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Section B

Examining Factors that Led to Chokwe Programs’ Stability

The views expressed in this presentation are Dr. Edward’s assessment of the model and are not necessarily those of World Relief.
Volunteer Motivation and Retention

Elements Contributing to Volunteer Motivation and Retention

- Clear job description and expectations
- Limited tasks
- Span of operation: 10 neighbor HH
- Job aids to support performance: health education
- Empowerment: decision making at community level
- Peer support
- Supportive supervision
- Sense of accomplishment
- Community recognition/status
- Preferred treatment
- Evidence of contributions: improved health, referral
- Availability of referral services
- Opportunity for training and skills development
- Non-monetary incentives: scarf, kapalana, t-shirt
- Community identity

Guija and Mabalane districts: 20m post-project <10% attrition
Chokwe District: <2% drop out rate/y
Volunteer Support Systems

- Regular supervision and joint problem solving
- Animators reside in communities
- Supervisory checklists
- Peer support “Care”
- Culturally appropriate support structure: VHC, Pastors
- Community feedback and recognition: graduation ceremony

Photos: Melanie Morrow, World Relief
Beneficial Outcomes of the CG System

- Pivotal role between health system and community
- Wide spectrum of services (preventive/curative)
- Develop local capacity
- Equitable and cost-effective delivery of services
- Rebuilding social infrastructure—especially in post conflict settings
  - Rwanda and Cambodia
SCALE Dimensions

- Geographic: multiplicative strategies, modified approach of SEED/SCALE
  - WR expand scope to province level
  - USAID mission CSP in three provinces

- Organizational
  - WR Cambodia (2), Malawi (2), Rwanda (2)
  - FHI (scaling up in Sofala province), Curamericas, Africare, PLAN Int, ADRA

- Political
  - Provincial and district MOH
  - Leveraging interests of USAID mission, UNICEF, and other multilateral agencies to adapt model for strengthening community infrastructure and empowerment
    - UNICEF, ITN re-treatment

- Functional
  - Potential for integrating MED, PEPFAR, PMI, food security, child development initiatives
### Examining Factors Influencing Success of Scale-Up

<table>
<thead>
<tr>
<th>Factors Influencing Scale</th>
<th>Present</th>
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</thead>
<tbody>
<tr>
<td>Predictable adequate funding from international and local sources for 20 years</td>
<td>?</td>
</tr>
<tr>
<td>Technological innovation within an effective delivery system at a sustainable price: use of existing community structures, effective simple interventions</td>
<td>✓</td>
</tr>
<tr>
<td>Technical consensus on public health approach</td>
<td>✓</td>
</tr>
<tr>
<td>Project and community governance (trade-offs between quality and scale)</td>
<td>✓</td>
</tr>
<tr>
<td>Effective use of information: evidence for advocacy, integration with other sectors</td>
<td>✓</td>
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### Assessing Potential for Scale-Up

<table>
<thead>
<tr>
<th>Steps for Scaling Up</th>
<th>Present</th>
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<tbody>
<tr>
<td>Establishing a vision for scale up</td>
<td>?</td>
</tr>
<tr>
<td>Determine effectiveness of approach</td>
<td>✔️</td>
</tr>
<tr>
<td>Assessment of potential for scale up</td>
<td>✔️</td>
</tr>
<tr>
<td>Consolidate, define and refine the approach</td>
<td>✔️</td>
</tr>
<tr>
<td>Build consensus for scale up</td>
<td>✔️</td>
</tr>
<tr>
<td>Advocating for supportive policies</td>
<td>✔️</td>
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## Efforts for Supporting Scale Up

<table>
<thead>
<tr>
<th>Support Systems for Scaling Up</th>
<th>Present</th>
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</thead>
<tbody>
<tr>
<td>Determine roles and functions of stakeholders</td>
<td>✔️</td>
</tr>
<tr>
<td>Ensure funding and other resources</td>
<td>✔️</td>
</tr>
<tr>
<td>Develop/strengthen partner’s capacity to implement activities</td>
<td>✔️</td>
</tr>
<tr>
<td>Design and institute M&amp;E and supervision systems</td>
<td>✔️</td>
</tr>
<tr>
<td>Support institutional development for scale</td>
<td>❓</td>
</tr>
</tbody>
</table>
The Case for Going to Scale

- Donor driven, demand driven, top down, and bottom up
Strengthening Capacity of Health Systems

- Strengthening capacity of health systems to support scaling-up
  - Training district directors on supportive supervision, HFA, and QA
  - Improving competency of nurses in HC/HP through training in technical interventions
  - Designing and instituting CHIS and integrating into HIS
  - Establishing community infrastructures (CG, VHC, socorrista), financing mechanisms, referral systems
  - Providing a prototype for sustaining community mobilization and empowerment
  - Advocating appointment for additional personnel (1/district) to support socorrista and volunteer activities
Balancing Going to Scale with Equity

- CG model achieves universal coverage of all community HH—reach poorest
- *Socorristas* provide health care to all patients, regardless of ability to pay
- Quality may be compromised if efforts for scale-up is the sole responsibility of MOH
Scale Squared Center: Training and Learning

Population 140,000 130,000 227,000

Guija
Mabalane

Chokwe

Chicualacuala
Masangena

Chigubo
Chibuto
Massingir

Monitoring CG activities

Best Practices for C-IMCI

SCALE up districts
Operations research
Scale Squared Training Center

Photos: Melanie Morrow, World Relief
Scale-Up: Strengths

- Compliments MOH efforts and addresses priorities for IMCI
- Facilitates a coordinated approach within the districts in the province
- Supports the establishment of an effective management and health information system—early warning system
- Ensures compliance of case management protocols and guidelines
- Strengthens linkages between the community and health systems—and improved communication
- Joint problem solving and resource sharing
Scale-Up: Strengths

- Enables the establishment of effective strategies for sustainability and phasing out
- Allows top-down, bottom-up, and inside-out capacity building
- Long-term vision and effective liaising of partners
- CG model: equitable and sustainable approach mobilizing and empowering communities
- Prototype for multisectoral platform: PEPFAR, PMI, food security
- Increased demand for services
Scale-Up: Weaknesses

- Vision for “scale” not planned at outset
- Creating and sustaining local enabling environment
- Limited access to the provincial capital from the districts
- Reduced capacity of health systems in some districts (rural HP/HC lower staff competency/performance)
- Increased geographic constraints (roads, scattered households, public transport) requiring additional resources for transport, communication equipment, safety of project personnel, etc.
- Integrating and coordinating priorities of stakeholders (for example, national HFA)
- Advocating high-level leadership and political environment
Linking Community-Based Systems

1. Improved quality of services at health system
2. Training & supportive supervision by project staff
3. Capacity building of VHC, traditional healers, pastors, grannies
4. Network of trained CG volunteers
5. Behavior change at community/HH level
Beware!

Carl Taylor

Community Empowerment