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THE ONE-MILLION COMMUNITY HEALTH WORKER CAMPAIGN

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Written by Professor Jeffrey D. Sachs & Prabhjot Singh.



Across Sub-Saharan Africa, fever in a young child can be an ominous sign. With the possible causes ranging from a self-limited virus to a fatal pneumonia or malaria, a child's life may depend on rapid diagnosis and treatment. In poor, rural settings, the visit of a Community Health Worker (CHW), who is part of a larger healthcare system can be life saving. Across Africa and the low-income world, governments and NGOs are turning to a new generation of CHWs which are equipped with new technologies, training, and organization. The Campaign for One Million Community Health Workers in Sub-Saharan Africa by 2015 can mark a decisive step towards success of the health Millennium Development Goals.

The logic of the campaign is the following. Experience has shown that each CHW can cover around 100 households, visiting each every 60-90 days. With an average of five people per household in rural Africa, one million CHWs can cover – to a rough approximation – the 500 million or so population of rural sub-Saharan Africa. Some countries have already embarked on the modernization and scale up of their CHW work force. Most others have not, and still rely on poorly trained and poorly supervised volunteers. The Campaign for One Million CHWs aims to help African governments to deploy an upgraded generation of CHWs, trained, supervised, remunerated, and supported by the latest in community-based health technology.

We have learned a lot about the design of CHW systems through the experience in the Millennium Villages Project. In our work in the 10-country project, a CHW is alerted about a child who has a fever in one of three ways: (1) the mobile phone-enabled emergency response system; (2) symptom recognition during a regular household visit by the community health worker; or (3) a community member's request for the CHW based on acute symptoms. Upon arrival in the household, the CHW quickly administers a rapid diagnostic test (RDT) for malaria, part of the standard CHW supply kit, to the child with the fever. If the test is positive, the CHW uses a mobile phone to record the encounter, register the results, receive confirmation on dosage, and alert the primary health care system to support follow up. The CHW then provides the requisite treatment dose of Coartem (or other first-line medicine) on the spot, ideally around thirty minutes after arrival onsite. If the test is negative, the child can be referred to clinic for a more detailed workup of the fever and possible treatment.

Based upon the work of the One Million CHW taskforce that the Earth Institute hosted in 2011 (add the link to the report or your web site), a system that can support this protocol-driven response to a limited set of high priority conditions requires a paid, full-time CHW. But that's not enough; the community workers need a robust management system that is integrated with the rest of the primary health care system. Building on the expansion of the mobile broadband and the existence of hundreds of mHealth projects in the developing world, the One Million Campaign, under the auspices of the UN Secretary General's Office and part of the UN Sustainable Development Solutions Network (www.unsdsn.org), takes as its premise that the rapid scale-up of CHWs organized as a system is now possible.

There are five key features of the CHW system:

Information and Communications Technology and Broadband Connectivity – Substantive experience, from around the African continent, shows how broadband can have a key role in achieving the MDGs. Free broadband and smartphones, linking community health workers to the national health system, will allow for real-time disease surveillance, child and maternal health monitoring, supply chain management, and capturing of vital events. The UN Broadband Commission is a leading convener of organizations for Digital Development and has championed this campaign from its inception.

Point of Care Diagnostics with Treatment Protocols – Arming CHWs with consistent supplies of life-saving medicines and easy-to-follow treatment algorithms supports a minimum quality of services. This is improved by rapid diagnostic tests for a range of conditions, especially malaria which remains one of the major causes of child mortality in sub-Saharan Africa. Active care and disease detection, according to rigorous guidelines, have greater benefit to the formal health system than passive case detection and dependence upon clinic visits.

Rapid Training – Shorter, intensive trainings on the most critical competencies for community healthcare delivery can be effective for deploying on-the-ground, functional frontline health workers at scale, without a large initial time lag between recruitment and deployment. This, however, requires a scalable supervisory system and mobile learning techniques to lead continuous improvement of the CHW system.

Affordability – Based upon the One Million Community Health Worker Taskforce, convened by the Earth Institute in 2011, the cost of training, equipping, and deploying CHWs throughout rural Sub-Saharan Africa translates to \$6.58 per person served per year (add the reference and the link). The estimated total, of \$2.5 billion, falls within overall governmental health budget constraints in addition to pledged donor assistance.

Integrated Community Delivery for MDG Targets and Beyond –With only three years to 2015 and, in the face of the persistent shortage of skilled human resources for health at the periphery of health system and in rural areas, a campaign for scaling up of CHWs in sub-Saharan Africa is probably the most effective and feasible way to provide comprehensive access to primary health care. Supporting the development of sustainable health service delivery mechanisms will help achieve several of the Millennium Development Goals (MDGs) and build the capacity for national primary health care systems to address the growing challenge of noncommunicable diseases.

The Campaign for One Million CHWs has five aims as it moves towards achieving its title goal:

1. Upgrade Existing National CHW Programs: CHW programs in countries such as Ethiopia, Kenya, Malawi, Nigeria, Rwanda, Senegal, and Tanzania should build upon programmatic strengths to become national CHW systems including deployment of quality-controlled protocols and use of mHealth, ideally linked with national health information systems. This will require coordination across major global funding mechanisms, as well as new commitments to augment national commitments to their own CHW system development.
2. National enumeration of CHWs: Limited data sources exist that can help enumerate CHWs. Starting a comprehensive database of CHWs (with an inclusive definition, and a subset for those qualified as fully functional) will go a long way towards delineating how, where, and to what extent members of this cadre serve, both as governmental employees and in private or nongovernmental organizations. This count will also provide a baseline against which to record progress toward the goal of comprehensive CHW systems. Regional networks, local governments, and community organizations are at the frontline of accurately identifying gaps in CHW numbers and support.
3. MDG-linked indicators: Measuring the progress of the campaign should be linked to reductions in MDG indicators by 2015, not simply the number of personnel deployed. Metrics pertaining to fever detection, prevention of mother to child transmission of HIV, tuberculosis control, ante-natal/maternal care, and child mortality can be improved with an effective CHW system. This will also allow clear linkages to vertical disease program funding and operations.
4. Close gaps on shortfall to systematic healthcare: CHWs are instrumental in healthcare provision for the underserved, however they work best in the context of a health system. Functionally deployed and properly equipped CHWs can improve primary healthcare in peripheral or remote areas cost-effectively, and expand the reach of existing facility-based care. This will require systematic coordination with other frontline health workers, who in concert are the foundation of the primary health care systems that will last beyond 2015.
5. Provide international support and financing for national efforts: National governments will of course have to take the lead in the scale up, but when they do, they should find predictable international support for their efforts. This support can include incremental funding (e.g. matching domestic budget outlays) from the Global Fund, GAVI, PEPFAR, the World Bank and other funding agencies; training facilities and support, such as offered by the Novartis Foundation, access to broadband connectivity facilitated by the telecommunications providers and software design and support to provide ICT services for the CHW system.

In order to achieve these aims, the Campaign is led by a steering committee of international partners that includes UN agencies, the Global Fund for Aids, Tuberculosis and Malaria, the ITU, broadband industry leaders, and bilateral aid agencies. The steering committee will present a basic strategy to African Union leadership in January. As African governments adopt policies to scale up their CHW workforce, the Campaign will work continuously to support the efforts at the national level and to help mobilize the needed complementary funding.

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