COMMUNITY LABORATORY CORPS FRAMEWORK

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CONTENTS

LIST OF ABBREVIATIONS

CHW - Community Health Worker

CLC – Community Laboratory Corp

ASLM – African Society for Laboratory Medicine

GHSA – Global Health Security Agenda

WHO – World Health Organization

IHR - International Health Regulations

OIE - World Organization for Animal Health

Q-Corp - Volunteer Quality Corp

NGO – Nongovernmental Organization

M & E – Monitoring and Evaluation

INTRODUCTION

Historical Perspective

In 1800s, Russia Feldhsers were trained as paramedics to assist physicians and to function in rural areas where there was paucity of physicians; this gave birth to the notion of community health workers. Feldhsers were local people with limited training who were empowered by the government to provide primary health care services in rural villages, and constituted an important unit of the Community Health Worker (CHW). Therefore, the concept of Community Laboratory Corp (CLC) program that the African Society for Laboratory Medicine (ASLM) is introducing is not an entirely new concept, except with a focus on laboratory testing. CHWs are designated differently in various countries, and range from health auxiliary workers, village health worker, community health worker, to front-line health workers.

COMMUNITY LABORATORY CORP PROGRAM & GLOBAL HEALTH SECURITY

Background and Context

The Global Health Security Agenda (GHSA) is an effort by nations, international organizations, and civil society to accelerate progress toward a world safe and secure from infectious disease threats; to promote global health security as an international priority; and to spur progress toward full implementation of the World Health Organization (WHO) International Health Regulations 2005 (IHR), the World Organization for Animal Health (OIE), and other relevant global health security frameworks. The GHSA Workforce Development Action Package's (GHSA Action Package Detect-5)

overall goal is to strengthen a sustainable multi-sectorial workforce. Therefore, implementing innovative workforce development strategies and plan is critical and fostering and expanding the public health workforce at the district and provincial levels is vital in order to produce adequate and culturally adapted work force capable of conducting timely outbreak detection and investigation, public health response, and public health surveillance.

ASLM and the WHO Regional Office for Africa (WHO AFRO) recently issued a the Freetown Declaration calling for member states to develop a functional tiered laboratory network that is integrated very closely with disease surveillance. Therefore, the CLC program will be a vital workforce at the lowest level of the tiered laboratory pyramid. CLC should not be developed as a stand-alone workforce for the GHSA; rather, they could be trained to play a critical role in the community by providing basic diagnosis and management of selected infectious diseases and conditions with public health importance, such as Malaria, HIV, Syphilis, Tuberculosis, reproductive health, anaemia, high blood pressure, and diabetes. Thus, because CLC would have had the experience in managing other diseases, they could be easily deployed to support other disease outbreak surveillance programs.

CLC could be established and maintained as a partnership with the community and the government: the community identifies the CLC workforce to be trained according to appropriate government standards and the government may opt to integrate CLC into the existing healthcare system. CLC could also be established within the existing governmental healthcare system. Regardless, a simple governance structure would be required, as CLC needs to have a clear identity that is legally recognized and institutionalized.

Thus, the government has to: 1) establish the rules about what can be done – standards; 2) provide the funding for infrastructure and training or seek partnerships in financing CLC programs according to local requirements and possibilities; and, 3) the need for the biosafety of the CLC and how to handle waste resulting from laboratory diagnostics. There are important lessons to be learned from the experience of using community volunteer quality Corp (Q-Corps) officers program that has been initiative in several Africa countries to ensure the accuracy and reliability of HIV testing in remote areas. In these countries, thanks to the Q-Corps program, significant gains were made in improving the quality assurance at testing sites with significant turnaround time for proficiency testing and return of results, suggesting if CLC are well managed and implemented, they could contribute significantly in the function of the tiered laboratory network.

Who are Community Health Workers?

The term community health worker is currently used to cover a wide variety of cadres and programs. In this framework document, we use the terminology to imply:

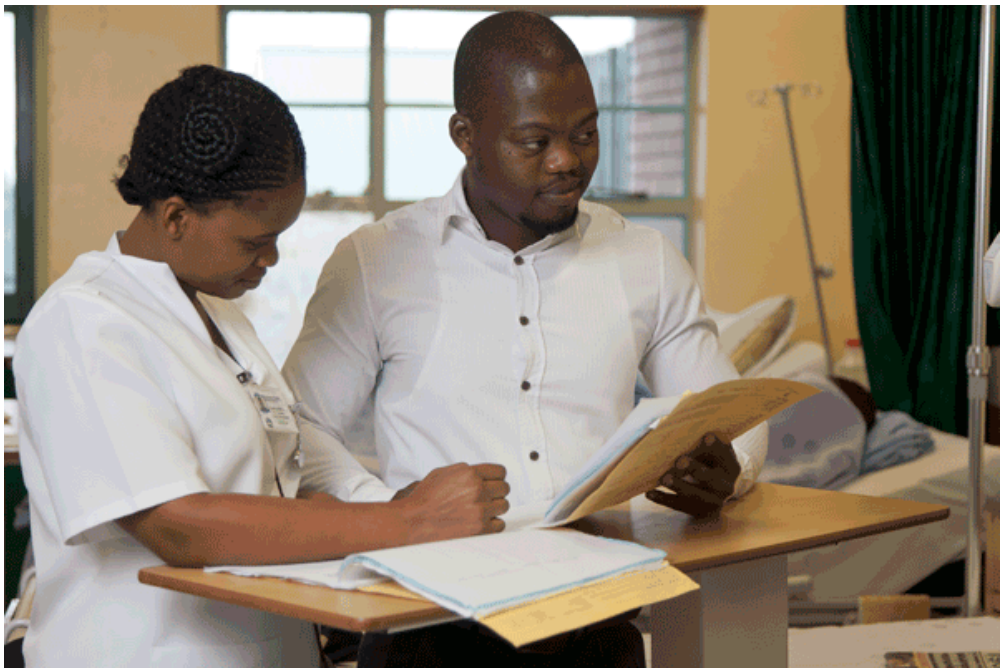
1. ***Auxiliary health workers:*** Generally paid full-time workers with a few months of pre-service training, who may or may not be recruited from the localities where they serve.
2. ***Health extension workers:*** Full-time paid employees, and has a few weeks to < 1 year of training and are generally recruited from the localities where they work.
3. ***Village volunteer health workers:*** Usually not paid as a full-time worker but are trained using standard curricula and used as required.

A country may decide on which scenario best fits their context by either using one or a combination of the three different concepts outlined above. The use of a particular cadre of worker is only one strategy to meet workforce needs in a particular community.

Goal of the Framework

The goal of this framework document is to guide policymakers and program implementers to develop and implement an effective and sustained CLC program that is part of a tiered laboratory network capable to be used to respond to existing and endemic diseases, outbreaks surveillance, and event-based surveillance. This framework is not intended to be overly prescriptive; rather, it tries to suggest options and possibilities that need to be considered.

CLC programs cannot be one-size-fits-all solution; therefore, context-specific considerations must be made.



Community Laboratory Corp as an Ecosystem: Systems Approach

The CLC will work within the context of a program, a community, and a health system. The effectiveness of a CLC program will depend on various systems. Systems are usually very interconnected and dynamic. CLCs will need to interact in a setting along with other health workers, CHWs, managers, and others; each with their own roles and interactions. This relationships and interactions look like an ecosystem as they can affect the performance of the CLC, competing interests, and changing dynamics over time. Often, in a single location there may be multiple programs making use of different types of CHWs. With different external partners supporting the programs, there may be little harmonization. Some partners may be more generous in providing more attractive training allowances or other

incentives, with significant differences in how supervision is done, and without any provision for coordination across programs or across the different types of CHWs.

What are the Possible Phases of Implementing a Community Laboratory Corp Program?

1. Planning

A national-level plan at the level of the Ministry of Health could coordinate planning committees and stakeholders from multiple governmental and community levels, as well as nongovernmental organizations (NGOs) and relevant implementing partners. Support and engagement from the Ministry of Finance is critical, since the MOH in many countries may not have sufficient political influence on decisions involving significant commitment of new resources. This will help

create an informed overall laboratory strategic plan that takes into account the critical role of CLC workforce.

Key considerations could include:

1. A situational analysis
2. Operational model
3. Integration of the program
4. Training
5. Supervision
6. Deployment strategy
7. Monitoring and evaluation

Wisely selected strategies within each of these areas, factoring in the inter- relationships, could contribute to a success and sustainability CLC program. Planning and development efforts must give careful attention to ensure that the program will continue to be adequately supported by the multiple levels of government involved, from national level down to the community. This support should include appropriate provision for long-term sustainability and respect for local norms. It is important that district and regional authorities play a strong role in the planning and design processes. Regional and district leadership involvement in the planning is just the beginning, since their participation is needed across all the areas: supervision, training, support, supplies, and incentives. To ensure an effective CLC program, it is crucial to begin with a perfect understanding of the local context. A situational analysis will help recognize context-specific requirements and challenges.

. A program may use a variety of implementation strategies depending on the local situation: in some cases, there may be already a community development programs that the CLC program can build on. A situational analysis will also enables the documentation of the current state of the health system and may include information on health services offered by the formal and informal sectors, care-seeking behaviours, supply chain management, utilization and coverage of care provided by the health system, and human resources challenges. An operational model is a representation of how the current health system operates, including service provision, human resources, mHealth, information management systems, and the supply and distribution of commodities. Specifically, using an operational model to map the dynamics of the current health system helps those involved in planning for a CLC program. For example, if a health system currently has only one clinic for every 10,000 people that offer voluntary HIV counselling and testing along with anti- retroviral drug treatment for patients with HIV/AIDS, then an outreach program may need CLC to provide additional services and support the quality assurance program of the HIV testing.

2. Coordination, Roles and Responsibilities

Before implementing a CLC workforce program, it is critical to determine how the several levels of government will communicate and interact during the planning, funding, and implementation stages. The level of coordination will depend on the country, the current state of decentralization, and what responsibilities have been delegated. Depending on the situation, it may be appropriate to incorporate NGOs and the private sector as part of a national CLC program. The establishment of responsible bodies at each level, with oversight from central level, helps to ensure that clear roles and responsibilities are determined through the process of conducting the situational analysis and building the operational model.

The national-level planning body is responsible for providing leadership for the development of the CLC program. A national committee can provide high-level leadership, make decisions on resource allocation, oversee the development of implementation guidance, monitor implementation, oversee national monitoring and evaluation, and adapt the program based on M&E findings.

Considerations when forming the CLC workforce national-level planning committee:

1. **What national governing bodies need to be on the committee?**
2. **Who are the high-level leaders and advocates for CLC workforce programming?**
3. **What policy changes are needed to support or integrate a CLC workforce program with the national health sector policy?**

3. Community-Level Responsibilities

A community committee could undertake a planning function. This may include a village development committee, traditional or other local leaders, and representatives from other committees concerned with community health development.

These committees potentially have the ability to undertake certain responsibilities for CLC workforce oversight. They can assist the CLC workforce in mobilizing the community, especially in cases of disease outbreaks surveillance and event-based surveillance. A strong community commitment will certainly help ensure more effective community health services and can alleviate stress points on the system.

4. Implementation

Converting the policies into an operational national-level plan is a critical next step. Adequate funding, proper rules, and alignment with the existing health system are critical for the success of a CLC workforce program. Without properly defining the role of CLC workforce within the health system and adequate financing to support this cadre of workers, such a system will be challenging to develop. With an operational national plan created, development of a detailed implementation plan is key. Key components for implementation include: governance, financing, selection and recruitment, training, supervision, relationship with the health system engagement with communities, scaling up, and M&E.

5. Monitoring and Evaluation

Supervision approaches varies considerably by countries; some national policies may mandates that doctors or nurses supervise CLCs. However, this approach would not be effective in places where there are massive human resources shortages. Planning for supervision has to take into account the capacity of existing staff to take on additional time-consuming responsibilities. In many places health facilities have only one or two providers and are submerged with patients starting early in the morning. Adequate planning for the time and human resources required for CLC supervision can contributor to a successful CLC programs.

6. Governance for Implementing the Community Laboratory Corp Program

Governing encompasses the approach and structures through which the CLC will exercise rights, resolve differences, and express concerns. Governing could include on-going interactions among health care decision makers, community representatives, and agencies with regard to the laws, resources, and beliefs within which these CLC operate.

Governance of CLC workforce programs should be guided by existing regulations on health services workforce development in the country. As such CLC programs will need regulations that clearly define the rule of conduct of their activities in the community and a formal recognition by the Ministry of Health or local authority. The development of a CLC program also requires effective planning strategies: supervision, training, and community relations. Considerations should be given on ways to incorporate CLC into existing health system infrastructures.

This requires involvement of multiple stakeholders including the national to the community level and should be context-appropriate. CLC programs that successfully train, supervises, and retains participants, while demonstrating improvements of health service delivery in the community level will likely be owned and supported by the community. Community programs frequently fall outside of the governance structures of the formal health system or are poorly integrated with it—making governing these programs more challenging. A close attention should be paid to ensure that this doesn't happen.

7. Role of mHealth in Community Laboratory Corp Workforce Program

The practice of medicine and public health supported by mobile devices called mHealth could be of enormous importance to support the CLC workforce. The use of mHealth is gaining increased attention as it provides opportunities to rapidly connect people, thereby reducing delays in patient care, managerial, and supervisory decisions required for day-to-day health system functioning. With the continuous growth of mobile network coverage and unprecedented spread of mobile devices in Africa, many mHealth initiatives are now being implemented in developing countries. In designing the CLC workforce consideration should be given on how to take advantage of this tool.

8. Motivations and Incentivizing Community Laboratory Corp Workforce & Retention

Designing effective incentives to increase motivation and performance can be a challenging undertaking that necessitates careful attention.

Like any other aspect of the health system, incentives need to be 1) properly designed through review and consultation with shareholders, 2) implemented, managed, and monitored on an on-going basis, and finally, 3) evaluated to assess their effectiveness and plan for changes. Motivation of CLCs could include the use of discrete incentives such as payments, promotions, or awards — to motivate CLCs to perform specific tasks or achieve a certain level of performance.

9. Costs of CLC Programs

The cost of implementing a CLC workforce should be carefully examined. The CLC workforce program would be more horizontal as in the case of the Global Health Security Agenda. Sufficient attention must be paid to the full resources needed for successful and sustained implementation of CLC workforce programs. The absence of fully defined costs and unrealistic plans can undermine a CLC workforce program. It should not be assumed that once CLC are trained, they could be sent back to their communities and the communities would pay the costs required to support their activities. Key questions to consider in determining the financing of a CLC workforce program include: