Community based health workers

Why? One reason among others: Millenial Development Goals

• MDG’s 4&5: reduction in mat & child mortality –need CHW input:
  • U5MR: 59 in LDC’s; 7 dev.cntries

NB:-U5MR=deaths/1000 live births
Rate of decline: 2.2 vs 3.6%
Ref: Lancet Vol.378; 24 Sept 2011
now more than ever: CHW’s to reach Mill. Develop. Goals
“Medicine Without Walls” PHC

• Ref: Lancet, Sept 24 2011:
• Child/Mat mortality reduction needs this:

Ex: - “Vaccination, distrib. of treated Bednets, Vit A distribution, and deworming can be delivered without a health system that has the capacity for referral and emergency management...” to achieve MDG’s
Types of CHW’s

• **1) Indigenous healers:**
  Ex: Traditional birth attendants (TBA’s); herbalists, NB:-- May be illiterate; may have nefarious practices: ex.: cow dung on the umbilicus; -- cannot be ignored! Can be recruited, trained.

2) “Outreach workers from health centers”
Ex.: -- Public health nurse home visitors, vaccination teams, CHWS targetted to a disease
Who are the best CHW’s?

• 3) Best CHW’s: are Resident Home Visitors: identified, recruited in their own communities and with:
  • One-the-job, skill-by-skill training
  • Residing in communities they serve:— “Resident home visitors”
Errors in CHW recruitment and training

• Not chosen by their own community
• Brought to central area for training and never on the-job
• Training not oriented to prevention of most common, preventable causes of mortality and morbidity
• Not supervised; need direct and indirect supervision
Know the terrain before you train

1) Field reconnaissance: Know studies
2) **Home visits** (your own!!)
3) Nearby hospital/health center data
4) Data from pregnancy/birth histories from a mothers. Ref:

Ref: World Fertility Survey Methods
Rajaratnam et al:
Priority setting & preliminary steps for CHW action:

- **What does the community want?:**
  example: 100% want a nearer health center; 60% want clean water; no mention of CHW’s

**Your questions:**

Was the voice of the under-fives represented?
Was there democratic representation from across the geographic area at the meeting(s)?
Were women represented? Was there discussion of what is killing children?
Priority setting (continued)

• **What does the local and national govt want of CHW’s? Are there resident home visitors?**

• **Is there a curriculum/certification process that one must respect?**

• **Are they volunteers or trained, salaried**

• **Comment:** Training health workers not recognized by the Ministry of Health may later pose a problem. One may need to include curriculum that is not “on the job, skill oriented” at first
Supervision: essential ingredient

• 1) **Direct Supervision:**
  -- should be “formative” not “punitive”
  -- the supervisor is there to solve problems.

2) **Indirect Supervision:** depends on adequate information system Ex: Malaria control program: Chw’s map, house number, visit regularly, record, sign “guest book”, make slides, give Rx. Also invite to vaccine posts, etc.
  Supervisor checks all records.
Resource assessment Vs. needs assessment for CHW implementation

• Needs assessments are out of date; the new approach is resource assessment can identify:

• Human & material resources available:

Ex:- teachers and pupils distribute anti-filariasis drugs in collaboration community health prog; Coca Cola trucks in Sudan help with cold chain capability; deliver vaccines to chw’s; money from use of local ferry-boat pays chw’s
Supporting CHW’s:

(Supervise)

Empower (validate role with community; may need salaries)

• Equip (ex:-- if eclampsia prevails, chw’s can take blood pressure readings & refer)

• Advocate (ex: Haitian Health Foundation (HHF) & CDC proved CHW’s could Dx/Rx pneumonia & reduce deaths, but govt permission to spread method needs advocates)
**Equip**: ex: CHW vaccinator is protected
Advocate
Local clergy can announce, advocate with community for CHW’s and for the programs they support
Monitoring and Evaluation

- Choose indicators based on objectives:
  examples:
  - # and % of children immunized completely by 18 months of age
  - # and % of children under three attending growth monitoring/counseling sessions
- Enable CHW’s to participate in the monitoring and evaluation exercise
Strategy/Action Plan for CHW’s

Examples

-- Collaborate with vaccination/vit A/deworming programs by mobilizing community to attend assembly posts; organize same.

-- Create ongoing growth monitoring/counseling sessions for neighborhoods; include pregnant moms to get early “mini” antenatal care

-- Accomplish home visits for all “no shows” in the above and home visit families who absent themselves

-- Identify/refer members with special problems

Assist in or accomplish all door to door services (such as bednet distribution)

-- Identify recruit and train volunteer mothers and form “mothers clubs” (Haiti) and CARE groups (Mozambique)
Tool-box for CHW’s

- **CHW Toolbox Provides means of gathering ongoing data; examples:**
  1) **Ministry of Health/UNICEF tools**
     -- Home based hand carried child wt/age growth/vaccination record that chw distributes, completes at monthly assembly posts;
  2) **CHW registers that s/he carries;**
     -- Register of under three’s for immunization, nutrition surveillance;
     -- Register of women in the reproductive age group for fp, pregnancy follow-up;
Toolbox, continued

3) **Tools for special programs**

**Examples:** Blood pressure taking devices for pregnant women;
Insecticide treated bednets;

4) **Vital event reporting**

Pregnancies, preg. outcome, births and deaths

Method: Mother volunteer group reports on 20 households; chw investigates, fills form
Results:

  Projet Integre de Sante & Population (PISP): studied defined populations in three districts near Petit Goave with CHW services: Results Within 3 years:
  -- 1-4 year age specific mortality rate cut by 50%
  -- Infant mortality rate significantly reduced (neonatal tetanus disappeared);
  -- Malnutrition treated in communities by locals under supervision; 60% never get malnourished again.