Summary of Proceedings from a Technical Advisory Group Meeting to Discuss Community Health Worker Performance at Scale

Washington, DC December 9, 2010

Background

USAID's Maternal and Child Health Integrated Program (MCHIP) presently works in 37 Countries to support USAID Mission priorities and contribute to achieving impact at scale for proven life-saving interventions. The success of MCHIP's efforts rests largely on the shoulders of health workers, who are supported through national or local government funding to serve communities, and volunteer workers operating at the community level. With this reality in mind, MCHIP hosted a Technical Advisory Group (TAG) meeting to discuss the factors that influence effective Community Health Worker (CHW) Performance at Scale. While the TAG discussion was framed around CHWs, the meeting focused more broadly on considering effective community health work and the larger system in which community health workers function.

The meeting objectives were to: 1) establish a learning agenda for a community of practice around CHWs at scale; and 2) identify two to three specific actions or products related to the learning agenda that would facilitate attainment of the Millennium Development Goals (MDGs) and fit into MCHIP's mandate.

Thirty-one participants from thirteen organizations attended the meeting[1]. Collectively, they represented experience in designing and managing CHW programs at the community, district, and national levels in Asia, Africa, and Latin America.

Summary

The TAG reviewed current global CHW initiatives, discussed large-scale CHW efforts in several countries, and defined knowledge gaps that, if addressed, would further strengthen global efforts related to CHWs. Important gaps that emerged from this meeting were categorized into the following themes:

- the lack of a clear taxonomy to distinguish different types of community health workers and provide typologies for selecting appropriate community health agent strategies;
- the need for increased consideration of community health systems in achieving scale for community health work;
- a call for practical guidance program managers and policy makers can utilize to design CHW programs that can operate effectively at scale within the local cultural context; and
- a call for mechanisms to facilitate continuous learning on CHW issues.

[1] See Attachment A for list of participants

Context for the Discussion

This meeting occurred at a time when CHW issues are gaining increased attention in the global development community. While there is renewed interest in investing in CHWs and scale up of community-based health interventions, there is a large gap between expectations and hopes of working with CHWs and quality programming at scale. Existing initiatives supporting the development of community-based health services and specific country strategies for building a national cadre of CHWs framed the discussions that occurred.

Existing Initiatives

- In April 2010, the WHO Global Health Workforce Alliance (GHWA) hosted a Global CHW Consultation in Montreux, Switzerland and commissioned a study of national CHW programs to inform the dialogue. A series of recommendations for national programming emerged from this consultation (see text box on following page). Launched in May 2006, the GHWA serves as a catalyst and convener to identify and respond to the human resources for health crisis. They recognize that the current density of health workers in most developing countries is inadequate to meet the existing health service needs.

- The USAID-supported Health Care Improvement (HCI) Project developed the CHW Assessment and Improvement Matrix (CHW AIM) tool to define a set of key elements needed for community health worker programs to function effectively, assess program functionality, identify strengths and areas of need, and guide improvements. The domains covered by the CHW AIM tool include: recruitment; role of CHWs; initial training; continued training; equipment and supplies; supervision; performance evaluation; incentives; community involvement; referral system; opportunity for advancement; documentation, information management; linkages to health system; program performance evaluation; community-health facility linkages; and country ownership. HCI applied the tool in the review of national CHW programs for the GHWA. Currently, HCI is using it for research on CHW performance in Zambia and Madagascar to determine if strengthening the system supporting community-based provision of care improves individual CHW performance.

- A number of organizations, led by WHO and UNICEF, are developing a tool kit of materials and benchmarks for evaluation of community case management (CCM) programs. CCM programs assure that CHWs have life saving treatments, including appropriate supplies, commodities, training, and other resources, for childhood infectious diseases.

- There has been increased attention to “community health systems”, and some recognition that traditional national cadres of CHWs often do not reach all the way to the household level. The Global Fund has emphasized the importance of community systems strengthening (CSS) through their CSS Framework.

CHW Program Specific Recommendations from Montreux

Service Delivery

- Programs should have established referral protocols with community-based health and social service agencies.
- CHW programs should support provision of requisite and appropriate core supplies and equipment to staff in the field.

Health Workforce

- Given the broad role that many CHWs play in primary care, a training program for CHWs must provide a core set of skills and information related to MDGs. Curricula should incorporate scientific knowledge on preventive and basic medical care, while relating these ideas to local issues and cultural traditions.
- CHWs should be trained, as required, on the promotive, preventive, curative and rehabilitative aspects of care related to MNCH, malaria, tuberculosis, HIV/AIDS and other communicable and non-communicable diseases. Other training content and time may be added pertinent to the specific intervention that the CHW is expected to work on as detailed in main report.
- CHW programs should also provide opportunities for career mobility and professional development, to include opportunities for continuing education, professional recognition, and career advancement. This can be provided through specific programmatic opportunities or access to educational and training scholarships.
- CHW programs should have a clear selection/ deployment procedure to ensure trainees who complete the required coursework and pass the writing or verbal exam at the end of training are appointed.
- The programs should have regular and continuous supervision and monitoring systems in place.
- CHWs should be taught to work with supervisors in a participatory manner that ensures two-way flow of information.

Policy

- The outline of the country plan of action to develop and improve CHW program(s) should be finalized by a working group of relevant stakeholders, including identification of resources needed, indicators and targets, and monitoring tools, and formally authorized by the Ministry of Health
- The programs should be coherently inserted in the wider health system, and CHWs should be explicitly included within the HRH strategic planning at country and local level.

Financing

- Sustained resources should be available to support the program and workers therein.

Information

- Both external and internal evaluations need to be carried out on regular basis to improve the services and analyze the need for various logistics, supplies and training.
- Programs should evaluate their own performance on annual basis, while a third party evaluation could be recommended in every 4-5 years, which would generate a neutral and free from bias findings

Community Engagement

- Community preparedness and engagement is a vital element that is relatively rarely practiced. From the outset, program should develop village health committees in the community that can also contribute in participatory selection processes of CHWs.
- CHW programs should be based in and respond to community needs. In practical terms, such programs should continually assess community health needs and demographics, hire staff from the community who reflect the linguistic and cultural diversity of the population served, and promote shared decision making among the program's governing body, staff, and CHWs.

- The CORE Group, a network of over 50 international NGOs, developed and continues to use a community health implementation framework to design community health programs. It has four elements: improve partnerships between health facilities and the communities they serve; increase appropriate health care and information from community-providers; integrate promotion of key family health practices, and engage other non-health sectors to support sustained health and nutrition practices. Community health agents are often used to implement each of the framework's four elements.

Country Models

Three diverse models of CHW programs were presented and discussed at the TAG. The differences among these models illustrates the myriad variety of skill sets incorporated under the CHW rubric and the challenges of developing one standard set of global guidelines that can apply to all such programs.

Nepal. The Female Community Health Program evolved over 20 years to its current composition of 49,000 volunteers focused on improving community participation and outreach for health services. Existence of other cadres of government-paid semi-professional workers have been critical to the establishment of this cadre, including Maternal Child Health Workers (MCHWs) and Village Health Workers (VHWs) who are trained for about nine months and are attached to health facilities.

Ethiopia. The government created a paid cadre of 5,000 Health Extension Workers (HEWs) who receive a year of training and provide a wide-ranging package of preventive and curative services. JSI, which led the USAID Bilateral project supporting this initiative, created a volunteer CHW program in Ethiopia to expand the reach of the HEWs. These community-based volunteers started with a two-day, practical training focused predominantly on negotiation and communication skills. Over time, the program phased in additional themes for health education including immunization, exclusive breastfeeding, family planning, complementary feeding, vitamin A, environmental sanitation and hygiene, and malaria prevention.

Rwanda. The government is in the process of expanding the existing community health program from four to six CHWs per village. The four existing roles for CHWs include: a male/female pair focused on community case management, one CHW for maternal and newborn health, and one CHW for health and social affairs. In the future, two CHWs will focus on rehabilitative/palliative care for HIV/AIDS and chronic diseases. When all villages have a full team of six CHWs, anticipated in 2014, there will be 88,000 CHWs deployed throughout the country.

World Relief works in six districts in Rwanda using the Care Group model to extend the work of the government CHWs to the household level. A Care Group is a cluster of 10 to 15 volunteers, who serve as community-based health educators, meeting regularly with project staff for training and supervision. Each volunteer is responsible for regularly visiting 10 to 15 of her neighbors, sharing what she has learned and facilitating behavior change at the household

Key Messages and Recommendations:

1. **There is a need for more precise terminology defining different types of CHWs in order to provide useful guidance for program managers.**
   The term CHW covers a broad range of workers from people in the community with minimal contact with the health system doing health promotion to paid, full-time health workers based out of a health facility. The Montreux recommendations highlight the challenge of creating one set of guidance appropriate for all contexts. While these recommendations provide a good starting point, implementation of the recommendations will vary greatly based on the type of CHW considered.

   Recommendation: Create a typology that defines more clearly the range of community health agents to which the term "CHW" is often globally applied. Participants at this TAG meeting found it necessary to clarify the types of CHWs that they were discussing (ex. national level cadres of paid workers, unpaid community volunteers, or health extension workers) in order to have meaningful dialogue about how best to support these groups. The examples presented from Nepal, Ethiopia, and Rwanda reinforced the nuances in these terms, as CHWs in each country had very distinct skill sets and targets. Using a clear vocabulary to describe CHWs would help us better understand characteristics critical for the performance, retention, supervision and motivation of each of these different types of community agents. Developing a typology of CHW programs may yield several different general profiles for which it may be possible to give more detailed guidance, based on what has been learned about what contributes to or hinders the effectiveness of CHWs in existing programs.

   A recent paper by Standing, Mushtaque and Chowdhury in *Social Science and Medicine*, discussed how "poor populations can obtain access to trusted, competent knowledge and services in increasingly pluralistic health systems where unregulated markets for health knowledge and services dominate."[2] The paper outlined four potential types of CHW:

   1. **General CHW.** A generic community health worker important in contexts with shortages of qualified local staff and a need to fill basic gaps in health prevention and provide limited curative care;
   2. **Specialized CHW.** A specialized CHW that focuses on conditions that are of high prevalence or great public health need such as ARI or TB;
   3. **Advocate or Instructor CHW.** An expert patient advocate or peer educator who can empower those affected by various diseases (ex. diabetes, HIV/AIDS) to take responsibility for their own health; and
   4. **Facilitator CHW.** A community mediator that serves as a local facilitator to enable people to develop solutions to problems, access resources, negotiate market alternatives, and be aware of their rights.

[2] Social Science and Medicine 66 (2008) 2096-2107

These categories could be a starting point for further work on classifying CHW programs, based on their target populations and the roles workers are expected to fill.

2. **There is a need to better understand the community health system in which CHWs function.** CHWs do not function in isolation – their effectiveness depends on the functioning of the wider health system in which they operate. Discussions at this TAG suggest that although there has been increased attention on the part of some global actors to the issue of community systems, the aspects of health systems that are present at the household and community levels are still largely ignored or stand-alone in many comprehensive health systems approaches. It is important to define the systems and factors at the community level that support health work—including community context, civil society partners, local government, traditional healers, shop keepers, traditional birth attendants, etc. and to consider how these systems can be leveraged to extend the reach of national cadres of CHWs beyond facilities to the household level.

   Recommendation: Develop a community health system checklist. Participants recommended defining the building blocks of the community health system and clearly identifying the competencies that need to exist at the community level in order to decrease mortality. TAG members requested a tool that would define community health work and the system within which community health work can best be done. They envisioned the tool including a community self-assessment component and describing various teaming models of volunteer and paid workers to meet community needs.

3. **Program managers and policy makers lack guidance for designing and maintaining CHW programs at scale**

   The program examples from Nepal, Ethiopia and Rwanda highlight the importance of government commitment, national financial investment and the existence of a national policy on community health for the sustainability of effective community health programs at scale. But these experiences also suggest that other important adaptations are necessary to tailor this commitment to the local context.

   There is often a need for policy to establish and maintain a cadre of paid or volunteer workers whose services extend the reach of government CHWs to the household level. Participants discussed the role of volunteers who support government CHWs and extend their reach to the household level, providing essential interpersonal communication to effect behavior change. Since the majority of health decisions are made in the home, not reaching the home decreases the potential of effecting long-term change in health status. Data from Ethiopia demonstrated that when Health Extension Workers did not make home visits, there was no impact on health statistics. Care Groups, like those deployed in Rwanda, were discussed as one model to achieve high levels of household-level behavior change associated with mortality reduction by complementing the work of government CHWs.

Recommendation: Develop guidelines for designing and maintaining effective CHW programs at scale for program managers and policy makers.

This recommendation builds upon the important contributions of the Montreux meeting, as well as the previous two recommendations. Creating such guidelines will require a clear distinction between different types of community health workers; a recognition of the considerations necessary for the local context; and linkage of the community health system with the larger overall health system.

4. **There is a need for good knowledge management in order to learn from program experiences**. Program managers routinely seek out more effective methods and tools to support recruitment, training, supervision, logistics management, performance evaluation, program performance evaluation, and referrals. TAG participants specifically identified a need for standard-based tools to support various kinds of supervision, performance review, and costing. While key informants identified a number of gaps in the current knowledge base about effective CHW program development, they acknowledged that many of the solutions exist in current and past programs, but have not been rigorously evaluated and/or documented. The USAID-funded Health Care Improvement Project is developing CHW Central, a web portal to house a variety of resources related to CHW programs.

   Recommendation: Develop a variety of options to support knowledge management. Participants recommended:

   - Actively supporting CHW Central to serve as a hub of information by providing appropriate tools, resources, and expertise. The CHW typology discussed earlier could be a useful construct for organizing available tools and assisting program managers in selecting the most appropriate tools for their program context.
   - Improving links between programmers and academia to conduct evaluations and submit articles for publication. Suggested topics for research include:
     - Impact on mortality reductions resulting from community-based volunteers extending the reach of the government community health workers;
     - Provision of interpersonal communication for behavior change at the household level; and
     - Strategies for strengthening community health systems.
   - Documenting effective strategies. Strategies of specific interest were:
     - Peer supervision;
     - Team management; and
     - Generating resources from local government to support community health work in various countries.
   - Using mhealth technologies to enhance supportive supervision such as use of cell phones to administer a routine visit for supervision.

- Developing a community of practice with active facilitation to enable enhanced learning and provide opportunities for coordination of activities. Potential questions for discussion include:
    - Urban experiences with CHWs at scale;
    - Drivers for volunteerism;
    - Selection criteria and processes;
    - Needs of literate and illiterate CHWs; and
    - Integrating program data into the national health information system in order to track the inputs and impact of community health work.

Conclusion

The importance of community health programs and the roles filled by community health workers is evident in the successful implementation of existing programs, available literature, and expert opinions. Numerous gaps persist, though, in clear definition of the skills and qualifications a CHW possesses; the roles CHWs fill in different country and community contexts; how to best bring CHW programs to scale; and how to practice good knowledge management. The TAG has identified numerous pointed and practical strategies to address these challenges, as listed above, and plan to work together as well as with their respective organizations to follow through on the recommendations.

To access the presentations made during this meeting, visit the MCHIP website at http://www.mchip.net/TAGDecemberMtg.

Attachment A: Participant List

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