

CHWS Community Health Workers

What is the proven high-impact practice in family planning service delivery?

Train, equip, and support community health workers (CHWs) to provide a wide range of contraceptive methods. When appropriately designed and implemented, community-based family planning services can increase people’s use of contraception, particularly where unmet need is high, access is low, and geographic or social barriers to use of services exist. Community-based family planning programs are particularly important to reducing inequities in access to services.



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...CBD [Community-based distribution] is viewed as the single most important family planning innovation.

– Phillips et al., 1999

Background

In communities where contraceptive use is low, individuals often face social as well as physical barriers to accessing family planning services. Community health workers help to address these barriers by bringing information, services, and supplies to women and men in the communities where they live and work rather than requiring them to visit health facilities, which may be distant or otherwise inaccessible.

CHWs “provide health education, referral and follow up, case management, and basic preventive health care and home visiting services to specific communities. They provide support and assistance to individuals and families in navigating the health and social services system” (ILO, 2008). This cadre of provider is also referred to as a village health worker, community-based distributor, community health aide, community health promoter, or lay health advisor. The level of education and training, scope of work, and employment status of CHWs vary across countries and programs.

Training, equipping, and supporting CHWs is one of several “high-impact practices in family planning” (HIPs) identified by a technical advisory group of international experts. When scaled up and institutionalized, HIPs will maximize investments in a comprehensive family planning strategy (USAID, 2011). For more information about other HIPs, see <http://www.fphighimpactpractices.org/about>.

Why is this practice important?

CHWs can help meet the immediate and growing need for human resources for health care where services are most needed. *The World Health Report 2006* identified 57 countries facing critical shortages in health personnel. Moreover, most highly trained medical staff are concentrated in wealthier, urban areas (WHO, 2006). CHWs can be trained to provide quality family planning services in rural and other underserved communities.

CHWs can safely and effectively provide a wide range of methods. CHWs are particularly effective when programs support them to provide services and products directly to clients, such as direct provision of contraceptives. To assist countries in optimizing health worker performance, WHO developed a comprehensive set of evidence-based recommendations to facilitate task sharing for key, effective maternal and newborn interventions, including contraceptive provision (WHO, 2012). While most CHWs provide condoms and pills within their communities, evidence shows that these workers are also highly effective at providing and referring for other methods.

- Based on evidence from 16 projects in nine countries, experts found that the provision of injectable contraception by trained and supported CHWs was safe, effective, and acceptable to clients (WHO et al., 2010).
- A study in India demonstrated that low-literacy CHWs can effectively provide the Standard Days Method®(SDM) to their clients (Johri et al., 2005). CHWs in the Democratic Republic of Congo (DRC), Guatemala, and the Philippines provide SDM and support users (Georgetown University, 2011; Suchi and Batz, 2006; Georgetown University, 2003).
- A study in India demonstrated that community-level providers, even those who are illiterate, can teach the Lactational Amenorrhea Method (LAM) successfully (Georgetown University, 2008).
- A study in Bangladesh demonstrated that all categories of health care providers, including NGO outreach workers, could effectively provide emergency contraception (EC). An evaluation of training and service provision found that more than 90 percent of the workers had mastered the important points of EC use and instructed their clients appropriately (Khan et al., 2004).
- A recent review of the Health Extension Worker (HEW) program in Ethiopia found that HEWs play a significant role in expanding access to implants at the community level and that clients appear willing to accept insertion of Implanon implants by HEWs (MOH Ethiopia, 2012).



In Ethiopia, a village health leader, who is also the local community health worker (CHW), facilitates a discussion about family planning. Male CHWs are acceptable in a number of diverse countries and can be particularly effective at serving male clients.

CHWs mobilize contraceptive use through counseling and referrals. Evidence from Ethiopia demonstrates that, even where CHWs are restricted to providing a limited set of contraceptive methods, they are capable of increasing the use of other methods, including long-acting reversible methods, through proper counseling

and referrals to clinic-based services. An analysis of DHS data found that in areas where CHWs were located, use of injectables, implants, and IUDs was significantly higher than the national average even though CHWs did not provide these methods directly (Tawye et al., 2005). A recent review of strategies to increase IUD use concluded that community-based contraceptive counseling and referral can double the rate of IUD use among women of reproductive age (Arrowsmith et al., 2012).

CHWs can help overcome large disparities in family planning use. Analysis of DHS data shows that women who are young, poor, less educated, and who live in rural areas have more difficulty meeting their need for family planning than their counterparts. These inequities exist in all regions except Central Asia, and the gaps are larger and more common in sub-Saharan Africa (SSA). In addition, many countries in SSA demonstrate little or no progress toward reducing the equity gap (Ortayli and Malarcher, 2010). Community-based programs can be designed to reach these underserved groups.

CHWs reach women whose mobility is constrained by social norms. In some countries, cultural practices restrict women's movement or their ability to make independent decisions. CHWs overcome such barriers by bringing services to where women and their families work and live.

Elements of Successful CHW Programs

- Broad range of services and commodities that reflect the preferences of the communities served
- Community involvement, particularly at the strategic planning stage
- CHW selection guided by community opinion
- Agent compensation:
 - Paid workers perform better than volunteers.
 - Scope of work for unpaid volunteers should not be demanding.
 - Completely voluntary schemes do not work well. If workers are not paid, some other motivational scheme is required.
- Incremental, practical, and competency-based CHW training
- Supportive, rather than directive, CHW supervision
- Management information systems support the informational needs of CHWs as a first priority
- CHWs linked to facility-based services

Factors Contributing to Failure of CHW Programs

- Misconception that CHW programs are simple and self-sustaining
- Preoccupation with a single commodity or service resulting in failure to develop a comprehensive service system
- Lack of broad political support
- Focus on sustainability and cost recovery which may be incompatible given the objective of reaching poor and remote communities
- Failure to address quality-of-care requirements and social barriers to Family Planning use
- Responsibility of galvanizing and mobilizing communities rests solely with CHWs

Source: Adapted from Philips et al., 1999 and WHO 2007

What is the impact?

CHW programs increase contraceptive use in places where clinic-based services are not utilized by all segments of the population. A review of community-based programs in SSA found six out of seven experimental studies demonstrated a significant increase in contraceptive use (Philips et al., 1999). In Madagascar, individuals who had direct communication with CHWs were 10 times more likely to use modern contraceptives than individuals who did not have contact with CHWs (Stoebenau and Valente, 2003). In Ghana, a single nurse equipped with a motorbike who was relocated to a village health center outperformed an entire subdistrict health center. The nurse increased the volume of health-service encounters in study areas eightfold and improved immunization and family planning coverage (Nyonator et al., 2003).

CHW programs reduce unmet need in countries with large rural populations. In countries with strong CHW programs in which CHWs deliver a significant share of modern methods to their communities, such as in Bangladesh and Indonesia, there is low unmet need for family planning in rural areas (Prata et al., 2005).

CHWs reach underserved populations. A review of injectable use in community-based programs found that in Guatemala, clients of CHWs were more likely to be indigenous women (83%) than clients using clinic-based services (17%). In Uganda and Ethiopia, clients of CHWs were more likely to be single (16% and 12%, respectively) than clients at clinics (9% and 8%, respectively), and in Uganda, clients of CHWs were less likely than clients at clinics to have supportive husbands (41% vs. 52%, respectively) (Malarcher et al., 2011; Prata et al., 2011).

Community-based programs coordinated with a functioning health system reduce fertility. In Ghana, in communities where Community Health Officers operated in conjunction with community volunteers, the total fertility rate was reduced by one birth after three years (Phillips et al., 2006). In Bangladesh, the Matlab program achieved a 25% reduction in fertility over an eight-year period among women who were visited every two weeks by a trained CHW. The program also achieved a statistically significant reduction in maternal mortality rates among the intervention group during the same time period (Koenig et al., 1988).

Programs that combine CHWs with clinic-based service delivery are cost-effective. Cost and cost-effectiveness of CHW programs often vary depending on the program setting, worker compensation, maturity of the program, strategies used for training and supervision, and the number of clients served (FRONTIERS et al., 2002). A review of family planning programs in 10 developing countries found that programs that combine CHWs with clinic-based service delivery are more cost-effective than either clinic-based or volunteer CHW programs alone (see Table 1).

Table 1. Cost per Couple Years of Protection (CYP)* by Service Delivery Mode**

Service Delivery Mode	Average Cost per CYP (Range)
Clinic + CHW	\$9 (1-17)
Clinic	\$13 (1-30)
CHW	\$14 (5-19)

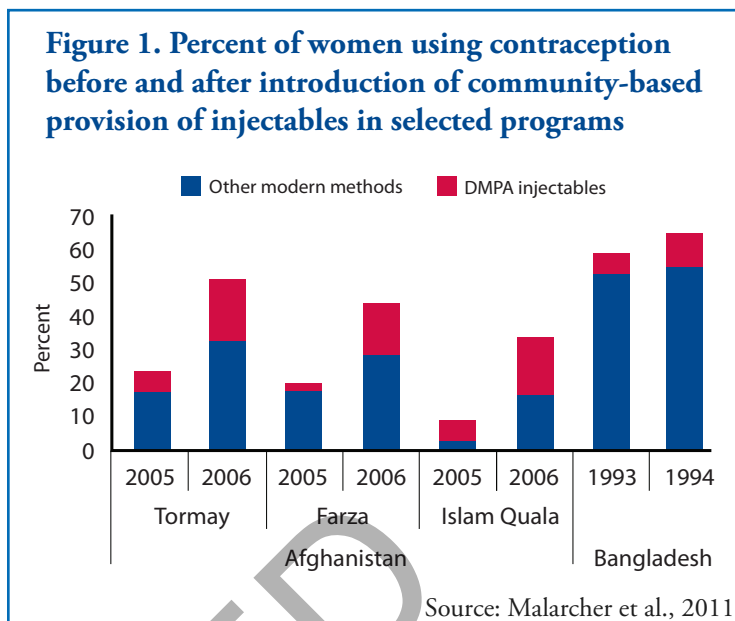
Source: Adapted from Prata, 2004; data from Huber and Harvey, 1989

*CYP is the estimated contraceptive protection provided by contraceptive methods during a one-year period.

** Original analysis was based on community-based distribution (CBD). Reference to CBD has been changed to CHW for consistency.

How to do it: Tips from implementation experience

- **Expand the variety of methods provided at the community level to increase overall contraceptive use and new contraceptive users.** CHWs are particularly effective when programs support them to provide services and products directly to clients. In India, when SDM was introduced into rural health programs, contraceptive prevalence increased from 24% to 41%, with 7% of women using SDM, over a four-year period (Lundgren et al., 2005). Similarly, evidence from four programs that introduced community-based provision of injectables into existing programs documented increased uptake of injectables as well as other modern methods (see Figure 1).



- **Recruit CHWs from the beneficiary communities.** In Peru, evidence showed that successful CHWs typically share commonalities (language, culture, education, religion, social class, or sex) with their target populations. Those who differ greatly from their target populations tend to have less success (Foreit et al., 1992; Best, 1999). Two Cochrane reviews and a systematic review of CHW programs confirm this recommendation (Lewin et al., 2005; Lewin et al., 2010; Bhutta et al., 2010).
- **Engage the beneficiary communities in monitoring and supporting CHWs.** In Madagascar's successful national CHW program, CHWs are supervised by the Community Health Committee.
- **Link CHWs to the health system with well-defined referral and supervision structures.** In Ethiopia, where contraceptive use has increased from 15% in 2005 to 29% in 2011 since the Health Extension Workers program was established, CHWs receive regular supervision by supervisors who are linked to health facilities. In Madagascar, CHWs report monthly to the head provider of the health center and receive supportive supervision.
- **Consider recruiting men as CHWs.** A review of community-based programs found that men have great potential in increasing the distribution of male condoms, which provide dual protection against both unwanted pregnancy and sexually transmitted infections (STIs). Male CHWs are acceptable in countries as diverse as Kenya, Pakistan, and Peru. Evidence shows that male CHWs distribute more condoms than female CHWs. Male CHWs also appear to serve more male clients. In controlled studies, male CHWs distributed contraceptives that amounted to equal or greater couple years of protection than female CHWs (Green et al., 2002).
- **Be dynamic and evolve with changing needs.** Community-based programs are most effective when they evolve with the changing needs of the communities that they serve. A study of Profamilia clinics in Colombia showed that once CHWs improved contraceptive knowledge and use among the community (55% to 65% among ever-married women), contraceptive social marketing (CSM) programs were more profitable than CHW programs and equally effective (Vernon et al., 1988). Similarly, in Bangladesh,

after a door-step family planning delivery program attained high contraceptive knowledge and prevalence (55% CPR), the success could be maintained through a less intensive and more cost-effective centralized depot approach (Routh et al., 2001). However, some regions of Bangladesh still need door-step delivery to address the social and cultural norms that continue to inhibit women's freedom of movement and impede consistent contraceptive use.

- **Invest attention and funding to improving supply chains for CHWs.** A variety of considerations must be taken into account when designing an effective supply chain for community-based programs, such as organizational capacity, CHW literacy levels, ways to track logistics management information systems forms, and ways to track and aggregate data (Hasselberg et al., 2010).

Considerations for Scaling Up

When scaling up and institutionalizing HIPs, make sure to plan for changes needed in:

- financing
- policy and guidelines, particularly for task shifting
- health information systems
- logistics and supply needs
- community sensitization
- health communication
- supervision
- training

Tools and Resources

The Community-Based Access to Injectable Contraceptives (CBA2I) Toolkit contains global guidance and a range of country-specific materials to guide advocacy, implementation, and scale-up of CBA2I. Available at www.k4health.org/toolkits/cba2i

The Community-Based Family Planning (CBFP) Toolkit, a one-stop source for knowledge and lessons learned about CBFP programs. Available at www.k4health.org/toolkits/communitybasedfp

Community Health Worker Toolkit for SDM, a package of resources for training CHWs on how to provide SDM and use CycleBeads[®], using hands-on, low-literacy and interactive training approaches. Available at <http://irh.org/resource-library/offering-cyclebeads-a-toolkit-for-training-community-health-workers/>

Supply Chain Models and Considerations for Community-based Distribution Programs: A Program Manager's Guide, presents four supply chain models for community-based programs with guidance and lessons learned on supply chain functions, including logistics management information systems, inventory control systems, storage, distribution, and capacity building, that can be adapted and applied to a variety of country contexts. Available at <http://www.k4health.org/toolkits/communitybasedfp/supply-chain-models-and-considerations-community-based-distribution>

For more information about High-Impact Practices in Family Planning (HIPs), please contact the HIP team at USAID at fhip@k4health.org.

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Access the current, up-to-date version of this HIP: <http://www.fphighimpactpractices.org/briefs/community-health-workers/>