approach would not be appropriate in places where there are massive human resources shortages, such as Sierra Leone, where there are only 1.9 health care providers per 10,000 people. In many instances, clinics have only one or two providers and are bombarded with lines of clients starting at sunrise. Planning for supervision has to take into account the capacity of existing staff to take on additional time-consuming

responsibilities. For instance, if a program requires that supervisors accompany and evaluate all CHW work at the household level at least quarterly, fill out reports on CHW commodity use, manage their supply of commodities, and ensure that CHWs have a proper monthly work plan, then the supervisors must have sufficient time for these duties. Inadequate planning for the time and human resources required for CHW supervision has been a common contributor to failed CHW programs.

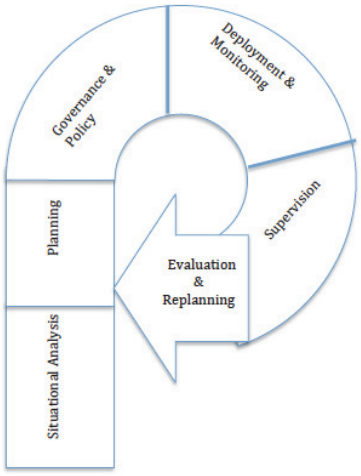
Ultimately, adequate ongoing monitoring is necessary for sound community health services. M&E is an integral part of any CHW program, particularly since services provided are far away with limited personal contact among CHWs and other members of the health team. As such, M&E tools and mechanisms for their use for feedback into modifying program operations are important when developing a detailed implementation plan.

Data Use for Continuous Improvement

Developing an initial plan based on these three phases is just the beginning of national CHW program planning. As a program is implemented, scaled up, or modified, an ongoing re-planning process is required. Based on M&E feedback, certain program components may be working very well, while others may not be functioning as intended. To know what is actually occuring requires adequate tracking of intervention coverage and its impact/effectiveness (e.g., whether the CHWs are actually functioning, whether the supply chain is working, and so forth). Based on information from a variety of sources (e.g., routine monitoring, field visits, special studies), almost invariably certain aspects of program performance will not meet expected standards. Based on such findings, re-design of some program features may be needed to address performance problems.

In short, planning is an iterative process that requires many revisions, improvements, and modifications in order to have an effective CHW program that responds to local needs and that improves the health of the population (Figure 1). Regardless of whether a CHW program is new or old, re-planning of program components must happen on a continual basis and be informed by evidence arising from monitoring, evaluation, and current recommendations from the global health community. Re-planning at least once every 10 years and preferably every five years would seem reasonable. Table 2 contains some of the key components of selected CHW programs that might be useful as one thinks about the content of a plan for a large-scale CHW program.

Figure 1. The P-Process of CHW program planning



Adapted from the *Health Communication*, Piotrow et al. Praeger, 1997, page 27; and Health Communication Partnership (December 2003), The New P-Process: Steps in Strategic Communication [PDF]. Baltimore: Johns Hopkins Bloomberg School of Public Health / Center for Communication Programs / Health Communication Partnership.

Table 2. Examples of key components of selected CHW programs

BRAZIL[9–11]	**POLICY**
	▪ The *Programa Saúde da Família* (Family Health Program) was launched in 1994. ▪ CHAs were officially recognized by law in 2002.
	MANAGEMENT
	▪ CHAs are managed by local nurses who spend half their time working in the local clinic and the other half fulfilling their supervisory role. ▪ The CHAs have a strong referral system in which they report any ill person within their catchment. ▪ Upon discharge, the CHA is expected to maintain the continuum of care and follow up with the patient.
	COMMUNITY INVOLVEMENT
	▪ One of the goals of the Family Health Program is to "promote the organization of the community" and analyze community needs. ▪ Some communities are involved in the organization and budget of health system. At times, the public is able to vote on the proportion of the overall budget devoted to health.
	QUALITY ASSURANCE
	▪ Data is collected by CHAs, which provides municipal-level data on implementation. ▪ CHAs in the program keep records that allow for population-based monitoring of local health conditions and help to identify problems are they arise. ▪ CHAs' role in the community is expected to increase the accountability of the health system.
PAKISTAN[12, 13]	**POLICY**
	▪ In 1993, Pakistan established the Program for Family Planning and Primary Health Care, which employed only female CHWs to deliver health services to communities and was informally called the Lady Health Worker (LHW) Program. ▪ In 2003–2011, the strategic plan set the two goals of improving quality of services and expanding coverage nationwide.
	MANAGEMENT

	▪ Supervision is highly organized and tiered, with several levels of supervision (i.e., supervision of the supervisors). ▪ LHWs are supervised monthly by the LHW supervisors, who are in turn supervised by the District Coordinator and Assistant Coordinator. ▪ Once a month, LHW supervisors should meet with LHWs' clients and make a work plan for the next month.
	COMMUNITY INVOLVEMENT
	▪ There is a community member on each LHW selection committee and each LHW supervisor selection committee. ▪ The community is involved in programmatic decision-making, planning, and M&E. LHWs provide a range of community development services and participate in community meetings.
	QUALITY ASSURANCE
	▪ For the LHW Program, high-quality service is described as: selection based on merit; provision of professional knowledge and skills to the LHW; supply with necessary medicines and other supplies; and adequate remuneration, performance management, and supervision. ▪ A management information system is also essential to assess and encourage quality performance and facilitate informed programmatic decision-making.
ETHIOPIA[8]	**POLICY**
	▪ In response to unmet needs, the government of Ethiopia launched the expansion of primary health care (PHC) and the Health Extension Program (HEP), targeted at rural areas, which included community-based HEWs, vCHWs, and health promoters.
	MANAGEMENT
	▪ There are multiple levels of HEW supervision, including the *woreda* (district) supervisory team, comprising: a health officer, public health nurse, hygiene expert, and a health education expert. ▪ In 2005, HEWs reported an average of three supervisory visits over the course of nine months. HEWs supervise a lower cadre of vCHWs.
	COMMUNITY INVOLVEMENT
	▪ There are active health committees involved in the selection and oversight of HEWs. ▪ The committee is supposed to be involved in every step of the HEP from program planning through to evaluation.
	QUALITY ASSURANCE
	▪ The program has extensive M&E systems that include routine reports and monitoring of indicators for maternal, neonatal, and child health; disease prevention and control; nutrition; hygiene; and environmental health. ▪ Indicators include maternal, neonatal, and child health; contraceptive acceptance rate, and number of deliveries attended by skilled birth attendants and/or by HEWs.

NEPAL[14, 15]	**POLICY**
	▪ The first Nepal Health Sector Program (NHSP) was developed for implementation from 2004-2009 to increase equality of access and to improve health outcomes. ▪ A second NHSP from 2010–2015 aims to increase access/utilization of high-quality services, and reduce cultural and economic barriers to accessing care.
	MANAGEMENT
	▪ Voluntary health workers (VHWs) and maternal and child health workers (MCHWs) supervise the female community Health volunteers (FCHVs) in their catchment areas. ▪ They are responsible for providing support, advice, and feedback during monthly supervision visits. FCHVs meet with village groups every four months to review progress.
	COMMUNITY INVOLVEMENT
	▪ Women's groups and local Village Development Committees (VDCs) are highly involved in the selection and oversight of FCHVs. ▪ A national evaluation demonstrated that mothers groups' functioning improved and they were more supportive of FCHVs.
	QUALITY INSURANCE
	▪ A recent qualitative study highlighted the need for "context-specific incentives" for FCHVs. Despite serving as volunteers, attrition rates in the program are very low with less than 5% turnover each year. ▪ Data, particularly program evaluations and research in the field, are highly influential in programmatic policy development and implementation.
INDIA[4, 16]	**POLICY**
	▪ In early 2000, the government of India developed the National Rural Health Mission (NRHM) to improve rural PHC, accountability and community engagement in the public health sector, including a provision for a national CHW cadre that focused on FP and maternal and child health. ▪ In 2005, the NRHM launch an Accredited Social Health Activist (ASHA) program.
	MANAGEMENT
	▪ According to national guidelines, there is one ASHA facilitator (supervisor) for every 20 ASHA workers. The facilitator is to help with the selection of the ASHAs, run monthly ASHA meetings, establish a grievance re-dressal system, accompany ASHAs on home visits, maintain records of ASHA activities, attend Village Health and Nutrition Days with the ASHAs, and attend monthly block PHC meetings. ▪ The ASHA facilitator is supervised at the block-level by the Block Community Mobilizer, who is in turn supervised by the District Mobilization/Coordination Unit, which liaises with the state-level ASHA resource center.
	COMMUNITY INVOLVEMENT
	▪ ASHAs are to be selected by and accountable to the local village-level government, called the Gram Panchayat, through a participatory process involving the whole village. ▪ After selection, ASHAs are to work closely with the Village Health and Sanitation Committee (VHSC), comprising key stakeholders in the village including the ASHA workers, Anganwadi Workers, and self-help group members (women's groups).
	QUALITY INSURANCE
	▪ Several states have introduced ASHA motivation and recognition initiatives, such as cash awards for the best performing ASHAs, newsletter and radio programs, bicycles for all ASHAs, and career development opportunities through scholarships to study nursing. ▪ The main source of performance monitoring data is generated by the ASHA facilitator based on monthly meetings with the 20 ASHAs she or he oversees. ▪ The ASHA facilitator is responsible for developing health reports on ASHA functionality, as well as consolidating information about pregnancies, births, deliveries, newborn care, and deaths.

IRAN[17]	POLICY
	▪ Shortly after 1978, the West Azerbaijan project, developed in one province, aimed to expand health services through the establishment of a comprehensive health delivery system and training of CHWs (*Behvarzs*). ▪ In other parts of Iran, the use of CHWs expanded to deliver services beyond maternal and child health to include care for the elders and management of non-communicable diseases.
	MANAGEMENT
	▪ Regular supervisory visits to Health Houses, where CHWs are based, are planned and performed by staff members at rural health centers and by provincial and national teams to evaluate program effectiveness and to increase the quality of care. ▪ A unique practice for CHWs in Iran is the "*behvarz* council," established in 2006, with the aim of engaging *Behvarzes* in problem identification, problem-solving, knowledge transfer, and policymaking.
	COMMUNITY INVOLVEMENT
	▪ Promotion of community participation and other social sectors in health programs is part of the role of *Behvarzs*. ▪ *Behvarz* council meetings are held on a regular basis to discuss a broad range of issues concerning the *Behvarzs'* work, work-related problems, and recommendations to overcome any problems. Meeting minutes and the final report are submitted to the higher-level council for further follow-up. ▪ *Behvarzs'* representatives are responsible for transferring ideas and solutions to other team members and to follow up issues raised in the meeting.
	QUALITY ASSURANCE
	▪ Provincial and national teams use checklists to assess data recording, *Behvarz*'s knowledge, drug supplies and equipment, review of work-related problems, and suggestions from each *Behvarz*.

CONCLUSION

Although health systems are varied and complex, careful planning during the design and early implementation of a national-level CHW program is essential for a context-appropriate program that successfully trains, supervises, and retains CHWs, while simultaneously improving the health service delivery on the community level. The methodology of planning a program at scale is somewhat flexible, but each of the phases outlined in this chapter should be included to ensure that the program design and implementation is both feasible and appropriate. Phase One includes a situational analysis, operational model, coordinated planning effort, and supportive policy changes. Phases Two and Three are processes meant to ensure that the implementation steps are carefully planned and that information is continually fed back about how well the program is being implemented and how it can be improved. Re-planning a program should happen periodically—at least every 10 years—and be informed by evidence arising from monitoring, evaluation, and recommendations from those engaged in program implementation. Policy-makers and program planners should note that the biggest challenge in planning a national CHW program is the capacity of each level to adequately complete the tasks assigned.

Key resources

GUIDES TO FORMATIVE RESEARCH

Fisher AA, Foreit JR. 2002. *Designing HIV/AIDS Intervention Studies: An Operations Research Handbook.*

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GUIDES TO USING THE FINDINGS FROM FORMATIVE RESEARCH TO INFORM PROJECT DESIGN

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