Community Health Worker Program Overviews

May 2014

unicef

1,+++,+++
One Million Community
Health Workers Campaign

COMMITTING TO CHILD SURVIVAL
A PROMISE RENEWED

American
Red Cross

BRIEF HISTORY OF DOCUMENT AND NEXT STEPS

Document background

- The purpose of this document is to provide a **high-level overview** of current CHW programs covering countries in Africa to help inform stakeholders, in-country decision makers, and the work of the iCCM Financing Task Team and other partners.
- This document draws on a range of sources (see next slide), including **2013 UNICEF iCCM Survey as well as 1mCHW Operations Room** and these sources are cited where possible.
- The **1mCHW Campaign, Red Cross, and UNICEF** have all contributed substantively to the development of this document.

KEY SOURCES AND ABBREVIATIONS

Primary sources utilized

Program background and components :

- One Million Community Health Worker Task Force Report
- UNICEF 2013 iCCM Survey
- UNICEF ESA CHW Report

Key bottlenecks :

- UNICEF 2013 iCCM Survey
- Interview with UNICEF and additional partners

Key partners :

- iCCM Dashboard
- Evidence Symposium Participants List

Key abbreviations

- ACT: Artemisinin-based combination therapy
- CHW: Community Health Worker
- CMNCH: Community maternal newborn and child health
- iCCM: integrated community case management
- MOH: Ministry of Health
- MUAC: Mid-upper arm circumference
- NMCP: National Malaria Control Program
- ORS: Oral rehydration salts
- PSM: Patient self-management
- RDT: Rapid diagnostic test

iCCM IS AN EQUITY FOCUSED STRATEGY WITH PROVEN HEALTH IMPACT

What is iCCM?[1,2]

- iCCM (Integrated Community Case Management) is a strategy to extend access to life saving services to those living beyond the reach of health facilities.
- It aims to address the three top causes, **pneumonia, diarrhea and malaria,** of child mortality in sub-Saharan Africa and other common childhood illnesses.
- Since 2000, the use of iCCM to treat children with pneumonia, diarrhea and malaria has increased – over 30 countries today, 17 highlighted in this document
- Utilization of iCCM is also being widened to address neonatal infection and child malnutrition.

Evidence of CHWs utilizing iCCM to reduce child mortality

- "Assessing Early Access to Care and Child Survival during a Health System Strengthening Intervention in Mali: A Repeated Cross Sectional Survey" Paul Farmer et al. Plos One (8) 12
- "Factors associated with utilization of community health workers in improving access to malaria treatment among children in Kenya" Kisia et al. Malaria Journal 2012, 11 (248)
- "Community case management of malaria: a pro-poor intervention in rural Kenya" Kendra Siekmans et al. International Health 2013 (5) 3

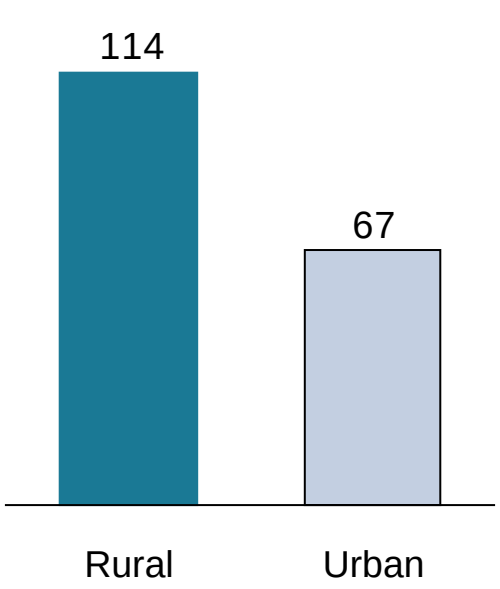
Sources: [1]iCCM Symposium Website, [2]WHO iCCM of Malaria

iCCM IS AN EQUITY FOCUSED STRATEGY WITH PROVEN HEALTH IMPACT

Distance from health facility is a significant challenge

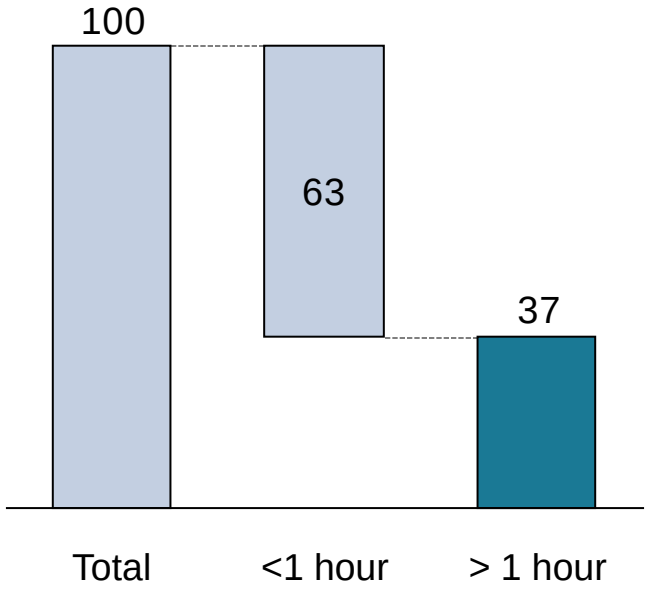
Mortality is driven by rural areas

U5 mortality rate, by residence[1]



Because many are not able to access care

Distance travelled to closest health center[2]
Kenya



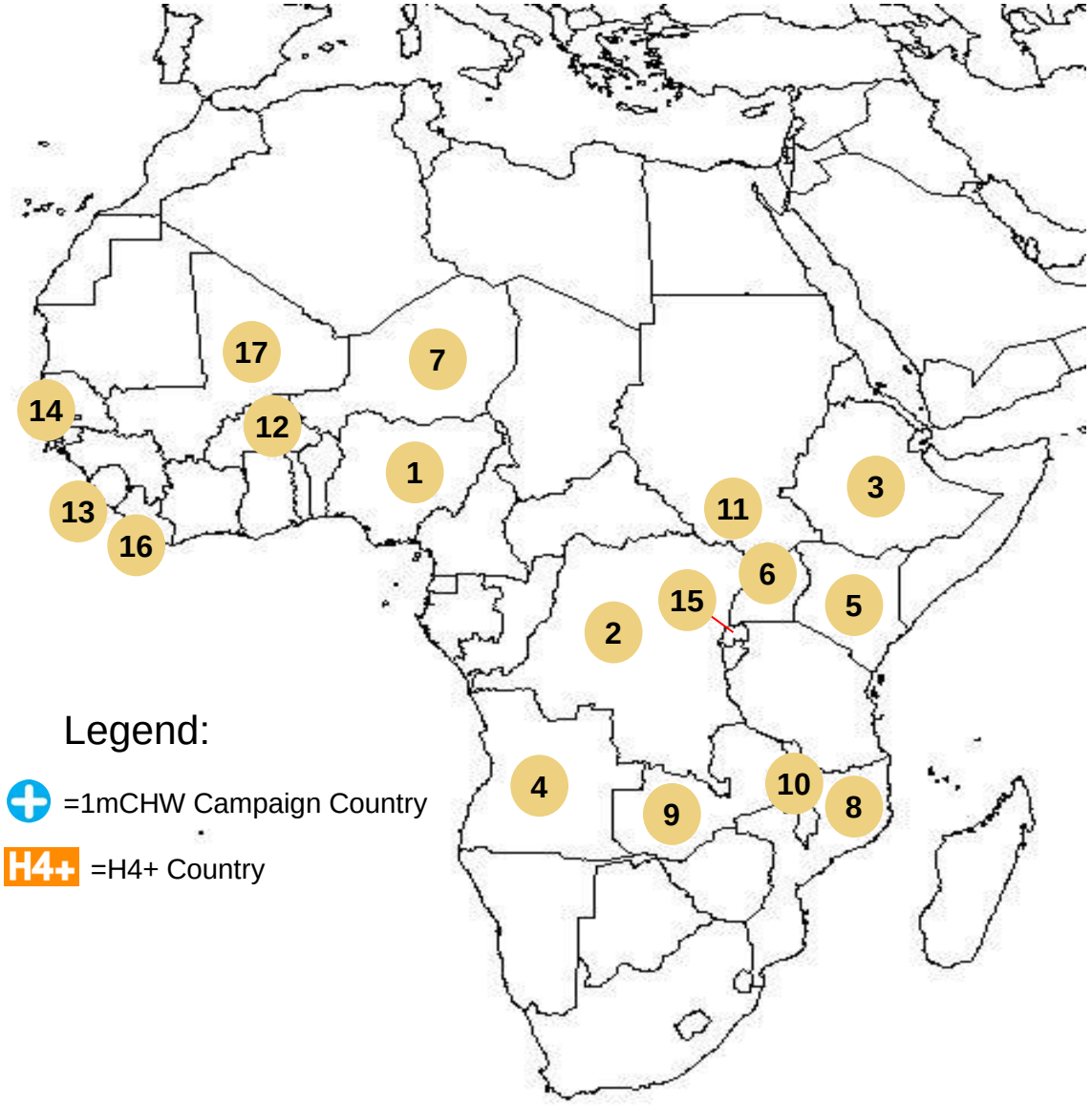
- **Countries need to bring care closer to where mothers and children are** (and where most deaths occur)
- Need to increase equity & access
- Key strategies: **campaigns or** outreach through CHWs

(1)Source: Inter-Agency Group for Child Mortality Examination (IGME) analysis utilizing DHS data from 45 countries
Definitions of rural and urban are country specific
(2)Modelling distances travelled to government health services in Kenya

OVERVIEW OF COUNTRIES INCLUDED IN THIS DOCUMENT

Countries

1. Nigeria ⊕ H4+
2. DRC H4+
3. Ethiopia H4+
4. Angola
5. Kenya ⊕ H4+
6. Uganda ⊕ H4+
7. Niger H4+
8. Mozambique H4+
9. Zambia H4+
10. Malawi ⊕
11. South Sudan H4+
12. Burkina Faso ⊕ H4+
13. Sierra Leone H4+
14. Senegal ⊕ H4+
15. Rwanda H4+
16. Liberia ⊕ H4+
17. Mali H4+



Legend:

⊕ =1mCHW Campaign Country

H4+ =H4+ Country

NIGERIA

Annual # of under 5 deaths (000): 827, Rank: 2

Program background

Name

- Community Health Extension workers (CHEWs)[1] and other community resource persons (CORPs)

Coverage

- CHOs – serve 10-20,000 people (covers the PHC facility they serve and the villages in proximity of the facility)[6]
- CHEWs & JCHEWs serve one ward or village[6]

Services

- CHOs, CHEWs, JCHEWs distribute: zinc, ORS, malaria treatment, antibiotics for childhood illness & infection[6]
- CHOs also distribute immunizations, vitamins & minerals for childhood infection[6]
- CHEWs distribute bed nets, IRS for malaria prevention[6]
- JCHEWs distribute bed nets and some immunizations[6]

Other cadres in country

- Voluntary Village Health Workers (VHWs) are generally unpaid[6] and are trained by CHEWs and other facility-based providers. They treat minor ailments, provide health education and referral[1]
- Community Resource Persons (CORPS) are comprised of TBAs, CBDs and VHWs. They are generally managed and trained by various NGOs.[6]

Count

- Approximately 85,000 CHWs (includes CHOS, CHEWs, JCHEWs)[5]
- NPHCDA is the ownership agency for all health services levels.

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Integration with formal health sector
- Monitoring
- PSM
- Quality of care
- Drug resistance
- Logistics management
- Training
- Supervision
- Retention
- Non-financial incentives and motivations
- Sustainability
- Cost of program
- Scaling up

Plans for Future Scale-Up:

- The Office of the Senior Special Assistant to the President (OSSAP) on the MDGs aims to deploy 154,800 VHWs before December 2015[4]
- The national iCCM guidelines also outlines a plan for iCCM scale up – to achieve 80% access to quality care for U5 by 2015

Components

Training

- For CHEWs, 1-2 years of training, proposed 5 days for CCM, retraining every 2 years[2]

Supply

- The government is responsible for providing supplies to the CHEWs and JCHEWs as their services are part of the public health sector.[6]

Supervision

- CHOs supervise CHEWs, CHEWs supervise JCHEWs and volunteer Village Health Workers (VHWs)[1]
- CHEWs are monitored and supervised by health facility, community supervisor, health committee, Federal and State ministries, partners, NGOs[2]

Rewarding

- CHOs, CHEWs and JCHEWs are paid employees of the Govt. of Nigeria and incentives for CHOs, CHEWs and JCHEWs are provided by the state and local MoHs[6]
- VHWs are unpaid

mHealth

- NPHCDA is planning on retraining 30,000 JCHEWs, CHEWs, and CHOs. Retraining would include mobile tech for community-based management of MCH[1]

Key Country Action Plan Points from iCCM Symposium:

- Develop iCCM Taskforce framework and create workgroups (BCC, PSM, M&E, etc.) tasked with creation of each plan (BCC, PSM, M&E, etc.) under iCCM Taskforce framework (ASAP)
- Arrange national advocacy and sensitization meeting of iCCM (timing not specified)
- Create state level iCCM Task Force (timing not specified)

Sources: [1]1MCHW Task Force Report, [2]UNICEF 2013 iCCM Survey, [3]Interviews with MOH & UNICEF, [4]1mCHW Campaign press release, [5]Intrahealth Nigeria estimate, [6]Advancing Partners and Communities Country Profile

DRC

Annual # of under 5 deaths (000): 391, Rank: 6

Program background

Name

- Community Relais:
  a) Promotional Relais (PRs)
  b) Site Relais (SRs)[1,5]

Coverage

- Expected to cover 100 to 250 households or 250 to 500 households[1]
- There are 3-4 SRs per village and each SR is responsible for covering 10-15 households. In urban areas SRs are assigned by roads[5]
- PRs theoretically cover 15-20 households[5]

Services

- PRs' services depend on the needs of the communities they serve (may include providing information about malaria, nutrition and FP)[5]
- SRs primarily provide iCCM services (treatment of diarrhea, fever, refer malnourished children to health facilities, provide limited scope of FP commodities[5]

Count

- 2,286 Community Relais[1] mixed gender[2]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Integration with official health sector
- Monitoring
- Procurement and supply
- Quality of care

Plans for Future Scale-Up:

- Govt. plans of CHWs providing CCM services. by 2015: N/A status on planned # of Community Volunteers[1]
- Progressive extension from current scale, depends on funding development partners (diarrhea, malaria, pneumonia)[1]
- Neonatal sepsis scale up depends on funding development partners[1]
- Behavior change strategies (diarrhea, malaria, pneumonia, neonatal sepsis) treatment for diarrhea, pneumonia and neonatal sepsis, facility referral to health center (neonatal sepsis)[1]

Components

Training

- Training: 1 week and 4 months of monitoring[1]
- SRs receive formal training which allows them to provide iCCM services. SRs deliver a higher level of services than PRs because of their more formal training[5]

Supply

- CHWs dependent upon resupply points for commodities[4]

Supervision

- Monitored and supervised by health facility, and community supervisors[1]

Rewarding

- Non-monetary, margin on medicines and other products[1]
- PRs and SRs are volunteers and are not paid although in some areas SRs are paid[5]

mHealth

- Ligne Verte is a toll free hot line to provide information about family planning services, the first of its kind in DRC and launched in 2005[3]

Other

- Average estimate for 1st year: USD 200[1]
  Following years: USD 200[1]

Key Country Action Plan Points from iCCM Symposium:

- . . .

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, [2]UNICEF ESA CHW Report, [3] Ligne Verte, [4]DRC CCM Central Supply Chain , [5]Advancing Partners and Communities DRC Country Profile

ETHIOPIA

Annual # of under 5 deaths (000): 205, Rank: 41

Program background

Name

- Health Extension Workers (HEWs)[1]

Coverage

- HEWs are expected to cover >=500 households < 1,000 households[1]

Services

- Treatment of pneumonia, diarrhea, neonatal sepsis, rapid diagnosis and treatment of malaria. Other services include: immunizations, iCCM, FP and maternal health services and pre-referral for severe malaria[1,4]

Other cadres in country

- Urban Health Extension Professionals (UHEPs) are the official cadre of CHWs in urban areas, HDAs (support HEWs and UHEPs, primary service is tracking pregnant women), Urban Health Development Army (UHDA)[4]

Count

- 32,000 HEWs
- 30,000 HEWS trained and delivering iCCM[1], exclusively female except in Somali regions[2]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Procurement and supplies management
- Logistics management
- Supervision
- Low service utilization

Plans for Future Scale-Up:

- Govt. plans of CHWs providing CCM services. by 2015: 40,000 HEWs[1]
- Continue at present scale (diarrhea, malaria), gradual expansion from present scale (pneumonia), neonatal sepsis (introduction and expansion in phased manner using iCCM platform)[1]

Components

Training

- General: 12 months iCCM: 1 week[1]
- Regular supportive supervision and clinical mentoring provided after initial training. Training of CMNCH every 2 years[1]

Supply

- Most HEWs access supplies from health centers[4]

Supervision

- Monitored and supervised by medical professionals at health facilities on a weekly basis[1,4]

Rewarding

- HEWs are paid employees of Government of Ethiopia.
- Non-monetary: further educational opportunities extended for those with good performance[1]

mHealth

- M&E Error Eliminator is designed to identify common paper data entry errors for malaria spraying data[3]
- The system used by HEWs is still largely manual although there is experimentation with mHealth and HMIS

Other

- Average estimate for 1st year: USD 700 (train, supervise, supply one HEW for 1 yr., excludes salary of USD 80/month), following years: USD 200 (excludes salary)[1]

Key Country Action Plan Points from iCCM Symposium:

- Provide gap filling training for HEWs: Pre-service training on iCCM (in the next year), in service training for already deployed HEWs
- Engage in mHealth Exploration: Explore possibility to utilize mHealth for stock management uses, M&E, referral monitoring to determine the best fit in Ethiopian context (over the next year), plans to initiate utilizing mHealth for supervision and logistics (in the next year)
- Update/implement wider expansion of iCCM for the newborn procedures (revision of sepsis treatment protocol when findings reviewed and recommendations received, expansion of Community Based Newborn Package (ASAP)

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, [2]UNICEF ESA CHW Report, [3]Adapting Affordable Technology to Combat Malaria, [4]Advancing Partners and Communities Country Profile

ANGOLA

Annual # of under 5 deaths (000): 148, Rank: 8

Program background

Name

- CHWs (Community Health Activists, Community Volunteers, Leaders)[1]

Coverage

- Expected to cover >= 100 households < 250 households[1]

Services

- Diarrhea and malaria(in 2/164 municipalities)[1]
- Pneumonia: exploration stages[1]

Other cadres in country

- 2,016 Community Health Activists (CHAs) providing CCM/CMAM[2]; Voluntaries (1,211), Uhayele project CHWs (315) and workers from Pastoral da Crianca (15,000)[3]

Count

- 19,571 providing CCM[1] (15,000 through Pastoral da Crianca)[2,3], mixed gender[1]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Elaborate the CHW National Policy

Plans for Future Scale-Up:

- Government has tentative plans include about 100 CHWs in each of the 264 municipalities[1]

Components

Training

- General: 2-4 weeks; Specific for CCM: 2-4 weeks; Retraining: 2x per year[1]

Supply

- . . .

Supervision

- Monitored and supervised by health facility and NGOs[1]

Rewarding

- Non-monetary, incentive payments from MoH, incentive payments from NGO[1]

mHealth

- . . .

Other

- . . .

Key Country Action Plan Points from iCCM Symposium:

- . . .

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, [2]UNICEF E Africa Office CHW count document, [3]Cadre profiles for ESAR countries

KENYA

Annual # of under 5 deaths (000): 108, Rank: 11

Program background

Name

- CHWs (under Community-based Health Workers Program)

Coverage

- Expected to cover <50 households at least once a month[1]

Services

- Diarrhea, malaria prevention, behavior change and treatments
- On-going discussions/research on CHW pneumonia Tx guidance
- CHWs prohibited from providing treatment for pneumonia and sepsis, but can provide prevention, behavior change, and carry out referrals[1]

Other cadres in country

- 46,470[5] CHEWs- mid-level health workers that are involved in supervising CHWs[2]

Count

- 59,810 CHWs (42% provide CCM, and these CHWs cover 29% of population)[1,3]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Integration with formal health sector
- Integration across health conditions
- Procurement and supply management
- Quality of care
- Supervision

Plans for Future Scale-Up:

- Community-based Health Workers Program will be scaled up to reach nation wide reach by 2017[4]

Components

Training

- General: 10 days; Specific for CCM: 1 week for malaria endemic regions and 5 days in other regions; Retraining: every 4 months[1]

Supply

- CHWs access all supplies at the community unit (health post)[4]

Supervision

- Supervised by CHEWs
- Managed by MoH and NGOs[2]

Rewarding

- Non-monetary; Incentive payments from NGO[1]
- CHWs receive a standard stipend defined by the Division of Community Health Services and the MoH and other partners follow these guidelines[4]

mHealth

- The NGO LifeStraw has trained 4,000 CHWs in Western Kenya to use a mobile app to gather info on water sources for the distribution of 4m water treatment units by LifeStraw as part of their Carbon for Water campaign[2]

Other

- Average estimate for 1st year of CHW: USD 120, following years: USD 2,304[1]
- 90% in the community, 10% of time in health centers[2]

Key Country Action Plan Points from iCCM Symposium:

- Launch iCCM Documents (subsequent dissemination and sensitization of county teams) (next 6 months)
- Include iCCM in Global Fund Proposal (next 6 months)
- Strengthen supervision and performance quality assurance (next 6 months)

Source, [1]UNICEF 2013 iCCM Survey, [2]1MCHW Task Force Report, Interviews with MOH & UNICEF, [3]UNICEF E Africa Office CHW count document , [4]Advancing Partners & Communities Country Profile, [5]1mCHW Campaign Communication

UGANDA

Annual # of under 5 deaths (000): 103, Rank: 14

Program background

Name

- Village Health Team (VHT)

Coverage

- Expected to cover 25-30 households each[5]

Services

- Information management[2]
- Health Promotion & Education[2]
- Mobilization of communities for utilization of health services and health action[2]
- iCCM (simple treatment for malaria, pneumonia and diarrhea)[2,5]
- Newborn care[2]

Other cadres in country

- Peer Counsellors for HIV, Community Medicine Distributors, Condom Distributors, Community Vaccinators, Community Counselling Aides, Nutrition Scouts, Sengas and Kojas (Aunties and Uncles), Parish Development Committee members ,Uganda Red Cross Volunteers, Parish Mobilisers, Network support Agents (HIV) and Community Owned Resource Persons[2]

Count

- 83,396 VHTs trained since 2002[2]
- New/newly functional CHWs as of 2009: 7,000[3]
- iCCM enabled VHTs (UNICEF): 13,500[4]
- VHT Program is overseen by MoH and other partners.

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Integration with formal health sector
- PSM
- Supervision
- Logistics management

Plans for Future Scale-Up:

- Government plans to scale-up to 28,000 iCCM enabled VHTs by 2015[4]

Components

Training

- General: 10 days; Specific for CCM: 1 Division of Health Promotion and Education has a standardized cascade system of Training for Health Promotion; 5 days with 3 facilitators; 25 participants/class
- General training: 1 week CCM: 1 week Retraining: Every year

Supply

- Largely dependent on NGO supplies
  - Brac, Living Goods, PACE/PSI – VHTs sell commodities
  - Millennium Villages Project – CHWs receive commodities via MVP

Supervision

- VHT supervisors - Very few VHT supervisors have had specific training on when what and how to supervise VHTs.

Rewarding

- VHTs are volunteers however the VHT Strategy & Operational Guidelines stipulate that a monthly stipend of 10,000 Uganda shillings (USD 4) should be budgeted. However, in most areas this stipend is not provided.[5]
- Non-monetary incentive payments.[1]

mHealth

- Phone not essential - VHTs carrying out CCM should have a respiratory timer (or phone with that function)[2]
- for Water campaign[2]

Other

- Average estimate for 1st yr: USD 600, following years: USD 380[1]

Key Country Action Plan Points from iCCM Symposium:

- Facilitate the process of iCCM commodity inclusion into the national system (next 6 months)
- Define clearly the type of supervision needed, expected outcomes, frequency, at which levels and how to measure outcomes (next 6 months)
- Engage further district leadership on the most recent VHT guidelines and iCCM involvement (in the next year)

Source: [1]Community Health Workers and Policies and Progress in Uganda within a Global Context; [2] VHT Situational Analysis, [3]Global Experience of CHW for Delivery of Health Related MDGs, [4]UNICEF iCCM Survey, [5]Advancing Partners & Communities Country Profile

NIGER

Annual # of under 5 deaths (000): 91, Rank: 15

Program background

Name

- Community Health Agents[1]

Coverage

- Each covers 100 to 250 households[1]

Services

- Behavior change strategies and provision of prevention strategies (diarrhea, malaria, pneumonia, neonatal sepsis), provision of ORS + Zinc, ACTs, oral antibiotics, use of RDTs, respiratory timer[1]
- Health promotion[1]
- Referral to health facility for neonatal sepsis[1]

Count

- 3,500 Community Health Agents[1]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Monitoring
- Quality of Care
- Scaling Up
- Integration with the health topics

Plans for Future Scale-Up:

- Govt. plans of CHWs providing CCM services by 2015: N/A status on planned # of Community Volunteers[1]
- Gradual expansion plan from present scale of diarrhea, malaria, pneumonia and neonatal sepsis[1]

Components

Training

- General: 6 months iCCM: N/A Retraining: N/A[1]

Supply

- . . .

Supervision

- Monitored and supervised by the health facility and health committee[1]

Rewarding

- Mix: Non-monetary, MoH salary, premiums by NGOs[1]

mHealth

- NICe Project (Niger Integrated Child Health Services) with the Niger MoH will implement in 2014 an iCCM project for rural CHWs. GPS will be utilized to aid in tracking CHWs in the field and to aid World Vision and MoH to understand which areas are receiving services and which areas need more services and surveillance. The first phase will train and equip 50 CHWs in Dogondoutchi, Dosso, Boboye, and Keita districts.[2]

Key Country Action Plan Points from iCCM Symposium:

- Boost mechanism for high-level coordination between the different programs concerned: the fight against malaria and child health (next 6 months)
- Validate NSP to ensure availability of medical products/pharmaceutical products in Niger (in the existing plan) (next 6 months)
- Develop roadmap for scaling over three years iCCM for newborn management at Community level (next 6 months)

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, [2]mHealth and iCCM in Niger

MOZAMBIQUE

Annual # of under 5 deaths (000): 84, Rank: 17

Program background

Name

- Agentes Polivalentes Elementares (APE) as part of the APE Program

Coverage

- Expected to cover 100 to 400 households each[1]

Services

- Diagnostic and curative care of diarrhea, malaria (delivery of ACT (1st dose and referral)), pneumonia[1,3]
- Prevention, identification and referral for newborn sepsis[1]

Other cadres in country

- Community Health Team Program has three cadres:
- ACS (Agentes Comunitários de saúde) – are lead CHWws and provide support to lower level cadres
- VCS (Voluntarios de comunitários de saúde) – provide an integrated package of services to the community
- TBA (Traditional Birth Attendants) - provide maternal health care to pregnant women

Count

- 2,000 APEs[3]
- 1,950 carrying out CCM[1] , 60/40 mix of females/males at minimum[3]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Supervision
- Remuneration, financial incentives and motivation
- Sustainability

Plans for Future Scale-Up:

- Government plans to employ 3,809 APEs by 2015[1]

Components

Training

- General: 11 weeks
- Specific for CCM: 5 weeks
- Retraining: every 2 years[1]

Supply

- Receives supplies from local health facilities, but delivery irregular and stock outs common[2,3]

Supervision

- No pool of existing supervisors; will be public servants working for local health facilities; inconsistent performance evaluations currently[2]
- Supervised at a high level by MoH and District Health Directorate

Rewarding

- Paid stipend of min. wage by local gov. (50 USD), annual contract; limited room for advancement beyond role[2]

mHealth

- Malaria Consortium role regarding mHealth[1]

Other

- No currently existing documentation or processes around information management[2]
- Average estimate for 1st yr: USD 5,000, following years: USD 4,300-4,600[1]

Key Country Action Plan Points from iCCM Symposium:

- Improve iCCM Supply Chain (next 6 months)
- Promote role of APEs as a central element of the community participation plan (to increase demand for iCCM services) (in the next year)
- Close inconsistency between APE system national policies and actual APE system practices (to address through strategic and operational plans) (in the next 6 months)

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, 1MCHW Campaign, [2]Global Experience of CHW for Delivery of Health Related MDGs, [3]Advancing Partners & Communities Country Profile

ZAMBIA

Annual # of under 5 deaths (000): 50, Rank: 32

Program background

Name

- CHWs and Community Health Assistants (CHA)[1]

Coverage

- CHWs are expected to cover 250 to 500 households each[1]

Services

- Behavior change strategies (diarrhea, malaria, pneumonia, neonatal sepsis), delivery of prevention interventions for diarrhea and newborn care (e.g. postnatal follow-up by CHWs)[3], delivery of ORS+Zinc, ACT, oral antibiotic (pneumonia), use of RDT(pneumonia) and respiratory timer, referral for neonatal sepsis[1]

Other cadres in country

- Several other cadres, including malaria agents, but plans are to align with government CHWs through standardized training[3]

Count

- CHW: 2600[1]
- CHA:307[1], mostly male[1]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Integration with formal health sector
- Monitoring
- Procurement & Supply Management
- Quality of Care

Plans for Future Scale-Up:

- Govt. plans of CHWs providing CCM services by 2015: 8,000[1]
- Gradual expansion plan from present scale for diarrhea, malaria, pneumonia. No current plans for neonatal sepsis scale up[1]

Components

Training

- General: CHAs: 1 year, CHWs: 6 weeks, of which 6 days on iCCM[1]
- Retraining: none[1]

Supply

- Supplies are obtained from health facilities by CHWs[5]

Supervision

- CHWs are monitored and supervised by health facility on a monthly basis[1]

Rewarding

- Non-monetary for CHWs. Government salary for CHAs[1]

mHealth

- World Vision is working with MoH to provide CHWs with mobile phones to collect data and transfer data to health facilities to aid referrals, reporting and health messaging. Jan-April 2013 the iCCM/ttC solution built and tested in Sinazongwe district. Initially this mHealth initiative worked with 1,050 CHWs and plans to scale up when more funding is available[2]
- Mama Health program may be expanded to include iCCM

Other

- Average cost for 1st year: USD 6500 Following years: USD 5000[1]

Key Country Action Plan Points from iCCM Symposium:

- Harmonize the newly established paid cadre of CHAs with the volunteer CHWs (timing dependent on funding for workshop to harmonize CHAs with volunteer CHWs)
- Determine frequency of refresher trainings for CHWs on iCCM (next 6 months)
- Explore opportunities to train pharmacists and lower level drug vendors in iCCM (in the next year)

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, [2] mHealth in Zambia & Phases of mHealth initiative in Zambia, [3]Email Communication with Rory Nfedt, [4]iCCM MASTER Participants and Presenters Sheet, [5]Advancing Partners and Communities Country Profile, [6]UNICEF Innovation: Project Mwana ,

MALAWI

Annual # of under 5 deaths (000): 43, Rank: 35

Program background

Name

- Health Surveillance Assistants

Coverage

- Expected to cover between >=500 and <1000 households[1]

Services

- iCCM
- Health promotion
- WASH[6]
- Nutrition/Food Safety[2]
- Community Mobilization[2]
- Treatment of diarrhea (delivery of ORS + zinc), malaria (delivery of ACTs and pre-referral for severe malaria, pneumonia (delivery of oral antibiotics[1]
- Referral to health facility for neonatal sepsis[1]

Other cadres in country

- Community Health Nurses
- CBDAs
- Peer Educators
- Growth Monitoring Vistors
- Community Based Home Care Providers
- Sanitation Promoters
- TBAs

Count

- 3,746 HSAs delivering CCM services[1]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Procurement and supply management
- Logistics management
- Supervision/mentorship
- Retention (of HSAs in hard to reach areas)
- Low service utilization

Plans for Future Scale-Up:

- Government plans to scale up to 5,000 HSAs delivering CCM by 2015[1]

Components

Training

- 3 Modules in 12 Weeks (1 week dedicated to CCM): Preventive, Family Health, Basic Management/Admin[2]

Supply

- Central/Regional Medical Stores Trust supply the health facilities
- JSI cStock

Supervision

- For HSAs delivering CCM, CCM Supervisors are facility based medical assistants or nurses[1]
- Other supervisors include Community Supervisor, Environmental health Officer and Senior HSA

Rewarding

- Civil Servant Grade M: $102 annually
- $80 paid by government + $22 donor top up

mHealth

- JSI cStock and CommTrack for supply management[3]

Other

- Average cost for 1st year: USD 900 Following years: USD 500[1]

Key Country Action Plan Points from iCCM Symposium:

- Strengthen utilization of data (particularly for SCM) (in the next year)
- Engage stakeholders (e.g. SWAP, MoH, Ministry of Finance) regarding issues surrounding iCCM Financing (next 6 months)
- Orient and strengthen DHO and health facilities regarding cStock (next 6 months)

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF and MCHW Campaign , [2]HSA Training Curriculum, [3]cStock case study

SOUTH SUDAN

Annual # of under 5 deaths (000): 40, Rank: 13

Program background

Name

- Volunteer: CBDs (Community Based Distributors), CDDS (Community Drug Distributors)[1]

Coverage

- Expected to cover <50 households each[1]

Services

- Behavior change strategies, delivery of prevention strategies and treatment for diarrhea, pneumonia, malaria, referral for malaria and pneumonia[1]

Other cadres in country

- . . .

Count

- CBDs over 8,000 CBDS providing CCM services[1] Community volunteers mostly female[2]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Procurement and supplies management
- Logistics management
- Supervision
- Remuneration, financial incentives,

Plans for Future Scale-Up:

- Govt. plans of CHWs providing CCM services by 2015: ~ 15,000 Community Volunteers[1]
- Gradual expansion plan from present scale for diarrhea, malaria, pneumonia. No current plans for neonatal sepsis scale up[1]

Components

Training

- General: Unknown CCM: 1 week[1]
- Retraining every 6 months[1]

Supply

- . . .

Supervision

- Monitored and supervised by a community supervisor who is recruited and managed by implementing partners[1]

Rewarding

- Non-monetary[1]

mHealth

- . . .

Other

- Average estimate for 1st year: USD 1500[1]
  Following years: USD 2250[1]

Key Country Action Plan Points from iCCM Symposium:

- Maintain MoH leadership to continue the existing good partner relationships and push for higher level political advocacy of iCCM (next 6 months)
- Establish shared vision for future of iCCM with a fully costed iCCM Implementation plan (including M&E framework) (next 6 months – note: timing dependent on security situation)
- Ensure partners are using a standardizing training package (package needs to be finalized) (next 6 months)

Source: 1UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, [2]UNICEF ESA CHW Report

BURKINA FASO

Annual # of under 5 deaths (000): 66, Rank: 24

Program background

Name

- ASBC- Agents de Sante a Base Communautaire[1]

Coverage

- Expected to cover 100 to 400 households each[3]
- Those delivering CCM services cover 100 to 150 households each.

Services

- Malaria
- Diarrhea
- Pneumonia pilots in 2 districts
- BCC, preventative interventions, referral for neonatal sepsis
- Nutritional screening and referral

Other cadres in country

- ASBCs include Community Based Distribution Agents, Village Midwives, VHWs, Peer Educators, Vaccine Correspondants and Community Relays

Count

- ASBCs doing malaria, nutrition and diarrhea CCM: 3650
- Pneumonia CCM: 510
- Newborn CCM: 1825[1]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Monitoring
- Procurement and supply
- Quality of care
- Supervision
- Retention
- Compensation, incentives and financial incentives
- Sustainability
- Cost of program
- Scale-up

Plans for Future Scale-Up:

- Government plans to scale up to 16,000 CHWs[1]

Components

Training

- Month-long training on basic health and common diseases[1]
- CCM training for 3-5 days[1]
- Annual 3 day retraining[1]

Supply

- . . .

Supervision

- Supervised by nurses at health clinic[1]
- Managed by MoH and NGOs[1]

Rewarding

- Primarily volunteer
- Payment available as: per diems from MoH for mass campaigns, profit margins for prescriptions of medicines and health products, some NGOs provide incentive top-ups[1]

mHealth

- The UltraSound4Africa Project has launched a pilot in 2011 (still active) which utilizes low-cost smart phone based ultrasound imaging systems to prevent obstetric complications[2]

Other

- Cost for first year: USD 250, cost for following years: USD 150[1]

Key Country Action Plan Points from iCCM Symposium:

- Implement effective scaling of CCM diarrhea with ORS + Zinc (next 6 months)
- Adopt health promotion policy (next 6 months)
- Reflect on incentive mechanisms for permanent retention of CHWs, funding already acquired with UNICEF (next 6 months)

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, 1MCHW Campaign , [2]Ultrasound4Africa Burkina Faso, [3]National CHW Profile Synthesis (April 2013)

SIERRA LEONE

Annual # of under 5 deaths (000): 39, Rank: 38

Program background

Name

- Unpaid Community Health Workers[1]

Coverage

- Expected to cover 50-100 households[1]

Services

- Treatment of diarrhea (ORS + zinc), malaria (delivery of ACT, use of RDT), pneumonia (delivery of oral antibiotics, use of respiratory timer)[1]
- Referral of neonatal sepsis[1]

Other cadres in country

- Community drug distributors; Blue flag volunteers; Mother Support Groups; Traditional Birth Attendants[1]

Count

- CHWs supported by UNICEF providing CCM: 7,636[1]
- Non-UNICEF CHWs providing CCM: 6,770[1]
- Mostly male[1]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Integration with formal health sector
- Integration across health conditions
- Monitoring
- PSM
- Quality of care
- Training
- Supervision
- Retention
- Remuneration, financial incentives, motivation
- Sustainability
- Cost of program
- Scale-up

Plans for Future Scale-Up:

- Government plans to scale-up to 13,000 CHWs by 2015[1]

Components

Training

- General: 10 days[1]
- CCM training for 5 days[1]
- Retraining approximately every year[1]

Supply

- . . .

Supervision

- Monitored and supervised by the health clinic and community supervisor[1]

Rewarding

- Per diem from MoH for mass campaigns, make profits on medicines and health products, some NGOs pay premiums[1]

mHealth

- World Vision utilizes the MOTECH Suite application in Bonthe district to improve maternal and child health. This application allows CHWs to register pregnant women and children under 2 years, collect health information during the timed and targeted visits to the household and refer high-risk and emergency cases to the nearest health center for treatment.[2]

Other

- Cost for 1st year: USD 250, cost for subsequent years: USD150[1]

Key Country Action Plan Points from iCCM Symposium:

- Develop strategy to incorporate MoHS programs within CHW programs (in the next year)
- Strengthen coordination between all levels (especially national level) (next 6 months)
- Develop comprehensive plan to implement CHW Program (including costing) (in the next year)

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, 1MCHW Campaign, [2]World Vision Sierra Leone MOTECH Suite Application

SENEGAL

Annual # of under 5 deaths (000): 30, Rank: 41

Program background

Name

- Agent de Sante Communautaire (ASCs)[1]

Design

- ASCs - in combination with other cadres - are expected to cover 50 to 100 households each[1]
- ASCs work out of health huts and visit homes as necessary[1]

Coverage

- Treatment of diarrhea (delivery of ORS and Zinc), malaria (delivery of ACT, use of RDT), pneumonia (delivery of oral antibiotics and use of respiratory timers)[1]
- Moderate malnutrition: VAS, MUAC screening, referral[1]

Other cadres in country

- ASC/ matrone polyvalente : 1,839 ; Relais Communautaire: 8,243 ; Matrones : 114 ; DSDOM – malaria, pneumonia and diarrhea iCCM: 501 ; DSDOM malaria : 1,051; Badienou Gokh: 7,723 (health care mentor/honorary aunt), ASBCs (go door to door)[1,3]

Count

- ASC : 1,650

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Integration with the formal health sector
- Integration across health topics
- Monitoring
- Purchasing management and approval
- Quality of care
- Supervision

Plans for Future Scale-Up:

- Community health strategy currently being validated – will inform national Community Health Worker strategy and plans

Components

Training

- 6 weeks on general health
- 6 weeks specific to CCM
- Retraining approximately every two years[1]

Supply

- Supplies are purchased by ASCs from health huts

Supervision

- Monitored and supervised by health facility supervisor and community health committee[1]

Rewarding

- Non-monetary, user fees, margin on medicines and other products, premiums paid by NGOs[1]

mHealth

- . . .

Other

- Cost for 1st yr: USD 1000, following years: USD 1000[1]

Key Country Action Plan Points from iCCM Symposium:

- Establish national iCCM Technical Working Group (under leadership of MOH's Division of Child Survival) (next 6 months)
- Map community based iCCM services throughout country, prioritize newborn care in iCCM delivery and scale up of home based iCCM (in the next year)
- Improve CHW/Supervisor data utilization and management (next 6 months to one year)

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, [2]MoH Draft Community Health Strategy, [3]Advancing Partners & Communities Country Profile

RWANDA

Annual # of under 5 deaths (000): 24, Rank: 42

Program background

Name

- Community Health Workers (Binomes- male and female pair)[5]

Coverage

- Expected to cover 50-100 households each[1]

Services

- Malaria, pneumonia and diarrhea treatment[1]
- Prevention and referral for neonatal sepsis[1]
- Nutrition screening and RUTF provision as part of CCM[1]

Other cadres in country

- Outside of MOH under the Ministry of Local Affairs there is an elected person for Social Affairs who is not a MOH CHW but whose responsibilities cover behavior change in the community.[4]
- ASMs (maternal health CHWs) – 1 per village[4]

Count

- CHW providing CCM services: 30,000[1]
- Maternal Health CHWs:15,000[4]
- Mixed genders (binomes)[4]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Monitoring
- Quality of care
- Logistics management
- Training
- Supervision
- Strengthening cooperatives for sustainability

Plans for Future Scale-Up:

- Government plans to scale up to 30,000 by 2015

Components

Training

- General: unknown
- CCM-specific: 1 week
- Retraining every 6 months[1]

Supply

- SC4CCM projects developed quality improvement teams in 6 districts- found significant improvements in supply chain, scaling up nationally[3]

Supervision

- Monitored and supervised by health facility, community supervisor (at district hospital and health centre), health committee, and community health desk (MoH)

Rewarding

- Incentive payments from Ministry of Health: through PBF and cooperatives[1]

mHealth

- RapidSMS tool helps CHWs track pregnant women under their care, monitor and identify risk signs during antenatal care[2]

Other

- Cost for 1st year: USD 320, following years: USD 320

Key Country Action Plan Points from iCCM Symposium:

- . . .

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, 1MCHW Campaign , [2]Center for Health Market Innovations (http://healthmarketinnovations.org/program/rapidsms-Rwanda), [3]Discussions with SC4CCM (Jan 31, 2014), [4]Advancing Partners and Community Country Profile

LIBERIA

Annual # of under 5 deaths (000): 11, Rank: 33

Program background

Name

- Community Volunteer known more commonly as gCHVs (General Community Health Volunteers)[1]

Coverage

- gCHVs expected to cover 250-500 people each
- gCHVs are deployed for people who live more than 5km away from a health facility (59% of population)[6]

Services

- Routine immunization follow-up for children, growth monitoring, surveillance and reporting for immunizable diseases, CCM and referral, infant and young child feeding[6]

Other cadres in country

- 2,856 Trained Traditional Midwives (TTMs), 586 (Traditional Midwives) TMs, 238 Household Health Promoters (HHPs), and 645 Community Directed Distributors (CDDs)[6]

Count

- 3,727[3] gCHVs mostly male (79%)[2]
- May not all be CCM enabled

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Procurement and supplies management
- Logistics management
- Sustainability
- Cost of program

Plans for Future Scale-Up:

- Govt. plans of CHWs providing CCM services by 2015: 5,468 gCHVs at population rate of 500/gCHV[1]
- Gradual expansion plan from present scale of diarrhea, malaria, pneumonia and neonatal sepsis[1]

Components

Training

- 11 days: 3 days for diarrhea and pneumonia (ARI), 5 days: malaria. Retraining policy unclear thus implementation[1] dependent on partner providing support[1]

Supply

- Supply Chain Management Unit created circa 2010 by MoHSW with support from various NGOs to address Liberia's poor health supply chain[5]

Supervision

- Monitored and supervised by health facility, community supervisor and health committee[1]

Rewarding

- Non-monetary, incentive payments from NGOs[1]
- Incentives include: transportation, trainings, gear, bicycles[3]

mHealth

- Last Mile Health has implemented an mHealth system to help health workers collect and utilize data about the populations they serve[4]
- M&E Error Eliminator is designed to identify common paper data entry errors for malaria spraying data[6]
- Medic Mobile programs to expand

Other

- Average estimate for 1st year: USD 412 (average is based on costing tool, however change to USD 600 in some counties)
- Following years: USD 300[1]

Key Country Action Plan Points from iCCM Symposium:

- Strengthen iCCM Supply Chain (timing dependent on acquiring TA)
- Standardize and strengthen supervision for iCCM (next 6 months)
- Cost and leverage partnerships (next 6 months)

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, [2]UNICEF ESA CHW Report, [3]Advancing Partners and Communities Website. [4]Last Mile Health (Tiyatien Health) website, [5]Liberia 1mCHW Roadmap, [6]Adapting Affordable Technology to Combat Malaria

MALI

Annual # of under 5 deaths (000): 83, Rank: 9

Program background

Name

- Agents de santé communautaire (ASCs) and Relais (volunteer CHWs)[1]

Coverage

- Expected to cover 1000 to 2500 households each[1]

Services

- Behavior change strategies (diarrhea, malaria, pneumonia, neonatal sepsis), deliver of prevention strategies (diarrhea, malaria, pneumonia), treatment for diarrhea, pneumonia. Referral for neonatal sepsis[1]

Other cadres in country

- . . .

Count

- 1,847 delivering CCM services[1]
- ASCs: 2,000[6]
- Relais: 20,000[6]
- Majority female[1]

Key bottlenecks

Primary concerns from MOH (per UNICEF survey)[2]

- Remuneration, financial incentives and motivations
- Cost of program
- Implementation
- Procurement and supply
- Retention

Plans for Future Scale-Up:

- Govt. plans by 2015: At least 3,000 Community Volunteers[1]
- Progressive extension plan from current scale of diarrhea, malaria, pneumonia, neonatal sepsis[1]

Components

Training

- General: at least 6 months CCM: 2 weeks
- Retraining approximately once a year[1]

Supply

- Frequent stock out of commodities at community level[3], workshop held in March 2013 to develop SOPs for logistics management of essential medicines[4,5]

Supervision

- Monitored and supervised by health clinic[1]

Rewarding

- Non-monetary, salary from MoH, salary from NGOs[1]

mHealth

- ChildCount+[3] - SMS messaging to register patients and send health information to a centralized web database that shows the real time health status of the community[3]

Other

- Estimate for 1st year and for following years: External evaluation conducted in Sept. 2013, results by Feb. 2014[1]

Key Country Action Plan Points from iCCM Symposium:

- Partners to the President to advocate to find solutions to financing challenges (next 6 months)
- Support for the health of newborns (next 6 months)
- Integrate M&E simplified tools and implement national SEC database (next 6 months)

Source: [1]UNICEF 2013 iCCM Survey, Interviews with MOH & UNICEF, [2]UNICEF ESA CHW Report, [3]ChildCount+,[4]SIAPS Program Assessment of Mali SCMS (February 2013), [5]Integration of CHWs in Mali's Essential Medicines Information & Logistics Management System, [6]Advancing Partners and Communities Country Profile