



MINISTRY OF HEALTH
Republic of Zambia
Ministry of Health

NATIONAL COMMUNITY HEALTH WORKER STRATEGY IN ZAMBIA

August 2010

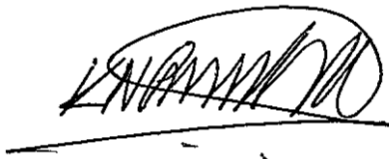
Foreword

The health sector in Zambia is facing a major human resources crisis, with shortages of health workers at every service delivery level. The Government of the Republic of Zambia (GRZ) recognises that human resources for health are critical to the provision of quality health care and that to address the current crisis it is essential that the Ministry of Health (MOH) **ensures an adequate and equitable distribution of appropriately skilled and motivated health workers providing quality health services.**

In view of the crisis, a National Community Health Worker Strategy has been developed by the Ministry of Health with the aim of repositioning and expanding the currently available Community Health Worker (CHW) cadre. CHWs will deliver essential and priority health services, where there are gaps and reported deficiencies, through a task-shifting approach (from nurses to CHWs). The term "CHW" refers to the cadre that will have received a standardized training programme of twelve months, including both theoretical and practical training, by qualified and experienced tutors and instructors. This training will enable the CHWs to provide promotive preventive and curative services at the community level.

The goal of the NCHW strategy is to have an adequately trained and motivated community-based workforce that will contribute towards improved health service delivery and the attainment of National Health priorities and the Millennium Development Goals (MDGs). Ultimately, the new CHW cadre will contribute towards alleviating the human resource crisis by handling a basic package of health services, thereby improving efficiency within the health sector and allowing nurses and clinicians to focus on more complex services.

The launch of the NCHW strategy marks the culmination of several years of investigation into best-practices from successful community health worker programs in other countries, as well as careful assessments of current CHW programs operating throughout Zambia. The Ministry of Health is proud to initiate this ambitious program, which we hope will produce rapid and concrete improvements for the health and well-being of rural community members country-wide.



Hon. Kapembwa Simbao MP
MINISTER OF HEALTH

Acknowledgements

This National Community Health Worker Programme Strategy has been developed through a collective and collaborative effort, with input from over fifty national and international partners. The Ministry of Health acknowledges the efforts of key stakeholders, policy implementers, academic institutions and Cooperating Partners who participated in the development of this important strategy.

Special thanks go to the financial and technical support given by Cooperating Partners as well as international and local organizations as their support was instrumental in the completion of this document: the Global Health Workforce Alliance, World Health Organization, DfID and the Clinton Health Access Initiative and many more organizations who have, and will continue to contribute to the successful implementation of the new CHW strategy.

I would finally like to thank the Ministry of Health staff, especially the editorial team, for their participation, contributions and support.

A handwritten signature in black ink, appearing to read 'Peter Mwaba', with a stylized flourish at the end.

Dr. Peter Mwaba
PERMANENT SECRETARY

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Abbreviations

BHCP	Basic Health Care Package
CBO	Community Based Organization
CHP	Community Health Programme
CHW	Community Health Worker
CHAI	Clinton Health Access Initiative
DMO	District Medical Office
DHRA	Directorate of Human Resources & Administration
DTSS	Directorate of Technical Support Services
GHWA	Global Health Workforce Alliance
GNC	General Nursing Council
GRZ	Government of the Republic of Zambia
HMIS	Health Management Information System
HPCZ	Health Professions Council of Zambia
HRH	Human Resources for Health
HRSP I	Human Resource Strategic Plan 2006 - 2010
IHP	International Health Partnership
JAR	Joint Annual Review
LATH	Liverpool Associates in Tropical Health Ltd.
MAFF	Ministry of Agriculture
MDGs	Millennium Development Goals
M&E	Monitoring & Evaluation
MOH	Ministry of Health
MTR	Mid-Term Review
NCHWP	National Community Health Worker Programme
NGO	Non-Governmental Organization
NHCs	Neighbourhood Health Committees
NHSP	National Health Strategic Plan
PMO	Provincial Medical Office
PSMD	Public Service Management Division
RDT	Rapid Diagnostic Test
SI	Statutory Instrument
tTBA	trained Traditional Birth Attendant
VHT	Village Health Team
WHO	World Health Organization

MINISTRY OF HEALTH

COMMUNITY HEALTH PROGRAMME IN ZAMBIA

1. Introduction

Zambia is experiencing a serious shortage of human resources in the health sector, which adversely affects the delivery of health services at every level. Zambia's human resources for health (HRH) crisis has been described as the key obstacle to reducing the country's crushing disease burden and achieving the Millennium Development Goals (MDGs).

Since the 1978 Alma Ata Declaration on Primary Health Care, many developing countries with human resource shortages in the health sector, including Zambia, have utilized community health workers (CHWs) to alleviate the workload of scarce clinicians, especially for the provision of basic preventive, promotive and curative health services in under-served rural areas.

To date, the role of CHWs in Zambia's health sector has not yet been formalized or standardized. Community-based health service delivery is mentioned in the National Health Strategic Plan 2006 – 2010 (NHSP IV), although the specific role of CHWs is not articulated. Since the drafting of NHSP IV, there has been increasing national recognition of the need to formalize and strategically utilize the services of CHWs.

The Mid-Term Review of 2008 (MTR) of the NHSP identified major constraints in the effective utilization of CHWs, including insufficient numbers to provide large-scale community health interventions, as well as inadequate incentive schemes and erratic provision of supplies. According to the above-mentioned MTR, "Zambia will not be able to provide quality health services in all communities and will not be able to fully achieve its public health priorities and MDGs as planned, if community health will not be prioritized and better coordinated." Other documents, including the 2009 Joint Annual Review (JAR) and the draft NHSP V emphasize the importance of CHWs in the provision of basic health services, as well as the need to standardize their management.

In response to the current situation and in line with Ministry of Health's mission statement, the Government of the Republic of Zambia (GRZ), through the Ministry of Health (MOH), is taking the initiative to develop a more strategic approach towards community-based healthcare. A National Community Health Worker Programme (NCHWP) has been created with the aim of repositioning and expanding the CHW cadre.

The rationale for the development of the NCHWP is *to bring basic health services closer to the family, in line with Ministry of Health's mission statement*. The creation of this plan recognizes that: 1) the clinician shortage, particularly in the rural areas, leaves many Zambians with scant access to basic preventive, promotive and curative services, and 2) the Zambian health system already relies on CHWs to carry out these services but without the quality assurance mechanisms inherent to a standardized management scheme, which includes an approved Scope of Work and standardized training, supervision and remuneration.

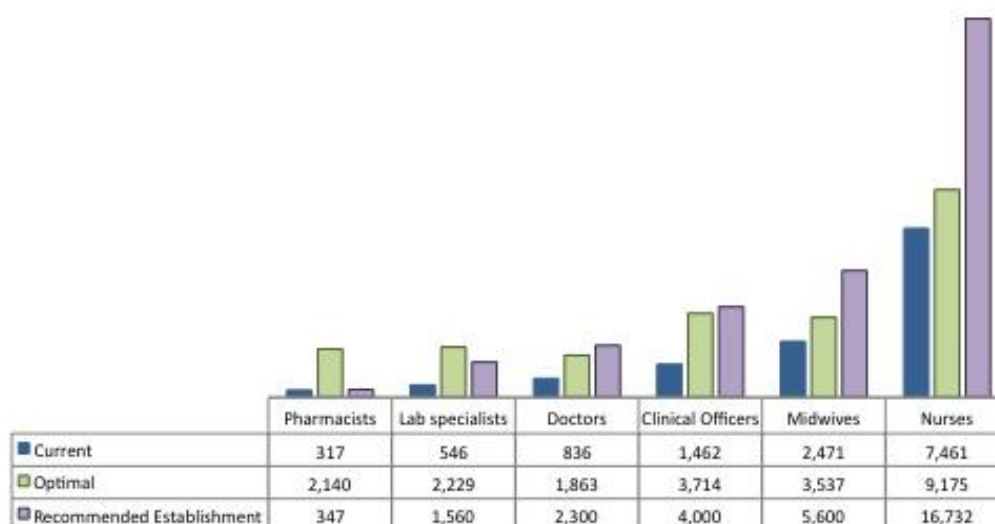
This document serves to articulate the strategies to be employed by the NCHWP. Given the complexity and importance of strengthening community health services nationwide, the NCHWP will be implemented in phases. A rigorous monitoring and evaluation plan will provide timely and continuous data to inform the decision-making process as the strategy reaches national scale, and will measure the impact of the programme both on the health system and on the health of Zambians who utilize CHW's services.

2. Background

A detailed analysis of the scale of the human resource crisis can be found in the Human Resources for Health Strategic Plan 2006-2010. This section aims to provide a brief discussion with updated information.

As of January 2010, Zambia faces a shortage of professionals in every health cadre. Zambia's healthcare workforce is at 39% of the Recommended Establishment, and 58% of the interim target established through Ministry of Health's Optimization Model, which measures demand for health services. According to the recommended Establishment list, Zambia faces a shortage of 9,271 nurses (vacancy rate of 55%), 2,538 Clinical Officers (vacancy rate of 63%), and 1,464 doctors (vacancy rate of 64%). The Optimization Model, which estimates vacancies based on the levels of health service utilization, confirms the gravity of the shortage, indicating a 61% vacancy rate for Clinical Officers, 55% vacancy rate for doctors, and 30% vacancy rate for midwives. The shortages are illustrated in Table 1.

Table 1: Healthcare Workforce Gap¹

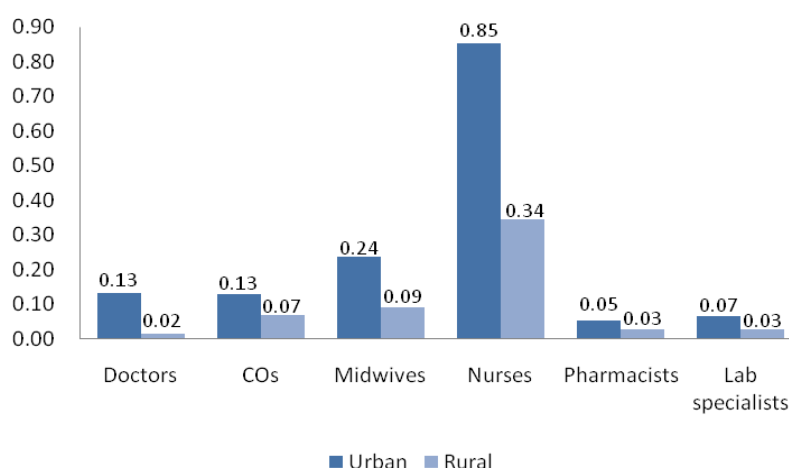


In addition, the distribution of the healthcare workforce is skewed toward urban areas, with 159 health care workers per 100,000 population in urban districts as compared to 70 per 100,000 in rural districts². Meanwhile, approximately 60% of the country's population, or 7.5 million Zambians, live in these rural areas. Table 2 illustrates the disproportionate distribution of clinicians.

¹ Source: Ministry of Health payroll January 2010

² MoH Payroll, January 2010. Chingola, Chipata, Choma, Kabwe, Kafue, Kasama, Kitwe, Livingstone, Luanshya, Lusaka, Mansa, Mazabuka, Mongu, Monze, Mufulira, and Solwezi districts defined as urban.

Table 2: Disparity in Urban-Rural Distribution of Clinical Health Care Workers: Number per 1,000 people³



Efforts have been made to increase clinical staffing levels in rural areas through the *Zambian Health Workers Retention Scheme*, which provides special incentives to clinicians to work in the rural and remote districts. The total number of health workers participating in the retention scheme increased by 31% between 2008 and 2010, from 656 clinicians to 889; however, this number is only 64% of the scheme's current target of 1,350 staff members⁴.

In summary, despite important gains made through innovative initiatives, Zambia faces considerable challenges in the delivery of health services, especially in rural areas. The NCHWP aims to complement existing efforts to expand access to preventive, promotive, and curative health services in rural communities. If CHWs provide high quality preventive and promotive services, health facilities should experience a reduction in the flow of cases of preventable illness, while the provision of basic curative services should allow health facilities to focus on cases that require higher-level medical expertise, thus mitigating the impact of the clinician shortage. If combined with the implementation of an effective Referral System, then this will reduce the overflow of patients at higher level health facilities. Monitoring and evaluation of the Pilot Phase of the NCHWP will provide critical insight into whether CHWs are an effective means of contributing to the Ministry of Health's mission to provide cost-effective, quality health services as close to the family as possible.

3. Situation Analysis

3.1 CHWs in the Zambian Context

In preparation for the development of the NCHWP, the Ministry of Health, with support from the *Global Health Workforce Alliance*, carried out a Situation Analysis in 2009 to understand the roles, scope, and challenges of organizations and facilities that incorporate CHW services into their health programmes. The full results of this analysis can be found in the *CHW Strategy Concept Note 2009*. This section (3.1) includes a summary of the most relevant findings.

³ Source: MOH Payroll May 2009; Central Statistics Office Population Estimate.

⁴ Ministry of Health 2009 *Joint Annual Review Report*

The Situation Analysis spanned 61 districts and comprised of several surveys to collect data from District Medical Offices (DMOs), hospitals, implementing partners, and CHWs. A total of 57 hospitals, 18 implementing partners, staff from 60 District Medical Offices, and 76 CHWs participated in the surveys.

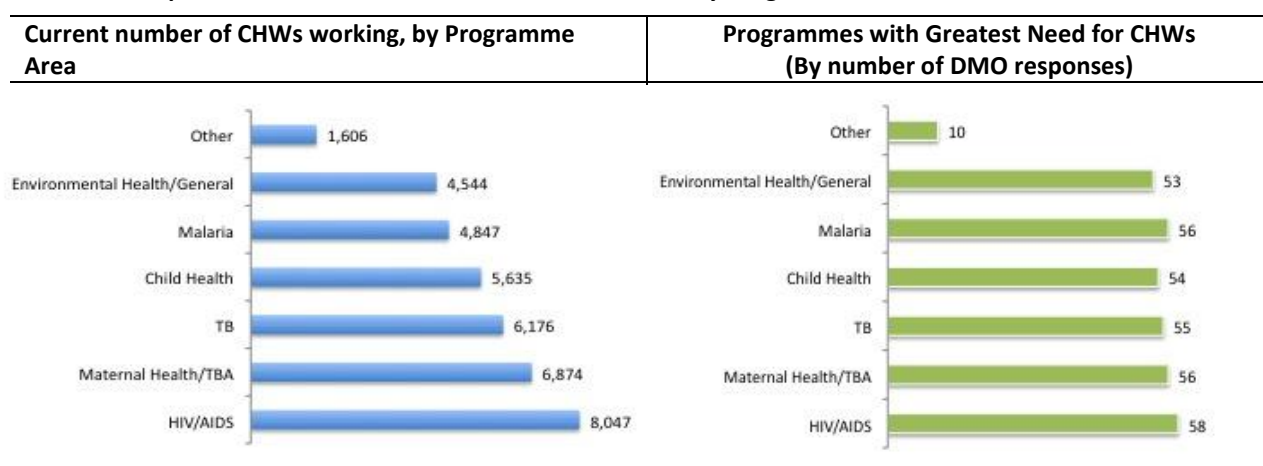
The analysis found that CHWs were “members of communities who work either for pay or as volunteers in association with the local health care system...and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve.” Furthermore, it was noted that CHWs had many titles, including health promoters, community health advisors, lay health advocates, community health representatives, and peer health educators. Many of the volunteers had been introduced during the past 10 years, and it was estimated that 23,500 CHWs were active throughout Zambia.

The Situation Analysis reported the following findings:

General

- MOH does not have a dedicated CHW desk or Community Health Focal Person, nor is there an official policy to guide the management of CHWs.
- Implementing partners have different policies for training, recruitment, remuneration, and incentives for CHWs.
- CHW programmes funded and managed by implementing partners are typically on contracts of two-to-five years.
- While DMOs believe there is an equal need for CHW services across all programme areas, HIV/AIDS programmes have the most CHW support (8,047) while environmental health and malaria programmes have the lowest support (4,544 and 4,847, respectively). This disparity is illustrated in Table 3.

Table 3: Comparison of Number of CHWs vs. Need for CHWs by Programme Area



- 62% of CHWs surveyed indicated that they were not engaged in any type of formal employment, although 85% participate in farming.

- 70% of CHWS believed the recruitment process could be improved. The following were the primary suggestions:
 - Increase minimum education requirements, specifically the ability to read and write.
 - Better communication on incentives.
 - Stronger community involvement.

Training

- Considerable variability exists in the training of CHWs, which ranges from 2 to 5 weeks for health facilities, while implementing partners' training sessions vary from 2 to 11 weeks. Duplication of efforts was reported, as cooperating partners will train CHWs in their programme areas, even if they have already received similar training from other stakeholders.
- Most implementing partners utilize MOH's *CHW Handbook 2005* to train their CHWs; however, training materials and delivery of content varies widely across partners.
- CHWs do not have access to ongoing training. 97% of CHW programmes managed by implementing partners do not provide follow up training.
- Half of DMOs and a quarter of CHWs felt that trainings did not adequately prepare CHWs for their duties. CHWs expressed a wish for training of longer duration, while both DMOs and CHWs recommended continued on-the-job training and standardization of training.

Remuneration

- DMOs reported that the most common reasons for attrition among CHWs included a general lack of motivation and incentives. Implementing partners cited differences in remuneration between stakeholders as the most common reason for CHW attrition. CHWs tend to migrate towards the programmes that offer the best remuneration packages.
- Incentives vary considerably. Non-monetary incentives include training certificates and transportation (i.e. a bicycle). CHWs employed by health facilities receive an average of K100,000– K200,000 per month, while implementing partners provide incentives ranging from K100,000 – K500,000 per month. DMOs recommended a maximum payment of K600,000 per month.
- Remuneration varies across programme areas, with CHWs employed in environmental health and HIV/AIDS compensated the most (K204,000 per month and K168,000 per month, respectively) and those in maternal health and child health paid the least (K113,000 per month and K103,000 per month, respectively).

CHWs in the Field

- Consensus exists among those surveyed regarding the top three current roles of CHWs: monitoring patient adherence, patient counselling, and community education.
 - There are no standardized guidelines on how to conduct supervisory activities for CHWs. DMOs and implementing partners cited distance and time to travel between supervisors and CHWs as the greatest challenges to supervisory activities.

Key recommendations:

- DMOs indicated that, with additional training, a number of activities could be delegated to CHWs at the facility level to assist health professionals, including:
 - Taking temperature, blood pressure, and pulse,
 - Weighing patients, primarily children,
 - Bed-making,
 - Dressing uncomplicated wounds,
 - Rapid diagnostic testing,
 - Registering patients.
- DMOs recommended standardization of recruitment, education requirements, training, remuneration, and supervision of CHWs.
- Implementing partners recommended standardization of training, remuneration, and supervision. Just over half of the implementing partners recommended standardization of recruitment.
- DMOs and CHWs recommended that monetary incentives are the most appropriate form of remuneration. DMOs recommended a monthly payment.
- Interviewees agreed that the MOH should develop a standard training manual and CHW curriculum for Zambia, and that they require refresher courses periodically.

The Situation Analysis provided rich insight into the context in which CHWs currently work. A picture emerged of an *ad-hoc* system of workers who clearly add value (as evidenced by competing incentives provided by facilities and organizations), but the lack of coordination yields considerable time and resource inefficiencies in the hiring, training, and management processes. Training and Scopes of Work for CHWs seem to be based more on the programmatic priorities of organizations and their donors than on the health needs of the communities as observed by DMOs. Furthermore, the lack of minimum requirements for training and supervision beget concerns about the quality of CHW services currently provided, and information regarding the impact of CHWs on community health is lacking.

Currently, many public health interventions are increasingly relying on community health volunteers to take services closer to the people. Shortages among professional health workers have at the same time increased the need for additional non-formal (community) health volunteers to assist with service delivery at health facilities.

Over the past decade, a broad network of CHWs were monitored through the MOH's Health Management Information System's district collections and submissions, and MOH provided CHWs with drug kits based on reporting of services. However, a variety of factors, including the lack of availability of kits, inadequate incentives, absence of follow-up training and lack of recognition, contributed to reduced motivation and high attrition of volunteers. Many of these factors can be attributed to the lack of a coordinated national programme to guide the management of CHWs.

The overwhelming recommendation from those interviewed was the creation of a standard approach to managing CHWs in order to glean the most benefit from their work. Interviewees identified myriad benefits to standardization of the various components of CHW projects.

Standardization of recruitment may improve CHW services if all recruits meet minimum criteria, and alleviate confusion among CHWs themselves over eligibility requirements. Furthermore, a standard recruitment system can include procedures to facilitate buy-in from health sector staff and the community. Standardized training will establish minimum skill levels and knowledge that must be demonstrated, and promote an improved quality of CHW services. Standardized supervision would allow for more consistent monitoring of CHWs and provide an opportunity to give them feedback to enhance the quality of their work, using the existing performance management system. Standardized remuneration can reduce friction among CHWs, minimize attrition, and promote sustainability of CHW programmes.

Therefore, the information gathered clearly illustrates the need for a National CHW Programme in Zambia, and provides insightful recommendations to ensure the strategy meets Zambia's needs.

3.2 CHWs in the International Context

Much research has been published on CHW programmes throughout the past decade. After the launch of the Primary Health Care package (WHO, Alma Ata 1978) many countries all over the world expanded their health systems to include the community level, with an important role for voluntary community cadres.

Recently, however, a rapid transition has taken place in demand from traditional (lay) caregivers to professional (higher competence) care. CHWs were bypassed because the care provided by lay people, when used as an alternative, rather than a complementary resource to professionals, was perceived as poor.

The recognition of the global HRH crisis brought new interest for the role that CHWs could play in healthcare service delivery. The WHO's World Health Report 2008 described opportunities for the "rapid expansion of access to health care by relying on non-professional CHWs with the added advantage of cultural competence".

The International Health Partnership (IHP) also promotes new interest in CHWs as it "has the potential to catalyze efforts to tackle the HRH challenges in developing countries."

Recent research carried out by Hermann *et al* (2009) provides an extensive review of the experiences in Malawi, Uganda and Ethiopia. A framework of criteria for successful Community Health Programmes (CHPs) was used to assess multi-purpose programmes in the three countries. Some of the findings were that "without adequate remuneration community health workers cannot be retained in the long-term" and that "insufficient attention to quality supervision and continuous training will lead to decreasing quality of programmes over time." The researchers concluded that "community-based extension of health services are essential for ART scale-up and comprehensive PHC..... but the (fast) scale-up of CHW programmes runs a risk of neglecting the necessary quality criteria, if it is not aligned with broader health systems strengthening."

The following criteria were identified for successful CHW programmes:⁵

- 1. Selection and recruitment (motivation to serve the community)*
- 2. Initial training (depending on package of services (c-BHCP), available funding, regulation and remuneration of cadres)*
- 3. Simple guidelines and standardized protocols (e.g. Home Management of Malaria, TB treatment support, etc.)*
- 4. Supervision, support and relationship with formal health services*
- 5. Adequate remuneration and career structure*
- 6. Political support and regulatory framework*
- 7. Alignment with broader Health Systems Strengthening*
- 8. Flexibility and dynamism (best practices, stakeholders support and innovations)*

Another study by WHO⁶ identified several shortcomings of semi-professional health cadres and these are the fact that technical responsibilities assigned to CHWs often exceed their skills, lack of formal contract relationships, supervision and routine reporting are often erratic and attrition is generally high. Although the emphasis of training is on preventive care, CHWs tend to shift their attention to basic curative care, particularly where CHWs are replacing absent professionals. Some countries resolved to facilitate the absorption of CHWs into their Government's payroll with a professional qualification. The author of the study states that the label of CHWs in that case is misleading, as they simply have become low-cost, elementary level health care providers.

A recent article in *The Lancet*⁷ reviewed the positive potential contributions of CHWs to child survival. They warn, however, that "CHWs are not a *panacea* for weak health systems and will need focused tasks, adequate remuneration, training, supervision and active involvement of the communities in which they work." CHWs do not replace the need for facility-based health services and require additional financing. The authors recommend that the "implementation of large-scale CHWs programmes should be accompanied by research to assess the impact and cost-effectiveness and to document reasons behind successes and failures."

A number of countries are already investing in new cadres of CHWs as one of the strategies to reach the health-related MDGs and to alleviate critical professional staff shortages.

Ethiopia, for example, has trained 30,193 (female) Health Extension Workers (HEWs) to focus on maternal, newborn and child health, Malaria and HIV interventions. The training programme is included in their policy statement and national strategic plan, allowing for standardized country-wide training. The 1-year training (10 months of theory, 2 months of practical training) covers a package of 16 preventive and curative services that are delivered from village health posts by two (2) HEWs for every 5,000 people. The HEWs are employed on contract and deployed by the Government to serve a minimum of three years.

Additionally, existing health officers are trained to supervise HEWs and to provide more specialist care. Incentives packages, career ladders and training are included in the programme.

⁵ Adapted from: Hermann, K. et.al.: CHW's for ART in Sub-Saharan Africa: learning from experience, HRH April 2009

⁶ Analyzing Human Resources for Health (Module 10), Pavignani, E, WHO 2003.

⁷ Achieving child survival goals: potential contribution of CHW's, Haines, A.; Saunders, D.; Lehman, U.; et.al., *The Lancet*, Vol. 369, p. 2121-2131 (June 2007)

Simultaneously, 10,996 new health posts have been constructed by the community against a goal of 15,000. HEWs will work from these health posts, although they are expected to spend 75% of their working time in the communities.

In addition to the HEWs, there are also groups of voluntary CHWs that work with the communities and are complementary to the HEWs.

An MOH team conducted a study visit to Ethiopia and identified a number of challenges:

Selection criteria for HEWs did not meet WHO selection guidelines (candidates for training should be those from the community)

- Lack of transport to villages to enable them to perform community programme work
- Inadequate supervision of HEWs and hence HEWs do not receive feedback on their performance
- Lack of proper accommodation, for example, an HEW was sleeping in the store room of one of the health posts.

A recent development in **Malawi** is the changing and expanded role of Health Surveillance Assistants (HSAs), which became officially regulated as part of the Malawi's MOH structure in 1995. Between 2004 and 2008 their numbers increased from 4,000 to 11,000 (funded with the assistance of the Global Fund ATM), to reach a ratio of one HSA for every 1,000 people. HSAs are selected centrally and originally were trained for 10-weeks. Rapid scale-up without adequate training capacity occurred, resulting in many new HSAs being trained on the job by NGOs and existing HSAs. A recent field assessment revealed that many HSAs feel overloaded by the many tasks expected of them, which is seen as one of the reasons affecting the quality of their performance (e.g. in the area of immunizations). The very broad range of tasks may over-strain general CHWs, as can be judged from past experiences.

In **Uganda** a wide range of Community Health Workers are found, but none are recognized or regulated by the Ministry of Health of Uganda. In line with the national strategy for community involvement in health, the formation of "Village Health Teams" (VHT) is currently promoted. A VHT is "an embracing group of all former community health worker categories," with a wide variety of tasks such as the treatment of minor ailments, routine immunization, HIV counselling and testing, health education and mobilization, home visits and maintaining community health registers. They provide a link between the community and health care providers. The VHT has a responsibility in selecting, recruiting and supervising the CHWs.

The strategy is still under development with different modalities of implementation in different districts. Some of its successes have been attributed to the integration of pre-existing volunteer cadres, inter-sectoral approach to the monitoring of the teams and community involvement in the selection of its members.

The VHT members do not receive regular allowances, except for transport refunds and participants' allowances during training sessions. They are linked to nearby health facilities and provided with identification badges, t-shirts, bicycles, pay phones and household registers. The

initial training comprises five days, with additional follow-up trainings for various members of the team in different services to be delivered.

A number of case studies looked at Community Health Programmes mostly from the perspective of the formal public health system (their role in e.g. HIV & AIDS, Malaria and TB treatment and control programme). They largely ignored the important aspect of the original CHWs concept: their role as agents of change in the relationship between health services and the population and for community empowerment.

The World Health Report 2008 highlighted some of the key comparative advantages of CHWs as:

- Cultural and relational competence (citizens are not looking for technical competence alone)
- Increasing recognition that the resolution of health problems should take into account the socio-cultural context of the families and communities where they occur
- Health services should be people-centred (“neglecting people’s needs and expectations is a recipe for disconnecting health services from the communities they serve”).

Both the HSAs in Malawi and the HEWs in Ethiopia are recognized cadres by the country’s Governments and officially regulated by the Ministries of Health, as part of more comprehensive community health and primary health care strategies. However, strengthening the capacity of CHWs to provide quality community health services, is only one aspect of Community Health, as was also noted during the MTR.

4. Guiding Principles for the National Community Health Worker Programme

The vision, mission and goal of the Ministry of Health of Zambia are as follows:

Vision:	Equity of access to assured quality, cost-effective and affordable health services as close to the family as possible.
Mission Statement:	To provide cost-effective, quality health services as close to the family as possible in order to ensure equity of access in health service delivery and contribute to the human and socio-economic development of the nation.
Overall Goal:	To further improve health service delivery in order to significantly contribute to the attainment of the health Millennium Development Goals and national health priorities.

The aim of the first national Human Resources for Health Strategic Plan (HRHSP I) is:

“To ensure an adequate and equitable distribution of appropriately skilled and motivated health workers providing quality services”.

The HRHSP I focuses on professional health workers and strategies to address their management and development; CHWs were not formally included in this plan. The renewed national interest in CHWs requires a solid national strategy to guide and coordinate

interventions, to ensure that their full potential is recognised, and to facilitate their contribution to improved health service delivery and access.

The NCHWP Strategy is formulated in line with the vision of MOH and the aim of the HRHSP I. The goal of the NCHWP Strategy is:

"To have an adequately trained and motivated community-based health workforce, contributing towards improved service delivery, the attainment of the Millennium Development Goals, the National Health Priorities, and towards reduction of the HRH crisis"

The objective of the NCHWP is:

"A cost-effective, adequately trained and motivated community-based health workforce that will contribute to improved management of malaria, child and maternal health and common preventable health conditions".

Guiding Principles

Tackling root causes rather than symptoms:

Many of the current human resources challenges, including the shortages, are long-standing and require long-term strategies. There is widespread agreement on the potential of CHWs to improve access to and coverage of communities with basic health services and, consequently, health outcomes. CHWs are one important component of the provision of health services in Zambia. Simultaneous efforts are being made to reduce the staffing shortage in other essential cadres, including doctors, medical licentiates, clinical officers, nurses, and midwives, as their specialized expertise is essential to providing high quality services to Zambians.

Evidence-based Action:

The NCHWP was created based on the findings of a national Situation Analysis and the experience of other African countries that have incorporated CHWs into their health systems. However, it is essential to understand the effects of the NCHWP on the provision of health services in Zambia and on the health of the communities served. Therefore, the Pilot Phase of the programme will entail epidemiologically rigorous assessments to determine whether CHWs carry out their tasks adequately and as envisioned by this strategy (monitoring), whether the health system provided appropriate support (process evaluation), and the effect of CHW activities on health outcomes in their communities (impact evaluation).

Sustainability:

The Ministry of Health's goal is to integrate the NCHWP into the existing health system especially if proven to be a cost-effective strategy to bring health services closer to Zambian families.

Institutional Learning:

The Ministry of Health is committed to institutional learning, gleaning lessons learnt throughout the launch of the NCHWP to strengthen institutional processes and systems.

Integrated approaches to human resource management:

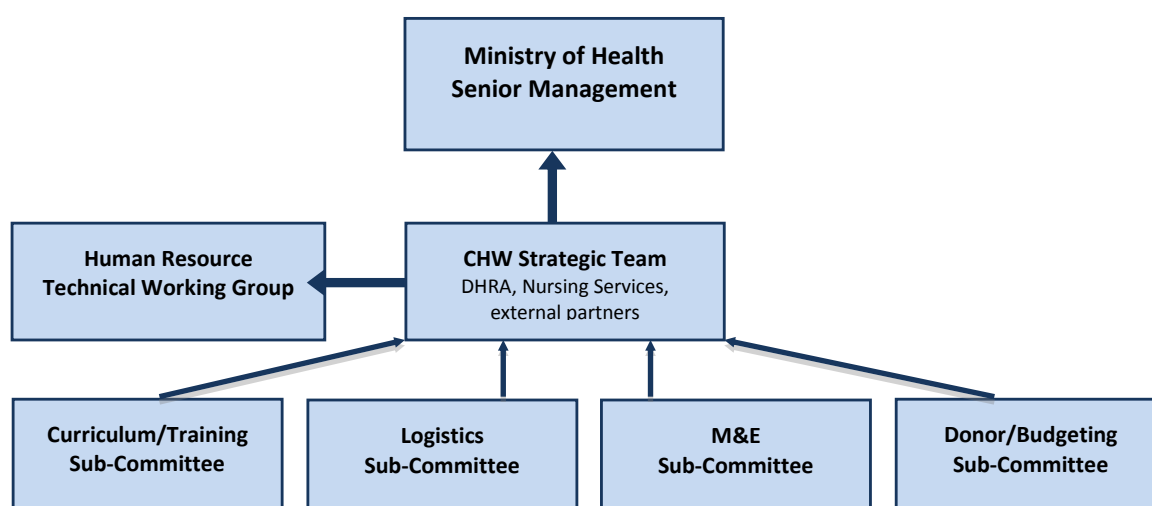
The work of CHWs should complement that of the existing health professionals. The investment

in training of CHWs should add value to the current healthcare service delivery levels, in accordance with the MOH strategic plan.

5. Strategies for the National Community Health Worker Programme

The conceptualization and planning of the NCHWP has involved over 50 national and international stakeholders, and is the product of collaboration across Directorates within Ministry of Health. (See Table 4) The primary responsibility for planning the NCHWP was given to the CHW Strategic Team, comprised of MOH representatives from several Directorates, with input from a few committed external partners. The CHW Strategic Team has been tasked with keeping the Human Resource Technical Working Group and Senior Management up-to-date on progress made, and with obtaining the necessary authorizations throughout the planning process.

Table 4: Planning Structure for the NCHWP



In order to inform the planning for this national strategy, the CHW Strategic Team created four separate sub-committees to manage specific tasks:

Sub-Committee 1: Curriculum/training

Sub-Committee 2: Logistics

Sub-Committee 3: Monitoring and evaluation (M&E)

Sub-Committee 4: Donor & budget coordination

Stakeholders from GRZ, cooperating partners, and implementing partners were invited to engage in planning and to provide feedback as the strategy coalesced. Members of sub-committees provided technical input to their respective components of the project and are responsible for validating the implementation plan and products, including the training curriculum, supervisors' manual, monitoring & evaluation and financial support plans. Each sub-committee is chaired by an MOH representative, who is responsible for updating the CHW Strategic Team on progress made and recommendations given for the national programme. Hence, the creation of this

strategy has been a collaborative, consensus-driven process involving all key stakeholders and role-players.

The National CHW Programme (NCHWP) will be rolled out in a total of four phases, commencing with a pilot programme, which will inform decision-making vis-à-vis the national scale up. The pilot programme will provide essential information both on the health impact of CHWs in their communities and on the functioning of processes required to carry out the strategies articulated in this document. The roll out plan is illustrated in Table 5.

Table 5: Roll-Out Plan for the National CHW Programme

Phase	Number of Training Intakes per year	Number of Participating Provinces	Number of CHWs Trained and Deployed	Cumulative Number of CHWs
Pilot	1	7	318	318
Phase I: National Launch	2	9	1,224	1,542
Phase II	2	9	1,224	2,776
Phase III	2	9	1,224	3,990
Phase IV	2	9	1,224	5,214

Training of CHWs will last for one year, and will include theoretical and practical training. The pilot will last for two-and-a-half years, with the first year dedicated to training and a baseline assessment, and having CHWs deployed to the field and practicing within their communities during the second year and a half.

Monitoring and evaluation activities will take place throughout the pilot, and the formal follow-up evaluation to assess impact will be implemented after the first year of deployment. It is estimated that the evaluation and refinement of the implementation plan will require six to nine months, and it will take three to six months to plan and prepare for the National Launch. Subsequently, each phase shall commence its training during the year in which the previous phase commences its deployment to the field. Hence, after the National Launch, a new phase will begin each year, through to the launch of Phase IV. By the end of the NCHWP, Zambia anticipates having a cadre of over 5,000 trained CHWs providing preventive, promotive, and curative healthcare services in rural areas.

The NCHWP will be piloted in seven provinces and 48 districts. The provinces include the following:

- Central (4 districts)
- Eastern (5 districts)
- Luapula (7 districts)
- Northern (10 districts)
- North-western (7 districts)
- Southern (8 districts)
- Western (7 districts)

Table 6 lists the participating provinces and districts. These districts were identified as high-priority by the Provincial Medical Officers, based on staffing, health issues, and access to service

delivery. Furthermore, districts are required to have sufficient access to trained clinical staff at the “parent health centre”, which is charged with supervising the CHWs.

The cost of the Pilot Phase can be found in Annex II. Estimates for the costs of the full strategy will be made during the refinement of the implementation plan, based on input from the evaluation of the Pilot regarding CHW recruitment, training, deployment, and supervisory processes.

Table 6: Provinces and Districts Participating in the NCHWP Pilot

Provinces	Districts						
Central	Mumbwa	Mkushi	Serenje	Kapiri-Mposhi			
Eastern	Chadiza	Chama	Lundazi	Mambwe	Nyimba		
Luapula	Chiengi	Kawambwa	Mansa	Milenge	Mwense	Nchelenge	Samfya
Northern	Chinsali	Kaputa	Mbala	Mporokoso	Luwingu	Chilubi	Isoka
	Mungwi	Nakonde	Mpulungu				
North-western	Chavuma	Kabompo	Kasempa	Mufumbwe	Solwezi	Mwinilunga	Zambezi
Southern	Gwembe	Itezhi tezhi	Kalomo	Kazungula	Namwala	Siavonga	Monze
	Sinazongwe						
Western	Kalabo	Kaoma	Lukulu	Mongu	Senanga	Shang’ombo	Sesheke

The CHW Strategic Team and sub-committees will continue to convene during the roll-out of this strategy in order to provide guidance and to help address any challenges that may arise.

5.1 Incorporating CHWs into the Community and the Health System

5.1.1 Community-Level Health

The NCHWP will contract CHWs to bring basic health services closer to the family, in line with Ministry of Health’s mission statement; they will function as a link between the community and the health care system. Based on feedback from the Situation Analysis and lessons learnt from other programmes in Africa, CHWs will be selected by and embedded in their communities and incorporated into the formal health system. It is anticipated that CHWs will spend 20% of their time at a health post and 80% of their time in the field; they will be supervised directly by the trained Staff In-Charge at the nearest health centre as indicated by the DMOs.

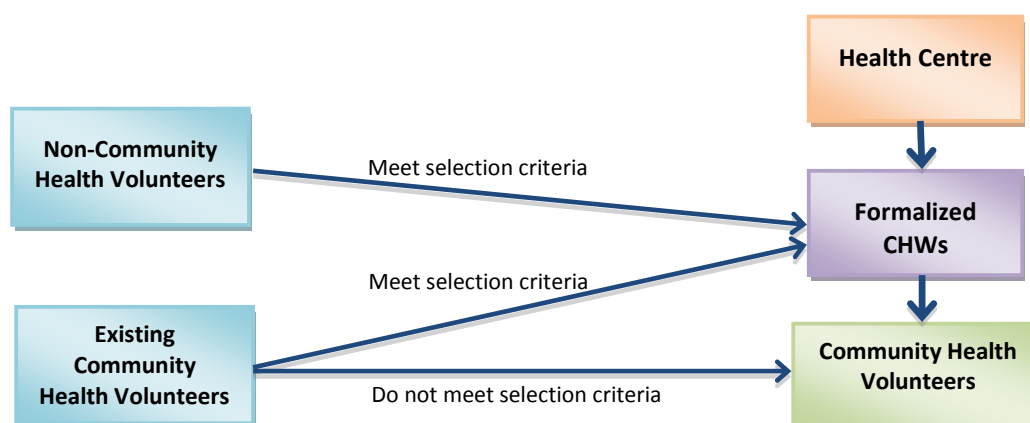
Table 7 demonstrates the variety of stakeholders who will participate in NCHWP processes (to be described in greater detail in subsequent sections).

Table 7: Health Sector and Community Stakeholders have an Active Role in NCHWP Processes

Recruitment	Training	Field Work	Referrals	Supervision
<ul style="list-style-type: none"> •Neighbourhood Health Committees •District Medical Officers •Health Centre •Traditional Leaders 	<ul style="list-style-type: none"> •Curriculum developed with input from: •General Nursing Council •Ministry of Health •HPCZ •Chainama College •Dental School •Zuno •UNZA, School of Medicine •Lusaka School of Nursing •External partners •Situation Analysis (DMOs, CHWs, NGOs) 	<ul style="list-style-type: none"> •Community •NHC •Traditional Leaders •Health Centre / Health Post •Schools •Church leaders •Councilors •Health professionals •NGOs/CBOs/FBOs •Other community groups 	<ul style="list-style-type: none"> •Health center •Hospital •Health professionals 	<ul style="list-style-type: none"> •Health centre (Staff In-Charge serves as primary supervisor) •DMOs/PMOs •Feedback from the community: NHCs, Traditional Leaders, etc.)

Important note: It should be noted that there are a large number of community health volunteers currently active in Zambia. These volunteers are not a formalized cadre, and many have received two-to-five weeks of training from implementing partners in a specific health area. CHWs are not intended to replace the existing network of community health volunteers; rather, they are meant to supplement and enhance the efforts of these volunteers. It is anticipated that many of the current volunteers who meet the selection criteria (see section 5.2) will be absorbed into the formalized cadre, and that this formalized cadre can help to provide supervision and support to community health volunteers. The community health structure can be observed in Table 8.

Table 8: Community Health Structure



5.1.2 The Role of CHWs

CHWs will be accountable to the health system and to their communities, and they will be supported by the Neighbourhood Health Committees. Their primary functions are to engage in promotive and preventive health that are initiated and accepted by the local community.

The CHWs role encompasses the following:

1. Community empowerment, including
 - a. Identifying health-related problems including disease outbreaks
 - b. Prioritizing community health problems
 - c. Determining strategies for solving problems, including mobilization of resources at local and national levels
 - d. Implementing strategies with the participation of the community
 - e. Mobilizing the community for local health activities, including National Immunization Day, World AIDS Day, and other commemorations.
2. Serving as a liaison between health facility staff and the community.
3. Implementation of promotive and preventive health activities.
4. Provision of basic curative services and identification of referral cases for further management at the health centre or hospital.
5. Distribution of supplies, including condoms and contraceptives.
6. Provision of follow-up care including home visits for patients with chronic conditions such as TB and AIDS, pregnant and post-natal mothers, and defaulter tracing for malnourished children, immunizations, and TB patients.
7. Liaising and networking with other community-based agents (mentioned in Table 7).
8. Collaboration with the community and the health facility in implementing health care activities.
9. Maintain records, including the following:
 - a. Community register for catchment area, reflecting population by sex and age group, births and deaths
 - b. Client register for common diseases including outbreaks, promotive and preventing interventions, stocks and supplies, referrals, and patients under home care
 - c. Recording data for inclusion in the District Health Information System.

5.1.3 The Role of Community Stakeholders

The role of Traditional Leaders will vary by District and Province. However, overall Traditional Leaders should:

1. Be made aware of the Community Health Worker Strategy and the recruitment process by the District Medical Officers.
2. Have the ability to express their opinion during the process of recruiting CHWs.

3. Ensure that, after deployment, the CHWs are meeting the needs of the community and contributing to positive health outcomes.

CHWs will work in close collaboration with local Neighbourhood Health Committees (NHCs). The NHCs' role includes:

1. Identifying and analyzing problems in the community and to work with the CHW to determine possible solutions
2. In collaboration with the CHW, exploring opportunities for solving problems and developing action plans for the implementation of interventions, including monitoring and evaluation
3. Mobilizing communities, local resources, and advocating for support for the implementation of action plans
4. Supporting Community Based Agents in the implementation of health programmes
5. Initiating and supporting developmental activities to improve household health
6. Representing the community on the Health Centre Committee.

5.1.4 Registration of CHWs by a Regulatory Body

The regulatory framework protecting patients and professional health workers will be applied to CHWs because the cadre will perform basic health care procedures, limited invasive procedures and selected diagnostic procedures. Therefore, it is mandatory that their practice be monitored by a regulatory body.

It is anticipated that CHWs will be registered with the General Nursing Council and the Health Professions Council of Zambia. The regulatory body will address the issues of patient care and safety, the ability of CHWs to perform identified activities, and they will monitor the development and implementation of the training programme. In order to ratify this process, the MOH will pass a Statutory Instrument (SI) for the training and practice of this cadre. This SI will stipulate the entry qualification and the duration and scope of the training.

5.1.5 CHWs in the Health System: Supervision and Referrals

A Provincial CHW Coordinator will be contracted and placed in each Province in order to provide logistical and supervisory support to the NCHWP.

CHWs will be based at a health post in their community for approximately 20% of their time, and they will spend 80% of their time directly in the community. Two (2) CHWs will be assigned to each health post selected for participation in the NCHWP pilot programme.

CHWs will be supervised directly by the Staff In-Charge based at the nearest health centre. The supervisors will be trained for one week and will be equipped with a supervisor's manual and monitoring tools. Supervisors will conduct supervisory visits on a monthly basis, will fill out assessment forms and provide feedback to the CHW regarding his/her performance, and will ensure the supervisory forms are submitted to the Provincial CHW Coordinator.

CHW supervisors will be responsible for:

- Identifying challenges and solutions for CHWs in implementing their community activities
- Assisting CHWs in identifying, prioritizing and solving health issues in their communities
- Identifying weakness in the provision of CHW services, as well as and factors influencing performance. Supervisors should provide reinforcement of relevant training topics during review meetings
- Ensuring the collation of relevant data for the DHIS
- Providing mentorship to the CHWs
- Completing CHW performance evaluation reviews.

The Provincial CHW Coordinator will submit supervisory data to the central authority for Monitoring and Evaluation purposes.

The CHW will refer all cases that require procedures outside of the approved Scope of Work (see section 5.4) to the nearest health centre or hospital, depending on the gravity of the case. It is expected that CHWs will strengthen the national referral network, and it is essential that CHWs refrain from conducting procedures that are beyond their proficiency as outlined by their training and approved Scope of Work.

5.1.6 Ethical and Legal Issues

CHWs will be trained in ethical and legal issues.

Pertinent ethical issues include, but are not limited to:

- Privacy of client information: not to be discussed with anyone with the exception of health care professionals at the health centre or hospital
- Distribution of medications: to be provided to the patient only, never to intermediaries, with the exception of custodians if the patient is under the age of consent
- Corruption: CHWs should never ask clients for money or gifts
- Disclosure: CHWs should not hide information about patients' health from health professionals at the health centre or hospital
- Authority: CHWs should never abuse authority.

Legal issues in community health work include, but are not limited to:

- Criminalisation of deliberate infection: for example, it is illegal to knowingly use unsterile equipment in a procedure and to knowingly distribute damaged condoms
- The right to refuse medical care: clients have a right to refuse care and/or medications if they believe it is not in their best interest
- Research on human subjects: all research on human subjects requires the authorisation of the appointed research ethics authority, and patients have the right to informed consent

- Abortion: it is illegal for a CHW to conduct an abortion.
- End-of-life decision-making: it is illegal to use drugs or any other means to assist a patient in ending his or her life.

CHWs should conduct themselves with proper etiquette and ethics within the bounds of the law at all times. If a CHW conducts him- or herself in a contrary manner, he or she will be held liable and subjected to disciplinary action by the local health facility authority and the Provincial CHW Coordinator and the case will be referred to the District Medical Officer as well as to the Provincial Medical Officer, with oversight by MOH Headquarters.

5.1.7 Strengthening Professional Health Cadres in the Public Sector

The NCHWP aims to provide a career path for talented CHWs who take initiative and who work both effectively and efficiently in their jobs. Those who graduate from the CHW Training Programme and after working in their positions for a period of at least three years, may apply to be selected for additional education in nursing, environmental health or clinical officer programmes.

5.2 Recruitment for the NCHWP

Establishing selection criteria is essential to ensure a high quality level of service by CHWs across the country. At the same time, it is important to allow community involvement in the selection of CHWs. Active participation of communities in the selection of CHWs ensures that cultural, relational, and socio-economic factors are appropriately accounted for in the health provider to patient relationship.

CHWs will be recruited from the existing corps of community health volunteers, and from local community members.

The following are the criteria for the selection of CHWs:

- Minimum Grade 12 and 2 "O" levels
- 18 to 45 years old
- Zambian citizen
- Living in the catchment area
- Endorsed by their Neighbourhood Health Committee
- Must pass personal interview with a panel composed of the NHC, health centre staff, and a member of the DMO

Preference will be given to women and those previously or currently working as volunteers in the community, provided that they meet the abovementioned criteria.

The recruitment process involves the community (NHC) and the health system at local (health centre), district, and provincial levels, and is aimed at selecting qualified CHWs who will be accepted by their communities.

The process for recruitment is as follows:

1. The open CHW positions will be advertised in the catchment area in strategic locations (e.g. health centre and nearby schools) with the minimum qualifications detailed
2. Application forms for CHW candidates will be made available at the “parent” health centre charged with supervising the position
3. Applicants submit their applications to the Staff In-Charge at the health centre together with the following:
 - a. Recommendation from the NHC (to be verified by health centre staff)
 - b. Grade 12 with 2 “O” level documentation
 - c. Copy of National Registration Card
4. After the application deadline, the DMO will collect all applications from the health centre, and create a DMO Selection Review Panel, preferably comprising the Nursing Officer, Environmental Health Technologist and the District Human Resource Officer. The review panel will create a short-list of applicants which qualify to be interviewed.
5. The DMO Selection Review Panel will then forward the short-list to the health centre. The health centre will inform the short-listed applicants and schedule the panel interviews at health centre level.
6. Interviews of CHW candidates will be carried out by an Interview Panel comprising:
 - a. Three members of the NHC: one of whom will serve as the Chair on the Interview Panel
 - b. One member of the DMO who will serve as the Secretariat, disseminating and collecting the appropriate forms (standardised ranking sheets, interview questions, etc.).
 - c. One staff member from the health centre
7. The Interview Panel will confirm the top two CHW candidates and two alternatives. The Chair of the Interview Panel will lead the discussion until consensus is reached regarding the top two candidates.
8. The DMO Selection Review Panel will submit all ranking sheets and application forms to the PMO under cover of a letter signed by all members of the Interview Panel.
9. The PMO will then generate and sign decision letters (using the approved MOH templates) and dispatch them to the health centre for delivery to the CHW candidates.

5.3 Training of CHWs in the NCHWP

CHWs will be trained for a period of twelve (12) months in total. The programme will comprise theoretical training as well as practical experience at selected health facilities and communities under the supervision of CHW Tutors at the training schools and selected MOH staff members at health facilities.

5.3.1 Curriculum

The CHW curriculum was created in a collaborative, consensus-driven process during a 10-day workshop (and later, a 5-day refinement workshop) that involved 25 experts in Zambia from the following institutions:

- MOH
- GNC
- HPCZ
- Chainama College of Health Sciences
- Dental School
- ZUNO
- UNZA - School of Medicine
- Lusaka School of Nursing

The workshop resulted in the following products to be used for the NCHWP:

- Curriculum for the Community Health Worker
- Teaching and learning materials for the curriculum
- Facilitator's Manual to guide CHW tutors
- CHW Handbook
- Draft of the CHW Supervisor's Manual
- Draft of the Supervisor's Monitoring and Evaluation Tools

The deliverables from the workshop were presented to MOH Senior Management Team, the Human Resources and the Training Sub-committee for feedback and approval.

The curriculum was developed in conjunction with the approved Scope of Work (see section 5.4) to ensure that CHWs have the knowledge and skills to carry out their responsibilities. The curriculum courses are in modular format. Each module includes recommended teaching methods and assessment, continuous and final exam and contact hours for each course.

The curriculum is comprised of 11 modules:

Module 1: The Health Care System in Zambia

- Organization and functions of the Health Care System in Zambia
- Roles and responsibilities of the CHW
- Code of Conduct for the CHW
- Gender and Health
- Community mobilization and networking

Module 2: Behavioural Sciences

- Introduction to Psychology
- Mental Health and common Psychiatric conditions
- Introduction to Sociology
- Family and community

Module 3: Health Promotion and Counseling

- Health promotion

Module 4: Environmental Health and Infection Prevention

- General principles of infection prevention
- Water supply
- Excreta disposal
- Solid waste
- Food hygiene and safety
- Housing and health
- Control of insects and rodents

Module 5: Disease Prevention, Control and Primary Health Care

- Introduction to Disease Prevention and Control
- Infectious Diseases Epidemiology
- Sources of Data and Methods of Data Collection
- Epidemic Investigation and Management
- Epidemiological Surveillance
- Primary Health Care

Module 6: Introduction to Reproductive and Child Health

- Introduction to child health
- Introduction to reproductive health
- School health services

Module 7: Introduction to the Human Body

- Introduction to the Human Body
- Musculoskeletal System
- Cardiovascular System
- Respiratory System
- Digestive System
- Urinary System
- Special Senses

Module 8: Basic Procedures

- Provision of a safe and therapeutic environment for the client in the Health Post and community
- Reception and needs of the client
- Wound care
- Palliative care

Module 9: Common Medical Conditions

- Common medical conditions including: Malaria, Diarrhoea, Anemia, HIV and AIDS, STIs, TB, Respiratory Infections, Malnutrition, skin problems, worm infestations, Hypertension, Diabetes Mellitus and eye diseases
- Oral Health and hygiene

Module 10: Diagnostic Procedures

- Safety
- Malaria Rapid Diagnostic Tests
- HIV: Dry Blood Spots
- Sputum Collection for TB Diagnosis

Module 11: First Aid and Common Surgical Conditions

- Aims and principles of First Aid
- Principles and practice of bandaging
- Methods of lifting and transportation of patients
- Handling of selected emergencies

5.3.2 Training Sites

CHWs will be trained at existing MOH training institutions. However, it is essential that the training of the new CHW cadre not infringe upon the capacity of the institution to train other cadres. As of October 2010, the CHW Strategic Team has assessed 24 potential training sites to determine which ones are best suited to hosting new classes of CHWs and to identify the modifications that must be made to ensure the capacity exists to host the new students. Capacity will be increased as necessary through construction to bolster the institution's infrastructure and ability to provide lodging to the students. The final decision regarding the participating institutions will be made by the MOH Senior Management Team.

5.3.3 CHW Tutors

CHW tutors must possess the following qualifications:

- BSC in Nursing, Science or other related clinical field
- 3 to 5 years teaching experience

The following were recommended advantages:

- Knowledge of community health
- Willing to work in rural areas.

5.4 Scope of Work

The CHW Scope of Work can be categorized into three major areas: preventive, promotive and curative activities. It is anticipated that CHWs will spend most of their time dedicated to disease prevention and health promotion.

The Scope of Work was created to allow CHWs to fill gaps in the delivery of basic health services at the community level in rural areas. Therefore, the NCHWP aims to bring health services closer to the family, in line with the Ministry of Health's mission statement. The Scope of Work was also developed to reflect the skills and knowledge expected of graduates from the one-year training programme.

The approved Scope of Work for CHWs is as follows:

- Promotive activities
 - Health Promotion activities such as IEC and health advocacy within the community
 - Reproductive and Maternal/Child Health programmes such as Immunizations, Growth Monitoring, Family Planning, Nutrition, Antenatal and Postnatal care
 - School Health Programmes such as Health Promotion, Screening, Nutrition, and Mass Drug Administration
- Preventive activities
 - Carrying Environmental Health Programmes in schools
 - Screening Programmes

- Curative activities
 - History taking, recognition of vital signs, managing fevers, general pain relief, administration of specified drugs to patients, wound care
 - First aid and common surgical conditions
 - Treatment of common medical problems such as Malaria, Diarrhea, Respiratory Infections
 - Simple diagnostic procedures: collection of sputum for TB, staining of slides for Malaria
 - Facilitate referrals to the health centre or health facility
- Community empowerment
 - Community mobilization for involvement in local health
 - Problem identification that involves identifying disease outbreaks e.g. Measles, Cholera, Malaria, Scabies and several other illnesses.
- Distribution of supplies such as condoms and contraceptives
- Provision of lay counseling services
- Maintenance of basic records/registers for clients and activities
- Recording and collation of data for the District Health Information System (DHIS)

5.5 Remuneration

During the Pilot Phase, CHWs who successfully complete the training will be given an incentive of approximately K500,000.00 per month once they are deployed to the field. They will be appointed on contract and will not be on the Civil Service payroll.

The evaluation of the Pilot Phase will assess whether CHWs are a cost-effective means of providing basic health services at the community level. If the evaluation finds that CHWs are a worthwhile investment, the Ministry of Health will enter consultations with the Ministry of Finance and National Planning to commence the process of adding Community Health Workers as a cadre onto the Funded Establishment for the Ministry of Health as formal Civil Service employees.

6. Monitoring & Evaluation of the NCHWP

Monitoring and Evaluation (M&E) of the National CHW Programme Strategy will be essential to inform decision-making vis-à-vis the national scale-up after the Pilot Phase. The M&E Sub-committee is chaired by the Chief Monitoring & Evaluation Specialist, and will validate all data collection instruments. Consequently, it is anticipated that Monitoring and Evaluation of the NCHWP will utilize indicators and instruments that are complementary to national Monitoring and Evaluation activities and in line with national priorities. All data collected by the CHWs will feed into the District Health Information System for inclusion in the National Health Information System.

Rigorous assessments will be carried out to determine:

1. What is the actual contribution of CHWs to the management of primary healthcare in the community?

2. Is the CHW programme the best and most cost-effective way of achieving positive community health outcomes in the short- and medium term?

In order to answer these questions, a Monitoring & Evaluation (M&E) Plan will be developed for the Pilot Phase. It is expected that the plan will help to inform M&E activities for the following phases of the NCHWP as well. The M&E Plan for the Pilot programme will be comprised of four parts, outlined below.

Components of the NCHWP Pilot M&E Plan

- **Impact Evaluation**

To assess the effect of CHWs on the health of the communities they serve, and whether they represent value for the resources invested to recruit, train, and deploy them.

- **Process Evaluation**

To assess structural issues that affect CHW performance: did the recruitment, training and management systems function correctly?

- **Monitoring**

To assess whether CHWs carried out their tasks adequately and effectively. Supervisory visits will serve as part of the monitoring activities for the Pilot.

- **Community-Level HMIS**

Data collected by CHWs on the activities they carry out with patients will feed directly into the community Health Management Information System (HMIS) through the District Health Information System

Impact Evaluation

A rigorous impact evaluation will be carried out by an academic institution and will entail a baseline and follow-up survey of catchment areas included in the Pilot programme and of comparable control areas to allow for meaningful analysis of differences observed. The evaluation may examine the impact of CHWs on a health outcome, such as all-cause mortality of children under five, or of important health outputs such as antenatal visits, detection and treatment of TB cases, and/or the use of bed nets. The exact study design must be feasible given the timeframe of field work of the CHWs in the Pilot programme and remain within the resources envelope available.

The Ministry of Health's M&E Sub-committee will review the academic institution's evaluation plan and make recommendations regarding the final outcomes to be measured, and final approval will be granted by MOH Senior Management.

Process Evaluation

The process evaluation will provide an important context for the findings of the impact evaluation, as the success of CHW performance can be greatly affected by the functioning of the management and supervisory structures. The process evaluation will likely examine a range of structural issues which will include the following important issues:

- CHW attrition rates (during training and in the field)
- The recruitment process
- The supervisory structure (whether supervisory visits took place monthly; if not, identify the obstacles)
- Community acceptance of CHWs
- Use of the referral system, amongst other process-related factors incorporated in this strategy.

Monitoring

Monitoring of the quality of CHW services will take place through the NCHWP supervisory structure.

CHWs will be supervised directly by the Staff In-Charge based at the nearest health centre approved by MOH, and which will be known as the “parent” health centre. The supervisors will be trained for one week and will be equipped with a supervisor’s manual and monitoring tools. Supervisors will conduct supervisory visits on a monthly basis, will fill out assessment forms and provide feedback to the CHW regarding his or her performance, and will ensure that the supervisory forms are submitted to the Provincial CHW Coordinator each month.

CHW supervisors will be responsible for:

- Identifying challenges and solutions for CHWs in implementing their community activities
- Assisting CHWs in identifying, prioritizing and solving health issues in their communities
- Identifying weaknesses in the provision of CHW services, as well as factors influencing performance. Supervisors should provide reinforcement of relevant training topics during review meetings with CHWs
- Providing mentorship and guidance to the CHWs
- Completing CHW performance evaluation reviews
- Ensuring that the health data has been recorded accurately and can be included in the District Health Information System.

The supervisors’ assessment forms and performance evaluation reviews will serve as data collection tools for the monitoring of the Pilot programme. The Provincial CHW Coordinator will submit these forms to the central authority for analysis.

Community-Level HMIS

CHWs will be provided with forms to keep records of their activities with patients and in the community. This data will feed directly into the community Health Management Information System (HMIS) and will allow for monitoring of health outcomes of the patients served in the long term.

ANNEX I - Editorial Team

Mr. J. Mwila	Director- Human Resources & Administration
Dr. V. Mukonka	Director – Public Health and Research
Dr. E. Chizema	Director Technical Support Services
Dr. M. Libetwa	Deputy Director – Nursing Services
Mr. F. Nyirenda (EOH)	Deputy Director – Public Health and Research
Dr. B. TambaTamba(EDC)	Deputy Director – Public Health and Research
Dr. R. Mbewe(RHC)	Deputy Director – Public Health and Research
Dr. P. Kaleshe-Masumbu	Child Health Specialist
Mr. H. Kansembe	Chief Planner
Mrs. K. Mulalelo	Chief Planner (I)
Mrs. P. Chanda	Principal Research and Surveillance Officer
Mrs. B. Mwape	Health Promotions Officer
Mr. G. Sikazwe	Health Promotion Specialist
Mrs. M. Musonda	Actg Assis. Director: Human Resources Management
Mr. Busiku	National Malaria Council Centre

ANNEX II – Cost of the NCHWP Pilot Phase (in US Dollars)

Activity	Year 1 12 Months	Year 2 12 Months	Year 3 6 Months	Budget Total
Programmatic				
Over 300 CHWs trained and placed back in their communities				
<i>Recruit and Train CHWs</i>				
Training materials / text book procurement	65,833	0	0	65,833
Training of CHW Tutors	4,805	-	-	4,805
Student lodging, transport, meals, site refurbishment	1,120,613	138,916	-	1,259,529
Tutor accommodation and salary costs	465,752	77,143	-	542,895
Training program pre-assessment	12,067	-	-	12,067
<i>Finalize and Launch the CHW Pilot</i>				
Meetings, dissemination of information nationally	6,316	180	90	6,586
Advert and salary for CHW MoH Coordinator	10,929	11,267	5,634	27,830
<i>Successfully Deploy CHWs into the Community</i>				
CHW salaries and administrative fees	-	303,089	181,854	484,943
Medical kits, bicycles, and communications	-	218,128	55,041	273,169
<i>Create a Comprehensive Supervisory System</i>				
Recruitment and salaries for Provincial CHW Coordinators	1,703	103,912	53,520	159,135
Office and logistical operational costs for Provincial CHW Coordinators	31,232	52,277	19,082	102,591
Supervisor tool finalization and training	84,992	-	-	
Supervisor transport	-	16,838	8,419	25,257
Subtotal Programmatic	1,804,242	921,750	323,640	3,049,632
Evidenced-based assessments of CHW contributions				
Develop Monitoring & Evaluation Tools and Data Systems	6,011	-	-	6,011
Conduct Baseline Assessment	302,992	-	-	302,992
Conduct Mid-term Assessment	-	377,090	-	377,090
Conduct End-line Evaluation	-	-	356,055	356,055
Conduct peer review	-	17,500	-	17,500
Subtotal Assessments	309,003	394,590	356,055	1,059,647
Costed and sustainable scale-up plan and initial preparations for National CHW launch				
Create a CHW Scale-up and Sustainability Plan	-	-	-	-
Incorporation of CHW Cadre into the System	-	-	9,963	9,963
Refine the M&E System, Incorporate into HMIS	-	-	5,145	5,145
Subtotal Scale-Up Plan and Preparations	-	-	15,108	15,108
Program Implementation In-Country	230,979	191,539	95,462	517,980
Programmatic Total	2,344,224	1,507,879	790,264	4,642,367
Overhead	132,432	61,652	26,793	220,877
Overall Total CHW Pilot Phase	2,476,656	1,569,531	817,057	4,863,243

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