WEBINAR:
Getting more bang for the buck from community-based health workers in the HIV response:
Insights from field studies

Thursday, October 12, 2017
8:00–9:30am EDT/12:00–1:30pm GMT
Welcome and Context:
Community-based Health Workers in the HIV Response

Diana Frymus, MPH
moderator

Health Workforce Branch Chief
USAID Bureau for Global Health | Office of HIV/AIDS
Context for this webinar

- PEPFAR funded several studies over the life of the USAID ASSIST Project to advance the evidence base for improving performance and productivity of the community-based health workforce (CHWs).

- As roles for CHWs grow with the roll-out of Test and Start and Differentiated Care, improving performance and productivity of this critical workforce more critical than ever.

- This webinar shares findings from CHW research in Uganda and Swaziland and a four-country Southern Africa case study and discusses how findings can be utilized to advance CHW programming for HIV.
Questions for speakers

• Participants should use the chat function to post questions for any of the speakers, by directing the message to “All Panelists”

• Questions may also be emailed to Kim Rogers at krogers@usaid.gov

• Responses to questions not addressed during the webinar will be posted on the event page for this webinar on the USAID ASSIST website
Productivity and Performance Among VHTs in Uganda

Sarah Smith Lunsford, PhD, MPH
USAID ASSIST Project, EnCompass LLC
Rationale for this study

Gap in literature on CHW productivity and relationship to performance

Critical to advance understanding as roles of CHWs expand for HIV (e.g., Test and Start, differentiated care)

Performance: how well tasks are done
Productivity: how much is done

USAID Applying Science to Strengthen and Improve Systems
Village Health Teams (VHTs) in Uganda

Responsible for 30 households

Seven tasks (2013):

1) *Record*: data collection
2) *Save lives*: provide health services and referrals
3) *Mobilize*: mobilize village members and health workers for health activities
4) *Support*: assist in the care of PLHIV
5) *Model*: practice model behavior
6) *Link*: improve linkages between health care and catchment population
7) *Visit*: visit household and communities
VHTs in Uganda (current situation)

• VHTs can help move toward community-based patient-centered HIV health services

• Over 179,000 VHTs trained since 2001 BUT an estimated 30% have left their position; 60% received basic training

• VHTs operating in all 112 districts of Uganda

• Insufficient supplies and transportation may impact productivity
Study objectives

• Describe VHT productivity and performance in Busia District in Eastern Uganda

• Explore relationships between VHT productivity and performance

• Investigate independent factors that influence VHT productivity and performance to inform strategies to increase CHW effectiveness
Methods

Cross-sectional (data collected March-May 2013):

1) *Record*: data collection
2) *Save lives*: provide health services and referrals
3) *Mobilize*: mobilize village members and health workers for health activities
4) *Support*: assist in the care of PLHIV
5) *Model*: practice model behavior
6) *Link*: improve linkages between health care and catchment population
7) *Visit*: visit household and communities
# Methods: Observation

<table>
<thead>
<tr>
<th>Service</th>
<th>Productivity</th>
<th>Performance</th>
</tr>
</thead>
</table>
| Visiting village members | Number of home visits  
Duration of home visit | Quality of home visit                                                        |
| Helping save lives     | Assessing danger signs in children and pregnant mothers                      | % agreement between VHT and gold standard assessments                        |
| Measures               | Composite Services Index (CSI)                                               | Standardized score                                                          |
Methods: Record review and survey

- VHT Record Review (maps, registers, monthly summary forms)
- VHT and Supervisor Surveys (individual characteristics)
## Findings: Productivity

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean (SD)</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td># home visits in last 90 days</td>
<td>10.2 (13.7)</td>
<td>6</td>
<td>1-90</td>
</tr>
<tr>
<td>Time taken to complete home visit (hours)</td>
<td>0.7 (0.4)</td>
<td>0.6</td>
<td>0.2-2.8</td>
</tr>
<tr>
<td># children evaluated in last 90 days</td>
<td>4.2 (5.5)</td>
<td>3</td>
<td>0-41</td>
</tr>
<tr>
<td>Time taken to evaluate 1 child (hours)</td>
<td>0.8 (0.4)</td>
<td>0.7</td>
<td>0.2-3.2</td>
</tr>
<tr>
<td># mothers evaluated in last 90 days</td>
<td>3.8</td>
<td>3</td>
<td>0-30</td>
</tr>
<tr>
<td>Time taken to evaluate 1 mother (hours)</td>
<td>0.8 (0.4)</td>
<td>0.7</td>
<td>0.2-2.0</td>
</tr>
<tr>
<td><strong>Productivity Score (CSI)</strong></td>
<td><strong>20.8 (20.6)</strong></td>
<td><strong>13.2</strong></td>
<td><strong>2-114.9</strong></td>
</tr>
</tbody>
</table>
# Findings: Performance

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean (SD)</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>% home visit performance measures completed</td>
<td>90 (19)</td>
<td>100</td>
<td>20-100</td>
</tr>
<tr>
<td>% agreement between VHT and gold standard – child danger signs</td>
<td>95 (10)</td>
<td>100</td>
<td>56-100</td>
</tr>
<tr>
<td>% agreement between VHT and gold standard – pregnant woman danger signs</td>
<td>89 (16)</td>
<td>100</td>
<td>14-100</td>
</tr>
<tr>
<td>Performance Score (scale 0-100)</td>
<td>91 (11)</td>
<td>96.4</td>
<td>50.9-100</td>
</tr>
</tbody>
</table>
Findings: Covariates associated with productivity and performance ($p<0.05$)

- **Productivity**
  - Older VHT age (50 yrs)
  - Knowledge of danger signs

- **Performance**
  - Job satisfaction
  - Knowledge of danger signs
Implications

• **No evidence that:**
  – performance was being sacrificed for increased productivity or vice versa
  – improvements in one would contribute to improvements in the other
  – there were specific characteristics that may be targeted to improve both

• **Programs should intentionally plan to address both performance and productivity**
Implications for improving VHT effectiveness

• Improving Productivity
  – Explore reasons behind huge variability in number of home visits conducted by VHTs and variability in duration of home visits
  – Identify productivity benchmarks

• Improving Performance
  – Build competencies across critical tasks
  – Tailor interventions to increase VHT job satisfaction
Implications for HIV services delivered by VHTs

- Balance productivity and performance on time-intensive tasks (e.g., ART adherence)
- Increase attention on monitoring workload
- Ensure HIV competency for improved performance
- Age; efforts to retain older VHTs may impact productivity
- Further research needed as Uganda moves from volunteers to paid CHWs (CHEW Strategy)
Recommendations for monitoring CHW performance and productivity for HIV

• Continual monitoring of CHW performance and productivity as CHWs take on new roles with roll-out of Test and Start and Differentiated Care Models

• Couple quantitative methods with qualitative exploration of what influences CHW effectiveness and efficiency in delivering HIV services to the community
Questions for Sarah Lunsford

• Participants should use the chat function to post questions for Sarah Lunsford on the Uganda VHT study findings

• Questions may also be emailed to Kim Rogers at krogers@usaid.gov

• Responses to questions not addressed during the webinar will be posted on the USAID ASSIST website on the event page for this webinar
Comments from USAID Uganda

Wilberforce Owembabazi Ndyanabo MD, MPH
Project Management Specialist for Health Systems Strengthening
USAID Uganda Health and HIV Office
Questions for Wilberforce Owembabazi

• As this study is from several years back, how have roles of VHTs and other CHWs evolved in supporting HIV in Uganda?

• What strategies have been effective in Uganda to support CHW performance and productivity in HIV service delivery? What are outstanding concerns?

• What is the current update on the discussions around VHTs and developing a paid CHW cadre in Uganda? How will this impact HIV services?
Harmonization and performance of CHWs for HIV care in Swaziland

Edward Broughton, PhD, MPH
USAID ASSIST Project, URC
Background: Role of CHWs in HIV

- CHW performance is critical for 90-90-90 goals
- The roles of CHWs are expanding in HIV prevention, care, and treatment:
  - Improving linkages between those who need care and those who can provide it
  - Supporting retention in care, adherence, and self-management for improved clinical outcomes
  - Supporting ART distribution
  - Key cadre in differentiated care models
Background: Swaziland’s HIV epidemic

• Swaziland has world’s highest adult HIV prevalence: 27% - 220,000 with 73% of those virally suppressed (IAS 2017)
• 66% of those with HIV aged 15-24 know their HIV status, though proportion on ART with viral suppression is increasing (IAS 2017)
• Major shortage of skilled health care workers
  – 1.7 physicians/10,000 (global mean = 14)
  – 16.0 nurses / midwifery / 10,000 (global mean = 28)
• Task-shifting already common in primary health care
• CHWs essential for high coverage of HIV patient to deliver care
### Background: Swaziland CHW programs with HIV tasks

<table>
<thead>
<tr>
<th></th>
<th>RHMs</th>
<th>Expert clients</th>
<th>M2M mentors</th>
<th>M2M Early Childhood Development</th>
<th>Community counselors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year initiated</strong></td>
<td>1976</td>
<td>2011</td>
<td>2008</td>
<td>2008</td>
<td>2010</td>
</tr>
<tr>
<td><strong>Responsible agency</strong></td>
<td>MOH</td>
<td>MOH</td>
<td>M2M</td>
<td>M2M</td>
<td>PSI</td>
</tr>
<tr>
<td><strong>Number</strong></td>
<td>5000+</td>
<td>480</td>
<td>225</td>
<td>126</td>
<td>150</td>
</tr>
<tr>
<td><strong>Org. support</strong></td>
<td>MOH</td>
<td>URC, EGPAF, ICAP</td>
<td>M2M</td>
<td>M2M</td>
<td>PSI</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>12 wks pre-service, 1 wk annual inservice</td>
<td>5 wks pre-service, 2 wks annual in-service</td>
<td>5 wks pre-service, 2 wks annual in-service</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Target group</strong></td>
<td>General Population</td>
<td>Mainly HIV-infected individuals</td>
<td>Pregnant women and new mothers</td>
<td>Children and pregnant women</td>
<td>General Population</td>
</tr>
</tbody>
</table>
# CHWs’ HIV responsibilities in Swaziland

<table>
<thead>
<tr>
<th>Rural Health Motivators (RHMs)</th>
<th>Expert Clients</th>
<th>Mother2Mothers</th>
<th>Community Counsellors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Govt program</td>
<td>• Tracking HIV and TB patients who have missed a clinical appointment to encourage them to attend</td>
<td>• Tracking women/infants who have missed a PMTCT appointment</td>
<td>• Offer mobile HIV testing services during community gatherings</td>
</tr>
<tr>
<td>• Health education to households</td>
<td>• Educating and motivating ART patients to be adherent to treatment</td>
<td>• Educating and motivating PMTCT patients to be adherent to treatment</td>
<td>• Promote and offer male medical circumcision services during community gatherings</td>
</tr>
<tr>
<td>• Referral of sick clients from the community to an appropriate healthcare facility</td>
<td>• Motivate and educate the general population about the importance of HIV and TB testing</td>
<td>• Counsel HIV-negative pregnant women and new mothers about staying HIV-negative</td>
<td>• Conduct community dialogues to engage communities on health matters</td>
</tr>
<tr>
<td>• Coach those looking after the sick on how to care for them</td>
<td></td>
<td>• Encourage pregnant and lactating mothers to test</td>
<td></td>
</tr>
<tr>
<td>(RHMs have a broader primary health care role, not specific to HIV)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ASSIST PEPFAR-funded CHW research in Southern Africa

• Overarching question: What are the most efficient and effective strategies to improve and sustain CHW performance?

• Two complementary studies:
  1) Apply the CHW Performance Logic Model to examine how it can inform improvements in CHW program performance for HIV in Swaziland
  2) Factors enabling and constraining harmonization of CHW HIV programs in Southern Africa: Qualitative study with stakeholders in Lesotho, Mozambique, South Africa, and Swaziland
Study 1: CHW Logic Model
Scope of Study 1: CHW Logic Model

Background: Study rationale

- The CHW performance logic model (Naimoli et al. 2015) was developed to guide policy and programming to improve CHW program performance.
- This study was developed to apply the model to HIV services.
- Why Swaziland?
  - Has many CHW programs providing HIV-related services.
  - Can provide insight on how to further support and sustain CHW program performance.
- Why the logic model?
  - Offers a comprehensive range of factors that may contribute to CHW performance.
Methods

Quantitative (Feb to June 2015 data collection)
- A two-stage cluster household survey to determine the coverage of, and satisfaction with CHW programs in Swaziland
- Data collection from:
  - 2,000 households in Lubombo and Manzini regions
  - 2,300 household members were interviewed
  - 306 rural health motivators were interviewed

Qualitative (Feb – June 2015 data collection)
- Qualitative evaluation of four CHW programs for HIV in Swaziland
- Interviews and focus group discussions
Inputs

- Policies: Swaziland Nat Health Strategy: Community-based care is integral part of health care delivery
- People: RHMs (MOH) + 4 other cadres
- Funding: Disproportionately low
- Organizations: RHMs and NGOs
- Materials & Equipment: Viewed as inadequate for patient expectations
- Time
System-level activities

Governance: RHMs have defined structure; other cadres smaller
Variability in community-based workforce eligibility and training

<table>
<thead>
<tr>
<th>CHW eligibility criteria</th>
<th>RHMs</th>
<th>Expert clients</th>
<th>M2M mentors</th>
<th>M2M Early Childhood Development</th>
<th>Community counselors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Diagnosed with HIV</td>
<td>Completed PMTCT</td>
<td>Completed PMTCT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Basic literacy and numeracy</td>
<td>Basic literacy and numeracy</td>
<td>Basic literacy and numeracy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stable health status</td>
<td>Stable health status</td>
<td>Stable health status</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Good ART adherence</td>
<td></td>
<td></td>
<td>High school graduate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>At least partially disclosed HIV-status to community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>12 wks pre-service, 1 wk annual inservice</td>
<td>5 wks pre-service, 2 wks annual in-service</td>
<td>5 wks pre-service, 2 wks annual in-service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Program-level activities

<table>
<thead>
<tr>
<th>Services provided</th>
<th>RHMs</th>
<th>Expert clients</th>
<th>M2M mentors</th>
<th>M2M Early Childhood Development</th>
<th>Community counselors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tracking HIV &amp; TB patients LTFU</td>
<td>Tracking women/infants LTFU</td>
<td>Monitoring child development</td>
<td>HIV testing &amp; counseling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Promoting ART adherence</td>
<td>Promoting PMTCT</td>
<td>Promoting ART adherence</td>
<td>Promoting PMTCT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Promoting HIV and TB testing</td>
<td>Promoting ART adherence</td>
<td></td>
<td>Promoting male medical circumcision</td>
</tr>
<tr>
<td>Services provided</td>
<td></td>
<td>HIV prevention: pregnant women &amp; mothers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Target group</td>
<td>General Population</td>
<td>Mainly HIV-infected individuals</td>
<td>Pregnant women &amp; new mothers</td>
<td>Children &amp; pregnant women</td>
</tr>
<tr>
<td></td>
<td>Monthly salary</td>
<td>SZL 350 (US$ 28)</td>
<td>SZL 1,650 ($US 131)</td>
<td>SZL 1,500 (US$120)</td>
<td>SZL 1,500 (US$120)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>SZL 7,000 (US$ 556)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Results: Outputs

• 50% of sampled households ever visited by an RHM
• 15% of household survey respondents ever visited by a non-RHM CHW

Satisfaction with CHW services
  • RHM = 6.5 (95% CI: 6.4 - 6.7) [10 highest]
  • Non-RHM CHWs = 6.9 (95% CI: 6.6 - 7.2)

Trust in CHWs
  • 51% trust RHMs with confidential health information
  • 68% trust non-RHM CHWs with confidential health information

CHW development & job satisfaction
  • 58% don’t think they are being paid a fair amount
  • 83% meet their supervisor once a month
  • 76% satisfied with supervision but 65% would like more
  • Pre-service training generally prepared them well for their work
  • 90% get in-service training 1+ /year
  • 91% would like more in-service training
### Findings: Outputs (RHMs only)

<table>
<thead>
<tr>
<th>Services provided by RHM</th>
<th>% of respondents receiving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education</td>
<td>97</td>
</tr>
<tr>
<td>Children's vaccinations</td>
<td>98</td>
</tr>
<tr>
<td>HIV test</td>
<td>14</td>
</tr>
<tr>
<td>TB screening</td>
<td>14</td>
</tr>
</tbody>
</table>
Conclusions

• **Swaziland CHW programming:**
  – Coverage appears less than mandated, and there are issues around satisfaction with and trust of CHWs
  – 90-90-90 goals difficult to accomplish without better CHW performance
  – Logic model points to areas needing more attention

• **Logic model is useful for:**
  – Focusing planning, monitoring, and assessment on CHW performance for HIV
  – Facilitating consistency among studies of CHW HIV performance in different settings
  – Structuring questionnaires and selecting sample
Study 2: Country case studies of harmonization of CHW HIV programs
Guidance on harmonization of CHW programs

- What do we mean by harmonization?
  - Increased coordination, integration, and sustainability

- Harmonization important to improve effectiveness, efficiency, and sustainability of CHW programs supporting HIV and advancing 90-90-90

- Purpose of country case studies:
  - Identify facilitating / impeding factors to harmonizing HIV CHW programs
  - Develop policy recommendations for harmonizing HIV community programs for greater efficiency, consistency, equity, and accountability
Context for CHWs in HIV in Southern Africa

- High HIV burden in 4 countries in southern Africa
  - 11% to 27% of adults ages 15-49 infected
- Large-scale national CHW programs since 1970s
  - e.g., Rural Health Motivators (RHMs) in Swaziland
- Parallel donor- and NGO-supported CHW programs
- Varying accountability of all CHW programs
- Funding often inconsistent and time-bound
- Varying in-country dialogue around harmonizing CHW programs and HIV services

UNAIDS 2014
Priority areas of harmonization

- **Coordination:**
  - Duplication of services
  - Confusion created by competing models
  - Overlapping responsibilities of different CHWs

- **Integration:**
  - Existing networks of larger health systems
  - Role of MOH / large private providers/ CBOs

- **Sustainability:**
  - Long-term funding
  - Improve performance to control HIV epidemic

Atun et al., 2009
Methods: Four country case studies

- Lesotho, Mozambique, South Africa, Swaziland (2015-2016)
- Participants:
  - Government officials
  - Donors
  - Expert observers working with CHW HIV programs
- Semi-structured interview questionnaire
- ~15 interviews per country (~45 min. each)
- Data recorded, transcribed, and coded
Analytic framework for integration of targeted health interventions

Atun et al., 2009

USAID Applying Science to Strengthen and Improve Systems
Examples of informant questions

- How does government coordinate CHW activities supported by various donors and NGOs?
- Is integration of CHW plans with facilities, districts or national planning processes of the MOH required?
- How do you perceive the MOH’s financial capacity to sustain CHW activities after the current funding provided by your organization ends?

Zulu et al., 2014
## Facilitators

<table>
<thead>
<tr>
<th>Mediator</th>
<th>Lesotho</th>
<th>Mozambique</th>
<th>South Africa</th>
<th>Swaziland</th>
<th>Overarching theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large national CHW program</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>National government structure dedicated to CHWs</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td>Recognition of non-MOH CHW programs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>Clear definitions of CHWs, CHW program</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td>Similar job descriptions, matched pay rates</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>Broad community healthcare package</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td>Engagement of community leaders</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>CHWs linked to health facility</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td>National data collection</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td>National training</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>No</td>
</tr>
<tr>
<td>Political support for harmonization</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Barriers

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Lesotho</th>
<th>Mozambique</th>
<th>South Africa</th>
<th>Swaziland</th>
<th>Overarching theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHWs focused on HIV alone</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td>Multiple ministries with different guidelines</td>
<td>✓</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td>Variation by province/district</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>No</td>
</tr>
<tr>
<td>Lack of continuing education/career path</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td>Lack of accountability of non-MOH programs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>Paper-based measures</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>✓</td>
<td>No</td>
</tr>
<tr>
<td>Lack of funding</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Yes</td>
</tr>
<tr>
<td>Lack of human resources</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td>Lack of technical resources</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>No</td>
</tr>
<tr>
<td>Political turnovers and instability</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>-</td>
<td>No</td>
</tr>
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</table>

USAID Applying Science to Strengthen and Improve Systems
Conclusions

• Underperformance in service delivery
  → clients’ needs unmet
  → perceived gap filled by a different
    NGO-supported cadre
  → fragmentation

• Multiple cadres can lead to inefficiencies, inequities, less accountability
Conclusions

- Resource and skills/knowledge limitation impede CHW performance
- Better alignment of CHW educational standards, training, and incentives can reduce disparities in performance
- Harmonization can reduce duplication & improve efficiency, improve equity, may encourage better recruitment/retention, accountability…but it is not the answer to all problems
Questions for Edward Broughton

• Participants should use the chat function to post questions for Edward Broughton on the Swaziland logic model and Southern Africa CHW harmonization studies

• Questions may also be emailed to Kim Rogers at krogers@usaid.gov

• Responses to questions not addressed during the webinar will be posted on the event page for this webinar on the USAID ASSIST website
Comments from USAID Swaziland

Grace Masuku, MA
USAID Program Specialist
PEPFAR Swaziland
Questions for Grace Masuku

• In your experience, how have CHWs supported the advances that Swaziland has made toward 90-90-90?

• How have the results of these activities been used to inform further strategies for the use of CHWs in HIV services?

• How is the sustainability of the various cadres being considered? Have there been any discussions regarding advancing harmonization efforts?
Closing Remarks

Diana Frymus, MPH
Health Workforce Branch Chief
USAID Bureau for Global Health | Office of HIV/AIDS
Key takeaways

• Although there continues to be great variability of CHW programs across countries, the roles of CHWs for HIV have expanded with the roll-out of Test and Start and Differentiated Care Models.

• There is a need for increased focus on continual monitoring of both CHW performance AND productivity in delivery of HIV services → critical for ensuring optimal utilization of CHWs in contexts with constrained HRH environments.

• The CHW Logic Model can be a useful tool in planning, monitoring, and assessment on CHW performance for HIV.

• The CHW context in most countries includes a combination of both country and donor/NGO supported programs. Increased focus on harmonization of programs can support greater effectiveness, efficiency, and sustainability of programs → critical for ensuring sustained HIV progress.
Responses to questions not addressed during the webinar and the webinar recording will be posted on the USAID ASSIST website on the event page for this webinar:

https://www.usaidassist.org/content/webinar-getting-more-bang-buck-community-based-health-workers-hiv-response