

# CHW “Principles of Practice”

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*Guiding principles for non-governmental organizations and their partners for coordinated national scale-up of community health worker programmes.*

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## Abbreviations and acronyms

CHW	Community health workers
CHW AIM	Community Health Worker Assessment and Improvement Matrix
CCM	Community Case Management
C-IMCI	Community-Based Integrated Management of Childhood Illness
FBO	Faith-based organization
GHWA	Global Health Workforce Alliance
HMIS	Health management information systems
HRH	Human resources for health
IMCI	Integrated Management of Childhood Illnesses
INGO	International non-governmental organisation
MDGs	Millennium Development Goals
NGO	Non-governmental organization
pMTCT	Prevention of mother to child transmission (of HIV)
WHO	World Health Organization

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## Introduction

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Non-governmental organizations have long been involved in community health programmes globally, many of which draw on the efforts of community members and volunteers to implement a wide range of activities. Among different countries and regions, cadres of trained health volunteers have emerged with diverse titles and responsibilities, according to the context's existing health infrastructure and needs, or to the interests of donors and NGOs. Amongst these, community health workers (CHWs) are emerging as key players in delivering health to the poorest and most underserved communities.

CHW programmes globally have evolved from grass-roots activities led by different agencies, including public health services, international and local NGOs, and faith-based organizations. As such they have an inherent diversity of activities, methodologies and modes of engagement. In more recent years, the crisis of health workforce shortages in many developing contexts has led to the promotion of 'task-shifting' or 'role-optimization' initiatives, which aim to formally recognise and strengthen lay health workforces to deliver basic health services. Indeed it is becoming increasingly recognised that CHWs are an essential extension of the health system in countries with low health service access, and progress towards the Millennium Development Goals (MDGs) for health may not be achieved without them<sup>1, 2</sup>. We commonly consider the term of CHW very broadly, defined as "any health worker carrying out functions related to health care delivery; trained in some way in the context of the intervention; and having no formal professional or paraprofessional certificated or degreed tertiary education"<sup>3</sup>. Amongst these, certain cadres are becoming gradually more formally recognised or linked with existing health services, in particular those cadres providing basic services and treatments in the community.

The Principles of Practice outlined in this document are intended as a framework for advocacy, programming and partnership between implementing NGOs, government and donor agencies working with key CHW cadres in countries for which rapid and urgent scale-up of CHW programmes is a priority. They aim to guide NGOs to work with existing health structures through strong, long-term partnerships in order to deliver consistently high standards of quality implementation, training and support, toward the creation of community health workforces that are sustainable, functional and effective and can be successfully implemented at scale.

### Context

Historically, CHW programmes had come to be regarded with some scepticism by the global health community, with lingering concerns around their effectiveness and sustainability given the rapid turnover and continual investment of resources. Throughout the late 1970's and 1980s, in the wake of the Alma Ata declaration, CHW programmes were considered the centrepiece of the "Health for All" agenda, but after substantial investments in initial training, further necessary investments were found to be lacking in many countries leading to high attrition rates and variable quality. Political and economic changes within some countries, corruption or inconsistent donor investment also affected implementation. Government health systems were largely unable to sustain the supervision required to maintain active CHWs on the ground, so the initial high expectations were diminished. Yet, in other countries such as Brazil, Bangladesh, India, Iran, Nepal and Pakistan, political support for CHWs was maintained over time, leading to flourishing CHW programmes<sup>4, 5</sup>.

In the last decade the global health community has returned with renewed enthusiasm to CHW programming in the light of evidence showing CHWs can make an impact on health under certain conditions and methods, especially in the areas of child survival, nutrition and HIV / AIDS care<sup>3-8</sup>. The introduction of Integrated Management of Childhood Illnesses (IMCI) preceded this shift, as CHWs were sought out as partners in the delivery of its community-based component of preventive and protective

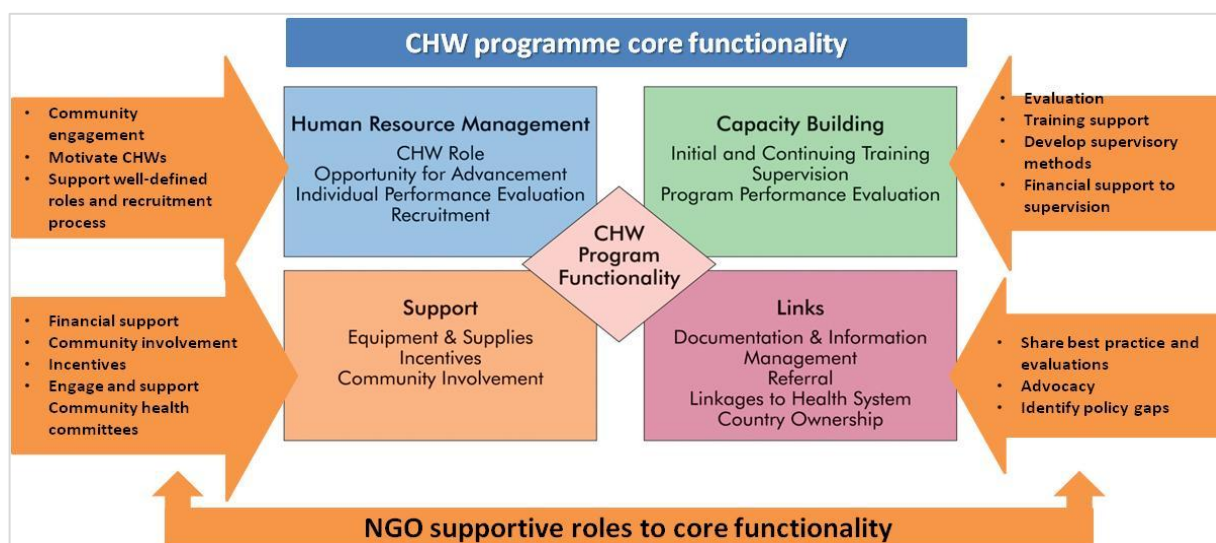
care, leading to Community-Based Integrated Management of Childhood Illness (C-IMCI). The logical and simplified treatment protocols of IMCI have been adapted to enable improved community case management (CCM) of childhood diseases such as diarrhoea, pneumonia, and malaria, which have been shown to be successfully delivered at scale in countries such as Malawi, Ghana, Ethiopia and Senegal<sup>9</sup>.

The fact remains that countries with the greatest delays in progress toward the health MDGs, are also those in which the health workforces are critically low and suffer from severe rural–urban disparities in health worker distribution. Human Resources for Health (HRH) crisis countries are key candidates for urgent coordinated efforts to increase frontline health workers of all kinds including CHWs<sup>10, 11</sup>. But sustaining these initiatives will require long-term partnerships between government health authorities, donors and NGOs as well as civil society involvement.

### CHW Programme Performance & Sustainability

Because of the notable weaknesses in early CHW programme implementation, the global community became increasingly reflective on programming approaches and activities leading to success. Today there is a vast evidence base which supports a multifaceted programme design to enhance performance, effectiveness and sustainability of CHW programmes<sup>2,4,5,7</sup>. Various tools are now available to guide decision-makers into improved programme design choices which can address the many facets required to ensure functionality<sup>12,13</sup>. One such tool, the CHW-Assessment and Improvement Matrix lists 15 programmatic components derived from evidence-based practices<sup>12</sup>; provide simplified benchmarks against which to assess country CHW guidelines and implementation in the field. The results can be used to broker discussions with local and national government stakeholders and partners towards programme strengthening activities. Findings on the use of this tool show weaknesses in implementation, even where CHW policies are strong<sup>14</sup>. Most common gaps include ongoing training and professional development, inadequate or irregular supervision systems, lack of supplies and sustainable supply chains, and poor linkages between the communities, CHWs and the wider health system. NGOs focus especially on building engagement at the community level and can have key roles in the motivation, support, training and supervision of CHWs. In low resource contexts direct support might be given in the form of finances, staff or supplies, while other areas where government programmes are more advanced NGOs may be more focused on advocacy or evaluation of existing initiatives.

**Figure 1. CHW AIM functionality Matrix and NGO Support Mechanisms.** 15 programming elements are identified as important to sustainable functional CHW programs. NGOs support these element in multiple ways listed in the arrows.



## Emerging Issues with Diverse Programmatic Approaches

The grass-roots development of CHW programming leads to variation in roles and activities, and in the distribution of programmes and quality. The degree of leadership an NGO takes in overseeing and resourcing the work of CHWs influence the degree to which state services are empowered to strengthen their community activities in the long term. Issues around CHW implementation continue to arise in the field; these need to be addressed in planning national and international scale-up of CHW programmes.

- **Mosaic training systems**

NGOs and civil society organizations support CHW trainings often using curricula which are diverse in content and expectation of CHWs. This has resulted in a mosaic distribution of CHW programmes in many countries, making it difficult to determine whether a basic minimum training standard has been achieved, and if trainings were delivered with a similar quality and methodology.

- **Competitive and duplicative working strategies**

In areas with multiple NGOs in operation, CHW programmes may overlap geographically causing them to work in competitive or duplicative ways. Multiple CHWs are sometimes attributed to different NGOs and projects in the same communities. While appropriate divisions of tasks may improve efficiency and coverage in some instances, it could limit the continuity of care and integration of community services, especially if different providers report to different bodies, and may lead them to focus on programme requirements rather than centring on the needs of the client. CHWs delivering health services need to work together to ensure integrated and client-centred care. CHW oversight should be provided by the same community health structures, endeavouring where possible to strengthen existing structures, without introducing new ones. Where pockets of inequities remain, tailored and more intensive CHW strategies may be required to address specific contexts, which can be built into scale-up plans.

- **Diverse incentives amongst NGOs and project types**

Most countries lack a guiding policy around motivational strategies at a national level, resulting in different NGOs or projects issuing different levels of incentives. Often, the best financed programmes are grant-funded initiatives which are time-limited and driven towards rapid short term gains in health outcomes, enabling larger financial packages for CHWs. Many NGOs working through longer term programmes tend to have lower annual budgets and are unable to match these incentives. Competing incentive packages can cause conflicts of interest in the communities. NGOs operating in the same area should seek unity on the issue of incentives and avoid the possibility of neighbouring communities and CHWs being subject to different methods and standards.

- **Direct provision of services**

Most NGOs do not directly provide services, but facilitate and work to strengthen existing services, promoting their use in communities. However, in some instances, NGOs and faith based organizations (FBOs) work directly with the communities providing medicines and medical services through CHWs in parallel to the health system. In certain contexts, such as disasters, conflicts or emergencies in need of external support, short-term direct service provision is necessary to ensure access to life saving interventions, and CHWs can have an important role in ensuring frontline services during disasters<sup>15</sup>. Contexts which are fragile or where state services are suffering poor functionality or corruption are also areas where NGOs and FBOs are essential, sometimes the only providers of services. Programmes in such contexts tend to be maintained by short term finance mechanisms, which promote fast acting solutions rather than slow-built sustainable approaches.

It is ultimately the responsibility of governments to ensure their citizens are able to access and realize their right to health so it is important that NGOs support progress in building both capacity and accountability of state services in HRH crisis contexts. In the recovery of fragile states, the re-building of

state-society relations must be addressed, of which accessing quality health services are a key component<sup>16</sup>. Current NGO / FBO approaches in fragile contexts through direct or parallel service delivery by NGOs through CHWs does little to promote accountability between the government and citizens, and in worst cases may actually be competing with or contributing to a breakdown of trust in state health services. Therefore, a long-term plan for CHW scale up, health governance, funding and NGO programming must take into consideration the need to build trust and dependence in internal health providers, and work together to strengthen unreliable or weak health systems.

- **Parallel services and supply chain management**

Frustrations related to medical supply chains exist in many high priority countries. Stock-outs of essential medicines and commodities are common, especially in rural areas. NGOs working with CHWs in community-based treatment programmes often opt to supply directly in order to circumvent issues related to traditional supply chain routes. While this method ensures efficient supply in the short term, and may be absolutely necessary in some circumstances, it does not provide a sustainable solution. Furthermore, weaknesses in health system supply chains remain unresolved, and parallel systems weaken the accountability of existing infrastructures. Once a project ends, supplies and services collapse, CHWs run out of the buffer stocks and with no replacement system community health delivery ceases to function.

- **Diversity in quality assurance, supervision and reporting systems**

In the era of HIV vertical programmes throughout the 1990s many projects responded to the crisis by setting up rapid-acting vertical HIV treatment and testing programmes<sup>17</sup>. While the urgency for action was undeniable, this also led to confusion over country coordination and reporting, as parallel systems were established. In a similar way it has now become difficult for health authorities to report on CHW activities as operations and reporting among agencies are so diverse. Many countries, especially those with weaker health systems, need strengthening in health information systems for quality monitoring. Field supervision of CHWs is rare or infrequent in countries with severe health workforce shortages. Consistent assessment of quality against appropriate standards and defined competencies is frequently lacking across projects. While the ideal would be for qualified health personnel to do regular supervision, in reality this gap is often filled by NGO staff, peer CHWs or not at all. Innovative methods for supervision can have an important role here, including CHW peer supervision groups, supervision days at clinics and remote supervision methods. Mobile technologies, when coordinated with the MoH, offer a possible solution to improving local data management.

## Scope and Objectives

CORE Group ([www.coregroup.org](http://www.coregroup.org)) emerged in 1997 when a group of health professionals from non-governmental development organizations realized the value of sharing knowledge, leveraging partnerships, and creating best practices for child survival and related issues employing a community-based health care approach. The *Community Health Network* evolved into an independent non-profit organization with Member NGOs, Associate Organizations and Individual Associates working in 180 countries. Collectively, the organization works to build the capacity of communities to collect and use data to solve health problems, foster partnerships between civil society, formal health care systems and other stakeholders, and train and support community resource persons to prevent and treat health-related issues. Currently, Core Group member organizations' health programmes, reflecting their grass-roots origins and community-driven development, have diverse approaches for CHW engagement. These Principles of Practice for Community Health Worker Programming, developed by World Vision in partnership with CORE group, build on the experience, knowledge and best practices of the *Community Health Network* and represent the collective wisdom for enabling a community health workforce that is functional, effective and sustainable when implemented at scale. The purpose of this document is to highlight emerging issues

of diverse programming approaches, then provide actionable steps for NGOs that promote the principles of good partnership coordination for ethical and long-term investments in those CHW priority countries and contexts.

- **What cadres of CHWs do the Principles refer to?**

In many countries there are various cadres of CHWs, which can function together in complementary ways, and the principles described here are not intended to extend to all possible cadres in a given context. The scope of the Principles applies specifically to those specific cadres of volunteers or workers whose activities have a *direct relationship* to the respective health authorities and are not solely linked to an individual project, NGO or civil society organization. This document refers to those CHW cadres whose role and relationship is fully sanctioned by the public health system and whose role includes some form of service provision to the community. This especially applies for cadres conducting curative services such as prevention of mother to child transmission of HIV (pMTCT), community case management of diseases (CCM), dispensers of family planning commodities, amongst others. This is not however to say that complementary volunteer cadres do not have important roles to play both through NGO and civil society engagements. The rationale for specifying principles of practice for this group is that we should aim to establish CHWs roles as part of an integrated *continuum of care* from households to health systems, and to ensure public health systems are committed to provide oversight of and accountability for quality care in the community.

- **Targeting CHW scale up in Health Workforce Crisis countries**

Currently not all countries where NGO-led CHW programmes are being implemented would stand to see the same benefits from strengthening partnership approaches for CHW scale up. Many places are now making strong progress towards MDGs and have multiple players and private enterprises working alongside in delivery of community based care. However, there are certain countries and contexts where national and regional coordination of rapid CHW scale-up are urgently required. These include in particular those countries identified as suffering severe shortage of human resources for health (HRH), or HRH crisis countries. Lastly, Principles are stated in a manner that reflects centralized health service management. Depending on the progress of decentralization in each country to regional authorities the Principles could be adapted to advocate for decentralized CHW management allowing for development of locally relevant strategies under centralized policies.

## Concurrent Works and Synergies

Renewed interest in scale-up of CHWs has led to a number of initiatives aiming to consolidate the evidence base for CHW programmes and put lessons learnt into practice. The Global Health Workforce Alliance (GHWHA) conducted a study of current CHW programme evidence and hosted a global consultation involving programme managers, policy makers and experts in Montreaux, Switzerland in 2010<sup>1</sup>. From this an agreement was developed on CHW integration into the health workforce, aligning with calls for expansion of Health Workforce in crisis countries and the highlighting of task shifting as a key component<sup>10,11</sup>. They expanded this work commissioning an in-depth case study review and guidance<sup>4,18</sup>. In 2012, four consultations took place to discuss how to harness the value of these cadres towards achieving related MDGs promoting evidence based and sustainable approaches to national level scale-up<sup>19</sup>, which included the USG-led CHW Evidence Summit<sup>5</sup>. GHWHA has developed a synthesis paper of these four consultations summarizing the key findings on typology, selection, training, supervision, evaluation standards, certification, deployment patterns, in-service training, performance and impact<sup>2</sup>. The paper calls for action around a set of common themes meant to increase collaboration between entities working on CHW initiatives, highlights positive partnership approaches and policy changes, and promotes a global research agenda to focus on sustainability and effectiveness. Efforts by GHWHA and the CHW Principles of Practice have several key synergies in our calls for action:

- Developing coordination strategies for HRH crisis countries where CHW scale-up is high priority;
- Creating a framework and infrastructure for coordination among multiple stakeholders at international, national and sub-national levels;
- Emphasising that national and regional level coordination processes be led and backed by a country-led coordinating bodies or processes;
- Applying contextual adaptation of evidence-based approaches in scale-up;
- Recognizing CHW cadres and integration in the health systems under unified policies;
- Emphasizing the important role of national level advocacy and transparent dialogue with all stakeholders on issues such as equity, access, coverage and quality of care.

The CHW Principles of Practice supports the related conclusions and calls for action, but identifies actionable processes for NGOs operating locally and internationally in CHW programming and advocacy. We present specific guidance at how we can work together at various levels to deliver common goals and reduce those working practices that currently hinder progress in global CHW scale up. This document is not intended to be a comprehensive review of literature or case studies, repetitive of existing works<sup>4-8</sup> These recommendations align with existing evidence, and with current initiatives to unify efforts towards expansion of CHW programmes at scale, including the Sachs Foundation's I Million CHWs Campaign<sup>a</sup>, the Frontline Health Workers Coalition<sup>b</sup> and the GHWA CHW Partnership Framework. Furthermore, it emphasises the central role NGOs will continue to have in any efforts to scale-up CHW programmes. We urge the international community, and donor governments and agents alike, to reflect on how current practices can limit coordination and country ownership as described here.

## Summary

The grassroots evolution of CHW cadres and their roles in diverse projects and organizations has led to a mosaic of implementation among countries. Minimum standards, processes, quality and coverage, as well as long-term sustainable health systems strengthening approaches are failing to be consistently established. In health workforce crisis countries, especially those with high mortality and rural-urban health inequities where CHW scale-up is high priority, country-ownership, quality, training and implementation standards are particularly weak. We propose that in such places, universal coordination approaches similar to the 'Three Ones' ought to be the norm, in order to ensure strong country ownership and long-term sustainable community health systems established under a unified system. In order to scale up CHW programmes necessary to meet MDGs in 2015 and beyond, efficiency, consistency and inter-organizational cooperation is paramount. We can no longer afford to continue working through duplicative, isolated and piecemeal approaches to achieve these ends. The CHW Principles of Practice calls upon NGOs member agencies to endorse this call for the unification of CHW programming approaches and work towards a more unified vision not only within our own projects, but also amongst our partners, donors and collaborators.

*These principles serve as a guide. NGOs that sign on to these principles of practice do so voluntarily and within their own agency's compliance systems.*

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<sup>a</sup><http://1millionhealthworkers.org>

<sup>b</sup><http://frontlinehealthworkers.org>



# CHW Principles of Practice

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## **The Seven Guiding Principles:**

*Non-governmental organizations working in CHW programming should endeavour to work with national and regional health authorities and all collaborating partners, understanding that each country will vary in its approach to CHWs, in order to:*

1. Advocate for the legitimization and recognition of appropriate CHW cadres within the formal health system through country policies and initiatives that support registration, accreditation and minimum standards for the role and performance of different cadres.
2. Enable and support country leadership including national or regional coordination bodies developed under a multi-stakeholder approach, empowered to provide oversight in CHW programme implementation across partner organizations, health authorities and communities.
3. Work with and through existing local health services and mechanisms where possible to strengthen them, avoiding the creation of parallel services, methods and supply chains or competitive working practices, while reinforcing the supportive role played by communities.
4. Establish standards and methods for the motivation and support of CHWs which are ethical, non-competitive, sustainable and locally relevant under a unified country policy.
5. Develop minimum standards of needs- and resource-based training and continuing education of specific cadres of CHWs, as well as necessary minimal tools, under an agreed unified system linked to accreditation.
6. Support unified mechanisms for reporting and management of community health worker data that promote consistent quality monitoring and accountability to existing health structures and communities reinforcing local use of data for decision making.
7. Maximise the NGOs roles in supporting CHW research, developing appropriate low-tech innovations, and judiciously taking to scale evidence-based cost-effective solutions made available in the public domain through partnership approaches.

**Principle I.** Advocate for the legitimization and recognition of appropriate CHW cadres within the formal health system through country policies and initiatives that support registration, accreditation and minimum standards for the roles and performance of different cadres.

There are still some health workforce crisis countries without supportive CHW policies, although many have worked towards solutions in recent years. Health workforce crisis countries need to consider fast-tracking supportive legislation to formalise the roles, performance, scope of practice, activities and standards that strengthen CHW initiatives. CHW scale-up requires elaboration within national health strategic plans, as well as specific guidelines drawn up for competencies and roles of each specific cadre deployed within a country. Greater efforts are needed towards operationalizing policies: wider availability of policies and guidelines, the creation of national level registration and accreditation systems, as well as standardised programme design tools and minimum standards. These processes should be government-led, but will require the collaboration of NGO partners and donors, to ensure consistent fulfilment of these standards. While this may not apply for all cadres of community health volunteers, for those implementing essential health services, appropriate policies for the legitimisation and recognition are the first steps towards integrating CHWs into health systems.

## **Recommendations**

### **Advocacy:**

- Advocate for countries to develop appropriate National CHW policies and guidelines which stipulate modes of operation of community health workforces, including those engaged by NGOs.
- Integrate CHWs fully into national health plans and health system strengthening initiatives, accounting for existing needs, expected social benefits, local values and preferences.
- Define roles and competency levels required for new cadres and for those extending their scope of practice. These standards should be the basis for establishing recruitment, training and evaluation criteria and how these processes are supported in the community.
- Advocate for the regular updating of national policies to assimilate new evidence-based recommendations. Support task-shifting of functions as close to the community as possible given evidence and safety considerations, including dispensing essential medicines and products for community-based treatment, such as antibiotics, diagnostic testing and artesunate-based treatment of malaria by trained and equipped CHWs.
- Advocate for the support of these initiatives to international development stakeholders including donor governments and agencies, transnational bodies and campaigns.

### **Programming:**

- Work with existing recognised cadres, before considering selecting and recruiting new ones outside of the existing system. Where new cadres or new selections are required, ensure plans for transition into or support of the existing systems, and that they are all registered and accredited by national bodies by the end of the programme term.
- Consider supporting complementary cadres of community health volunteers where needed, but ensure their work contributes to and promotes the work of formal CHW cadres.
- Ensure compliance to and alignment with standards, policies and strategic plans in all projects.

### **Partnership:**

- Involve key stakeholders in the decision-making and assessment processes, including communities, relevant government bodies, civil society, not-for-profit and health professional groups, as well as private sector where appropriate, to endorse alignment with national scale up plans.

**Principle 2.** Enable and support country leadership including national or regional coordination bodies developed under a multi-stakeholder approach, empowered to provide oversight in CHW program implementation across partner organizations, health authorities, and communities.

*“Governments should take overall responsibility for the quality assurance of CHWs as part of its stewardship role”<sup>18</sup>*

In various contexts NGOs and other private enterprises have direct roles in supporting CHWs, but often do so with limited direction or oversight by the appropriate ministries and authorities. Accountability to donors often takes precedent over accountability to clients and communities for a number of reasons. Government health administrators, both at regional and national levels, may feel reluctant to impose restrictions on NGO operations, or have limited time and resources to oversee programmes. As such, whether intentionally or not, NGOs may operate with little state intervention, and country ownership is not fostered in practice. NGOs take diverse approaches to promote country leadership in their own projects, and are limited by programme or financial requirements and contextual constraints. United Nations agencies such as UNICEF and UNFPA are a focal point in many countries providing both support and leadership in community health initiatives with an agenda to promote ownership and capacity in government, especially in fragile contexts. However, country ownership is not given emphasis by donors, and project processes such as short-term funding cycles and results-based frameworks may inadvertently disfavour country leadership processes from taking place. Vertical programmes promoted by donors, while useful in stimulating action on specific issues, can also result in complex or inconsistent management and resourcing of the CHW cadres. Historically CHW programming has been embedded within other initiatives and departments, subject to competing priorities with limited resources. To address these issues, appropriate positioning and resourcing of a centralised coordinating body within government is essential for country leadership in CHW scale-up. Coordinating units such as Community Health Desks should ideally be situated as a department with cross-cutting elements, which ensure integration and resource management across diverse initiatives. When vertical programming initiatives are required, or new NGO partners engaged, they can be delivered against a community health management structure which can be harmonized with ongoing services without offsetting or diverting resources from them. In many contexts such as fragile states and weak health systems the infrastructure and human resources capacity required for this coordinated approach is not there, so coordinating bodies in these contexts may have a stronger representation of UN agencies, NGOs and partners, but strategic plans should aim to describe a road map for transitioning to government-led coordination.

## **Recommendations**

### **Advocacy:**

- Specialist departments or coordinating bodies should be established at both national and sub-national levels, where lacking, to coordinate NGO partners and donor led initiatives. Such bodies should be adequately resourced with cross-functional expertise incorporating links to human resources, primary health and adult education.
- Coordination mechanisms or committees at district and sub-national level should be inclusive of both state and non-state actors, including representation by participating or contributing NGOs, CSOs and donors; include representation by experienced CHWs; include community health actors or civil society representation to ensure citizen’s voice is incorporated in the planning, design and evaluation of how CHW programmes meet community needs.

- CHW capacity building and supervision need to be built into existing national health curricula as a normal part of the roles of community health nurses, doctors and other health technicians.
- Donors should actively promote country leadership to be given greater priority within grant based programme standards.

#### **Programming:**

- Partner-implemented CHW programmes need to be approved by MoH and subject to any regulatory systems in place to ensure compliance to standards and policies.
- Report to MoH and health authorities on a regular basis at national and sub-national levels.

#### **Partnership:**

- NGO partnership for CHW programme delivery should support country leadership and coordination of state and non-state implementers using a multi-stakeholder approach as part of a long term commitment to health systems strengthening.
- Promote NGOs and partner agencies to engage with MoH-led coordinating bodies, and at sub-national levels establish regular coordination with key partner NGOs, community representatives and civil society actors in the spirit of transparency and accountability and role clarification.

**Principle 3.** Work with and through existing local health services and mechanisms where possible to strengthen them, avoiding the creation of parallel services, methods and supply chains or competitive working practices, while reinforcing the supportive role played by communities.

There has been a recent rapid expansion of community-based health programmes led by NGOs and the private sector. Recruitment of technically skilled staff for these programmes may lead to a ‘brain-drain’ of good technicians away from the public sector. In 2009, Health Alliance International led an NGO code of conduct for health systems strengthening, with the participation of several INGOs, academic bodies and the WHO, and called for NGOs working in the health sector to reconsider their hiring practices to prevent further limiting human resources for health in public sector services<sup>20</sup>, and work towards supporting initiatives which promote public health staff retention, although putting this into action is often challenging.

In the provision of medicines and medical products, a balance is struck between meeting the short term health needs of the population and the long term functionality of existing systems, through improved accountability and regulation. In the case of ‘goods in kind’ contributions and supply chain support, the provision of buffer stocks by NGOs may be necessary, but are often implemented without accompanying activities to strengthen existing systems. Similar oversights are made in the provisions of training, supervision, equipment and skills, using external resources rather than building local capacity to supply these needs in the long run, and maximizing the role and engagement of communities in health system strengthening.

### **Recommendations**

#### **Advocacy:**

- Advocate to increase the overall proportion of health spending directed at the community level, and improve the transparency of resource utilization at national and sub-national levels.
- Advocate to ensure national health budgets adequately meet the costs and resources required for CHW scale-up, including training and support, adequate supplies and incentives.
- Advocate for improving deployment of CHW supervising health staff to under-resourced areas with appropriate human resources support and retention strategies.
- Work with health authorities and civil society to create long term accountability and efficiency of existing medical supply chains.

#### **Programming:**

- Ensure programmes support provision of core supplies for consistent programme functionality.
- Work with existing public service staff to provide technical support to programmes in ways which can contribute to building capacity and motivation of the public sector workforce. If hiring project staff, every effort should be made to avoid depleting human resources from the public sector.
- Work with existing CHWs to strengthen their practices, before recruiting other complementary cadres, and ensure programmes nurture direct reporting to and linkage with local health structures. Complementary volunteer projects and community mobilization efforts can function in supportive roles to formal CHW cadres.
- Project models or treatments outside current MoH policy should be implemented only with explicit permission from the MoH for research or piloting purposes.

- Ensure time and resources are allocated to relevant health and community system strengthening activities in programme proposal and plans, and links between communities and services are strengthened through project activities.
- State-led medical supply chains should be utilized and supported as much as possible, alongside initiatives to promote their accountability. Gifts in Kind contributions, where applicable can be channelled through national systems, overseen by CHW-supervising staff to ensure rational use and management.

**Partnership:**

- Work together with local NGOs and partners to take into consideration the needs for complementary strengthening of existing health services without duplicating efforts.
- Work with partners to ensure referral centres are appropriately equipped and staffed to manage referrals and conduct high quality secondary-level care.

**Principle 4.** Establish standards and methods for the motivation and support of CHWs which are ethical, non-competitive, sustainable and locally relevant under a unified country policy.

The GHWA Montreaux statement on CHWs called for “a regular and sustainable remuneration stipend and, if possible, complementing it with other rewards, which may include financial and non-financial incentives”<sup>1</sup>. Offering financial and non-financial incentives to promote retention of CHWs is one of the most controversial topics in CHW programming. Health workforce crisis countries struggle to pay salaries of existing staff, or deploy motivational strategies for staff retention in under-resourced and isolated areas. High attrition undoubtedly impacts the quality and sustainability of community health interventions, yet financial incentives for CHWs are seen as unsustainable, and in many places the contribution of CHWs may not be sufficiently valued by policy makers. NGOs engage many individuals in activities on a voluntary basis; therefore introducing stipends without making legitimate distinction between paid and unpaid cadres can be problematic. Government recognition of specific CHW cadres is essential to distinguish this group from other voluntary cadres and promoting their work in the community.

There is growing evidence that quality improvements can be made through motivation and support strategies promoting good performance, long-term retention and nurturing ‘careerism’ among CHWs. Some countries have begun providing salaries for CHWs, such as Brazil and Madagascar<sup>21</sup>. An emerging promising practice is community performance-based incentives provided on the basis of achieving service delivery targets and may be awarded to individuals, community teams or health facilities. Rwanda’s experience with community performance-based financing has shown initial positive impact on service demand and supply, as well as improved reporting and motivation amongst health providers, and similar schemes are now being explored in other areas<sup>22</sup>. There are valid concerns around the introduction of financial reward specifically that it may detract from volunteerism as the backbone of civil society activities. Many voluntary programmes experience low attrition where workloads are reasonable and volunteers benefit from recognition, support and training, and where social or cultural factors support volunteerism. Moreover, research on volunteer motivations suggests that monetary incentives can displace or crowd out social motivators<sup>23</sup>. Placing existing voluntary CHWs under the domain of government may therefore alter motivation.

A key issue in current NGO practice is the lack of a unified policy or approach on incentives allowing for competitive or unsustainable incentives schemes to emerge. These can complicate future efforts to bring in a formal and sustainable system as financial rewards once acclimated are difficult to reduce or remove without creating conflict. Motivational strategies, whether financial or otherwise, may be highly contextual or culturally sensitive and require a higher level of country-level planning, clarity and transparency, and community-level engagement to be deployed successfully.

## **Recommendations**

### **Advocacy**

- *One Country One Policy* - Where possible advocate for a consistent “one country one policy” approach, to be determined by the MoH and applied in partnership with donors and various stakeholders, such that specific CHW cadres receive similar rewards for equivalent work efforts regardless of the financing agency, accounting for local variability in wage rates in different states or provinces. Stipends should reflect a low and sustainable rate for “business as usual” conditions, as well as agreed per diem rates for training or exceptional circumstances and events.

- Where such a policy does not exist at a national or province level, then NGOs working with CHWs should agree to abide by common terms of compensation.

### Programming

- *Community participation and accountability* – Communities are very important in determining and distributing any incentives. As such, communities ought to play an active role supporting and supervising CHW work. Agreeing and documenting incentives and remit of the project to support CHWs throughout programmes in a transparent manner will prevent potential conflicts. Communities or their respective health management structures, where they exist, may give inputs in the event of non-activity or poor practice, or reward good performance as they see fit.
- *Non-payment of services* - CHWs may occasionally receive rewards or gifts in kind directly from families, which may be a normal custom embedded in culture or context. NGOs, as they seek to ensure equitable service access to the poorest and hardest to reach households, should avoid formalising or promoting sale-of-services in so far as they may restrict access to the most at need. Further research is required to clarify how sale-of-service influences access and health inequality.
- *Implement sustainable financial stipends* - Financial stipend levels should reflect what can reasonably be awarded under standard conditions or budgets, not exceeding public sector affordability, and not determined by availability of short term finances e.g. grant based projects. Additional payments may be justifiable, subject to government agreement and compliance to other principles, under special conditions such as crises and campaigns, or for participation in NGO-led events.
- *Reasonable compensation* - Financial and non-financial incentives awarded are aligned to the expectations and work load placed on CHWs as reasonable compensation for their time. Any performance conditions, work agreements and rates should be documented.
- *Non-financial direct incentives and advancement* - Non-financial incentives and job aids should be awarded under agreement of the local or national authority. All non-financial incentives should be documented and transparent to all community members, and documented explanations should be provided to the CHW. Non-financial incentives which can promote good performance include:
  - Opportunities to participate in income generating activities;
  - Continuing education, modular training, professional recognition, and career advancement;
  - Public recognition of performance achievements;
  - Preferential access to health services.
- *Non-financial indirect incentives* – The provision of non-financial indirect incentives should be encouraged by state and non-state actors. These incentives include employment of strategies that establish trust, transparency and fairness between the CHW and her health system counterparts, and between the CHW and the community.

### Partnership

- If a unified incentive policy is not feasible to achieve, such as in highly decentralised systems, ensure NGOs and agencies work together with their state, provincial, or district authorities to agree on similar policies for financial and direct non-financial incentives, incorporating the above recommendations.



**Principle 5.** Develop minimum standards of needs-and resource-based training and continuing education of specific cadres of CHWs, as well as necessary tools, under an agreed unified system linked to accreditation.

National governments, with support from multiple stakeholders, need to set agreed quality assurance systems for education and training of formally recognized CHW cadres. This is not intended to discourage role diversification or limit innovations in training, but to define the lower limit at which an individual can be recognised as a specific cadre of trained CHW. In many contexts, and from CHW AIM surveys conducted in diverse locations, people who self-identify as CHWs may have not undergone formal training, or received one-off training related to a single initiative or campaign with no ongoing training or support<sup>14</sup>. For these reasons it is important to establish basic training packages, or harmonise competing curricula, based on competencies and skills for the tasks they perform, such as basic health services, effective communication and counselling, diagnostic methods and tools, safe use of medicines and record keeping. Complementary training modules and one-off trainings are of value in skills building and professional advancement, once pre-requisite base-line skills have been achieved. NGOs continue to make valuable contributions in the area of professional development opportunities for CHWs and other health worker cadres, but where possible, these should be integrated within a broader scheme of training and accreditation rather than done on an *ad-hoc* basis. A minimum standard for continuing education should be established to ensure CHWs retain competencies and advance in new skill development.

## **Recommendations**

### **Advocacy:**

- Advocate for coordinating bodies to oversee and harmonise CHW training and education systems, formalise curricula standards, ensure compliance amongst partners, and elaborate standardized certification and career progression mechanisms that are nationally endorsed.
- Promote the regular review of training curricula and standards to ensure rapid uptake of new WHO recommendations for CHW interventions.
- Advocate for a system of training and certification records for CHWs as part of a national or regional database of qualified CHW workforce that can be deployed for projects, including in emergencies.

### **Programming:**

- When introducing new trainings within a project, ensure selected CHWs have completed the minimum training standards prior to progression to the project-specific trainings.
- Any new training introduced can be compared with any existing accreditation systems, and attributed to some form of professional development, with records of trainings kept per individual. Avoid any non-essential one-off training and ensure all training is followed up by appropriate support to reinforce knowledge and skills and manage attrition effects.
- Ensure ongoing skills-based training is given adequate resources and time within all projects proposal budgets and plans.

### **Partnership:**

- Work in partnership at the regional level to ensure that equivalent CHW cadres operating in project areas have consistent basic training level and are accredited, and that training systems and curricula used are harmonized in terms of skills and competencies.
- Promote the above principles of practice amongst other agencies implementing CHW trainings.

**Principle 6.** Support unified mechanisms for reporting and management of CHW data that promote consistent quality monitoring, supervision and accountability to existing health structures and communities, reinforcing local use of data for decision-making.

Reporting and supervision is widely diverse across countries, districts and programmes, including in the types and sources of data collected, supervisor selection, training, methods and frequency and the availability and use of data by supervising authorities. Historically NGOs have introduced data collection methods and tools specific to project needs without effective assimilation of the data into government health management information systems (HMIS). Skills and resources of local health managers may also be limited in ability to collect or use data effectively, so they focus on facility level health statistics, only requiring basic data elements from community activities.

NGOs typically collect data focussed on the immediate processes in programmes such as numbers of visits, referrals and treatments done, but donors are increasingly requiring outcome and impact level data such as coverage and mortality statistics. Ideally outcome level data, captured by communities could be used to inform CHW management and resource allocation. Supervision systems are often the weakest component of CHW programming for many reasons. Availability of qualified supervision staff, transport means and resources for supervision in the field make establishing CHW mentoring relationships with appropriate supervisors severely limited, and innovations are needed to resolve these resource and logistical problems. Existing supervision methods led by health facilities often focus on collection of basic data elements such as stocks and case load, which are then analysed remotely, if at all. Tools may not be sufficiently user-friendly for supervisors with low statistical skills and or designed for instant trouble shooting and feedback. Quality of care may have diverse definitions amongst different stakeholders which are not reconciled or assessed in the same ways. Quality assurance and performance evaluation mechanisms designed to strengthen core CHW competencies could afford to be improved in many projects and countries, as well as community scorecards and other methods that allow for localized decision-making. NGOs can have roles to play in supporting innovation around mechanisms of supervision functionality, as well as improving the skills of training supervisors, particularly in the areas of adult education, quality assurance and facilitated learning of CHWs. New technologies open up great opportunities for remote support and learning for health workers; NGOs in particular can make valuable contributions in the gap.

## **Recommendations**

### **Advocacy**

- Advocate for HMIS to include CHW programming indicators, which are agreed nationally or sub-nationally appropriate to context, are gender-sensitive, and not project-specific.
- Advocate for agreement on quality standards and assurance systems, and competency-based methods to monitor services provided by specific CHW cadres and their supervising staff.
- Advocate for improved allocation and support of qualified CHW supervisors to remote and isolated locations and the integration of CHW supervision systems in national health curricula.

### **Programming:**

- Ensure continuous support supervision, and skills mentoring are prioritized within all existing and new CHW programmes, and work to improve the skills, tools and methods of appropriately qualified supervisors.
- Design reporting, monitoring and supervision systems that can easily be integrated with HMIS at community and facility level, and report regularly in a transparent two-way information flow.
- Conduct regular evaluations engaging key stakeholders in reporting and feedback processes.

- Innovate and support development of improved collection and automated reporting systems to enable data from diverse programmes to be easily assimilated and used by health managers.

**Partnership:**

- Invest in health information systems unified across projects which include CHW registration, training and activity outcome data, and performance information, improving the skills of local and regional health staff to implement evidence-based decision-making and enhance shared learning.
- Explore new technologies and innovative ways to bridge the supervision gap using improved tools that are time-saving and appropriate.

**Principle 7.** Maximise NGOs roles in supporting CHW policy research, developing appropriate low-tech innovations, and taking evidence-based cost-effective solutions to scale, through partnership approaches made available in the public domain.

There has been a surge of global health innovations and research in recent years, driven by donors, academics and private sector interests. Mobile phones for health (mHealth), mobile internet and radio-based learning programmes, as well improved diagnostic and treatment tools for malaria, pneumonia, and HIV are just some of the new developments beginning to see scale-up in the field. While innovation, motivated by inter-agency competition, can lead to great advancements they may not always result in sustainable or contextually appropriate solutions that can realistically be scaled within the existing health systems. NGOs should avoid creating 'boutique' projects with vertical funds if this cannot be integrated sustainably into standard funding mechanisms for the long term. Intention to take innovations to scale should be considered from the outset and small scale 'pilot' activities limited to those with a genuine research value. Not all novelty is positive, and innovation for innovation's sake may in reality overburden a workforce already beyond capacity. New developments should aim to improve system simplicity, be time and cost-saving, or improve quality and coverage of services. Innovation design must consider the user capacity and needs, and avoid favouring existing gender inequalities e.g. numeracy and literacy, as many CHW programmes seek to empower and include women. NGOs can play a key role in supporting governments to test, refine and scale-up appropriate interventions and policies at the national and regional levels, as well as partnering with academic bodies to support high quality research, cost effectiveness and impact evaluations. Evidence of impact and cost-effectiveness of innovations should be carefully reviewed by government and stakeholders alike. Lastly, many innovations developed through public private partnerships, may be developed with the limitations of sharing and copyright. Given the focus on the need for scalable interventions ensuring that such investments are available in the public domain is essential.

## **Recommendations**

### **Advocacy:**

- Government to approve and monitor existing and novel innovation projects in country and provide oversight and coordination on reviewing progress and impact.
- Develop public-private partnerships to ensure innovation availability in the public domain, and country ownership of the initiative is paramount.
- Promote donors and international bodies' further investment in advancement and research of low tech solutions for use at the community level.

### **Programming:**

- Engage government partners from the outset in innovation development, research and evaluation.
- Ensure sustainable financing strategies e.g. cost-sharing models, to achieve long term scalability.
- Invest in innovations within the current capacity of CHW cadres that are time or cost-saving in nature and are evidenced to improve service quality and equity.

### **Partnership:**

- Partner with other stakeholders to scale-up evidence based innovations through coordinated efforts and shared costs.

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