

Invest in Community Health Workers (CHWs)

International Evidence of CHWs in Family Planning

Community health workers (CHWs) have been acknowledged as a vital component of primary health care and in the context of family planning service delivery, the integration of trained, equipped, and supported CHWs into the health system is recognized as a proven “high-impact practice.”¹ Evidence from around the world confirms that CHWs “provide a critical link between their communities and the health and social services system.”² Particularly in areas where people’s access to health care is limited by geographic barriers, lack of financial resources, and social constraints.

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.³ In Afghanistan, a CHW program increased contraceptive usage 24 to 27 percentage.⁴ CHWs were reported as the last source of contraceptive supply by about a fifth of modern contraceptive users in Bangladesh and Indonesia.⁵

Integrating CHWs in the health system, especially through well-defined referral and supervision structures, is a key factor in the success of programs.⁶ Large-scale programs require ownership from the health system, with leadership from district authorities and health centers, and efficient integration of systems.⁷ In the long run, effective CHW programs alter healthcare seeking behaviors among their target populations and it can become viable to replace them with more cost-effective service delivery options. For example, in Brazil, once CHWs improved contraceptive knowledge and use among the community, contraceptive social marketing programs were more profitable than and as effective as CHWs programs in sustaining Profamilia clinics.⁸

Effectiveness and Sustainability of CHW Programs in Pakistan

CHW programs are being implemented by both the public and the private sector in Pakistan. The largest and longest-standing program is the Lady Health Worker (LHW) Program, which was launched as the “National Programme for Family Planning and Primary Health Care (FP&PHC)” by the federal government in 1994. Other evidence from private sector indicates that CHWs are highly effective in increasing demand for and use of contraceptives among all types of underserved communities. However, none of the models from public and private sector are entirely self-sustaining. The real hope for sustainability resides, not in the ability of CHW programs to finance themselves, but in how effectively they pave the way for more cost-effective service delivery options by increasing family planning demand, and long-term private sector involvement in family planning service provision.

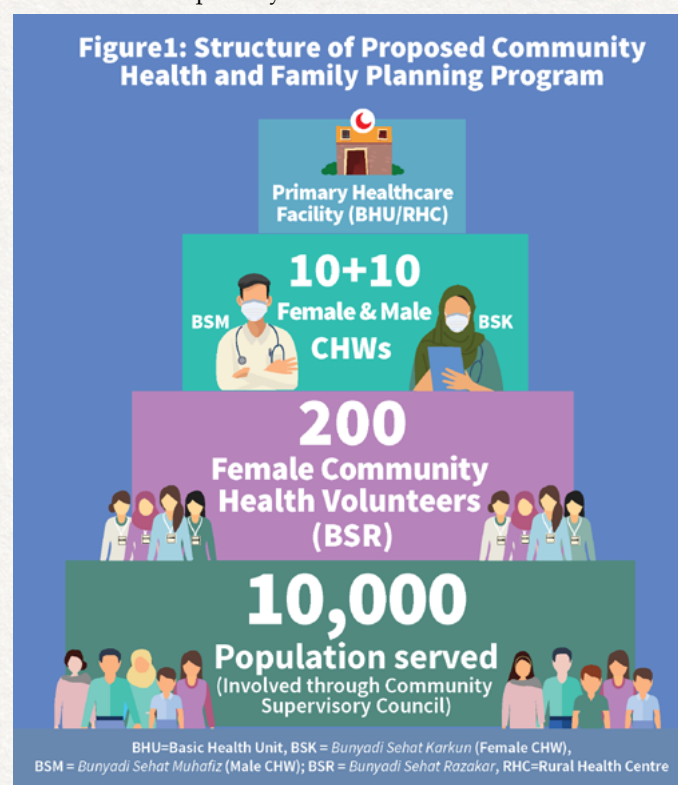
Investing in CHWs – Strengthening the Lady Health Workers Program

As long as the majority of people of Pakistan reside in rural communities with poor access to services, the role of CHWs will remain crucial for ensuring universal health coverage and for implementing the recent decision of the national Council of Common Interests (CCI) to accelerate uptake of family planning services to rein in the country’s alarming population growth rate. Our main recommendation is to test, and eventually scale up, a modified and repackaged model of the LHW Program that obviates the weaknesses that have crept into the original and includes some new elements that add value.

Overview of Proposed Model

The proposed model (Figure1) that essentially builds upon and strengthens the existing LHW program is as follows:

- Be owned by the government;
- Build upon existing structures;
- Strengthen community participation for improved accountability and responsiveness;
- Capitalize on community volunteerism to extend outreach, as in Indonesia, Ethiopia, and Iran;
- Engage male workers, to make the program less women-centric and especially to provide men a much-needed contact point for family planning discussion; and
- Focus strongly on family planning services while also providing other maternal and child health services within the ambit of primary healthcare.



Roles in the team

Bunyadi Sehat Karkun (BSK):

The key cadre in the proposed model is the female rebranded key cadre as BSK which will be more focused on provision of wider range of FP services.

Bunyadi Sehat Razakar (BSR):

The BSR will be respected elder women who will help the BSK in arranging home visits; group meetings; creating community awareness and arranging health education campaigns.

Bunyadi Sehat Muhafiz (BSM):

A newly added Male Mobilizer cadre to educate and motivate men, both collectively through group meetings and through individual counseling sessions, to use family planning.

Bunyadi Sehat Team (BST):

Within the health facility with which they are linked, the BSK and BSM will report to a 'Bunadi Sehat Team, comprising the Medical Officer, the Lady Health Visitor and a BSK supervisor to provide administrative support.

Community Supervisory Council:

A Community Supervisory Council will be established to ensure community ownership and participation, and to provide an effective mechanism for grassroots voice and accountability.

Operational Aspects

Recruitment:

The BSRs will be recruited from their own communities. The BSKs and BSMs will be required to have at least 10 years of education like the LHWs. They should reside within their target communities or close to them.

Training and Professional Development:

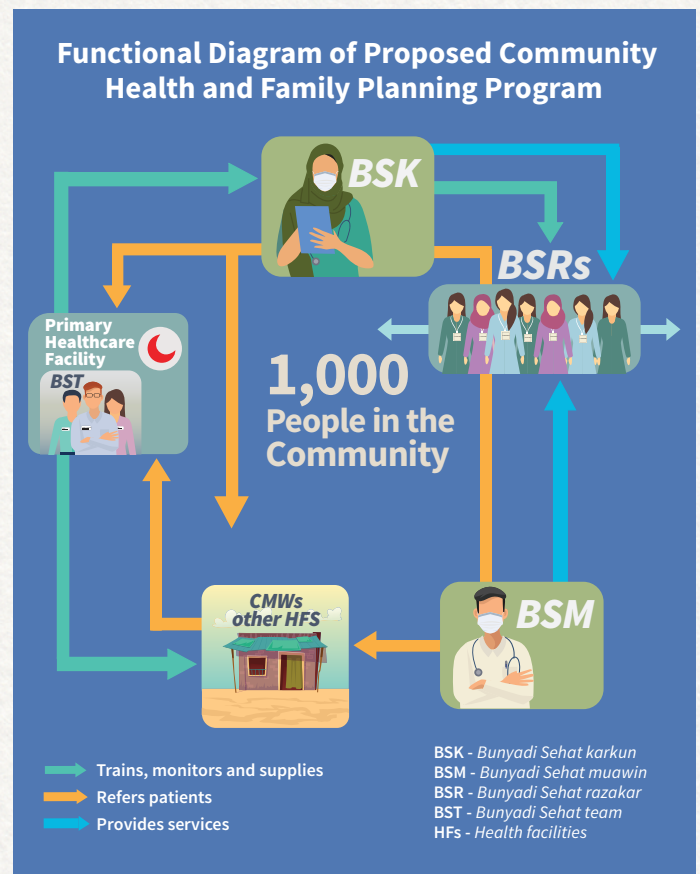
BSKs will be trained for their role through a standardized program, will train BSR and BSM will be trained by BST.

Supervision:

The BSKs will be responsible for providing supportive supervision to the BSR and BSM and BSK will be backed by BST.

Financing:

The program will entail significant expenditures on supplies, training, and management.



Building Evidence for Scale-up

Piloting a 'lean' version of the initiative, with a small number of teams trained to provide a limited range of family planning and basic health services in three settings within the same district—peri-urban, rural, and remote is the key recommendation.

Setting a Targeting Strategy

Stakeholders, including health and planning officials, relevant NGOs, donors, and social scientists, should work together to identify and agree on clearly defined criteria for areas where the proposed model of CHWs should be introduced. The criteria for identifying areas for CHW deployment should reflect both supply- and demand-side indications of need.

References

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