Lessons Learned Document

Thematic Area	Human Resources
Description	This Lessons Learned document reviews evidence on Community Health Worker (CHW) selection, motivation, retention, geographic disbursement and roles.
Organizations documenting Lessons Learned	Population Services International (PSI)

Background

Where access to formal health care services is poor, iCCM is able to help fill the gap between formal services and the community. In this model, Community Health Workers (CHWs) typically serve as the first point of contact for health promotion and care services. Human resource policies and practices are key factors in the effective delivery of care, especially to reach the most vulnerable populations. Information produced by iCCM programmes, together with research evidence, can help answer the question of which human resource strategies seem to work better than others.

Process for documentation

A structured literature review of programmatic information and research evidence was carried out by the Swiss Tropical and Public Health Institute (Basel). Twenty-nine programmes were identified and documents were provided by partners. Three types of information were extracted: (a) programme features; (b) programme tools highlighted as promising approaches to improve health care; (c) evidence on the effects of tools and approaches. This information was synthesised across programmes into two thematic areas: human resources and quality of care.

Strategies that worked well

While most of the evidence has a high risk of bias and statements of effectiveness have to be taken with extreme caution, the following strategies were identified as those that had a positive effect on CHW selection, motivation and retention within iCCM programmes.

CHW Selection

- Eligibility criteria and selection processes vary greatly between projects. In general, CHWs need only basic literacy and numeric skills and are often selected from and by the community. In some programmes Ministry of Health officials, local leaders and NGOs intervene in the selection process. Interestingly, in some programmes there is an explicit exclusion of political or local leaders as candidates for CHW or in the selection process.

Motivation & Retention

- Most programme incentives are in the form of goods, equipment or supplies related to CHW work. In some programmes, Malawi for example, CHWs are paid salaries at either the national or community level. Qualitative evidence from one study suggests that both intangible (recognition, interest by supervisors, reassurance, promotion) and tangible incentives (small signs of distinction, training, work-related equipment) are important elements for staff motivation and performance. Equally important elements are community relations and perceptions, appreciation

and 'capacity' recognition.

- As demonstrated in Uganda, social franchise models can help motivate private shop owners, clinics or sales representatives to offer quality-assured drugs to consumers through a branded network by offering a percentage of product sales and promoting the reputation of the network.

Geographic Disbursement

- Mapping tools were used in several projects. Mapping may be useful to: assess programme geographical coverage and gap analysis; assess complementarity with health facility services to better deploy CHWs; assess the load of supervision; and to enable spatial analysis of programme data linking other information systems. Mapping also facilitates coordination of support provided by various stakeholders.
- Programmes with very extensive CHW coverage seemed to have increased utilization when compared with control areas. Health Extension Workers (HEWs) in Ethiopia include more than 35,000 volunteers. The HEW programme showed improved supervision when compared with control areas and good clinical practice for 50% to 80% of consultations, depending on the specific indicators.

CHW Roles

- The way CHWs are organized seems to be an important factor. It has been suggested that peer support groups of CHWs have facilitated CHW capacity building, increased demand for CHW services and strengthened links between the health system and community. For example, the Kabeho Mwana project in Rwanda formed peer support groups to reinforce network relationships and provide a platform for more effective human resource practices, while other programmes emphasized teamwork development. Social franchise programmes can also promote exchange between branded CHWs and providers in the network.
- To support the daily work of CHWs, on-site training and supervision have been shown to improve clinical practices and improve immediate outcomes, such as CHW knowledge. Behaviour mapping helps CHWs to access vulnerable households, while mobile telephone monitoring improves data collection and information sharing between CHWs and supervisors. Large multi-component programmes have improved clinical practice indicators by improving health care processes such as correct diagnosis or targeting severe cases for referral.

What strategies did not work well

Few programmes or evaluations explicitly examined unintended effects (e.g. human resources attrition, deterioration of quality), making it difficult to assess which strategies did not work well. However, some problems were mentioned in the documents reviewed:

- While CHW incentives are part of all programmes, one noted problems related to the payment of CHW subsidies as the most important barrier to implementation of iCCM.
- Despite the size of the HEW programme in Ethiopia and the increase in service utilization, consultation volumes remained below target, with an estimated 79% of expected consultations not taking place.
- Variability in training schedules, lengths and intensity yields heterogeneous effects in CHW ability to execute tasks. In several programmes, CHWs have struggled with using timers, checking for specific symptoms and recognizing danger signs for accurate diagnosis and case management according to clinical guidelines.

CHW credibility may also be threatened when broader health system challenges, such as ruptures in the national supply chain, negatively impact the work of CHWs.

Lessons Learned

There is no blueprint to ensure that a specific strategy is better than another or even more effective than harmful, but common components of CHW programmes which need further investigation/ evaluation include:

- **Integration** of CHWs into wider health care frameworks (e.g. IMCI) through policy formation;
- Carefully defined CHW **eligibility criteria** and selection mechanisms, protecting processes from inappropriate political influence;
- **Coordination and integration** across partners and with other existing health care services;
- **Adequate support** of CHWs with clinical practice guidelines and management tools, supplies and incentives, without disregarding non-tangible incentives;
- **Networking** between CHW peers and supervisors, using explicit approaches such as mentorship;
- **Adequate training and supervision**, with appropriate length, intensity, approaches and tools;
- **M&E activities** to assess access, utilization, coverage and performance; and
- **Robust and standardized documentation** of CHW programmes to allow for assessment and comparison of specific strategies and their effects.