Incentivizing CHWs: BRAC Experience

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BRAC Historical Context

Origin of BRAC:

- Tied to the birth of Bangladesh after liberation war; 1971
- BRAC was born in1972; rehabilitation support to refugees
- Quick realization rehabilitation is not solution but development
- 1973, 10% mark-up on sales

"Poor people are poor because they are powerless. We must organize people for power."

-Sir Fazle Hasan Abed,
Founder and Chair, BRAC

BRAC is a development organization dedicated to alleviate poverty by empowering the poor, and helping them to bring about positive changes in their lives by creating opportunities for the poor

BRAC Mission and Goal

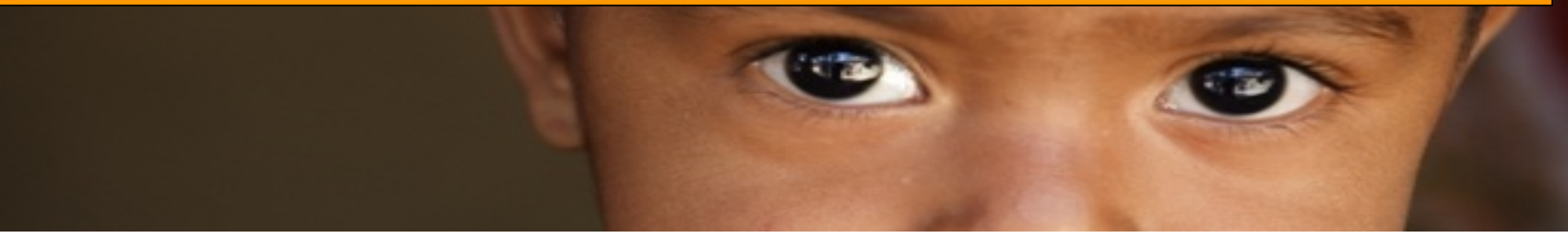
Mission: To empower people and communities in situations of poverty, illiteracy, disease and social injustice

Goal: To contribute to elimination of poverty and empowerment of marginalized people, especially women

Healthcare interventions *have been an integral aspect including CHWs. Started in 1973*

Our Comprehensive Approach

BRAC Health Nutrition and Population Programme



OUR APPROACH

Our approach is providing preventive, promotive, curative and rehabilitative care driven by the organization's overall mission, vision and values with a holistic approach to poverty reduction and empowerment of the poor

OUR AIM

Our aim is to improve reproductive, maternal, neonatal and child health and nutritional status, reduce vulnerability to communicable diseases, combat non-communicable diseases, and enhance the quality of life.

OUR SCALE

We are operating in all 64 districts of Bangladesh reaching 120 million people, particularly serving the hard to reach, marginalized population.

COMMUNITY HUMAN RESOURCE

Agent of Change

Shasthya Shebika/CHW

- Behavior and practices
- Empower community
- Women-friendly, culturally-appropriate services
- Continuum of care
- Prompt diagnosis and referral of complication

Shasthya Kormi

- Selected from community preferably BRAC VO
- Age 25-40 years
- Preferable education Grade 8
- Willingness to work
- Socially acceptable
- Voluntary service
- Serve around 400-500 HHs

- Training
- Continuing education
- Supportive supervision
- Frequent contact with community
- Incentives
- Quality of care
- Trust of the community

- Selected from community BRAC staff
- At least SSC degree
- Willing to work
- Age 25-35 years
- Nominal honorarium
- Serve 4000-5000 HHs

Incentives in Bangladesh

- Social : Community trust and acceptability and respect from BRAC
- Financial incentives

a) Revolving fund (interest free loan)

b) Selling Over the counter essential medicine and health commodities

c) Performance based incentives: Pregnancy identification and referral of complications; Infant young child feeding, maternal nutrition and MNP compliance; TB treatment compliance

d) Selling services: DM and hypertension screening

BRAC CHW Models in African Continents

i. Uganda: 4,075
ii. South Sudan: 120 CHP, 200 CBD
iii. Liberia – 599 CHPs
iv. Sierra Leone – 406 CHPs

- Essence of the BRAC CHP model was intact and best practices were incorporated,

a) CHPs providing basic health care within the community, and
b) sales of health products - the built-in entrepreneurial model for sustainability,
c) strong govt. linkages,
d) refreshers, supportive supervision,
e) monitoring/evaluation,
f) reports - easily measurable KPIs, target vs. achievements

BRAC CHPs in Uganda: Overview and Achievements

- Current Health Program

i. Since 2008, BRAC EHC, SS model with CHPs
ii. Maternal and child health focus
iii. Current coverage: 3.6 Million, 4,075 CHPs,
iv. 273 health staff, 139 branches across 72 districts

- Impact Achievements

i. *RCT* conducted by Stockholm University showed 21% mortality reduction among under 5 children
ii. *RCT* studies showed a spillover effect on the market price of ACTs and lowered counterfeit drugs
iii. *Another study* showed BRAC CHPs increased demand and service uptake

Scale and Innovations

- Scale (out and up)

i. Scale out - Expansion of the program in 2016 from 2808 CHPs to 4075 CHPs – 45% growth

ii. Scale up - Scope of activities enhancement – full ICCM, m-RDTs, FP, nutrition, m-health

- Innovations

i. Built-in entrepreneurial model - SS

ii. Technology incorporation - mobile applications and HMIS

iii. Incentive schemes testing, CHP input supply loan through MF

iv. Supportive supervision with certification, re-certification, knowledge tests

v. Enhanced nutrition and family planning

Incentives Experience

a. Monetary incentives:

i.Sales of products – supplementary income

ii.Performance based phase 1: components specific

b.Social incentives:

i.Community recognition and respect -CHPs as ‘musawo’

ii.CHP awards and recognition ceremony, i.e. CHP Appreciation Day;

iii.certification/recertification

iv.Technological inclusion – mobile phone for screening and reporting

Challenges and Successes

Challenges (Monetary incentive):

-Shift of focus on specific components

-Over reporting issues; monitoring – cumbersome; Operational feasibility

-Demotivated once fund for incentives runs out

-Donor focus differences/shifts brings challenges for a comprehensive mechanism

-Policy environment: mobilization to bring CHWs under pay scale, CHEW, VHTs

Challenges on Social incentives:

-Funding required, has cost implications

-Built-in entrepreneurial system is successful, but requires business skills development

Successes:

-Improved performances on specific components selected for monetary incentives - treatments, pregnancy;

-Even though short-term, CHWs seem to appreciate/motivated, low attrition rate

-Revolving fund – ensures 100% cost recovery of input supply of CHWs in Uganda

Lessons Learned

- Accountability and transparency with strong check and balance
- Advocacy - ways to also address bottlenecks on CHWs scope of work within the policies and guidelines based on evidence and regulation/compliance
- Innovations and flexibilities, learning by doing
- Expectation management at all level, CHWs, communities, staff, government
- More robust full PHC coverage through CHWs makes CHPs more sustainable
- Entrepreneurial model requires investments on marketing, outreaches, business skills,

Upcoming incentives testing

- **Phase 2:** comprehensive scoring system based on performance
- Overall performance is considered and components are incorporated/weigthed into a scoring system
- Probabilistic model with three treatment arms to find out which one enhance CHP performances most
- **Input supply loan** – testing this year for mechanism to scale out
- CHPs who are not part of the MF, provide them with a input supply loan/small loan for them to start/overcome barriers on their capitals with shorter recovery system
- **Sales of services** – sayana press, depo provera training with enhanced FP method mix and screening training

Thank you for listening!

Thoughts on HIVST

- Testing HIVST through BRAC CHPs, AHPs, ELA, combinations – incorporate into the CHP product basket
- Incentives (for products sales and/or service) and its' mechanism around self-testing
- Demand creation and supply chain