International Journal of Gynecology and Obstetrics 130 (2015) S32–S39

Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

SUPPLEMENT ARTICLE

Experiences engaging community health workers to provide maternal and newborn health services: Implementation of four programs

Jaime Haver [a,*], William Brieger [a], Jérémie Zoungrana [b], Nasratullah Ansari [c], Jean Kagoma [d]

[a] Jhpiego, Baltimore, MD, USA
[b] Jhpiego, Dar es Salaam, Tanzania
[c] Jhpiego, Kabul, Afghanistan
[d] Jhpiego, Kigali, Rwanda

ARTICLE INFO

Keywords:
Community health worker
Human resources for health
Primary health care
Maternal and newborn health

ABSTRACT

A paucity of skilled health providers is a considerable impediment to reducing maternal, infant, and under-five mortality for many low-resource countries. Although evidence supports the effectiveness of community health workers (CHWs) in delivering primary healthcare services, shifting tasks to this cadre from providers with advanced training has been pursued with overall caution—both because of difficulties determining an appropriate package of CHW services and to avoid overburdening the cadre. We reviewed programs in Rwanda, Afghanistan, Nigeria, and Nepal where tasks in delivery of health promotion information and distribution of commodities were transitioned to CHWs to reach underserved populations. The community-based interventions were complementary to facility-based interventions as part of a comprehensive approach to increase access to basic health services. Drawing on these experiences, we illuminate commonalities, lessons learned, and factors contributing to the programs' implementation strategies to help inform practical application in other settings.

1. Introduction

The Alma Alta Declaration of 1978 incorporated volunteer community health workers (CHWs) into the delivery of basic health services at the village level [1] and paved the way for the proliferation of CHW programs [2]. More than 30 years later, many low-income countries are striving to increase the numbers of skilled providers as a way to improve coverage of and access to basic health services, including maternal and newborn health (MNH), family planning, and nutrition [3]. Nevertheless, efforts to strengthen facility services have often not kept pace with the health system requirements needed to provide all citizens access to care [4]. The ongoing crisis in human resources for health remains one of the most critical system challenges, resulting from a severe paucity in the number of providers, inappropriate distribution of existing providers, and insufficient capacity of providers due to lack of training and education [5]. In this context, discussion around the appropriate role of CHWs in reducing maternal, infant, and under-five mortality has been revitalized [6,7].

The term "community health worker" encompasses the roles and responsibilities of various health cadres [6]. Lewin et al. [7] defines a lay health worker—a term often used interchangeably with CHW—as any health worker who: (1) performs functions related to healthcare delivery; (2) has received some form of training relevant to the given intervention; and (3) does not hold a formal professional or paraprofessional certificate or tertiary education degree. Although the profile of CHWs varies across countries, common attributes such as being recruited and supported by the community served [8] may uniquely position the cadre to help address some of the health system challenges that affect access to health facility services.

1.1. Current community health worker situation

Globally, many women, particularly in rural areas, continue to give birth at home without the presence of a skilled provider [9], and families in such settings often seek treatment for child illnesses from informal providers such as medicine vendors [10]. These challenges underscore critical gaps in healthcare access. National MNH survival strategies must employ complementary facility- and community-based strategies, which in some cases might be accomplished by CHWs delivering health promotion information and distributing commodities to communities to achieve greater coverage of priority interventions. Barros et al. [11] reviewed inequalities in maternal, newborn, and child health interventions and concluded that community-based interventions are more equitable than static facility-based services. Thus, task shifting to CHWs to

* Corresponding author at: Jhpiego, 1615 Thames Street, Baltimore, MD 21231, USA. Tel.: +1 530 592 3270.
E-mail address: jaime.haver@jhpiego.org (J. Haver).

http://dx.doi.org/10.1016/j.ijgo.2015.03.006

provide outreach services in rural communities can help increase overall access to basic interventions [12,13].

The role and need for CHWs has been examined in relation to programmatic opportunities for task shifting, and recommendations for program integration have been issued by both WHO [14] and USAID on this topic [15]. Community-level interventions in MNH have focused on health promotion and distribution of commodities such as iron, folic acid, and vitamin A supplementation [16]. CHWs have also been shown successful in strengthening management of uncomplicated child fever cases in community case management (CCM) of malaria [17], distributing and promoting contraceptives [18], and promoting exclusive breastfeeding [7], although not always sustainably at scale.

While there is evidence, at least in pilot settings, that CHWs can effectively deliver interventions when adequately trained and supervised, debate has persisted on how to best utilize the cadre. The global community has shifted responsibilities to CHWs with overall caution, focusing largely on the intervention itself, rather than on populations in need who are not reached by the current health system [2]. Exploiting opportunities to devolve select interventions to CHWs might help address the human resources for health crisis by enabling skilled providers to focus on those services (e.g. diagnostic, therapeutic) that require a higher level of education or training.

1.2. Jhpiego's experience with community health workers

As part of a comprehensive approach to care, Jhpiego has worked with CHWs in numerous countries as a complement to facility-based care and a key strategy for reaching underserved women and their families with lifesaving services with a focus on MNH. The objective of the present article is to illuminate commonalities and lessons learned from four country programs in which tasks in health promotion and distribution of commodities were intentionally shifted from skilled providers to CHWs to advance MNH strategies. These illustrative experiences, presented as case studies, are assessed—with a focus on CHW scopes of work and factors contributing to the effective implementation of the programs—to help inform practical application in other settings.

2. Methods

Keeping in mind Lewin et al.'s definition of a lay health worker [7], which aligns with Jhpiego's definition of a CHW, we reviewed program reports and other documents collected from Jhpiego's internal repository and program staff's inventories to identify those programs that met the following criteria: (1) CHWs delivered health promotion information and distributed commodities to the community for curative and preventive interventions in support of MNH; (2) CHWs performed a task that had been shifted from a skilled provider; and (3) data on MNH services were available.

We specifically looked for clear examples of "task shifting" because of the potential for this practice to provide relief to overburdened health systems and to reach women and children who are often overlooked. Programs that included components known to support CHW efforts (e.g. community involvement) were also given special consideration, in line with our focus on factors for effective implementation.

After the program documents were reviewed and discussed among staff who were knowledgeable about the CHW programs that fit our inclusion criteria, we selected four that best met our criteria and were "representative," collectively, on a current and global level, in terms of setting/culture and range of challenges. Drawing from these programs, we developed the following case studies to highlight information most pertinent to our objective.

3. Case studies

To provide a general overview of the four selected CHW programs, key information is summarized in Table 1.

3.1. Case study 1: Improving the health of women and newborns in Rwandan communities

Over the past decade, Rwanda has witnessed unprecedented improvement in many health outcomes, including those related to MNH, malaria, and HIV—due, in part, to the government's pioneering of health system reforms and decentralization of the healthcare delivery system. Community-based MNH care was built upon this strong existing foundation and has been embedded within the Ministry of Health (MOH) through community health point persons at the central, district, health facility, and cell (i.e. group of villages) levels.

Of the three CHWs selected per village, two (one female and one male) managed integrated community case management of childhood illness (iCCM), a strategy used to train, support, and supply CHWs capable of diagnosing and treating childhood illnesses including pneumonia, diarrhea, and malaria [19]. A third (female) CHW, called an Animatrice de santé Maternelles (ASM), focused specifically on pregnant women. In 2010, the Home-Based Maternal Neonatal Health Care program, supported by Jhpiego in partnership with Save the Children under the Access to Clinical and Community Maternal, Neonatal and Women's Health (ACCESS) Program and later the Maternal and Child Health Integrated Program (MCHIP), was initiated to increase the capacity of the ASMs. ASMs cover a catchment area of 100–150 households and are responsible for: (1) registering all women of reproductive age and identifying those who are pregnant in the community to encourage prenatal care attendance and facility-based deliveries; (2) promoting healthy behaviors during pregnancy and the postpartum period; (3) accompanying women in labor to the health facility; (4) providing misoprostol (as a uterotonic) in advance to pregnant women for self-administration following birth if they deliver unexpectedly at home; and (5) making early postpartum home visits to identify danger signs and refer women to the health facility as needed.

As part of the Home-Based Maternal Neonatal Health Care program, the ASMs were provided with an MNH care kit and training on how to use the included supplies. ASMs were selected according to specific criteria by community members from the village catchment area under the supervision of the village coordinator, in consultation with the facility health worker responsible for community health. A meeting with the village leaders and the community health supervisor was then held to finalize the selection. Selected ASMs received six days of initial education in community-based MNH services and refresher training after six months. Previously, also under ACCESS, Jhpiego had worked to improve the established ASM system through a wide range of capacity-building efforts.

The program was first implemented in a few districts; the MOH later decided to take the program to national scale. To help facilitate scale-up, innovative technologies were applied, such as the use of mobile phones for rapid short message service, which allowed ASMs to transmit information into a computerized recording and response system. Each ASM in the piloting zones received a mobile phone to report indicators—on community interventions (e.g. iCCM, community-based MNH services), deaths, and other information—directly to SISCom, Rwanda's health management information system. In addition, the ASMs sent alarm messages to the health center to help refer pregnant women quickly.

CHWs were organized by the local government minister into cooperatives composed of approximately 120 CHWs within the facility catchment area, which provided a supportive framework of peer-to-peer support, motivation, and accountability. For example, under the MOH's coordination, the CHWs conducted income generation activities to provide a means of subsistence, while the range and extent of activities were driven by the cooperative. The cooperative program was also