COMMUNITY HEALTH WOKERS PROGRAMME

Programme Guide

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TABLE OF CONTENTS

Contents

LIST OF TABLES

LIST OF FIGURES

FOREWARD

Nigeria has made several attempts to improve the health of its citizens, however, despite the laudable attempts, population health indices remain poor. Maternal and child mortality rates rank amongst the highest globally, with access to health care especially in underserved and rural areas severely limited. The poor mortality and morbidity indices are largely as a result of low and inequitable coverage with high-impact interventions and poor demand for services due to weaknesses in the healthcare delivery system.

Primary health care development is key to improving population health and achieving universal health coverage. We need to invest in strengthening our PHC system, especially the community component.

People and communities lie at the heart of health system strengthening, within the context PHC, as the foundation for universal health coverage. Innovative strategies for community health programming are needed to ensure access to essential healthcare services for the Nigerian population, emphasizing equitable access and coverage with high-impact community interventions. These strategies must take into context and improve on the challenges of previous community health programmes while ensuring there is co-creation with sub-national levels to ensure programme ownership.

This current strategy emerges from a deep understanding that effective health interventions must be rooted in the unique needs and strengths of our local populations.

Noteworthy in achieving these aspirations is the calibre of the health workforce deployed. To ensure high-quality services are delivered at the community level, we must begin to transition from utilizing lay health workers to professionalized, competent, salaried healthcare workers

This strategy outlines a comprehensive framework that encompasses recruitment, training and deployment of appropriate health workers, the spectrum of services to be provided at community level as well as governance and monitoring and evaluation systems. By leveraging data-driven insights and fostering cross-sector collaboration, we aim to address health disparities and promote wellness in a manner that is both sustainable and impactful.

Our vision is clear: to create environments where health is not just the absence of illness, but a state of complete physical, mental, and social well-being. As we embark on this transformative journey, we remain steadfast in our commitment to innovation, compassion, and resilience. We hope that this new “blended” model of Community Health Workers Programme in Nigeria will ultimately lead to an improvement in the overall health indices in Nigeria.

Dr Muyi Aina,

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The remodeling the Community - Based Health Worker Programme to strengthen the community component of Primary Health Care for improved population health outcomes in Nigeria was a product of collaborative efforts by different stakeholders in the PHC space. The development of the Implementation Guide for the revised programme is one of the key outcomes of this well-coordinated process led by the NPHCDA.

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Director, Primary Health Care System Development

ACRONYMS

ACBHW	**Auxillary Community Health Worker**
AEFI	Adverse Events Following Immunisation
AIDS	Acquired Immuno-deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Illnesses
CBHW	Community-based Health Worker
CBO	Community Based Organisation
CEFP	Community Engagement Focal Person
CHEW	Community Health Extension Worker
CHIPS	Community Health Influencers, Promoters, Services
CHO	Community Health Officer
CHPRBN	Community Health Practitioners' Registration Board of Nigeria
CMPDSR	Community Maternal and Perinatal Death Surveillance and Response
CORPS	Community-Oriented Resource Persons
DHIS	District Health Information System
DOTS	Directly Observed Treatment Service
FBO	Faith Based Organisation
FP	Focal Person
HH	Household
HIV	Human Immunodeficiency Virus
HTR	Hard to Reach
ICCM	Integrated Community Case Management
ISS	Integrated Supportive Supervision
JCHEW	Junior Community Health Extension Worker
LGA	Local Government Area
LGAHMT	Local Government Area Health Management Team
LLIN	Long Lasting Insecticide Treated nets
M&E	Monitoring and Evaluation
MDA	Ministries, Departments and Agencies
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, Neonatal and Child Health
MPDSR	Maternal and Perinatal Death Surveillance and esponse
NCD	Non-Communicable Diseases
NCHMIS	National Community Health Management Information System
NGO	Non-Governmental Organisation
NPHCDA	National Primary Health care Development Agency
NpopC	National Population Commission
OiC	Officer in Charge
PBI	Performance based Incentives
PHC	Primary Health Care
PNC	Post Natal Care
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SHT	School of Health Technology
SMOH	State Ministry of Health
SPHCDA/B	State Primary Health Care Development Agency/Board
TB	Tuberculosis
UHC	Universal Health Coverage
VCM	Volunteer Community Mobilisers
WASH	Water, Sanitation and Hygiene
WDC	Ward Development Committee
WRAG	Women of Reproductive Age Group

1. INTRODUCTION

1.1. Background

Nigeria has some of the worst health outcomes in the world for both women and children. Pneumonia, malaria, and diarrhoea combined account for a million deaths in children annually, while 33,000 mothers die from pregnancy-related causes. These figures account for 14% and 11%, respectively, of the yearly global deaths of mothers and children. Poor coverage of high-impact interventions, health inequities, barriers to accessing health care and lack of awareness of service availability are among the main contributing factors to the high rates of maternal and infant mortality, and majority of these deaths are largely preventable.

Inequities in access to and coverage of health services contribute unduly to the health outcomes. The poor and rural communities and other socially disadvantaged groups have disproportionately poorer access to health services despite their higher burden of disease and deaths compared to their wealthier and urban counterparts. In these underserved communities, demand and utilization of PHC services remain low because of persistent systemic weaknesses. Alternative health services from private health facilities are expensive – making them economically inaccessible to poor households. This results in vulnerable underserved populations resorting to sub-optimal care from informal private healthcare service providers including patent medicine vendors and traditional healers. Additionally, because of ignorance, individual households usually delay decisions on care-seeking.

Evidence has shown that the attainment of Sustainable Development Goal 3 and Universal Health Coverage (UHC) depend heavily on primary health care, which is the cornerstone of Nigeria's health policy and the foundation of its health system. It is important to note that the Primary Health Care System in Nigeria comprises two levels: the PHC facility and the community. It is increasingly being recognized that attainment of UHC is not feasible without investment in the community component of primary health care that seeks to expand access to underserved populations.

Nationally, several attempts have been made to strengthen the community component of Primary Health Care, the most recent being the implementation of the Community Health Influencers Promoters and Service (CHIPS) , which commenced in 2018, spearheaded by the National Primary Health Care Development Agency, in line with its mandate to strengthen the Village Health Worker . The overall goal of the was to contribute to the reduction of maternal and child morbidity and mortality by improving access to and equitably increasing coverage of basic primary health care services, especially relating to maternal and child health, including improved access to treatment for common childhood illnesses, and increasing demand for services. The also attempted to integrate and harmonize all vertical community-based health s for improved and efficient coordination, implementation and outcomes. The operational unit for planning was the ward and the

personnel used were the CHIPS Agents, who provided service through home visits and Community Engagement Focal Persons who supported the CHIPS Agents with data collation and transmission and engaged males in the communities to address constrains to PHC services uptake. The proposed a minimum of 10 CHIPS Agents and two CEFPs per ward. The CHIPS agents were linked to ward PHC facilities for referrals, collection of drugs and supervision. The key principles of the were volunteerism and harmonization/integration of community-based workforce and s. An economic empowerment component was added to provide the volunteer workers a means of livelihood. The was launched by the then President in 2018, and by 2023, all the states of the federation had started implementation of the , albeit, at different levels by 2023. A total of 18,559 CHIPS Agents and 3,493 Community Engagement Focal Persons had been trained, with 12,986 CHIPS Agents providing service across 26% of the wards in the country.

Following several calls to optimize and strengthen the community component of Primary Health Care, a redesigned community-based health workforce will be implemented to achieve this.

1.2. Justification

To improve critical health outcomes in Nigeria, the community health system has a key role to play, and sustained efforts to strengthen the community health and the primary health care systems they lean on must be made. At the heart of a high-performing and functional community health system lies a resilient community-based health workforce. The right cadre of workers must be recruited, adequately trained and equipped to provide services, appropriately remunerated with clear career development pathways and supportive working environments in line with sub-national contextual realities.

Accordingly, and in line with the Honourable Coordinating Minister of Health and Social Welfare's National Health Sector Renewal Investment , NPHCDA's strategic blueprint and feedback from the sub-national levels, there was a need to review and restructure the existing community-based health workforce model to ensure there is better alignment for the delivery of expected outcomes. This review revealed poor political commitment and ownership at the subnational level, grossly inadequate funding, capacity gaps and poor motivation of the CHIPS personnel, gaps in the supply chain for commodities and inadequate supportive supervision systems as key challenges to the optimal performance of the . Additionally, there were concerns about the competence of the CHIPS Agents to provide treatment and dispense drugs, and that the community health extension workers are better placed to provide these services, as they have been professionally trained for the role. Following the identification of these challenges and gaps, the Management of NPHCDA and their partners have redesigned the community-based health workforce to ensure a national that delivers on the intended outcomes, address the identified gaps with the CHIPS , while taking into contextual local realities and promoting state ownership in its implementation.

1.3. Goal and Objectives

The goal is to ensure the availability of a sustainable community-based health workforce model that will provide quality health services within Nigerian communities, leading to equitably expanding access to and demand for quality health services, thus increasing service coverage and ultimately improved RMNCAH and other health outcomes.

The goal of the redesigned will be achieved through the following:

1. Adoption of a **blended** CBHW model comprising a mix of formally trained, certified and regulated Junior community health Extension Workers (JCHEWs) **and informal** Auxiliary community health workers recruited the communities they will work in.
2. Deployment of a dedicated culturally competent, trained and equipped community health workforce who are linked to PHCs to deliver services through home visits to households while strengthening the community health system.
3. Generation of demand for PHC service for increased utilisation of facility level services.
4. Integration of service provision at the community level for enhanced effectiveness, efficiency and impact

2. CONCEPTUAL FRAMEWORK

2.1. Concept of the Community Based Health Workers

The Federal Government of Nigeria has initiated a redesign of the Community Based Health Worker (CBHW) to improve on the former CHIPS for the acceleration attainment of Universal Health Coverage. Community Based Health Workers play a vital role in health promotion, disease prevention, provision of basic services and demand generation. Because they link community members to available health facility services, there is a need for a more inclusive approach to their roles and work ethics.

Supported by global evidence, two cadres of community-based health workers will provide health services at the household level within the community and will initially focus on priority health s and health system strengthening activities, ranging from simple promotion (e.g., informing pregnant women about ANC) to more complex treatment services (e.g., administering DOTS for TB).

Nigeria's evolving community level PHC landscape supports a model where both Junior Community Health Extension Workers (JCHEWs) and Auxiliary Community Health Workers (ACBHW) will be employed to provide a broad set of services in which the skilled and formally trained JCHEWs deliver more complex prevention, diagnosis, and simple curative services.

- Skilled unemployed CBHWs (JCHEWs) are available for quick deployment to communities to provide services.
- Less skilled and informally trained Auxiliary CBHWs (ACBHW) (such as the CHIPS Personnel, VCMs, CORPs etc) will be upskilled to provide simple health promotive, preventive and basic curative services, where the former is not available.

The provision of a range of quality health care services at the community level will complement the facility services. Four health outcomes have been prioritized for improvement: RMNCH and Nutrition; immunizations for priority antigens; slowing down the prevalence of NCD and reduction in the incidence of HIV, TB, and malaria.

2.2. Strategic Approach

A minimum of 10 CBHWs per ward will be recruited, trained, deployed, mentored, and supervised. The ratio of the JCHEWs to ACBHW per ward will be determined by the states based on the availability of either cadre and availability of resources for efficient, effective, and sustainable implementation. The technical supervisors shall be the CHEWs, CHOs, or Midwives in the focal health facility. The Ward Development Committees (WDCs) shall provide oversight alongside other identified stakeholders for the non-technical supervision and other implementation support, including community involvement. (Figure x below).

The framework envisions increased access to essential health care along a continuum of care from the households within the community to the PHC facilities and referral to secondary health facilities. It requires revitalization of the PHC facilities for improved service delivery and strengthened wider system support (financial, procurement and supply chain, data and referral systems) to address the supply side challenges and achieve the desired goal.

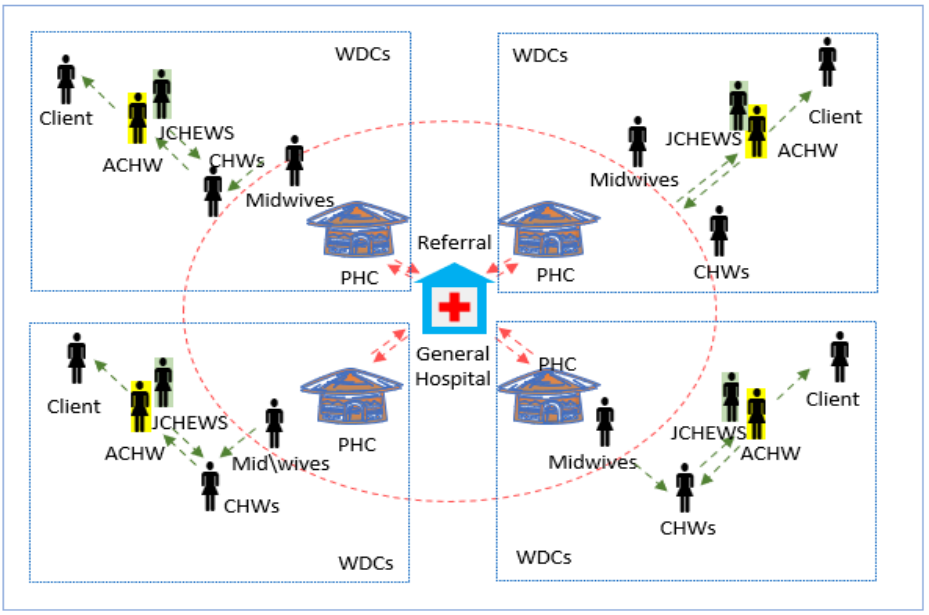

Figure 1: Framework for Community-Based Service Delivery and Demand Generation in a Ward by Community-Based Health Workers

The redesigned CBHWs will be implemented along 12 dimensions (roles, profiles and responsibilities, governance, financing, supervision, supplies and tools, data collection & use, community involvement, remuneration and incentives, training, accreditation, recruitment and placement, and career advancement) across three domains (Strategic, operational and workforce development). Table 1 briefly describes the dimensions.

Table 1: Dimensions for the Redesign of the Community Health Workers

	Dimensions	Description
Strategic	1 Roles, profiles, responsibilities (service packages),	**Roles, profiles, responsibilities** required to deliver a high performing CH program, including minimum service packages
	2 Governance	**Governance structure of the CH workforce**, incl. policy, administration and operationalization of the program
	3 Financing	**Funding allocation and overall financing methodologies** for personnel, supplies, and program administration
Operational	4 Supervision	**Coaching, mentoring and evaluation** structures including observation & feedback on service delivery
	5 Supplies and tools	**Supplies and equipment, including digital tools,** for service delivery
	6 Data collection & use	**Collection of data from the community** and utilization methodologies for use in performance management and service delivery
	7 Community involvement	**Engagement strategies** of CHWs with the wider community in decision-making, planning and prioritization
Workforce develop-ment	8 Remuneration and incentives	**Financial compensation** for services CHWs provide in the community
	9 Training	**Pre-service and in-service training provided** for upskilling and reskilling CHWs
	10 Accreditation	**Formal certification** for the health knowledge and competencies of CHWs
	11 Recruitment and placement	**Recruitment strategies** for community health workers **and deployment strategies** to address target demography and geographic feasibility
	12 Career advancement	**Pathways and opportunities** for career advancement (e.g., midwives and nurses)

1.Core competencies should include promotive and preventive services

Source: -AIM-Updated-Program-Functionality-Matrix_Dec-2018, WHO Guidance from 2018 ⁵ WHO, Community Health Impact Coalition, World Bank

3. THE COMMUNITY BASED HEALTH PERSONNEL

3.1. Scope of Work

Service provision at the community level will initially focus on priority health s and health system strengthening activities, within a wide range of promotive, preventive and basic curative services. As such, community-based health workers (CBHWs) serve as the link between households and communities to health facilities, facilitating the uptake of integrated PHC services.

The scope of work delineates the responsibilities of the CBHWs at household and community level within this framework, as described in Table 2

Table 2: Scope of work of the Community Based Health Workers

Activity	Description	Add-on for JCHEWs
Community Mapping	• Conduct community mapping, household numbering and collection of basic demographic information on all members of households in the assigned practice area for identification of target groups.	• None
Health promotion and demand creation	Conduct home visits to: • Promote appropriate health care seeking and positive health care behaviour • Create demand for health services and mobilise the communities for outreaches • Provide health education and counselling on: - Child Health services e.g. immunisation and nutrition - Maternal and Newborn Health Services e.g. ANC/Delivery - Water, sanitation & hygiene (WASH) - Reproductive, Sexual and Adolescent Health - Nutrition - Family planning - Communicable diseases e.g. HIV, TB, Hepatitis, Malaria prevention - Non-Communicable diseases e.g. Diabetes, hypertension – prevention and healthy lifestyles - Care of the elderly, disabled and people living with mental health disorders • Inform target populations of the services available in the PHC facilities, identify the target groups for the various services such as childhood immunization, antenatal, delivery and post-natal care, and encourage uptake of the services counsel and encourage them to avail themselves of the services. • Facilitate referrals and link the populations to the health facilities to access the appropriate care and provide follow-up care. • Encourage enrollment into health insurance schemes. • Encourage male support and participation	• Provide health education on nutrition and conducting food demonstration sessions
Integrated Community Case Management	Provide disease specific care for the sick child: • Identify and refer children newborns and children aged 2 – 59 months with danger signs and refer immediately, after giving pre-referral treatment, as appropriate. • Identify, assess and treat children aged 2 – 59 months with simple malaria, acute respiratory tract infection (ARI) and diarrhea. • Identify children with severe acute malnutrition and refer to CMAN centres and provide nutrition counseling for children with moderate malnutrition.	None

Activity	Description	Add-on for JCHEWs
Other Treatment services	• Provide first services and refer as appropriate.	
Continuity of care for essential services and community hdistribution of commodities	• Administer albendazole to children underage of 5. • Distribute misoprostol for pregnant women. • Distribute chlorhexidine gel for cord care in newborns. • Refer pregnant women with danger signs	• Refill oral contraceptives for women of reproductive age group (WRAG) and medicines for stable hypertensive, tuberculosis and HIV/AIDS patients. • Provide community-based immunisation services. • Refill anti-hypertensive and anti-diabetic drugs for stable patients receiving care at the focal facility
Screening for important health conditions		• Screening for eligibility for contraceptives • Screening for hypertension and diabetes mellitus
Surveillance and epidemic response	• Identify, monitor and report : - Notifiable diseases, especially public health emergencies - Maternal, perinatal and child deaths - Child health issues e.g. Immunisation, Nutrition - Health problems relating to HIV/TB/Hepatitis/NCD • Actively participation in the community maternal, perinatal and child deaths surveillance and response (identification and reporting, verbal and social autopsies and monitoring of implementation of community action plans), risk communication and community engagement within the epidemic response processes	None
	• Record and report services provided during every encounter with household members, including commodity management. • Report births and deaths • Support tracking and reporting of immunization defaulters	

3.2. Selection and Recruitment

The selection of the CBHWs is a collaborative process that is primarily community-driven with guidance and support from the Local Government Health Management Team, recognized civil society groups, SPHCBs, NPHCDA, and development partners. The community mechanisms involved include the community members, Ward Development Committees (WDCs), the PHC Facility Managers, and existing traditional institutions.

Ensure that in nominating community members to serve panel members, the nominees:

- Represent diverse community perspectives,
- Have the relevant expertise;
- Understand the local culture.
- Are respected and truste;
- Are committed to the program's goals;
- Are impartial;
- Possess strong communication skills; and
- Are available for all required activities.

3.2.1 Selection Criteria

a. **Auxiliary Community Health Worker**

- Age range 25- 65 years (However, this is flexibility and based on local contexts. In local adaptation there is a need to emphasize maturity for effective engagement with older women and physical capability for door-to-door visits)
- Minimum of primary education, with advancement contingent on secondary education
- Able to read and write in English (or the local language)
- Preferably female, though men can be recruited where locally contextualized.
- Ever married (this included currently married, divorced or widowed)
- Respected and resident within the community.
- Culturally competent (Able to communicate effectively in the local language and understand the norms and cultural values of the community)
- Willing to serve the community for at least 2 years.
- Existing CBHWs with prior training or experience and currently in the community should be prioritised and given equal screening opportunities, if eligible

b. **Junior Community Health Extension Worker (JCHEW)**

- Willing to work at the community level
- Resident in the community of service
- Possess a valid certificates, including that of current registration with the National Community Health Practitioners Board, and state of origin documentation.
- Can speak and write in English.
- Proficient in the local language and culturally competence.
- Accepted by the local community
- Documents audited and accepted by the LGA

3.2.2 Nomination and Screening Process for Auxiliary CBHW

Nominations are to be made by community members or through direct applications, where interested individuals apply directly to the community panel.

Conduct the screening of the Auxiliary CBHWs in collaboration with the focal ward PHC, the existing traditional institutions and the Ward Development Committees (WDCs), where they exist. The pre-selection meeting should be held at the ward level and should involve the National Team and/or state PHC Team, LGA Health Management Team, Officer-in-charge of

the PHC facility, WDC chairman and Ward Focal Person. This meeting should be conducted to communicate the goals and objectives of the CBHW , review the selection criteria, and define the CBHWs' roles and responsibilities. Subsequently, the nominated candidates should be screened using an eligibility assessment checklist which scores the following areas:

- Age, marital status, and residency status within the community.
- Ability to read and write, both in the local language and English.
- Experience in community health-related activities.
- Formal training and certifications relevant to community health roles.
- Educational background and attainment level.
- Competencies essential for effective community health work.
- Language proficiency

See Appendix 1 for the forms for screening of the candidates.

Hold a post-selection meeting to discuss the results and select the most eligible candidates, ensuring representation from all communities in the ward.

The biodata of the candidates finally selected should be collected, verified by the candidates, and uploaded to a central database, including their passport photographs.

3.2.3 Validation of the JCHEWs

A validation exercise should be conducted to ensure the JCHEWs identified meet the eligibility criteria. They would be expected to provide copies of certification and registration as well as proof of residence within the selected ward/community.

3.3. Distribution of the CBHW

The unit for implementation of the CBHW is the ward. The number of CBHWs will depend on the size of the ward and population density. Factors that may determine the variability include:

- Population- highly populated communities should have more personnel deployed.
- Spatial distribution of households across a geographic area and the time it takes to move between them,
- The geographical terrain: hard-to-reach areas may require more personnel .
- Prevalence and incidence of health conditions of interest

However, it is recommended that the minimum number of CBHWs to be deployed per ward should be ten (10). States are at liberty to determine the proportion of JCHEW to Auxiliary Community Based Health Workers required based on empirical evidence of availability of the JCHEWs and state capacity. However, the two cadres of CBHWs are expected to work in tandem within the wards, with JCHEWs prioritised for deployment to hard-to-reach (HTR) /under-served communities.

HTR settlements are in greater need of expanded access because they are (1), cut off from other communities around them by difficult terrain caused by mountains, forests, deserts, rivers and a host of other natural barriers disrupting the movement of persons, goods and services; (2), situated in areas of insecurity, wars or communal clashes which interrupt the normal flow of health system processes; and (3), located 5km or more than 40minutes' walk from the nearest functional health facility or any constructed road, whether tarred or untarred.

3.4. Incentives and Compensations

3.4.1 Financial Compensation

CBHWs will receive compensation to cover the logistics costs, time and effort expended during service provision. As part of the formal health sector, both JCHEWs and Auxiliary CBHWs will receive a salary in line with the state salary structure and in consideration of differential remuneration based on qualification and scope of work between the two cadres.

States should also consider providing performance-based incentives (PBIs) to CBHWs and their supervisors/focal persons (at state, LGA and ward governance levels) to improve motivation and productivity.

3.4.2 Non-financial Compensation

a. Status

CBHWs have an influential role in their community. This will give them a sense of satisfaction and purpose as they will make a positive impact on the lives of their community members.

b. Recognition

The performance of the CBHWs will be monitored. High performing ones will benefit from awards at local or even state and national levels. They may be nominated to represent their peers at conferences and events and may be identified as champions or role models for the .

c. Career Progression

NPHCDA/SPHCBs will engage Colleges/Schools of Health Technology (SHT) and Nursing and Midwifery Colleges/Schools to explore career pathways and requirements for high- performing Auxiliary CBHWs. This will enable them to become professional healthcare workers through training and advanced education. They can become JCHEWs in the facilities and progress to being Community Health Officers (CHOs) or Nurses/midwives. JCHEWs serving in the communities can also take additional training to become CHEWs and possibly CHOs, Nurses or Midwives. Other support towards career advancement will include the following:

- Provision of scholarships for completing secondary school
- Provision of continuous supportive supervision to enhance their skills and competences enable them deliver quality services.
- Provision of various targeted formalized trainings to prepare CBHWs for continuing professional development and to enhance their skills for their next roles.
- Provision of support to LGA Health Authorities working with supervisors and WDCs to shortlist eligible candidates based on predetermined criteria for career advancement.
- Performance assessment of CBHWs to measure their skills and readiness for advancement.

4. IMPLEMENTATION

4.1 Implementation Plan

The National CBHW implementation strategy targets coverage across the 8, 856 wards of the country within a 5-year period. Table 3 provides the roadmap for expanding CBHW in the country with recommended target of universal coverage by 2028, considering availability of the JCHEWs and possible resource constraints.

The national coverage of community health worker currently stands at with a baseline of 20.0% in 2024. This will serve as the baseline. The proposal is a frontloading incremental rate of 25% in the following 2 years (2025 – 2026) and 15% increase in the remaining two years (2027 – 2028).

Table 3: Phased coverage of community-based health worker

National Population targeted by CBHW services	Roadmap for CBHW Scale-up				
	2024	2025	2026	2027	2028
Rural areas (%)	30.0	60.0	85.0	100.0	100.0
Urban areas (%)	10.0	30.0	55.0	70.0	100.0
Total (%)	19.3.0	43.8	68.9	83.9	100.0

Considering the differential burden of diseases and unmet needs of basic health services based on place of residence, the strategy prioritizes coverage in the early periods in rural areas. Hence, the recommendation is to have a more rapid annual increment in the rural areas, whereby 100.0% of these populations will be covered with the by 2027, while the entire urban population, and thus the total population of the country will be reached with

community-based services a year later in 2028. With the current population distribution of 53.5% rural and 46.5% urban the projected scale-up coverage is shown in Table 3.

The entire national planning processes of this phased implementation framework is based on the recommendation of a **blended model** of the community-based health workers with a mix of 50:50 Auxiliary CBHWs and JCHEW ratio. States can, therefore, begin with an appropriate mix starting from their current point and build to an optimum of having a predominantly JCHEW led . Furthermore, as the ratio moves with time in favour of JCHEW the range of services in the comprehensive pack can be expanded to cover more curative, rehabilitative and palliative care needed in sufficient quality at the community level. Recognizing that attainment of universal health coverage requires provision of optimal primary health care services at both facility and community levels, all stakeholders are encouraged to fast track interventions aimed at revitalizing the primary health care facilities to optimize the supply side of the health care delivery at this critical level of care.

4.1.2 Implementation Process

The CBHW implementation processes will be carried out in three phases of pre-implementation, implementation and monitoring and evaluation. The various implementation activities will be carried out at the National, State, Local Government, ward and community levels, as appropriate. Table 4 lists the various processes that inform the activities required at each phase to ensure successful . The scope of the activities and the stakeholders involved depend on the governance level where it is conducted.

Table 4: CBHW implementation process

Implementation Phase	Implementation Processes
Pre-implementation /Planning	Policy review and adaptation
	Stakeholder engagement and consensus building with national and subnational state actors and partners
	Strategy finalization
	Financing and resource mobilization
	Development/revision of guide, training materials and data tools
	Branding of
	Development of operational work plans/roadmaps at national and subnational levels
	Establishing a commodity and drug supply chain system
	Procurement of training materials and commodities, drugs and supplies
	Development of a communication strategy
	Launch
Implementation	Stakeholder and community engagement/entry
	Establishing governance and coordination platforms
	Selection of the JCHEWs and ACHWs and identification of supervisors
	Capacity Building (Onboarding/Training)

	Accreditation of the CHWs
	Deployment of the JCHEWs and ACHWs
	Mapping of houses in assigned communities, house numbering and registration and delineation of practice areas.
	Service delivery
	Integrated supportive supervision
	Capacity Building (mentoring and continuous learning)
	Commodity and drugs supply and replenishment
	Performance management
	Operations and implementation research
Monitoring, Evaluation, Learning and Research	Routine monitoring
	Mid-year review
	Annual reviews
	Periodic evaluation

1. **Pre-implementation phase** is aimed at developing the strategy, building consensus on the implementation framework, securing buy-in of relevant stakeholders at all levels , mobilizing needed resources for implementation and setting up operational coordination platforms. The plan also includes assembling the needed resources, developing of work plans at national and subnational levels, environmental scanning and setting up objective basis for performance management through conduct of baseline assessment, development a monitoring and evaluation plan, and an accountability framework. Additionally there will be the development of and production of the guide, data tools and training materials, establishment of sustainable supply chain management system, as well as launch.

2. **Implementation phase** involves establishment of governance structure, procurement of commodities, printing of training materials and other documents, selection, recruitment, training and deployment of the CBHWs, service delivery, supervision, mentoring and performance management. During this operations and implementation research will be conducted to generate evidence for use to improve performance.

3. **Monitoring, Evaluation, Learning and Research** phase includes regular monitoring, periodic evaluation and operational research. The monitoring involves continuous and systematic collection, collation, analysis and presentation of data generated from the CBHW to track progress towards attainment of targets, identify progammatic bottlenecks for development of remedial actions to improve performance. This will be achieved through the regular analysis and use of routine data to drive decision making at all levels.

   evaluation will be undertaken periodically, both internally and externally to assess the level of attainment of goals and objectives and the impact, of the on population

health, as well as its relevance, scope, effectiveness, and efficiency. It is imperative to collect baseline data against which the performance of the can be evaluated.

4.2 Training

A well-coordinated training strategy is necessary to ensure the community health workers acquire the necessary competencies to perform their work effectively. The training will aid the Auxiliary CBHWs in promoting healthy practices healthcare seeking behaviour, distribution of health commodities and provision of basic curative care providing basic services, data capture and remittance. The JCHEWs training will deliver targeted and more complex prevention, diagnosis and treatment services in the communities. The robust training curriculum comprise 11 modules to be delivered using adult learning techniques, with in-class and field practical sessions is designed to focus on key things the CBHWs need to know and be able to do, so as to build the critical skills and competencies needed for effective service delivery at community level.

4.2.1. Outline of the Training Modules

The training of the CBHWs comprise 12 modules. Tale 5 gives an outline of the Modules which both the ACHBW and the JCHEW will be taught, indicating the additional areas of training the JCHEWs training will cover, in line with their proposed roles and responsibilities.

Table 5: Outline of the Training Manual for the CBHWs

Module	Description	Additional sessions for JCHEWs
Module 1: **Introduction to Primary Health Care and community health service delivery**	Understanding the concept of Primary Health Care and the community-based service PHC, including the roles and responsibilities of CBHW, including and their rewards and sanctions	
Module 2: **Knowing your community**	Understanding the community, their culture and norms, gender issues at community level, the target and how to conduct including micro-census, register household members and identify target populations.	
Module 3: **Interpersonal Communication and Behaviour Change Communication**	The module focuses on how they can become effective counsellors and communicators, through empathetic listening, clear communication, cultural sensitivity for effective patient and family engagement, and trust-building. It also	

Module	Description	Additional sessions for JCHEWs
	includes training on health promotion and conflict resolution principles.	
Module 4: **Conducting Home visits and referral networks**	The module introduces them to steps in the conduct of how visits and how to conduct the visits, identify target groups in need of services and provide the needed services, referral protocols and documentation including. It also includes the different types of home visits – routine, emergency and follow-up visits and mobilizing household and community members for health insurance	
Module 5: **Care of the Pregnant woman and newborn**	Participants are trained on identification of pregnant women, counselling pregnant women on health promotive and disease preventive practices during pregnancy, importance of antenatal care and institutional delivery and postnatal care, recognition of danger signs and referral and educating women and birth preparedness and complication readiness; newborn care, distribution of chlorhexidine, LLIN, misoprostol and SP and referral to the facilities for ANC, PNC and danger signs	
Module 6: **Care of the sick child**	How to identify, assess and treat children under-five for malaria, diarrhea and pneumonia and dentify children with danger signs and referr to the PHC facilities	
Module 7: **Promoting Child health and Nutrition**	How to provide health education and counsel for child health including immunisation and infant and young children feeding, detection of acute malnutrition and referral and counseling on appropriate feeding for children with moderate malnutrition, deworming of children and distribution of MNP and resupply of RUTF, where available)	• Provision of community-based immunisation services • Conducting nutrition education and food demonstration sessions
Module 8: **Adolescent health**	Education and counseling on adolescent transitional changes, hygiene, menstrual hygiene, high behaviours during	• Screening for eligibility for contraceptives

Module	Description	Additional sessions for JCHEWs
	adolescence and reproductive, sexual and adolescent health promotion. Needs-based referrals to PHCs.	• Dispensing condoms and oral contraceptives
Module 9: **Promoting family and community health**	Education on disease prevention (for malaria, HIV/AIDS and other infectious diseases) and health promotion including counselling on NCDs, WASH & nutrition, disease surveillance and community MPDSR, collection of information on birth and deaths	• Screening for hypertension, diabetes mellitus and appropriate referral
Module 10: **First Aid**	Provision of first aid and referral as appropriate	•
Module 11: **Care for vulnerable population**	Care for the elderly, disabled and people living with mental health disorders	
Module 12: **Monitoring and Evaluation**	Data collection and reporting, in addition to commodities management	

In addition to participating in the CHW Training, the supervisors will undergo additional training of supportive supervision and mentoring. The modules they will be trained on are shown in Table 6

Table 6: Modules for the Training Manual for the Supervisors of CBHWs

Module	Title
Module 1	Mentoring
Module 2	Supportive supervision
Module 3	Community-based communication
Module 4	Data management
Module 5	Logistics and Supply Chain Management

4.2.2. Approaches to the Training and Retraining Process

The training process will be decentralised with direct oversight by NPHCDA, SPHCBs and partners for quality control. The CBHWs will be trained by State Facilitators and health workers at the focal PHC facilities, supported by National Master Trainers to ensure quality control. The JCHEWs having been formally trained and certified, will have

a 14-day retraining with support from the CHPRBN focusing on the outlined modules and additional sessions.

A cascade model of training is proposed where trainers are expected to acquire same knowledge and skills as the CBHWs

The CBHW training will be in phases, comprising an initial total of 14-day classroom and field training. These training sessions will enable them to understand their roles and provide general guidance to help them commence their work. The CBHW supervisors will sit through the CBHW training and in addition, will have a 5- day training on their roles and responsibilities with focus on mentoring and supportive supervision. Following the training, they will have a one week supervised practical before the commencement of their work

This phase of learning is followed by a 3 months *structured mentoring sessions* to be anchored by the CBHW supervisors aimed at reinforcing and deepening the knowledge gained during the classroom sessions. Greater attention should be given to addressing weak areas and knowledge gaps for CBHWs. The conduct of the mentoring activity will be informed by a mentoring guide specifically developed for the .

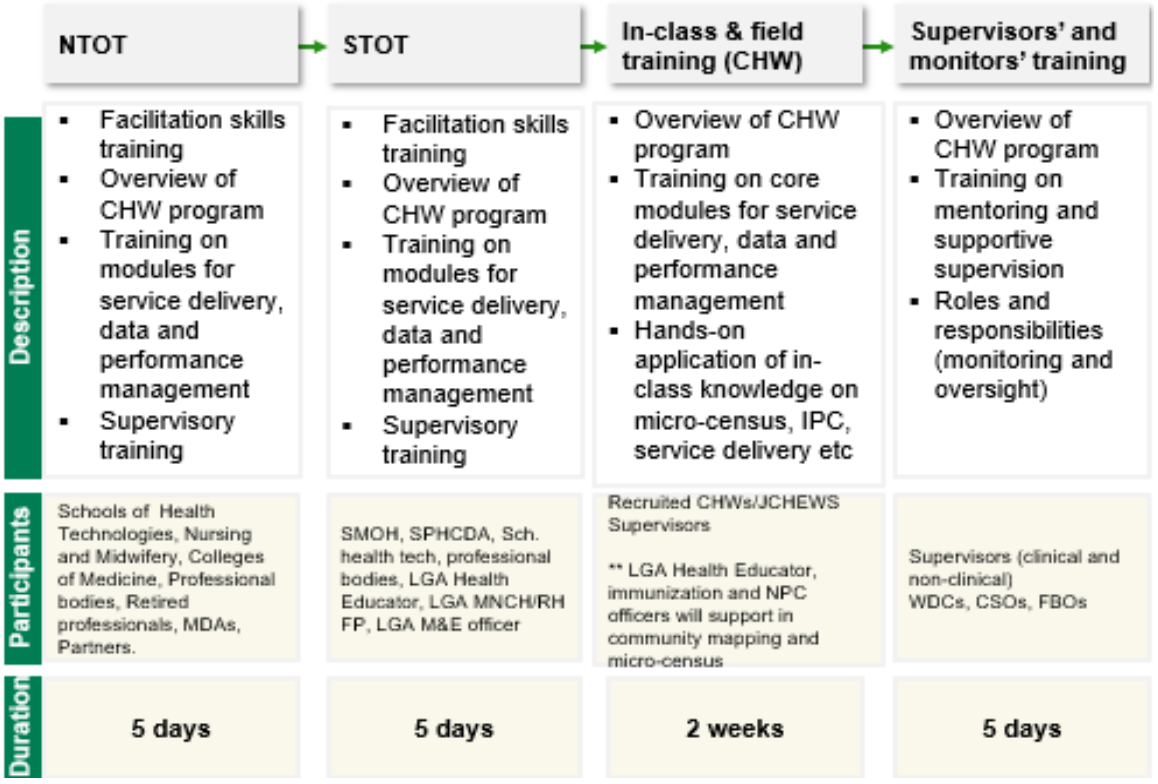

Figure 2: Training cascade for the community health workforce

The training at the national and state levels has been reduced from the 12 days to 5 days because across the country, a pool of national and state trainers have been trained, so it will be essentially refresher trainings. Where there is a need for training of fresh facilitators, the full complement of training is recommended.

The community based health workers will participate in an initial onboarding training and continuous learning exercises.

a. **Onboarding Training:** this will provide comprehensive foundational training on basic skills required for work in the community, as well as practical hands-on sessions to enable CBHWs to apply theoretical knowledge in real-world scenarios.

b. **Continuous Learning:** The formal training curriculum will be built into the continuous learning architecture to ensure the CBHWs get grounded in the required skills for their assigned roles and the relevant career pathway e.g. CHEW or Nursing pathway. The continuous learning exercises will include;

   i. On-the-job Mentoring: The CBHWs will be assigned to supervisors who provide continuous guidance, support, and feedback. This structured approach will be used to address specific challenges, refine skills, promote practical knowledge and facilitate personalized professional development.

   ii. Refresher Training: Periodic refresher trainings will be conducted based on gaps identified during supportive supervision and monthly review meetings. These trainings can be
      - Facilitator-led (in-class) - periodic courses delivered every two years to continuously update the CBHWs on guidelines, protocols and policies. This would be delivered through a centralized classroom approach, with focus on reinforcing essential skills and knowledge areas, and addressing gaps or weaknesses identified during routine evaluations.
      - Self-paced (e-learning) – there will be online training modules that the CBHWs can access at any time at their own convenience, allowing for self-paced learning. This approach will utilize interactive features, such as quizzes, videos and simulations to engage learners and reinforce concepts.

4.2.3 Methodology of Training and Training Resources

The training will be based on principles of adult learning and will use several different strategies as a way of keeping participants interested and involved. This will include pictorials, storytelling, role plays, experience sharing, repetition of key messages and use of similes. The use of such techniques will ease the users' ability to understand the content of the training manual and enable them carry out their responsibilities.

Evaluation tools (pre- and post-tests, evaluation forms, e.t.c) would be used to assess both the participants' understanding of the subject matter and the facilitators' delivery of the same.

The training resources for the CBHW training will include the following:

- Facilitators' training manual for the CBHW modules
- Facilitators' training manual for the CBHW supervisors
- Revised Standing Orders for the JCHEWs
- Job Aid for Auxiliary CBHWs

- Flipbooks
- Audiovisuals

4.2.3. Accreditation

CBHWs are critical members of the public health workforce; they connect the individuals they serve with resources and improve the quality of health care in their communities. CBHW credentialing/certification or licensure processes will standardize the delivery of CBHW services and provide a sustainable financial pathway to reimburse services rendered by such workers. This will ensure that the CBHWs have a standard skill set and knowledge base; ensure consistency in the quality of care provided; and confer opportunities for educational and professional advancement. The certification will comprise of the didactic training and CBHW experience, measured as the length of time served as a CBHW.

Table 7: Accreditation Process for both JCHEWs and Auxiliary CBHWs

	Auxiliary CBHWs	JCHEWs
Description	Auxiliary community based health workers will receive permits to be certified to provide services in the communities	Accreditation of the JCHEWS will be according to the policy and guidelines of CHPRBN
Responsible Entity	SPHCB	CHPRBN
Renewal requirements	- Completion of refresher courses, including summative assessments (attitude to work, client satisfaction etc.) - Satisfactory performance appraisals	Completion of mandatory continuous professional development training - Summative assessments (attitude to work, client satisfaction etc.) - Satisfactory performance appraisals
Validity	2 year	2 years
License Renewal Fee	NGN 2,000	NGN 6,000

4.3 Community Mapping and Deployment

In the early implementation phase, **Community Mapping and Household Registration (CMR)** is a critical activity to be conducted at the ward level after CBHWs are trained, kitted, and deployed, but before they commence providing services in their catchment areas**.** It is defined as a micro-census of CBHWs' catchment areas that provides a population count and data necessary to determine the target population for service provision. It also provides baseline information on household WASH practices. The objectives of this are to ensure:

- Determine an appropriate denominator to assess the work output of CBHWs.
- Setting an objective framework for State's implementation, including outputs, achievements, and targets.

- Proper quantification and planning for States' needs.
- Ensure CBHWs and supervisors have information on the community composition to plan their work effectively.

Community Mapping and Household Registration comprise the following tasks: community mapping, house numbering, household listing, and registration of household members.

Community Mapping: The CBHW catchment area is the specified location assigned to her/him to provide services. With the necessary support and oversight, each CBHW is expected to map her/his catchment area to define the boundaries of the area they will work and number the houses. This map serves as the basis identification of households and for compiling the household list.

House numbering: All occupied residential houses in the CBHW catchment area should be numbered using a defined numbering format that enables the household to be linked to its location (State, LGA, and ward) and the CBHW serving it.

Household Listing: All households identified and provided with household numbers should be listed in the Household Register. This list will enable the CBHW to count the number of households to which they will provide services and plan their work effectively.

Registering Household Members: Demographic information on all members of every household identified, numbered, and listed should be recorded. This will enable data collection for planning and decision-making starting from the ward level. During the registration, households are also provided with home-based cards in preparation for service delivery.

It is recommended that Community Mapping and Household Registration starts during the training period and is completed at least 2 – 3 weeks after completion of training and before CBHWs start service provision in their communities.

Following the mapping and household registration, the CBHWs are expected to place home-based cards in the households.

4.4 Service Provision

4.4.1 Service delivery mode and conduct of work

The Community Based Health Workers (CBHWs) will carry out their roles and responsibilities through home visits to increase utilization of essential health services and improve key household practices. The supervisors are expected to conduct community engagement activities including promoting male involvement in maternal and child health. The CBHWs will provide a wide range of services, broadly categorized into five key areas:

- **Health promotion and demand creation:** health education and counseling of individuals, members of the households and communities to adopt healthy behaviours; inform target populations of the services available in the PHC facilities, identify the target groups for the various services such as childhood immunization, antenatal, delivery and

post-natal care, encourage uptake of the services; link the populations to the health facilities to access the appropriate care and encourage enrolment into health insurance schemes.

- **Integrated Community Case Management** of key childhood illnesses: identification, assessment and treatment children aged 2 – 59 months with simple malaria, acute respiratory tract infection (ARI) and diarrhea. Identification of children with severe malaria, , diarrhea and other danger signs, administration of pre-referral treatment and immediate referral for appropriate care in the focal PHC facility.
- **Continuity of care for essential services and community distribution of commodities:** refill of oral contraceptives for women of reproductive age group (WRAG), provision of first aid treatment for minor injuries; administration of albendazole deworming tablets to children under age of 5 years; distribution of misoprostol and chlorhexidine for pregnant women and condoms for WRAG and men.
- **Screening for important health conditions**: screening for severe acute malnutrition among children aged 6 -59 months and hypertension among apparently healthy adults.
- **Surveillance and epidemic response**: identification and reporting of notifiable diseases including maternal, perinatal and child deaths, active participation in the community maternal, perinatal and child deaths surveillance and response, risk communication and community engagement within the epidemic response processes.

The services are organized into basic and comprehensive packs to be provided by the Auxiliary Community Health Workers and JCHEWs, respectively.

Table 8: Basic Package of Services

Priority Areas	Service contents
Reproductive Health	● Counsel on family planning and refer to facilities
Maternal Health	● Identify and line-list pregnant women. ● Counsel pregnant women on importance of optimal ANC, facility delivery, nutrition, disease prevention and general healthy practices. ● Refer pregnant women for antenatal care (ANC) ● Identify danger signs in pregnant women and refer to facility. ● Support pregnant women to develop birth preparedness and complication readiness plan. ● Distribute misoprostol to pregnant women. ● Refer parturient women to health facilities for delivery. ● Identify and link pregnant women with emergency transport. ● Encourage women to space their children using contraceptives. ● Educate pregnant women and her household on health insurance s
Newborn Care	● Counsel mothers on breastfeeding including early initiation, exclusive breast feeding, good positioning and attachment as well as common breastfeeding problems.

Priority Areas	Service contents
	• Provide education on essential newborn care. • Distribution of chlorhexidine to mothers of newborns for cord care • Identify and refer newborns with danger signs. • Counsel mothers on childhood immunization and refer • Counsel on birth registration
Child health	• Counsel on continuing breastfeeding for at least 24 months, and appropriate complimentary feeding for babies 6 – 23 months • Identify children with danger signs and refer. • Identify children with fever, conduct rapid diagnostic test (RDT) to diagnose malaria in children 2 – 59 months and provide appropriate treatment. • Identify and treat children diarrhea, including teaching mothers how to prepare low-osmolar oral rehydration solution (Lo- ORS). • Identify children aged 2 -59 months with cough, determine if child has pneumonia (fast breathing) and treat appropriately. • Deworm children. • Identify and refer children with severe acute malnutrition. • Identify children with moderate malnutrition and counsel mother. • Educate mother on prevention of diseases in children. • Counsel mother on importance of childhood immunization. • Determine immunization status of the child and refer children in need of immunizations. • Assist with defaulter tracking.
Adolescent Health	• Counsel on risky behaviours among adolescents. • Counsel on adolescent nutrition. • Counsel on general and menstrual hygiene practices. • Counsel on human papilloma virus (HPV) immunization. • Identify and refer adolescents in need of additional services
Care for other members of the household	• Counsel on WASH practices. • Counsel on disease prevention. • Counsel on adequate family nutrition • Distribute LLIN • Counsel on prevention of household injuries. • Provide first aid for minor injuries. • Educate household members on family planning. • Refer sick adults to facility. • Counsel household members on HIV/AIDS, Tuberculosis, hypertension and diabetes mellitus. • Counsel on care of the aged and the disabled. • Encourage health insurance registration

Priority Areas	Service contents
Community based surveillance	• Report any unusual illness or other health events. • Identify and record all births in HH registers • Identify and report maternal, perinatal and child deaths. • Participate in community MPDSR activities.

The basic services pack consists of counseling on and referral for reproductive, maternal, newborn, child and adolescent health plus nutrition (RMNCAH+N) services, integrated community case management of child illnesses, screening and linkage to care for severe acute malnutrition in children, counseling on water, sanitation and hygiene (WASH) and other disease prevention practices, provision of first aid for minor injuries, referring sick adults to health facilities, community based surveillance as well as risk communication and community engagement (Table 8)

The comprehensive service pack consists of the all the contents of the basic pack and additional services. The additional services to be provided by the JCHEWs are shown in Table 9.

Table 9: Comprehensive Service Delivery Pack

Priority Areas	Service contents
	• Basic service pack
Reproductive Health	• Refill of oral contraceptives • Distribution of condoms
Secondary prevention of priority diseases and conditions	• Screening for hypertension and diabetes • Identification and linkage to care for abnormal development in children
Continuity of care for priority diseases and conditions	• Participate in health outreaches in their catchment area
Promoting the health of children	• Provider nutrition education to caregivers and conduct group food demonstration sessions
Community based surveillance	• Monitor and report adverse events following immunization (AEFI)

4.4.2 Estimated work output

The expected work output for each CBHW should be objectively determined and monitored on two main streams; number of home visits conducted, and number of target population reached with the stipulated services.

The work of the CBHW is carried out though home visits. There are three types of home visits that they are expected to conduct:

- Routine home visits - for all the households in the assigned cluster to render general health promotion, disease prevention and demand creation activities.
- Targeted visits - for households with pregnant women and/or children eligible for immunization
- Emergency home visits – when invited to a household because of illness or other health emergencies.
- Follow-up visits, following treatment of children under the age of 5 or referrals for maternal and child health services.
- Emergency home visits – when invited to a household because of illness or other health emergencies.

Routine Visits

Overall, each CBHW is expected to cover the entire households in her assigned cluster within the ward with routine visits within a maximum of 6-month period, i.e. an expected minimum of two routine visits in a year to each household. Analysis of community mapping and micro-census of the assigned settlements will provide numerical basis for estimating the expected number of home visits to be conducted by each CBHW. Using an average population of 30, 000 per ward and an average household size of 5 and 10 CBHWs per ward. Each CBHW should be assigned about 600 households to ensure coverage of the entire ward. To achieve full coverage of assigned households, a CBHW must visit an average of 25 households in a week for routine visits. This estimate is a guide and could be modified at the sub national levels based on size and terrain of the ward, population density, number of CBHW per ward and availability of local information. The example cited is computed using national average of the indices.

Targeted visits

Whenever a CBHW identifies two key target groups (pregnant women and children under 2 years of age) in her assigned settlements, there are a minimum recommended visits she is expected to conduct to create demand for and ensure uptake of relevant essential services, as well as assessing for danger signs and need for referral. For instance, if a CBHW identifies a pregnant woman in the first trimester, she should conduct monthly visits to her to ensure she attends ANC clinic 8 times, give her the necessary health education and counseling and track the services she receives in the health facility. Post delivery, she should visit her at least six times as in her job aid to ensure she goes for PNC, monitor the baby etc. Additionally, it is recommended that children under two years are visited monthly to monitor nutritional status and uptake of needed immunization and other services.

Emergency and follow-up visits

When a sick child is identified during home visits or if called because of emergency, and is given treatment or referred, the CBHW is expected to conduct follow-up to monitor progress. If she identifies and institutes care for a sick child, she must follow up after 3rd day for malaria and diarrhea, and the 5th day for fast breathing to assess for improvement or occurrence of conditions that will necessitate referral. Based on incidence data, we estimate at least 2 emergency/follow up visits per household in a year.

Determination of the expected number of the target populations to be provided with services by each CBHW should also be evidence based. Key considerations for arriving at the target for the CBHWs and an objective basis for assessing their work output include:

1. The projected total population of the covered area
2. An empirical estimate of the proportion of the total population that represents each target population e.g. WRAG (22%), pregnant women (5%), children under age of 5 years (20%), children age 0 – 23 months (3%), children age 24 -59 months (17%).
3. Incidence and average number of episodes per annum for the ICCM diseases and proportion of whom care is not sought with skilled providers.
4. Utilization rates for the maternal health services such ANC, facility delivery, PNC, contraceptive prevalence rates, etc.
5. The programmatic target for the proportion of the burden of diseases and health needs to be covered in the community. In the initial years of the programme, the CBHWs should aim at reaching 30 - 50% of the burden of the key childhood illnesses not treated in the facility and also the unmet need of maternal and reproductive health services.

It is necessary to demonstrate how to estimate target population to be reached with specific services by a CBHW using; the national average of the incidence of 24.6% and 3 episodes per annum for malaria; 40.4% of cases treated outside the formal sector or no medical attention sought (MICS 2023); a programmatic target of reaching 50% of those cases. In a ward with a population of 30,000, each CBHW would be expected to identify and manage 90 children age under 5 years old with malaria in her catchment area in a year. Thus, targets for identification and treatment of children with diarrhea and fast breathing, identification of children eligible for immunization services and pregnant women for referral linkage to the health facility for ANC, delivery and post natal care services should be similarly computed and communicated to the CBHWs and their supervisors.

4.4.3 Record keeping

A CBHW is expected to record of all household members of her assigned settlements in the household register and note the main target priority population groups for her services; WRAG, pregnant women and children under age of 5 years. This information will be useful in planning her itinerary for home visits and service delivery. As she identifies a pregnant woman during subsequent home visits, she dedicates a row for her in the household record to document all the services she renders to her throughout her pregnancy, delivery and puerperium. A similar record line is dedicated to any child age 0 -59 months identified in the household and services rendered to him/her is documented

in the tool. Other services provided, including medicines or commodities dispensed, referrals made and health events identified, in the households are captured in the appropriate tools. This provides information for tracking the output of individual CBHWs and the overall the performance of the .

4.5 Supervision

Supervision is one of the key elements that define the success of the CBHW program, but can be challenging without proper planning. Integrated supportive supervision shall be carried out at different levels.

The shall focus on supervision in two broad areas: CBHW Supervision and Supervision of implementation

4.5.1 CBHW Supervision

This is the direct supportive supervision received by CBHWs during their work, highlighted as an integral component of community health worker programming. This is further subdivided into two (2) types of supervision - Technical supervision and non-technical monitoring.

a. Technical Supervision

An integrated supportive supervision addressing service delivery, logistics and data will be carried out by direct supervisors of CBHWs with the following objectives:

- Ensure adherence to guidelines and ensure that a standard quality of care is provided at the community level
- Provide ongoing training and professional development, offering support and problem-solving for clinical challenges
- Maintain accurate records of service delivery and commodity utilization

Technical supervision will utilize a checklist to ensure the systematic assessment and review of CBHWs' skills/competencies, work effort, output, motivation, and support.
A key component of this level of supervision is mentoring provided by the supervisors. The supervisors are expected to provide on-the-job mentoring and monitor CBHW’s participation in continuous learning programs. It also provides additional/new knowledge on health protocols and treatment/care guidelines.

b. Non-technical Supervision

Non-technical supervision aims to integrate CBHWs into the community, monitor engagement and feedback, facilitate community participation, address social and logistical issues, and promote accountability and transparency. It will be led by Ward Development Committees and achieved through community integration, engagement monitoring, and facilitation of participation, addressing social issues, and promoting accountability.

Community integration will involve monthly community meetings to discuss health issues and CBHW activities. Regularly scheduled meetings with community leaders, community members and CBHWs in local events and cultural activities will help achieve this integration. The WDCs will facilitate two-way community feedback mechanisms, with regular sessions organized to discuss feedback as necessary.

WDCs will also ensure transparent reporting of CBHW activities and outcomes to the community. Regular reports on CBHW activities and health outcomes will be reviewed at WDC meetings to ensure that CBHWs' data adequately represent the community situation and that discrepancies are addressed promptly and appropriately.

4.5.2 Supervision of implementation

This refers to the oversight conducted by each governance level over the subsequent levels. The three (3) levels involved in the supervision of program implementation include the LGA, State and National. The objective of these supervision activities include:

- Assess and identify implementation challenges, lessons learnt and best practices
- Address challenges to implementation by ensuring the participation of the stakeholders to provide context-specific information.

i. Selection of supervisors (criteria and numbers)

S/N	CBHW	Type of Supervisor	Criteria	Numbers
1	Auxiliary CBHW	Technical	Formally trained health workers: CHEWs, CHOs, OiCs, other health personnel, retired health workers	One (1) Supervisor to five (5) CBHWs
		Non-technical	WDC, CSOs, CBOs, School headmaster/principal, etc	
2	CBHW	Technical	Formally trained health workers: CHEWs, CHOs, OiCs, other health personnel, retired health workers	One (1) Supervisor to five (5) CBHWs
		Non-technical	WDC, CSOs, CBOs, school headmaster/Principal	

ii. Training of the supervisors

The CBHW supervisors will receive a five-day non-residential skill-based training on the following modules: Mentoring, Supportive supervision, Logistics supervision, Data management and Communication in Public Health.

Table 10: Organisation and conduct of work at different levels.

Level	Supervision Type	Supervisor	Supervision Focus	Frequency
Ward	Technical	Supervising CHEW	Technical	Monthly
Ward	Non-technical	WDC	Commodity security Oversight function Sanctioning and Reward of Personnel	Monthly
		CBOs	monitoring CBHW Work Effort Commodity supply and security	Monthly

LGA	Implementation Supervision	LGAHMT	Technical (CBHWs and focal health facility) Mentoring supervisors	Monthly
State	Implementation Supervision	SPHCDA	Technical (CBHWs) Mentoring (Supervisors) implementation monitoring	Quarterly
National	Implementation Supervision	NPHCDA & Stakeholders	implementation monitoring	Bi-annually

5. MONITORING AND EVALUATION

5.1 M&E Framework

The Monitoring and Evaluation (M&E) framework for tracking the progress of the Community Health Worker (CBHW) implementation, as depicted in Figure 1, is grounded in the global M&E operational framework. This framework links inputs to intended results, considering influencing and facilitating factors. To support performance analysis, core indicators have been identified along thematic areas and across the health indicator domains: input, process, output, outcome, and impact, where feasible.

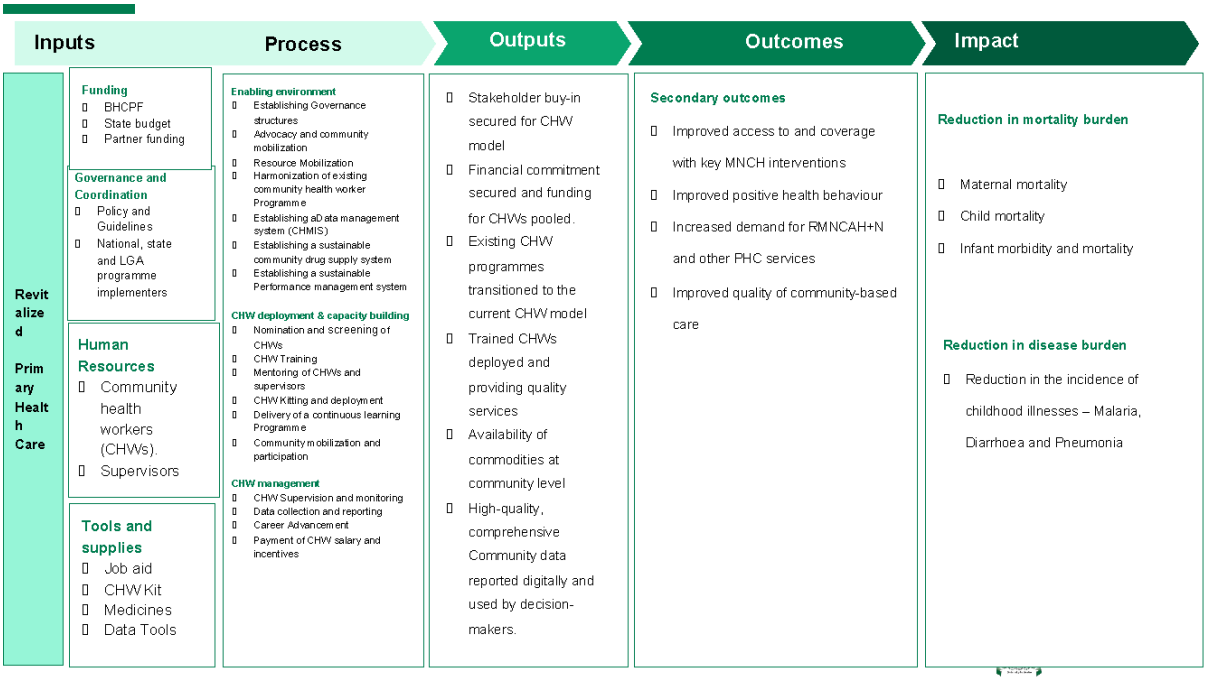

Figure 3: Logic Framework for M&E

Indicators

The key indicators that will be used in monitoring the are:

Impact Indicators

- Maternal mortality ratio
- Infant mortality rate
- Neonatal mortality rate
- Under-five mortality rate

- Incidence/prevalence rates of under-five morbidity rates for common childhood illnesses (diarrhoea, malaria, pneumonia, malnutrition)

Outcome

- Proportion of households that have benefited from any form of CBHW services in implementing communities
- Proportion of women with a live birth in the last two years who accessed at least 8 ANC visits during their last pregnancy
- Proportion of women with a live birth in the last two years who delivered in a health facility during their last pregnancy
- Proportion of women with a live birth in the last two years who a skilled birth attendant delivered during their last pregnancy
- Immunization Coverage
- Number of community members reporting improved knowledge of PHC services
- Proportion of households who express satisfaction with service received from CBHWs

Output

- Proportion of states that have commenced implementation of the revised CBHW Model
- Proportion of wards with CBHWs trained, kitted and deployed
- Proportion of supervisors trained in management and supervision of CBHWs
- Proportion of CBHW providing basic service package as defined by the
- Proportion of CBHWs who received a supervisory visit in the last month
- Proportion of CBHWs with stock-out of key commodities.
- Proportion of CBHWs utilizing digital tools for data collection
- Proportion of CBHWs reporting data monthly

Input

- Availability of standardized policies and guidelines for implementation of the CBHW
- Proportion of states with budget lines for the CBHW
- Number of partners providing funding for CBHW implementation
- Proportion of wards with functional WDCs
- Proportion of states with domesticated implementation plans
- Proportion of CBHWs receiving salary from Government funds
- Number of existing community based health worker s transitioned to the CBHW
- Number of existing community-based health workers transitioned to the CBHW

5.2 Monitoring

The availability of timely and reliable data from the is essential for community-based decision-making. This section outlines the ’s data collection, flow, monitoring, and evaluation guidelines. It will also assist in establishing and implementing a robust system to monitor outputs, identify challenges, and develop practical solutions to address them.

Recording and collecting community data

Community Health Workers (Auxiliary CBHWs/JCHEWs) will record community-level data across critical areas, including Household Enumeration and Profiling, Birth registration, Service provision, Community MPDSR, Disease notification, and Infodemics.

Household Enumeration, Profiling and Birth Registration

Following training, CBHWs will map their communities, number houses, and list households within their catchment areas using the Household Register which is designed for CBHWs to list households within their catchment areas, register household members, record essential socio-demographic information on members of households, document WASH practices, as well as updates on births, deaths, and migrations.

As part of these home visits, the CBHW will also ensure that newborns and all other family members are included in the National Birth Registry and register all unregistered household members using the CVR app. Similarly, they will also ensure that all deaths in their catchment areas are appropriately registered.

Service Provision, Community MPDSR, Disease Notification and Infodemic Management

- As CBHWs conduct home visits, they are expected to *identify and register pregnant women* in their communities. Once identified, CBHWs will *register and maintain a listing of pregnant women in their communities*. During their routine home visits, CBHWs will assess pregnant women to identify danger signs, refer them as appropriate and provide time-targeted counselling to ensure positive outcomes during the antenatal and postnatal period. These, along with the listing of pregnant women, will be recorded in the Maternal Register.
- The Child Health Register is a comprehensive record documenting all basic child health services CBHWs provide in their communities.
- The *Household register* records services not specific to pregnancy and childhood, such as Counselling on WASH, Adolescent Health, Disease Prevention, supporting community surveillance, monitoring maternal and child deaths and First Aid.
- Home-based cards *document/record services the CBHWs provide* to the *household members. These are* kept *permanently in the home* as a home-based record of service provision.

Other Data Areas

- Logistics Management: CBHWs will provide supplies and dispense medicines and commodities in their communities. A *Dispensing Form* will record medicines and commodities dispensed by the CBHW and information on recipients will be used as means of verification. This register will also record commodity and supply requests from focal health facilities and document commodities received by CBHWs from supervisors.
- Referrals: CBHWs will document referrals made in the community to health facilities in a Referral Form. Clients will be given a copy of the form to take to the health facility.

Following treatment, the health worker completes a feedback slip, which is returned to the CBHWs to document completed referrals.

- Data Collection and Reporting: Supervisors will use the monthly Summary Form to summarize and collate data recorded during CBHW service delivery and referral activities.

Digitizing Data Collection and Reporting

Community Health Worker data collection will be digitized to significantly enhance the quality and efficiency of health services provision data and reduce the burden of filling out multiple forms. Most registers will be electronically enabled to allow data collection to be conducted digitally utilizing mobile devices linked to the Community Health Management Information System (CHMIS) for easy reporting. However, forms (such as home-based cards and referral forms) that will be provided to community members will be simplified as much as possible to enable easy understanding by the client and reduce data points to be filled out by CBHWs.

3. Data Reporting

The will employ electronic reporting linked to the National Community Health Management Information System (NCHMIS) hosted on DHIS2. The data reported will be available at all governance levels - national, state, and LGA- and will provide data for use by all levels for planning, decision-making, and monitoring.

4. Data flow

- Data collection starts with Community Based Health Workers (CBHWs), who connect the Communities and Primary Health Care Facilities. CBHWs record and submit data from their community activities to the electronic data management system.
- Supervisors will validate the submitted data for accuracy and completeness, while the Ward Development Committee (WDC) will review the monthly data to provide feedback to the community on the .
- The electronic data management system (CBHMIS) will allow all higher levels (local government area, state, and national) to access community-level data.
- supervision and data flow monitoring will be through each governance level via established health system pathways.

5.3 Evaluation

The goal of the M&E is to improve current and future management of outputs, outcomes, and impact. The will be monitored with routinely collected community-level data, reports

of supervision, and review meetings at different levels. Periodically, the will be evaluated to determine the level of achievement of its objectives and impacts.

i. Baseline Assessment

A pre-implementation assessment will be conducted in each state to generate information for planning and provide baseline data that will aid in monitoring the progress of the over time. The baseline assessment is vital as it ensures accountability to partners and other stakeholders. The information obtained from the assessment will also serve as a basis for setting performance targets at all levels.

The baseline assessment template will be disseminated to all implementing states for the baseline assessment. Due to the challenges of conducting a national survey with a sample size large enough to determine the baseline values of the indicators at the ward level, existing data sources such as HMIS data available on DHIS2, recent household surveys, and related studies conducted will be used to determine the baseline for each community and ward. Where data cannot be obtained, it is recommended that trained personnel are deployed to the facilities to review the relevant HMIS data collection tools and extract the information needed.

ii. Mid-year Review

During the implementation phase of the , FMoH, NPHCDA and other relevant stakeholders will support states to conduct a comprehensive mid-year review of the . This will enable the identification of gaps, if any, and provide suggestions to bridge the gaps for improved efficiency and impact. All the states in the Federation will use a standardized template to ensure all the critical components of the are reviewed.

iii. Annual Review

An annual review shall be conducted at the National level. At this level, the state stakeholders will meet to identify gaps in the implementation, best practices, and lessons learned and proffer solutions to problems identified to improve efficiency and impact.

iv. Evaluation

The overall evaluation will be conducted as an external evaluation every 5 years to determine the 's relevance, scope, effectiveness, efficiency, outcome and impact. The

result of each evaluation shall be disseminated to all stakeholders and used for improvement.

6. MANAGEMENT

6.1 Governance

This section outlines the coordination platforms as well as the roles and responsibilities for coordination and implementation at each of these levels

6.1.1 Governance and Coordination

Nigeria's governance structure recognizes four levels of coordination – National, State, LGA and Ward.

Table 11: Roles and Responsibilities of the different stakeholders

Federal Level	**The Federal Ministry of Health**	- Provide policy and strategic direction - Provide implementation oversight - Advocacy, resource mobilization and deployment
	The National Primary Health Care Development Agency	- Oversight for implementation at sub-national level - Development/Review of costed CBHW Strategy - Alignment of all Community-based Programs - Development of Roadmap for institutionalization of community based PHC policy - Development and Review of CBHW training curriculum, materials and e-learning platforms - Setting standards of practice for CBHWs - Regulate practice of the CBHWs - Donor and partner coordination - Advocacy, resource mobilization and deployment - Consolidation of sub-national costed AOPs - State coordination - Pursue multi-sectoral collaborations and linkages essential to implementation and achievement of goals
	The Community Health Practitioners Regulatory Board of Nigeria (CHPRBN)	- Training of JCHEWs and CHEWs - Accreditation and licensing of JCHEW, CHEW and CHO cadres - Regulation of JCHEW, CHEW and CHO cadres
State Level	State Ministries of Health	- Provide implementation oversight - Advocacy, resource mobilization and deployment

	State Primary Health Care Development Boards	- Oversight for implementation at sub-state level - Adaptation, implementation, and institutionalization of the national CBHW policies and strategies - Training of CBHWs - Supervision and compliance monitoring of CBHW practice standards - Advocacy, resource mobilization and deployment - Development of costed AOPs - Donor and partner coordination
Local Government Area	The Local Government Health Authority	- Coordination of daily CBHW activities at LGA and Ward levels - Supervision and compliance monitoring of CBHW practice standards - Support to CBHW training
Electoral Ward	Ward Development Committees (WDCs)	- Resource mobilisation - Community-led monitoring - Oversight and accountability
	Civil Society Organisations (CSOs), Faith-Based Organisations (FBOs) & Non-Governmental Organisations (NGOs)	- Social Accountability

6.1.2 Roles and Responsibilities

1. National Focal Person

a. Coordinate program implementation at the national level
b. Provide oversight at the sub-national level

2. State Focal Person

a. Coordinates operationalization of activities at sub-national levels
b. Work with the relevant state officers to:
   - Procure and distribute commodities.
   - Adapt and distribute relevant IEC materials.
   - Conduct advocacy and stakeholder engagement laterally and vertically
   - Support trainings where applicable.
   - Analyse State data for the program and provide feedback to LGAs.
   - Participate in quarterly ISS visits with LGA teams.
   - Conduct State quarterly review meetings with LGAs and other stakeholders.
   - Participate in National review meetings.

3. LGHA Focal Person

a. Oversee day to day implementation of activities at the LGA and Ward levels
b. Work with relevant LGA Officers to:
    - Ensure communities are engaged
    - Coordinate tracking and utilization of commodities
    - Support nomination and recruitment of CBHWs
    - Conduct LGA quarterly review meeting.
    - Analyse LGA Data for the program and provide feedback to the community and ward.
    - Conduct quarterly ISS visits to all wards in the LGA (as part of a team that will comprise of State, partners and periodically, the National PHC teams).

4. Ward Focal PHC

a. Provide oversight for storage and dispensation of commodities
b. Collation, verification and transmission of service delivery data

5. CBHW Supervisor

a. Provide support to Community Health Workers in the conduct of their activities as well as special measures to address security challenges.
b. Work with the Community Health Workers to encourage male involvement in RMNCAEH+N related activities.
c. Address issues of non-compliance to lifesaving health interventions within the community and forward unresolved issues to the ward heads.
d. Facilitate the tracking of community referrals where male involvement is required.
e. Constitute community support groups to discuss topics such as WASH, HIV, Family Planning, Nutrition, NCDs etc. in collaboration with traditional and religious leaders.
f. Support the Community Health Workers in ensuring the recording of quality community-level data.
g. Communicate information on community outreach programs and other health activities to the Community Health Workers in the ward.
h. Collect community-level data from assigned Community Health Workers and submit it appropriately.
i. Verify data recorded by the Community Health Workers.
j. Mentor Community Health Workers on community data recording procedures.
k. Collate and Report commodity usage by the Community Health Workers Agents.
l. Present the consolidated ward level data at the WDC meeting

6. **Traditional leaders, religious leaders** -

a. Community entry and participation in the CBHW program, resource mobilization for program sustainability and community sensitization on services
b. Support birth and death notification and other required service delivery support
c. Dispute resolution.

6.1.3 Stakeholder Engagement

It is imperative, for buy-in that stakeholders are engaged in the process as early as possible. Ideally, national stakeholders - the Federal Ministry of Health, NPHCDA, regulatory bodies, professional associations and development partners, and the subnational level stakeholders, especially states, that have responsibility for implementation, should participate in the co-creation of the redesigned model.

The need for a detailed stakeholder mapping for appropriate engagement cannot be overemphasized. Appendix 4 provides some guidance on conducting the mapping and engaging the stakeholders.

NPHDCA should ensure that all stakeholders buy-into this redesigned strategy because of the significant changes in human resource and financial requirements. Meetings should be held with states to address any concerns they may have. Adequate support should be provided to the states to adapt the programme guide, map out an mobilize their stakeholders, conduct stakeholder engagement meetings and develop state specific workplans.

Lower-level engagement, especially at community level could be done through community dialogues or community workshops/meetings.

6.2 Commodity Supply Chain

Commodity supply chain management is foundational to the success of community health programs by ensuring the right commodities reach the right place at the right time, thereby improving the four (4) health outcomes outlined by NPHCDA (improved RMNCH and nutrition, accelerated immunisation programs for priority antigens, reduced prevalence of NCD and reduced the incidence of HIV, TB, and malaria) and supporting overall public health goals. The key aim of this component is to ensure uninterrupted availability of commodities (commodity security) to support quality services across the country.

6.3 Resource Requirements and Management

The resources required for effective implementation of the CBHW model *include*:

Selection and Training Costs

Cost of training is considered at the National, State, LGA and Ward levels, and includes personnel costs for selection team members, trainers, supervisors and participants, as well as costs of electronic and printed selection and training documents, hall hire, feeding and accommodation.

Commodities and Equipment

The commodities are grouped based on predetermined specifications and quantities and include items that deal with prevailing community needs. The commodities are listed in Appendix 3.

Data Collection Tools

Android Devices: This will be used for community level data collection and transmission. It will ensure that households and supervisors can communicate with the CBHWs when necessary.

Printed Materials: These include the data tools for use by the CBHWs and their supervisors.

Incentives and Compensation

CBHWs will require compensation for service provision, as well as incentivisation to improve motivation and performance.

Supervision and Monitoring Costs

This includes costs for Integrated supportive Supervision (ISS) of CBHWs, data quality checks, ward review meetings and monitoring activities.

7. BUDGET

7.1 Estimated Budget

The financial requirements for the accelerated phased implementation of the CBHW in the country is estimated at Six Hundred and Eighty Seven Billion, Eight Hundred and Twenty Eight Million, Four Hundred and Four Thousand, Five Hundred and Forty Eight Naira (₦ 687,828,404,548) spread over the five year period from 2024 to 2028. The estimates include costs for salary of the CBHWs (₦420billion), monitoring and evaluation (₦71.3billion), service delivery (₦71.6 billion), recruitment, training, accreditation and advancement (₦ 124.7billion) and governance (₦ 368million). The major key drivers are therefore salary (61.1%), Recruitment and Training(18.1%), M& E (10.4%) and service delivery (10.4%) as shown in Table 6.1

Table 12: Cost estimates for the CBHW implementation

Components	Estimated cost ₦ (%)					
	2024	2025	2026	2027	2028	Total
Governance	73,617,200 (20.0%)	92,021,500 (25.0%)	92,021,500 (25.0%)	55,212,900 (15.0%)	55,212,900 (15.0%)	368,086,000 (0.05%)
Monitoring and Evaluation	4,887,418,300 (6.86%)	9,922,428,500 (13.92%)	15,589,715,400 (21.87%)	18,698,114,900 (26.24%)	22,171,476,300 (31.11%)	71,269,153,400 (10.36%)

Service Delivery	14,317,948,750 (11.48%)	17,897,435,937 (25.0%)	17,897,435,937 (23.53%)	10,738,461,562 (15.0%)	10,738,461,562 (15.0%)	71,589,743,748 (10.41%)
Recruitment, and Training,	30,801,613,640 (24.70%)	29,345,655,550 (23.53%)	29,345,655,550 (23.53%)	17,607,393,330 (14.12%)	17,607,393,330 (14.12%)	124,707,711,400 (18.13%)
Salary	11,052,720,000 (2.63%)	35,920,800,000 (8.55%)	74,604,240,000 (17.76%)	121,576,680,000 (28.95%)	176,838,120,000 (42.1%)	419,992,560,000 (61.05%)
Total	**61,133,317,953 (8.89%)**	**93,178,341,575 (13.54%)**	**137,529,068,482 (19.99%)**	**168,675,862,763 (24.52%)**	**227,410,664,167 (33.06%)**	**687,927,254,548 (100.0%)**

The total estimated annual implementation cost rises from Sixty One Billion, One Hundred and Thirty three Million, Three Hundred and Seventeen Thousand, Nine Hundred and Fifty three Naira (₦61,133,317,953) in year one to Two Hundred and Twenty Seven Billion, Four Hundred and Ten Million, Six Hundred and Sixty Four Thousand, One Hundred and Sixty Seven Naira (₦227,410,664,167) in year five.

The following costing assumptions informed the computation of the financial requirements for the various components of the implementation, which should serve as a guideline for budgeting at the sub-national levels.

Ingredient (bottoms-up) approach is recommended for estimating the cost of commodities and supplies using the formula below:

Cost of commodities = Population in Need x Target Coverage x ∑Quantity of Commodity Required per Case x Unit Price of the Commodity.

- Total population is the entire persons living within a geographical area such as the country, state, LGA or ward
- Population in need (PIN) of the commodity/supply for ICCM diseases is computed as the product of total population, the target population, the incidence of the disease, average number of episode in the year, and the proportion of the affected population for whom care is not sought in the formal health care delivery system.
  = Total population (N) x target population (n) x incidence (I) x number of episodes (E) x proportion of the affected population for whom care is not sought in the formal health care delivery system (P) = N x n.x I x E x P
- PIN of the commodity/supply for other services is computed as the product of total population, the target population, the utilization rate/unmet need, and target coverage
- Quantity required per case for ICCM diseases is age based. The doses per case of children ≤ 23 month is half of that of children 24 -59 months.
- Unit price is the cost of commodity using prevailing market price at wholesale rate, 5% mark up. However inflation rate (34.2% as at June 2024) was not factored, implementers should consider it during the budgeting process.
- Target coverage is the proportion of the PIN planned to be reached with services by the CBHW .

Table 13: Population parameters for computing population in need of essential commodities for CBHW

Projected Total population		Target population (% of the total population)	
2024	229,248,770	WRAG*	22
2025	237,272,477	Pregnant women	5
2026	245,577,014	Children under the age of 5	20
2027	254,172,209	• Children under age of 2 • Children 24 – 59 month	3 17
2028	263,068,236		
		Crude birth rate 38 per 1000	

*Women of reproductive age group

To illustrate computation of the cost of Artemisinin Combination Therapy (ACT) for treatment of malaria among children under the age of 5, in a State with a total population of 9,032,200:

The PIN (≤ 23 months) = N x n.x I x E x P = 9,032,200x 0.03 x 0.246 x 3 x 0.404

= 80, 789 doses for this age group

This age group receives half the dose for children age 24 -59 months = 80, 789 x 0.5 = 40, 395 doses

The PIN (24 – 59 months) = N x n.x I x E x P = 9,032,200x 0.17 x 0.246 x 3 x 0.404

= 457, 804 doses of antimalarial for children for this age group

Thus the total doses needed in the state for a year is 40, 395 + 457, 804 = 498, 199 doses

Assuming that the State Primary Health Care Board sets a coverage target of reaching 30% of people in need and the cost of a pack of ACT of two doses is ₦1,200;

The cost of ACT for children under age of 5 in the state for that year is therefore = 498, 199 x 0.3 x ₦600

= ₦ 44, 837, 820 (Forty Four Million, Eight Hundred and Thirty Seven Thousand, Eight Hundred and Twenty Naira).

Table 15: Epidemiological indices for the calculating population in need of essential commodities for CBHW

Incidence/prevalence (%)		Average episode in a year	Percent for whom care in not sought in formal sector
Malaria	24.6	3	40.4

Cough	12.0	4	34.7
Diarrhea	13.0	4	47.0
Minor injury	2.0	2	
Utilization rate			
Unmet need for family planning	44.8		

Sources: MICS 2021

7.2 Sources of Funds and Resource Mobilization Plan

Health care financing is one of the critical determinants of the ability of a health care delivery system to attain universal health coverage (UHC) which entails that all individuals and communities have access to the health services they need without suffering financial hardship. Unfortunately, the burden of diseases and preventable death disproportionately affect populations that have the lowest ability to pay for health care and are covered less with essential health services. Thus, the realization that UHC cannot be attained without significant investment in community component of PHC that deliberately target underserved populations and promoting removal of out of pocket payment at point of care. Although increase in public spending for health is identified as the most effective approach in fast tracking the journey towards achieving UHC, harnessing other sources of funding is necessary to provide for the increasing need of the growing population in the context of other competing needs. The various funding options for the optimized CBHW in Nigeria therefore include the following:

1. Budgetary allocation earmarked for the by governments at federal, state and local government levels.
2. Existing sources of funding in PHC space such as Basic Health Care Provision Fund, National Health Insurance Authority, Nigeria Centre for Disease Control to support the various components of the
3. Grants from development partners
4. Contribution from organized private sectors in form of corporate social responsibility, grants and donations
5. Philanthropists and community based financing mechanisms
6. International financial institutions such as the World Bank, African Development Bank and Islamic Development through loans and grants

Expanding the fiscal space for CBHW requires concerted efforts aimed at harnessing these potential resources to provide a predicable source of funding for sustainable implementation of the renewed CBHW requires a more coordinated and result oriented approach. These include:

1. Leveraging the Sector Wide Approach within the Coordinating Ministers Health Sector Renewal Investment Initiative to dedicate a specific bucket of funds from the central pool to support implementation of the .

2. Develop an investment case that demonstrate cost effectiveness of optimal investment in community component of PHC, including long term result of investment on human development indices and cost of inaction. This will serve as an advocacy tool to policy makers and donors at the national and sub-national level promoting sustainable development
3. Constructive engagement of the State Ministry of Health, State Primary Health Care Development Boards, States Houses of Assembly, Ministries of Local Government and Local Government Councils for streamlining the various costs of community components of PHC in the different budget items into dedicated consolidate fund for the CBHW during the appropriation process.
4. Coordinate utilization of existing public funding lines in BHCPF, NCDC, NHIA and State Health Insurance Agencies (SHIAs) for procurement of commodities, surveillance activities and payment of the personnel costs of the CBHW .

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APPENDICES

Appendix 1: Commodities and Equipment needed for the

ority Areas	Service contents
roductive Health	A set of Family planning commodities (condoms. IUD, Pill, Beads etc)
ternal Health	Misoprostol (Packs)
wborn Care	• Chlorhexidine Gel
ld health	• Lo-ORS • Zinc Tab 20mg • Paracetamol (Card) • Amoxicillin (Dispersable) sachet • ACT (Artemeter Lumefantrin) • Malaria RDT Kits of 25 in a Kit • Albendazole
ting & Equipment	• Latex Gloves (100) • Respiratory Timer • MUAC Strips (per piece) • Ankara (Bundle of 4 Yards Each) • Masking Tape (Big) • Measuring jug • A big cup with a cover • Towel (for tepid sponging demonstration) • Spoon (Stainless) • Notebooks • Job Aids • Scissors • Apron • Long Lasting Insecticidal Net (LLIN)
E	• Liquid Soap (50cl Size) • Facemasks • Infrared thermometer • Veronica buckets • Hand sanitizers

Appendix 2: Rewards and Sanctions

Rewards shall be given to the most outstanding CBHWs at various levels while sanctions will be imposed on offenders as shown below. For the JCHEWs, these mechanisms will be awarded in collaboration with the CHPRBN.

REWARDS

S/N	REWARD RECIPIENT	REWARD TYPE	REWARD FREQUENCY
1	Best CHBW at Ward level	The picture of the CBHW displayed on the notice board at the focal health facility	Monthly
2	Best CBHW at LGA level.	The CBHW shall receive a reward in cash or kind. (A name tag stating the recognition award and the month(s) for which the person is rewarded)	Quarterly
3	Best CBHW at State level.	The CBHW shall receive a reward in cash or kind.	Bi-annually
4	Best CBHW, best CBHW Supervisor, best-performing State, best-performing LGA/Ward (Nationwide)	This shall be decided by NPHCDA	Annually

SANCTIONS

S/N	OFFENCE	DEFINITION	PUNISHMENT	ENFORCEMENT AUTHORITY
1	Falsification of records	Alteration of records or passing along copies of false documents to deceive another person	1st time offender- Warning and/or Suspension for a maximum of 3 months 2nd time offender – Dismissal	WDC Disciplinary Committee or the State Disciplinary Committee The National & State Disciplinary Committee
2	Misappropriation of Funds	Intentional and illegal use of funds for an unauthorized purpose	Dismissal	The National & State Disciplinary Committee

3	Extortion	Demanding cash or kind before rendering service or sharing free commodities	1st time offender - Warning and/or Suspension for a maximum of 3 months 2nd time offender – Dismissal	WDC Disciplinary Committee or the State Disciplinary Committee The National & State Disciplinary Committee
4	Misuse of drugs/ Drug abuse	This involves repackaging prescription and wrong dispensing of the drugs. Also, the use of the drugs by the CBHW to the extent that he/she carries out his/her duties while intoxicated.	1st-time offender - Suspension for a maximum of 3 months 2nd time offender - Dismissal.	The LGA Disciplinary Committee shall handle the first-time offender. The 2nd time offender shall be handled by the State & National Disciplinary Committee
5	Negligence	Negligence in carrying out his/her duty of care owed to the client to the extent that a client sustains an irreversible bodily injury like loss of a body part, serious disfigurement or death as a result of the CBHW's action, when such could have been avoided.	Dismissal. In the case of death, the CBHW shall be handed over to the appropriate authority for prosecution.	The State and National Disciplinary Committees

6	Prohibited Acts/Services	Administration of injections, examining pregnant women in their homes, taking deliveries, carrying out abortions, screening for HIV/ AIDS, screening for non-communicable diseases (for Auxiliary CBHWs) or any other thing outside their scope of work	• If the client had a mild or no side effect from such act of the CBHW, there will be a suspension for the 1st- time offender and dismissal for the 2nd- time offender, however, for carrying out an abortion, there will be a dismissal. • If the patient suffered a severe side effect, it is Dismissal • In the case of death, the CBHW shall be handed over to the appropriate authority.	• In the case of suspension, it shall be handled by the LGA Disciplinary Committee. • In the case of dismissal, it shall be handled by the State & National Disciplinary Committee. • In the case of death, this shall be handled by the National Disciplinary Committee
7	Breach of Patient Confidentiality	The disclosure of a patient's personal and medical information by the CBHW without the patient's permission and in the case of a minor, his parent, caregiver, or legal guardian's permission	1st-time offender- Suspension for a maximum of 3 months 2nd time offender- Dismissal	The LGA and State Disciplinary Committees
8	Criminal Offence	These include Theft, Rape, Murder, and any other act considered a criminal act by the Laws of the Federal Republic of Nigeria	Dismissal. The CBHW shall be handed over to the appropriate authority for prosecution	The State and the National Disciplinary Committees.

Appendix 3: Key Performance Indicators

The key indicators that will be used in monitoring the are:

Input	Availability of standardized policies and guidelines for implementation of the CBHW Proportion of states with budget lines for the CBHW Number of partners providing funding for CBHW implementation Proportion of wards with functional WDCs Proportion of states with domesticated implementation plans Proportion of CBHWs receiving salary from Government funds Number of existing community based health worker s transitioned to the CBHW Number of existing community-based health workers transitioned to the CBHW
Output	Proportion of states that have commenced implementation of the revised CBHW Model Proportion of wards with CBHWs trained, kitted and deployed Proportion of supervisors trained in management and supervision of CBHWs Proportion of CBHW providing basic service package as defined by the Proportion of CBHWs who received a supervisory visit in the last month Proportion of CBHWs with stock-out of key commodities. Proportion of CBHWs utilizing digital tools for data collection Proportion of CBHWs reporting data monthly
Outcome	Proportion of households that have benefited from any form of CBHW services in implementing communities Proportion of women with a live birth in the last two years who accessed at least 8 ANC visits during their last pregnancy Proportion of women with a live birth in the last two years who delivered in a health facility during their last pregnancy Proportion of women with a live birth in the last two years who a skilled birth attendant delivered during their last pregnancy Immunization Coverage Number of community members reporting improved knowledge of PHC services Proportion of households who express satisfaction with service received from CBHWs
Impact	Maternal mortality ratio Infant mortality rate Neonatal mortality rate Under-five mortality rate Incidence/prevalence rates of under-five morbidity rates for common childhood illnesses (diarrhoea, malaria, pneumonia, malnutrition)

Appendix 4: Stakeholder engagement strategy

SN	Consideration	Description	Details
1	Stakeholder Identification/ Mapping	Stakeholders will be mapped to determine those actors/players that can affect or be affected by the program, at national and sub-national levels	**Community Members** - those directly benefiting from the program, such as clients and their families. **Community based Health Workers** - The frontline workers who will implement the program. **Community Leaders and Influencers** - Community elders, religious and traditional leaders, etc. **Health Authorities** - FMOH, NPHCDA, SMOH, SPHCDB, LGA HMT, etc. **Non-Governmental Organizations** - CBOs, CSOs, FBOs, etc. **Donors and International Agencies** **Academic and Research Institutions**
2	Stakeholder Prioritisation	Stakeholders will be classified to determine those that should receive more attention, resources and communication based on their level of influence or exposure/vulnerability	**Assess Stakeholder Attributes** - based on influence, interest and impact. **Classify stakeholders** - using a matrix which plots stakeholders based on: ● High Influence, High Interest: Key players who should be closely managed. ● High Influence, Low Interest: Powerful stakeholders who should be kept satisfied. ● Low Influence, High Interest: Stakeholders who should be kept informed. ● Low Influence, Low Interest**: Stakeholders who require minimal effort. **Rank Stakeholders** - based on the assessment and mapping
3	Communication & Information Sharing	Communication content and channels will be determined based on the specific needs and expectations of the stakeholders, and the objectives of the program	**Understanding stakeholder needs and context** **Building Trust and Credibility** - transparency, participatory approach, long-term Commitment, etc. **Appropriate and effective channels for reaching different stakeholders** - traditional media, social media, engagement meetings, local gatherings, etc.
4	Stakeholder Engagement Activities	Activities will be planned, conducted and measured to build and maintain relationships to ensure active support and commitment of the stakeholders	**Develop engagement plan** - using gather Detailed Information about high-priority stakeholders **Allocate resources** - time, personnel, budget, according to the priority level of each stakeholder group **Execute activities** - develop necessary communication materials, conduct national and subnational stakeholder engagement meetings, etc.

		Ensure continuous monitoring & feedback to regularly assess the effectiveness of stakeholder engagement and adjust strategies as needed.