Case Studies of Large-Scale Community Health Worker Programs

Examples from Afghanistan, Bangladesh, Brazil, Ethiopia, India, Indonesia, Iran, Nepal, Pakistan, Rwanda, Zambia, and Zimbabwe

Condensed Version, Meike Scheiff, JHU-SPH

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The Maternal and Child Survival Program (MCSP), is a global U.S. Agency for International Development (USAID) cooperative agreement to introduce and support high-impact health interventions in 24 priority countries with the ultimate goal of ending preventable child and maternal deaths (EPCMD) within a generation. MCSP supports programming in in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP will tackle these issues through approaches that also focus on health systems strengthening, household and community mobilization, gender integration and eHealth, among others. Visit www.mcsprogram.org to learn more.

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The Community-Based Health Care System of Afghanistan

Background

The Afghanistan Community Health Worker (CHW) program is part of the Community-Based Health Care (CBHC) component of the Basic Package of Health Services (BPHS), which was disseminated in 2003 after a year-long consensus building process. The CHW program functions in a context where there are few health professionals and where social and economic structures remain weak.

Much of Afghanistan's population is dispersed widely in difficult-to-reach areas, including deserts and remote mountain valleys. Additionally, the health facilities that did exist in 2003 were not well equipped with either necessary supplies or adequate female staff to provide examinations and services to female patients. Both the maternal mortality ratio (MMR) and the under-5 mortality rate were relatively high, nearly half of children were stunted, and the total fertility rate was 6.7. Less than one quarter of the population had access to safe water, and sanitation was even lower. Communicable diseases, reproductive health needs, immunization rates, and disabilities resulting from conflict were major areas of need and challenge.

Implementation

Community Health Workers are based at health posts in pairs as a male and female team, usually as spouses or as family members. CHWs are selected through a process that includes the nongovernmental organization (NGO) staff and community elders from the population they will serve. The health posts are connected to the district-level facilities operated by the government. At present, there are approximately 29,000 CHWs.

The CHWs are trained and supervised by NGOs who have contracts from the government to implement the BPHS, including CHW training and supervision, in specific districts. These NGO-sponsored activities are funded by multiple international donors, including the World Bank, USAID, and the European Union, with other partners contributing substantially toward the initial development of the program.

Training

Community Health Workers receive three separate three-week modules with a month of field experience in the village in between. Trainers attempt to visit all the trainees in their villages during the month of field experience.

The three modules build from basic and simple knowledge and skills to more complex ones. First, CHWs learn hygiene and care of common conditions such as diarrhea. The second module focuses on maternal and child health (MCH), including pregnancy, birth, postpartum care, and care of newborns, including breastfeeding and immunizations. Finally, the third module focuses on managing childhood illnesses, reproductive health, tuberculosis (TB), and additional skills in communicating with their communities.

Roles/Responsibilities

Community Health Workers conduct a comprehensive set of activities, ranging from health promotion to provision of health services and to referral to the next level of care at a basic or comprehensive health center. Their services include educational services such as prevention of illnesses such as malaria, information on safe

pregnancy and delivery, promotion of breastfeeding and nutrition, hygiene, and reproductive health information. CHWs also report vital events (births and maternal and under-5 deaths) to the national health management information system (HMIS), maintain a community map, and manage the equipment and supplies at the health post.

Of note is CHWs' capacity to carry out community case management of acute childhood illness (pneumonia, diarrhea, and malaria where it is endemic), treatment of patients diagnosed with TB, and provision of family planning (FP) commodities.

Incentives

Community Health Workers are volunteers, which they have been since the program began. Communities have been encouraged to provide support to CHWs, but this has not been very effective. CHWs do receive allowances for travel and food during their monthly visits to the district health facility and any additional training. Other special events and occasions, such as national immunization days, may provide honoraria for CHWs who participate as well; in some regions, CHWs receive in-kind or financial support for caring for specific categories of patients. Since 2010, National CHW Day has been observed on December 5 to honor the contributions of CHWs in Afghanistan.

Supervision

District health facilities, which support health posts, have Community Health Supervisors (CHS)—who are typically males. The CHS usually has a high school education, good communication skills, and lives in the district where he works. CHSs make monthly visits to each health post to provide on-the-job training, check records, the quality of the community maps, as well as drug stocks and supports planning and management of CHW activities. CHWs also come monthly to the "parent" health facility where the CHS is based for a joint meeting with the other CHWs.

Impact

Community Health Workers now provide a major portion of primary health care services in Afghanistan and are widely recognized as one of the important contributors to Afghanistan's marked improvement in health status during the past decade.

Over the past decade, Afghanistan has seen marked changes for the better on numerous key health indicators. Total fertility, under-5 mortality, and the MMR have dropped, and rates of utilization of antenatal care (ANC) services and births attended by a skill birth attendant have increased. Care of common childhood illnesses, such diarrhea and symptoms of pneumonia, has improved as well. Although these positive changes cannot be attributed directly to the CHWs with any precision, the CBHC system has undoubtedly played a major role in this dramatic progress.

The Government Family Welfare Assistant and Health Assistant Programs in Bangladesh

Background

Bangladesh has a strong history of using CHWs to support health services. At present there are some 219,000 CHWs in Bangladesh, with approximately 56,000 of these being government CHWs (see the following section for a discussion of nongovernmental CHWs referred to as BRAC).This case study describes the government programs for Family Welfare Assistants (FWAs), Health Assistants (HAs), and Community Health-Care Providers (CHCPs).

The health status of the poor and vulnerable remains challenging, and families may suffer financial catastrophes if a member falls ill. Communicable diseases, poor MCH, and malnutrition are responsible for high levels of preventable morbidity and mortality. New challenges of the epidemiological shift to chronic and non-communicable diseases are also increasing along with environmental hazards from air and water pollution, injuries, and unhealthy behaviors, such as tobacco use and violence.

While officially Bangladesh's health system has a three-tier service delivery system within the Ministry of Health and Family Welfare (MOHFW) with a comprehensive network of public facilities at tertiary, secondary, and primary levels, in practice it is quite varied and unregulated. Utilization of public sector health centers and district hospitals is low, being responsible for less than 20% of curative services. The public and private sector have a porous boundary and doctors move between the sectors. Village doctors (informally trained providers who practice allopathic medicine) are the dominant providers of care at the community level.

Implementation

Family Welfare Assistants were introduced in 1976 and now number 23,500. Their work focuses on FP and referral of clients for antenatal and postnatal care (PNC). HAs were introduced in 1995—previously they were vaccinators or malaria control workers. At present there are 20,615 HAs. Their work now focuses on immunizations, vitamin A supplementation, and detection and treatment of pneumonia, diarrhea, malaria, and TB. CHCPs were introduced in 2010 to staff community health clinics. They now number 12,991.

Family Welfare Assistants were established to scale up the successful pilot FP program in Matlab, Bangladesh. As the program scaled up with external donor support and technical assistance, the details of the FWAs' work changed slightly, but for more than two decades FWAs were the backbone of the government's FP program. This program is widely credited as being one of the most successful FP programs in the world, which is noteworthy for a country not undergoing simultaneous rapid socioeconomic development.

The government's goal is to have one FWA for every 4,000–5,000 persons and one HA for 6,000 people. There is supposed to be one community clinic, served by one CHCP, for every 6,000 people. The location of each clinic is supposed to be such that 80% of the population is within a 30-minute walk of the facility.

Training

Family Welfare Assistants receive 21 days of training followed by on-the-job training. HAs receive training of a similar length. CHCPs receive 12 weeks of training.

Roles/Responsibilities

Family Welfare Assistants visit households every two months, register couples, motivate them for FP, distribute contraceptives, and refer clients for ANC and PNC. HAs provide immunizations and vitamin A capsules and distribute packets of oral rehydration solution (ORS). They visit homes to promote the use of ORS and to treat acute infections (acute respiratory infection, TB, and malaria). CHCPs provide ANC and PNC; treat cases of pneumonia, diarrhea, and anemia; and give injectable contraceptives.

The HAs' target population is women and children in need of immunization. In addition to their other duties, one FWA and one HA are each assigned to work at a community clinic three days a week.

Incentives

Family Welfare Assistants receive a government salary of $98 per month, HAs receive a government salary of $103 per month, and CHCPs receive a government salary of $110 per month.

Supervision

Family Welfare Assistants are supervised by male supervisors, with whom they meet twice each month. HAs are supervised by Assistant Health Inspectors, each of whom is responsible for five to six HAs. CHCPs are supervised by the Sub-district Hospital Manager.

Impact

There are no available evaluations of these CHW programs. The strong CHW presence in Bangladesh is widely perceived to have made an important contribution to Bangladesh's remarkable progress in reducing under-5 and maternal mortality.

The BRAC Shasthya Shebika Community Health Worker in Bangladesh

Background

Bangladesh's health system, though officially organized into a comprehensive network of three tiers of public service delivery is, in practice, a variable mix of public, private, NGO, and traditional providers. Public health facilities generally experience low rates of utilization.

Bangladesh has a history of using CHWs to support health services, both in the public and private sector, and the current model has grown up over several decades. The NGO BRAC, formerly the Bangladesh Rural Advancement Committee, has been refining its CHW strategy over time. Its CHWs, called *Shasthya Shebika* (SS), are rooted in a gendered perspective, focusing on the need for female health workers in Bangladesh to address socio-cultural barriers to access to health care services.

In Bangladesh, communicable diseases, poor MCH, and malnutrition are responsible for high levels of preventable morbidity and mortality. This is particularly true among the poor, whose health status remains vulnerable. New challenges of the epidemiological shift to chronic and non-communicable diseases are increasing, along with environmental hazards from air and water pollution, injuries, and unhealthy behaviors such as tobacco use and violence.

Implementation

BRAC began in the 1970s by adopting China's Barefoot Doctor model for male paramedics, but after that approach failed, it used lesser-trained female CHWs who focused on health promotion and disease prevention. SSs work part-time in the afternoons and serve an average of 250–300 households through monthly visits. In 1990, there were 1,080 SSs, by 2008 the number had grown to 70,000, and at present, there are approximately 100,000 SSs.

Training

Shasthya Shebikas are selected from within small groups of women who participate in BRAC's microcredit, savings, and loan programs. Once the women have selected a candidate, BRAC staff, local leaders, and government officials make the final approval of the candidate.

Shasthya Shebikas receive four weeks of basic training by the local BRAC office to treat common medical conditions, promote a wide variety of health behaviors, and refer patients to preventive and curative services as appropriate. Refresher training, done in an interactive and problem-solving way, is central to BRAC's method and serves to keep SSs' knowledge updated, provide opportunities for discussion of problems, and facilitate regular contact; it also allows SSs to replenish supplies, including drugs.

Roles/Responsibilities

During monthly household visits, SSs provide health promotion sessions and educate families on nutrition, safe delivery, FP, immunizations, hygiene, and water and sanitation. They also use this time to sell basic health products, a system described under the incentives section.

When someone has an illness that the SS cannot manage, the SS is trained to refer the person to government health centers or a BRAC clinic. SSs collaborate with traditional birth attendants and also link to the formal public health system by mobilizing and referring the population in their catchment area for services, such as immunization and de-worming, as well as for symptoms of illnesses such as TB.

Incentives

Shasthya Shebikas are given small loans to establish revolving funds, which they use to make money by selling health products at a small markup. These products include oral contraceptives, birthing kits, sanitary napkins, iodized salt, condoms, essential medications, and vegetable seeds.

BRAC introduced the sales component to provide a small profit as an additional incentive for and motivation to the SS, who are volunteers, to continue working. They also receive compensation for good performance such as identifying pregnant women during their first trimester. Since the SSs are also part of the women's savings and loan groups, they have access to resources and support to pursue other income-generating schemes as well.

Supervision

SSs are supervised by *Shasthya Kormis* (SKs), who are also recruited from their communities. SKs are paid a sum equivalent to about $40 per month to supervise the SSs and perform ANC in villages. The SKs, all women, have a minimum of 10 years of schooling and work between four and five hours per day. They accompany each of the SSs in their charge on community visits at least twice per month and meet monthly with their group of SSs to discuss problems, gather information, and provide supplies and medicines. BRAC program staff members also participate in supervision. There is a formal link to the local government's health service delivery system for referral when necessary.

Impact

Supervisors track SS performance and BRAC provides support to address challenges as they occur. One formal study assessed how well SSs managed childhood pneumonia using the protocol approved by the World Health Organization (WHO); the study revealed that the SSs performed as well as physicians in implementing this protocol. Another formal study compared the prevalence of TB in control districts with districts where SSs were identifying suspected cases and providing directly-observed treatment (DOT) for those diagnosed with TB and demonstrated that the prevalence of TB in BRAC areas was half of that in control districts.

The BRAC CHW program is self-sustaining and is widely perceived to have made an important contribution to Bangladesh's remarkable progress in reducing under-5 mortality and to its national TB control program.

The Community Health Agent Program of Brazil

Background

The Brazilian health system dates back to large-scale vaccination and other public health campaigns that were implemented by sanitary police in the late 1800s and early 1900s. A strong private health care system also developed in the 1950s; it continued to expand with the support of the federal government, as did primary health care programs. CHW programs have been implemented in Brazil for decades, including the successful *Visitadora Sanitaria* (health visitor) program in which CHWs provided immunizations, information, and various other MCH interventions. The *Programa Saúde da Família* (Family Health Program, now called the Family Health Strategy and abbreviated PSF) was launched in 1994, building upon several previous decades of experience in rural, underserved areas with Community Health Agents (CHAs), who were legally recognized as professional in 2002.

Brazil has undergone a demographic, epidemiological, and nutritional transition since the 1970s. During this transition, fertility, infant mortality, and illiteracy have all decreased as life expectancy and urbanization have increased. Despite these positive advancements, the country is plagued by increasing levels of non-communicable diseases, including very high levels of hypertension and diabetes as well as other health issues such as use of unsafe abortion, teen pregnancies, sexually transmitted infections, and road traffic injuries.

The health system in Brazil has three levels, but emphasis is placed on the primary health care (PHC) level for basic services. Secondary care consists of community-level hospitals and tertiary care is provided at specialty referral hospitals, mostly by the private sector and public teaching hospitals. Family Health Care teams (*Equipos de Saúde Familiar*) work together at the PHC level and include CHAs, auxiliary nurses, and a nurse and a doctor. The private sector also has a substantial presence, and coordinating the mix of public and private services remains a challenge for Brazil's health system. A central feature of the Brazilian health system is the engagement of civil society in decisions about government health programs.

Implementation

Originally, CHAs provided vertical (centrally directed) MCH services (such as immunizations and FP) in isolated rural areas where services were limited, but have evolved into the cornerstone of the national PHC program that reaches virtually the entire population of the country. The scope of work for the health care teams varies with geographic distribution, but most teams provide comprehensive care through promotive, preventive, recuperative, and rehabilitative services. Key services provided by CHAs include the promotion of breastfeeding; the provision of prenatal, neonatal, and child care; the provision of immunizations; and participation in the management of infectious diseases, such as screening for and providing treatment for HIV/AIDs and TB.

Family Health Care Teams are managed by municipalities. There are usually four to six CHAs on each team (but sometimes more), each CHA is responsible for 150 families (ranging from 75 to 200 households). Some teams also include a dentist, an assistant dentist, a dental hygienist, and a social worker. Currently, Brazil has 236,000 CHAs working as part of 33,000 Family Health Care Teams.

Training

The CHAs, who are often selected by local health committees, must be literate adults who work in the community where they reside. Training of CHAs is conducted at the national Ministry of Health (MOH), but the training curriculum is approved by the Ministry of Education. Nurses provide eight weeks of formal didactic training at regional health schools. Following this, CHAs receive four weeks of supervised field training. CHAs also receive monthly and quarterly ongoing training.

Roles/Responsibilities

The scope of work for the health care teams varies with geographic distribution, but most teams provide comprehensive care through promotive, preventive, recuperative, and rehabilitative services. CHAs register the households in the areas where they work and are also expected to empower their communities and link them to the formal health system.

Community Health Agents are full-time salaried workers, earning in the range of $100 to $228 per month.

Supervision

Community Health Agents are supervised by nurses and physicians from the local clinics. Supervisory nurses spend 50% of their time in their supervisory role and the rest of their time working in the local clinic. Brazil also has strong referral systems. CHAs report any ill person within their catchment area to a nurse and the CHA may, at times, escort the person to the local health facility. Upon the patient's release, the CHA is expected to maintain the continuum of care and follow up with the patient. The CHAs' role performed helps to ensure accountability of the health system to local health needs.

Impact

Brazil has experienced dramatic improvements in a broad range of national health indicators over the past three decades. A variety of factors such as socioeconomic development, social improvements, and conditional cash transfers have facilitated this progress, but the PSF and various health interventions, including the use of CHAs, have been critical components in the improvement of health indicators.

Some of the most striking health improvements have been in the areas of infant and under-5 mortality, which have decreased over the same time period as PSF coverage increased substantially. Encouragingly, the most drastic improvements were seen in some of the poorest municipalities as well as in rural areas.

Ethiopia's Health Extension Program

Background

Community health workers have a long history in Ethiopia dating back to around the time of the 1978 Alma Ata Conference on Primary Health Care; some programs in the 1970s and 80s trained several thousand workers. In fiscal year 1997–1998, the Ethiopian Federal Ministry of Health (FMOH) launched the National Health Sector Development Program (HSDP), which shifted the health system focus from predominantly curative to more preventive and promotive care, and it prioritized the needs of rural inhabitants, who make up 83% of the Ethiopian population.

The first cadre of Health Extension Workers (HEWs) was trained in 2004. In the following years, Ethiopia expanded its PHC programs in hope of achieving universal health coverage. Human resources that serve at the community level in Ethiopia include HEWs, voluntary CHWs, and Community Health Promoters (CHPs), now called Health Development Army (HDA) volunteers. There have been numerous recent changes in the Health Extension Program; following its rapid expansion of coverage in rural areas, attention shifted to scaling up services to urban and pastoralist communities.

Key health issues in Ethiopia include high rates of maternal and child mortality and malaria. Ethiopia also has a large burden of other infectious diseases and malnutrition, which stretch the health system's resources and are associated with substantial morbidity and mortality.

Implementation

Health Extension Workers are a formally recognized cadre that has strong political support, including from the FMOH and the prime minister. HEWs are full-time employees and are supposed to split their time between health posts and the community. These expectations have changed considerably since the HEW program was initiated. HEWs were originally conceived as links between their local community and the formal health services, dedicating at least 75% of their time to community outreach activities. Recent reports recommend that HEWs spend 50% of their time in the health post and 50% in the community. The main role of the HEW is in health promotion, disease prevention, and treatment of uncomplicated and non-severe illnesses, such as malaria, pneumonia, diarrhea, and malnutrition.

Related to HEWs, the HDA volunteers' role is to increase utilization of PHC services through part-time work (less than two hours per week) within their communities. Their services include prevention, health promotion, and health education; support for outreach work by health services; and participation in or support of campaign-type activities. They are expected to be model community members and to share health information with others in their communities.

Training

Health Extension Workers have more than one year of pre-service training conducted by trainers who were taught through a cascade train-the-trainer approach. HEW training is a collaboration of the FMOH and the Ministry of Education and occurs at 40 technical and vocational education training schools.

Health Extension Worker training includes didactic and clinical training in modules on (1) family health services, (2) disease prevention and control, (3) hygiene and environmental sanitation, and (4) health education and communication. Recently, HEWs received a one-time, one-month in-service training provided

in response to identified inadequacies in their initial training. Continuing education trainings are available, but are sometimes overlapping in terms of content and are not always well coordinated.

Community Health Promoters who train to become HDA volunteers receive an initial training conducted by the HEWs. HDAs are given 96 hours of training on prevention of communicable diseases, family health, environmental and household sanitation, and health education.

Roles/Responsibilities

Health Extension Workers provide a range of services, including prevention, health promotion, and health education; support for outreach health services; distribution at the community level of commodities whose use does not involve clinical judgment; clinical case-management that involves exercising clinical judgment; ongoing care or support to assist people with a chronic illness (e.g., HIV/AIDS); and participation in and support of campaign-type activities. They also provide immunizations, injectable contraceptives, basic first aid, diagnosis and treatment of malaria and diarrhea, and treatment of intestinal parasites. Finally, they help train and oversee the HDAs.

Incentives

Health Extension Workers are formal employees and are paid a salary. HDA volunteers are not monetarily compensated, but receive nonfinancial incentives such as formal recognition, ongoing mentorship, certificates, and recognition at community celebrations.

Supervision

Supervision is conducted by the *woreda* (district) supervisory team, which comprises a health officer, a public health nurse, an environmental/hygiene expert, and a health education expert. In 2005, HEWs had an average of three supervisory visits over the course of nine months.

Impact

At present, Ethiopia is making some of the strongest improvements in health in all of Africa. Its declines in under-5 mortality and in maternal mortality, along with dramatic improvements in the contraception prevalence rate, are among the most notable in all of Africa. HEWs are widely seen as the main reason that services have expanded and these results have been achieved.

India's Community Health Workers: Auxiliary Nurse-Midwife, Anganwadi Worker, and Accredited Social Health Activist

Background

India has three cadres of CHWs. The first cadre created was the Auxiliary Nurse-Midwife (ANM), who are based at a subcenter and visit villages in addition to providing care at the subcenter. The second was the *Anganwadi* Worker (AWW), who works solely in her village and focuses on provision of food supplements to young children, adolescent girls, and lactating women. The most recently created cadre is the Accredited Social Health Activist (ASHA), who also works solely in her village. ASHAs focus on promotion of MCH, including immunizations and institutional-based deliveries, for which they receive a performance-related fee.

India's health care system, including its network of primary health centers, was established in the late 1940s, soon after India's independence in 1947. Subcenters were added in the 1960s and the first ANMs were also added to the system to help staff the subcenters. The role of ANMs, originally envisioned as village-level midwives, expanded to include a wide range of preventive and curative work at the village level, particularly around FP and immunization. In the 1970s, *Anganwadi* centers were developed to address nutritional issues, and the AWWs were added. After some years of trial, error, and lack of necessary buy-in and support, the National Rural Health Mission was officially launched in 2005, and, with it the ASHA program.

Over the past 60 years, the health status of Indians has improved markedly. Progress has been seen in the areas of infant mortality rates (IMR) and MMR as well as in decreased fertility rates. However, despite rapid growth in GDP over the last 20 years, India has consistently failed to meet national and international health targets, and it has improved its health status more slowly than most other Asian countries. A "double burden" of disease, including communicable as well as rising incidence of chronic conditions—such as mental health disorders, diabetes, and cardiovascular disease—adds an additional layer of challenge and complexity.

India also has a prominent private health care sector. In fact, the majority of Indians seek care at private facilities rather than at free government health centers because of convenience, ease of accessibility, and perceived superior service.

Implementation

All cadres of CHWs in India must be female. The ANM cadre, based out of subcenters, is the most well-educated and oldest cadre among the village-level health workers, having been established in the 1960s. As the new and often younger addition, ASHAs are monitored and supported by ANMs and AWWs. The ASHA is seen by some policymakers as a means of reducing the labor burden on the ANM, and is often seen as the ANM's assistant or helper. Each village is supposed to have one AWW and one ASHA worker. AWWs provide information about basic child health and nutritional supplementation for children younger than six years of age, adolescent girls, and lactating women.

There are at present 208,000 ANMs, 1.2 million AWWs, and 857,000 ASHA workers. They each have their own supervisory systems and payment systems.

Training

The AWWs and ASHAs are chosen by their village while the ANMs are hired by the district health administration. ANMs receive 18 months of training while AWWs and ASHA workers each receive 3–4 weeks with additional trainings from time to time.

Roles/Responsibilities

ANMs are now officially Multipurpose Workers with a broad set of responsibilities, including supporting AWWs and ASHAs. Some obtain additional training to manage birth complications and refer women with complications to higher levels of care, and some obtain additional training for insertion of intrauterine devices. AWWs manage nutritional supplementation at *Anganwadi* centers for young children, adolescent girls, and lactating women. They also help with promotion of healthy behaviors and mobilization of the community for improved water and sanitation, participation in immunization activities, and other special health activities. ASHAs focus on facilitating institutional deliveries, immunizations, provision of basic medicines (including oral contraceptives), and referral of patients to the subcenter.

Incentives

ANMs are paid a government salary. AWWs are considered to be volunteers, but are paid an "honorarium" of about $27–$29 per month. ASHAs receive performance-based incentives, such as $10 for facilitation of an institutional delivery and $2.50 for facilitation of a child's completion of immunizations. They also now receive $16 per month for completing their day-to-day routine tasks independent of the specific tasks for which they receive performance-based incentives.

Supervision

Supervision of each of these three cadres is carried out independently. A system of monitoring the activities and records for each is in place, however, for all cadres, there is a widespread consensus that the supervision is inadequate.

Although ASHAs are supposed to be representatives of and accountable to the people, they receive their payments through the ANM at the primary health center and are often treated as extensions of the health system. ANMs consider ASHAs their assistants, which diminishes the ASHA's "social health activist role." In addition, ANMs provide mentoring and support for the ASHAs linked to their primary health centers, yet have no official supervisory position.

Impact

Evaluations of these programs have produced mixed results. Wide variations exist in the quality of training and in the competency and effectiveness of these CHWs, but strong efforts are under way (particularly for the ASHA Program) to improve training, supervision, remuneration, and logistical support. Despite these challenges, the value of CHWs is perceived as substantial in India and as a key strategy towards further development and improvement of health status.

Kaders: Indonesia's Community Health Workers

Background

Built on Indonesia's national women's Family Welfare Movement (PKK) of the 1970s, volunteers called *kaders* were trained to conduct health and nutrition promotion activities in each village. In the mid-1980s, the *posyandu* program was formally recognized by the MOH. The program's goal was to decrease infant and child mortality, improve FP acceptance, improve nutrition, and empower the community through community health activities.

The *kader* program was primarily developed to address malnutrition, which was identified as the greatest threat to Indonesian children in the 1970s. Over the next two decades, with regular attention to monthly monitoring of child growth and use of locally grown foods and recipes, malnutrition was halved without food supplementation programs, which was popular at that time in many other countries. Progress has been achieved in other areas, such as decreasing IMR and, specifically deaths from diarrhea. High rates death within the first month of life remain, pointing to the need for improved quality delivery and PNC services.

Indonesia's public health system includes facilities at the central, provincial, district, subdistrict, and village levels, largely managed through a decentralized system responsible to the provincial and district levels of government.

Implementation

A *posyandu* is a health post in the community that is staffed by *kaders,* who are almost exclusively women and are chosen by and from within their community to support services at the *posyandu*. Each *posyandu* serves approximately 100 children younger than five years of age or about 700 persons in the community. There are an estimated 1 to 1.5 million *kaders*, and there are 4–5 *kaders* who volunteer at each *posyandu*. Sessions at the *posyandu* are held monthly, at which time mothers and infants receive services for registration, weighing, result recording, advice or counseling on growth and development, and other health services (such as immunization or FP).

There is a community-level monitoring system called SKDN that is used in some *posyandus* to monitor progress. It consists of indicators that were designed to be simple and easy enough to use for community-level feedback and tracking of progress, but also to provide useful coverage information for the formal health care system. Key indicators are (1) the proportion of children reached (e.g., given growth cards); (2) the proportion of children with growth cards who were weighed; and (3) the proportion of children weighed who gained weight. A wall chart is then constructed at the community level to track a village's progress.

Training

Kaders are selected by their communities based on a set of characteristics, including education achievement, how integrated they are within the community, personality, dedication to service and willingness to commit to the time requirements. *Kaders* receive one week of training and, over time, accumulate the skills and equipment necessary to carry out a set of tasks, including growth monitoring and promotion, treating common illnesses such as diarrhea, and preventing disease and malnutrition.

Roles/Responsibilities

Kaders conduct the *posyandu* sessions, where their basic roles include registration and recording on mother-infant cards, weighing, growth monitoring, providing nutrition advice, and counseling on FP. Outside of the monthly *posyandu* sessions, the *kaders* carry out follow-up visits in the community, attend community committee meetings, and update *posyandu* target and utilization data. *Kaders* work about 8–10 hours monthly.

Incentives

The *kaders* provide voluntary service without financial compensation. However, *kaders* may receive informal types of compensation, such as free medical treatment from higher levels in the health system. There is also a high cultural value placed on doing something for one's neighbors, so volunteering as a *kader* is highly esteemed.

The low level of financial requirement for the program, once a *kader* has been trained, frees up community resources to be used in ways that the community committee decides on. Financing for the program goes to fund operational activities, nutritional foods for children under 5, *kader* transportation costs, start-up capital for *posyandu* commercial activities, and costs for transport for patients requiring referral. Community members, community health savings, donations from local groups and businesses, corporate sponsors, commercial activities undertaken by the *posyandu* itself, and government sources (mostly for early stage development of infrastructure) are some of the ways the program is financed.

Supervision

While the nearest subdistrict-level health center (*puskesmas*) provides technical guidance and support, the real accountability of the *kaders* is to the village committee that appointed and supports them in their work. *Kaders* undertake "welfare work" for their community, and the monthly *posyandu* session is seen as an important function and contribution to the welfare of the community. Health facility staff members who attend *posyandu* sessions are not expected to supervise *kaders*. Rather, they attend the *posyandu* session as respected colleagues, and they incorporate statistics of services provided at the *posyandu* session as the first layer of data used in the district health information system.

Impact

Quality and coverage of services is still variable; the *posyandu* sessions depend heavily on the *kaders* and the midwives from the *puskesmas* to attend, and so if motivation is low in that area, services suffer. However, the trend towards using more *puskesmas* structure will continue, particularly as a national health insurance scheme went into effect in early 2014 and will cover everyone in the country over the coming five years. The MOH has stated that the decrease in maternal and child mortality as well as the increase in life expectancy in Indonesia is partly attributable to the work of the *posyandus* and *kaders* in the community.

Iran's Community Health Worker Program

Background

Iran's first utilization of local workers to address health concerns of the poor dates as far back as 1942 with the *Behdar* (healer) Training Project, with several other examples following in the later 1970s and beyond.

Currently, 90% of health services in Iran are provided by the public sector, and a large portion of basic health services are provided are provided by village health workers (VHWs), called *behvarzs*, who focus on the health needs of the rural population and specifically on MCH. However, the PHC program in Iran has also expanded beyond MCH services and now also provides services pertaining to elder health, youth health, and non-communicable diseases. The content of CHW training is adapted according to changing rural health care needs. For example, midwifery programs in rural areas have been added relatively recently. Needs addressed beyond maternal health include non-communicable diseases, immunization, personal hygiene issues, acute respiratory infection, and FP.

There are four levels of health workers: the family, informal and traditional workers, CHWs, and professionals. Health system reform, focusing more on primary care, coincided with the Iranian revolution in 1979. The new health system also integrated medical education and health care services. A goal of the new health system has been the reduction of urban-rural disparities in health outcomes.

Implementation

Following health care reforms in the early 1980s, Iran built Health Houses, each of which was meant to serve approximately 1,500 people living within a 1-hour walking distance. Each Health House (*Khaneh Behdasht*) is staffed by one man and one or more women who provide preventive and basic care. Today 17,000 Health Houses serve 23 million rural Iranians through the services of over 30,000 *behvarzs*. The Health House facilitates referrals to higher levels of care.

Training

Local people, including religious leaders and families, are involved in the selection of *behvarzs*. By 2004, a more formal process involving *behvarz* recruitment committees had been established in each district to assess vacancies and to find the most appropriate candidates using local media. A written examination and interview with the candidates are the final steps of *behvarz* recruitment.

The *Behvarz* Training Centers provide pre-service as well as in-service training programs that consist of coursework divided into three grades over a two-year period. The *behvarz* training program consists of theoretical and practical coursework as well as clinical placements in Health Houses and rural health centers. Students receive free training and financial support (free accommodation, meals, transport) throughout the two-year period of their training. In return, they are formally obliged to remain in and serve in the village for a minimum of four years after the completion of their study.

Roles/Responsibilities

Behvarzs' responsibilities include MCH care, communicable and non-communicable disease management and detection, care of the elderly, oral health care, health care in schools, environmental and occupational

health, annual population census, completion of reports and forms, attendance at in-service training sessions, and membership on the Behvarz Council.

Specific behvarz roles and responsibilities include vaccination, growth monitoring, integrated management of childhood illnesses, breastfeeding promotion, and nutrition support for infants and children. ANC and PNC are provided along with FP services, treatment of minor illnesses, and first aid. Behvarz also provide care for the elderly, oral health care, care of young people at school, and occupational health.

Incentives

Because the *behvarz* program is an integral component of Iran's PHC system, financing of these workers is regulated into national health planning. The *behvarz* workers are paid a fixed salary approximately one-sixth that of physicians.

Supervision

Regular supervisory visits to Health Houses are planned and performed by rural health centers. Provincial and national teams also evaluate program effectiveness and quality of care.

A recent approach to CHW collaboration and feedback in Iran is the *Behvarz* Council, established in 2006 with the aim of engaging *behvarzs* in problem identification, problem solving, knowledge transfer, and policymaking. Councils have been established at various levels (national, provincial, and district) and meetings are held on a regular basis to discuss issues related to the *bahvarzs*' work such as recent policies, *behvarzs*' viewpoints about in-service trainings, work-related problems, and recommendations to overcome problems.

Impact

Iran has built a strong PHC system, and the *behvarz* CHW program has been a fundamental element of it. The strong progress that Iran has made in improving the health of its population and in narrowing the rural-urban gap in health status since the 1970s is due in large part to the performance of its community-friendly health workers and the PHC system more broadly.

Studies have examined the job satisfaction of *behvarzs* and the contribution of *behvarzs* to rural health outcomes. It has been suggested that the significant improvement in rural health outcomes is strongly related to the performance of these community-friendly health workers. Not all improvement can be attributed to the PHC efforts alone as substantial development efforts, including economic growth, rises in literacy, and improve sanitation and hygiene systems, have progressed in parallel, but these have likely operated in synergy with the community-focused health system to improve the health status of many Iranians.

Nepal's Frontline Health Workers

Background

Nepal's Female Community Health Volunteer (FCHV) program began in 1988, but faced early difficulties such as a lack of well-trained volunteers, a lack of supplies, and an inability to provide locally desired services, not to mention the challenges of working in mountainous areas with a highly dispersed rural population often reachable only by foot. In the 1990s, the National Vitamin A Program began to work with FCHVs to distribute vitamin A to all children 6–59 months of age; two other cadres of CHWs have been developed as well—MCH Workers (MCHWs) and Village Health Workers (VHWs)

The first Nepal Health Sector Program (NHSP) was implemented from 2004 to 2009. It worked to provide equitable access to free basic health services. Following the success of the first NHSP, Nepal developed a second NHSP for 2010 to 2015 to increase access to and utilization of quality essential health care services, reduce cultural and economic barriers to accessing health care services and harmful cultural practices—in partnership with non-state actors, and improve the health system to achieve universal coverage of essential health services.

Nepal is a country with immense health needs and substantial barriers to service delivery. It is a very poor country and most rural inhabitants live in mountainous areas. Thus, service delivery within Nepal is complex given the country's geography and lower resource environment. Nonetheless, substantial progress has been made in health outcomes over the past 20 years, such as decreases in IMR since 1990. The re-structured health system brings health services closer to the people through constructing health posts, introducing new cadres of workers, and integrating vertical programs, although the country remains quite centralized and struggles to effectively motivate and retain the health workforce.

Implementation

Each health facility has, in additional to one professional health worker, one VHW, one MCHW, and usually nine (but sometimes more) FCHVs to serve a catchment population of 5,000–10,000 people.

Roles/Responsibilities

Each of the three types of CHWs has a defined scope of work. The MCHWs are full-time employees who offer reproductive services for women. The VHWs are also full-time workers and they family-oriented services such as immunizations and management of newborn infections. The FCHVs are part-time volunteers (about eight hours per week) who provide basic services and health education.

FCHVs primarily promote healthy behavior through motivation and health education, but they also mobilize communities to participate in immunization campaigns, detect and treat common childhood illnesses, provide medications such as DOT for TB, and ORS packets and zinc for treatment of childhood diarrhea. Furthermore, FCHVs are now involved in reproductive and maternal health care through distribution of FP supplies and the dispensation of misoprostol. FCHVs also provide community education and counseling to facilitate healthy practices and generate demand for maternal, neonatal, and child health services.

MCHWs are full-time workers whose services include FP, treatment of patients at outreach clinics, clinical case management of childhood illnesses, health education/promotion, and participation in immunization and vitamin A campaigns. They also facilitate referrals and are responsible for the supervision of FCHVs. VHWs

are also full-time workers whose services are similar to those offered by MCHWs. These include provision of immunizations, management of newborn infections, and supervision of FCHVs.

Incentives

MCHWs and VHWs are formally employed and paid by the government for their services. Motivating factors for FCHVs include nonfinancial incentives, such as a clothing allowance and community recognition. There is, however, discussion regarding provision of cash incentives and some FCHVs are asking for salaries.

Supervision

VHWs and MCHWs supervise the FCHVs who work in their catchment areas. VHWs and MCHWs are responsible for resupplying the FCHVs and for providing support, advice, and feedback during monthly supervision visits. Additionally, all FCHVs meet with their respective Village Development Committee every four months to review progress.

Impact

Among low-income countries, Nepal has been a global leader in reducing its under-5 mortality rate, MMR, and fertility rate. In fact, it achieved the Millennium Development Goal (MDG) targets for child health and for maternal health in 2010. There is widespread agreement that CHWs in Nepal, particularly the FCHVs, have played an important role in achieving these important goals.

Pakistan's Lady Health Worker Program

Background

The Lady Health Worker Program (LHWP) was established in Pakistan in 1994, with the goal of providing primary care services to underserved populations in rural and urban areas. In 2003, the national strategic plan set two goals: (1) improving quality of services and (2) expanding coverage of the LHWP through the deployment of 100,000 Lady Health Workers (LHWs) by 2005.

Maternal and child health indicators in Pakistan have lagged behind the same indicators in other South Asian countries; these include both IMR and MMR, though more progress is being made to reduce the MMR than the IMR. The total fertility rate also remains quite high (3.8 in 2012/13, down from 5.4 in 1991, but above its MDG target of 2.1). Health professionals, particularly doctors, have nearly doubled in number from 1995 to 2007, yet access to health services is still lacking in many areas. Health care access in Pakistan is further restricted by social and cultural barriers, such as women's limited mobility outside of the home without an escort.

There are three tiers of governance in the Pakistani public health system: federal, provincial, and district. Provinces are responsible for LHW allotment, training, and performance.

Implementation

Lady Health Workers are deployed throughout all five provinces of Pakistan. These workers are attached to a local health facility, but they are primarily community based, working from their homes. The homes of LHWs are called Health Houses; emergency treatment and care are provided therein. A LHW is responsible for approximately 1,000 people, with priority given to couples of reproductive age and children younger than 5 years.

A 2000 evaluation estimated that 150,000 LHWs were needed to obtain optimal coverage in the country. This led to a strategic plan in 2003 to have 100,000 functioning LHWs by 2005. This goal had still not achieved by 2008, though the number of LHWs increased from about 75,000 in 2003 to over 90,000 in 2008.

LHWs are selected though a clearly delineated process that includes posting of an available position and review of the applicants by a committee. The committee includes health professionals and administrators at various levels and community representation.

Training

LHWs are trained in classrooms for three months and then have one year of on-the-job training. This should include 1one week of training per month for a period of 12 months as well as 15 days of refresher training each year. There is substantial variation in training patterns across provinces.

Roles/Responsibilities

The scope of services provided by LHWs has grown from an initial focus on MCH to include participation in large health campaigns, newborn care, community management of TB, and health education on HIV/AIDS.

LHWs visit an average of 27 households a week, providing advice and conducting consultations with an average of 22 individuals each week.

LHWs have a broad scope of work that includes 22 different tasks. These include promotion of use of contraceptives and provision of FP services; ANC; treatment of illnesses such as diarrhea, malaria, and acute respiratory tract infection; and referral of community members with more serious illnesses. In addition, LHWs are expected to provide DOT for TB patients, carry out surveillance for cases of polio, and keep comprehensive records for all of their patients.

Incentives

LHWs receive a salary of about $343 per year. They are not supposed to engage in any other paid activity, although some do. The LHW stipend is often the only source of family income and is a critical family support.

Supervision

Supervision is highly organized and tiered in the Pakistani LHWP. LHWs are each attached to a public health clinic and are supervised on a monthly basis by an LHW Supervisor (LHS). LHWs should have community-based supervision at least once a month in which LHSs meet with clients and with the LHWs, review the LHWs' work, and make a work plan for the next month.

An evaluation of the LHW program has put substantial emphasis on the supervision and support aspects of the VHWs, and has also helped to assess LHW knowledge and skills as well as whether they are receiving their entitled allowances. Although not all findings have shown optimal performance in the program, knowing the status of various aspects of the program allows for targeted efforts to improve challenging areas and some of these areas have shown improvement in subsequent assessments.

Impact

The LHWP has undergone four external evaluations since its inception. These evaluations found that overall LHW performance, defined as the percentage of households who received services from LHWs, improved between 2000 and 2008. Various health indicators also improved over that time frame, including deliveries attended, exclusive breastfeeding, and immunization coverage.

The LHWP is widely accepted and the LHWs have proven adept at taking on additional tasks. The population served by LHWs had substantially better health than the population without LHWs, including in the areas of FP and immunization coverage among children younger than three-years of age. The effect of LHW services was generally greatest in poorer households.

Pakistan is lagging behind in its efforts to achieve the MDGs for MCH. Although the LHWP has many positive aspects, the number of LHWs is still not sufficient to provide adequate coverage of services nationally. Thus, expansion of the program and continued efforts at program strengthening will be required to achieve a stronger impact.

Rwanda's Community Health Worker Program

Background

The Rwanda CHW Program was established in 1995, aiming at increasing uptake of essential maternal and child clinical services through education of pregnant women, promotion of healthy behaviors, and follow-up and linkages to health services. From 2005, after the decentralization policy had been implemented nationally, the MOH increased efforts to improve MCH services, and between 2008 and 2011, Rwanda introduced integrated community case management (iCCM) of childhood illnesses (pneumonia, diarrhea, and malaria). In 2010, the Government of Rwanda introduced FP as a component of the national community health policy.

Overall, the Government of Rwanda has demonstrated commitment to the MDGs through its health sector programs and various policies. Notable improvements have been achieved in maternal health, including major decreases in MMR, and contraceptive use has increased. In addition, there has been a vast improvement in the nutritional status of children, including decreases in underweight and stunting. Infectious diseases—mainly malaria, acute respiratory illnesses, and intestinal parasites—remain the primary cause of outpatient morbidity. Although Rwanda has achieved great success in its health sector, it still faces major challenges that include reaching the most vulnerable populations, adequately supporting its CHWs, improving community participation, strengthening programs for non-communicable disease prevention, and expanding the financial contribution of the private sector to ensure financial self-reliance of health services.

Health sector decentralization laws were implemented in 2005–2006. This led to health personnel and financial resources being decentralized to the district level and the MOH changing its role to a technical supervisor while district governments controlled health program implementation. Health services are provided in communities, at health posts (HPs), health centers (HCs), district hospitals (DHs), and referral hospitals.

Implementation

When the MOH endorsed the program in 1995, there were approximately 12,000 CHWs. Currently, an estimated 45,000 CHWs operate at the village level and provide the first line of health service delivery. There are three CHWs in each village or population of 100–150 households: a male-female CHW pair (called *binômes*) providing basic care and of childhood illness, and a CHW in charge of maternal health, called an ASM *(Agent de Sante Maternelle*).

CHWs use RapidSMS to submit reports and communicate alerts to the district level and to hospitals or health centers regarding any maternal or infant deaths, referrals, newly identified pregnant women, and newborns in the community.

Training

CHWs come from the village where they live. They are elected by village members in a process that involves gathering the volunteers and villagers on the last Saturday of the month (*Umuganda*, or community service day) and voting "with their feet" in a literal sense. The process has been described as one that involves community members lining up in front of the person they support. The individual with the most support is recruited.

Within each of the villages, *binômes* are trained in iCCM of childhood illnesses by preparing them to be first responders to a number of common childhood illnesses, including pneumonia, diarrhea, and malaria. The CHWs are also trained on when and how to refer severe cases to the facility. Refresher training is provided via the supervisors as well.

Although it is acknowledged in the Community Health Development Strategy that the CHWs in Rwanda should be appropriately trained, documentation detailing the duration, format, and content of overall training is difficult to find. However, in-depth information is available about CHW training for specific programs such as community-based provision of FP and iCCM of childhood illnesses.

Roles/Responsibilities

Three CHWs, with clearly defined roles and responsibilities, operate in each village of approximately 100–150 households. The ASM identifies pregnant women, makes regular follow-ups during and after pregnancy, and ensures deliveries in health facilities where skilled health workers are available. *Binômes* provide iCCM (assessment, classification, and treatment or referral of diarrhea, pneumonia, malaria, and malnutrition in children younger than five years of age), community-based provision of contraceptives, DOT for TB, prevention of non-communicable diseases, and preventive and behavior change activities.

Incentives

Although CHWs in Rwanda are volunteers, in 2009 the MOH introduced community performance-based financing as a way to motivate CHWs. CHW Cooperatives are organized groups of CHWs that receive and share funds from the MOH based on the achievement of specific targets established by the MOH. By linking incentives to performance, the MOH hoped to improve quality and utilization of health services.

Supervision

Cell coordinators, sometimes assisted by an assistant cell coordinator, visit CHWs to monitor activities, monitor supplies and drugs, and compile all reports from CHWs and submit the information to the In-Charge of Community Health on a quarterly basis. As part of this supervision, cell coordinators also make house visits to see how the CHWs are performing their activities and verify reports that have been sent by CHWs using mobile phone text messaging (SMS) to the health center.[1] In addition to this line of supervision, the CHW cooperatives also perform an evaluative function and CHWs are incentivized based on the performance of the cooperative.

Impact

Rwanda is close to being on track to achieving its MDGs for MCH by 2015. Its CHW program has played an important role in expanding coverage of basic services, particularly community-based FP services and treatment of childhood malaria and pneumonia.

Zambia's Community Health Assistant Program

Background

The Community Health Assistant (HA) program in Zambia is an emerging national initiative to bring PHC as close to the home as possible. The first Community HAs were trained during 2011–12 and deployed in late 2012. The Government of the Republic of Zambia (GRZ) aims to scale up the program nationally to include over 5,000 community HAs using a phased approach.

Similar to many other Southern African countries, communicable diseases (HIV/AIDS, TB, malaria) contribute greatly to the overall disease burden in Zambia. In addition to the communicable disease burden, in the last decade an increase in the prevalence of non-communicable diseases has been observed. Zambia is also faced with severe maternal, neonatal, and child health challenges and is not expected to meet targets for MDGs 4 and 5 by 2015.

Zambia's health facilities are predominantly within the public sector and serve a population of 14 million. The health system is structured into six tiers with oversight for the facilities and health workers being shared between the MOH and the Ministry for Community Development, Mother, and Child Health (MCDMCH) and district-level leadership of these ministries. Human resources for health are desperately lacking, and are skewed towards urban centers while a large proportion of the population remains based in rural areas.

Implementation

Community HAs are formally recognized as a cadre by the MOH and MCDMCH. Community HAs are expected to split their time between the health post (20%) and community (80%) for household visits, community education, and health promotion activities. Community HAs can work side by side and in collaboration with other formally trained health staff (typically nurses and environmental health technologists) at the health posts and with community development assistants as well as social welfare volunteers at the community level who work on issues related to gender, environmental health, education, personal finance, and home economics.

In addition to Community HAs, there are an estimated 23,500 Community Health Volunteers (CHVs) in Zambia. The CHV network is primarily managed by implementing partners, mostly NGOs. Community HAs coordinate with CHVs to develop monthly work plans

Training

Community HAs attend one year of formalized pre-service training on prevention, health promotion, and curative care that is tailored to match issues related to Zambia's disease burden. The 12 training modules include theoretical and practical training components. The tutors at the Community HA training school consist of well-experienced health professionals.

Roles/Responsibilities

The Community HA are recruited through a MOH and MCDMCH call to respective District Community Medical Officers (DCMOs) about how many recruits to send from their district to the Community HA

training school. The DCMO works with the neighborhood health committees (NHCs) to distribute recruitment flyers in catchment areas that need Community HAs. Each recruit is screened by a panel of NHC members, health center staff, and a DCMO representative; this panel is responsible for making the final selection of Community HA candidates.

The main responsibilities of the Community HAs are health promotion and disease prevention. Community HAs are also trained in basic curative services they can provide at the health post and in the community. In addition, they are responsible for identifying patients who are in need of referral to the next level in the health system, usually a health center.

Incentives

Community HAs receive a salary of 2,600 ZMK per month (US$465) and other civil servant benefits. They are also provided with a bicycle, mobile phone, shoes, an umbrella, a backpack, and a uniform—all of which are GRZ property.

Supervision

About half of Community HAs are supervised by the in-charge at the nearest rural health center. The remainder of the Community HAs work from a health post where one or more additional highly trained staff members are posted. In this case, one staff member is designated as the Community HA supervisor. Supervision is designed to be conducted at the health post and in the community level on a monthly basis using standardized supervisory checklists.

Impact

Since this is a new program that began only in 2011, there is no evidence yet of impact. An initial independent assessment will be carried out in late 2014.

Zimbabwe's Village Health Worker Program

Background

The VHW program began in the 1980s as part of Zimbabwe's transition toward PHC. From 1982 to 1987, the government trained 900–1,000 VHWs annually, so that by 1987 there were 7,000 VHWs. The VHWs were not considered to be extensions of the formal government health service, but rather were envisioned to be stewards of the community's commitment to health promotion. VHWs focus on disease prevention and provide community care at the primary level in rural and peri-urban wards, where they serve as a key link from the community to the formal health system.

A 1999 Review Commission of the Health Sector called for the reintroduction of VHWs into the Ministry of Health and Child Welfare (MOHCW); in 2000, the VHW program was reinstated under the Nursing Directorate of MOHCW. Since 2009, efforts have been under way to revitalize the VHW program.

There has been a dramatic deterioration in Zimbabwe's key health indicators since the early 1990s. This has included decreased life expectancy and rising MMR. While the prevalence of HIV/AIDS has dropped since 2000, there are still over one million Zimbabwean adults living with the disease. The nutritional status of children has also been recognized as a key challenge, particularly by the most recent Demographic and Health Survey.

The health system is divided into four levels of care: primary, secondary, tertiary, and quaternary. The primary level includes VHWs and the rural health centers or clinics that offer basic maternity, preventive, and curative services. For community members, these facilities are the first point of contact with the formal health system.

Implementation

The VHW program has several major objectives, which include equipping communities with the knowledge and skills to take responsibility for their own health, increasing capacity for communities to prevent and control diseases, managing and taking action on health activities, empowering communities to value their own health, and promote positive behavior change.

Village Health Workers have a broad scope of work, but they primarily focus on disease prevention. They provide some curative care, including first aid and treatment of common conditions with drugs (including malaria and diarrhea). VHWs collaborate with other community-based workers, such as traditional healers, traditional birth attendants, and community-based distributors of FP. VHWs are provided with various drugs and medical supplies to carry out their multiple roles.

Training

The VHW selection process starts when a clinic or hospital communicates with the community that it needs voluntary workers. The clinic development committee and the political leaders then take the lead in choosing suitable VHW candidates. Persons selected as candidates usually have a proven commitment to the community such as previous volunteer work at their local clinic. The community's participation in the selection process differentiates VHWs from auxiliary health workers in that the VHWs answer to the community, while the auxiliary workers answer to the formal health system.

The MOHCW conducts an initial eight-week VHW training. This consists of a period of classroom training followed by a period of practical training. Refresher trainings are conducted as needed and when funds are available.

Roles/Responsibilities

VHWs have a broad range of roles and responsibilities from prevention and health promotion to treating common conditions (including diarrhea and malaria) and identifying and referring complicated cases to higher levels of the health system. VHWs are expected to be key players in efforts to reach the MDGs, and they are also now viewed as an essential element of the health system decentralization process.

Incentives

Village Health Workers receive a quarterly allowance of $42, though remuneration is often irregular. They are also provided with a bicycle and a medical supply kit.

Supervision

At the national level, the MOHCW's Director for Nursing Services oversees the VHW program. Responsibilities are further delegated to the Provincial Nursing Officers, District Nursing Officer, and finally to clinic staff. VHWs are directly supervised by the Nurse-in-Charge at the rural health center within their ward. VHWs are also supported by the ward health team at the community level. VHWs are expected to attend monthly meetings at the rural health center

Impact

There is no information available about the impact of this program.