

# Community Health Workers and Universal Health Coverage

## A framework for partners' harmonised support

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# **Community Health Workers and Universal Health Coverage: *A Framework for Partners' Harmonized Support***

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## 1. Background and purpose

Actions and efforts to achieve the Millennium Development Goals (MDGs) are on the increase as we draw closer to the 2015 deadline. Equally, sights are being set on the post-2015 world and what will be required to achieve sustainable health and access to Universal Health Coverage (UHC). The presence of health workers with the right skills, present at the right place in the system and with appropriate technology and supplies and managerial and technical support represent the backbone of the health system and essential for achieving Universal Health Coverage.

However, shortages of skilled workers, unequal distribution and challenges with retention and communication between providers and users remain critical health workforce challenges across all continents. It is estimated that 1 billion people alive today will never see a health worker. Within this context, the role that the Community Health Worker (CHW) plays within overall health and community systems is re-emerging as a key theme of discussion.

Fragmentation is one of the main challenges to successful and sustainable CHW scale-up - in terms of programming, the service delivery chain, and the multiplicity of public and private organizations, training, deploying and supporting CHWs. This paper poses the following questions: What will it take to overcome fragmentation at the front line of health services, with a joined-up and effectively supported team of facility based and community based health workers? And how can this be done in ways that protect the results achieved and that preserve the creativity and innovations associated with community-level response?

In the wake of four separate consultations on CHWs in 2012<sup>ii</sup>, the Global Health Workforce Alliance (GHWA) noted the need for a common set of messages around CHWs and a joint framework to guide efforts to scale-up the role of CHWs within health and development programs<sup>iii</sup>.

This paper proposes a set of generally agreed guiding principles to support countries and their partners in their efforts to:

- Harmonize donor support, based on commitments by all partners to collaborate at global and national level
- Build greater synergies across CHW programs with communities, districts and countries, guided by national leadership, national strategies and nationally agreed systems for monitoring and evaluation
- Improve efforts to integrate CHWs into the broader health system, with a particular focus on effective linkages between community based and facility based health workers at the front line of service delivery, so that individuals receive the health services they need

At the global level, all actors need to contribute together to a comprehensive systems approach in advocacy, programming, funding, implementing, monitoring and in building the knowledge base for CHW programs.

At the national level, principles for alignment and harmonization across public and non-state programs and initiatives need to be compatible with broader national health system development frameworks.

## **2. CHWs in the context of Universal Health Coverage - a Health Team approach**

In order to deliver on universal health coverage, the global health community will have to work together to address critical gaps and inefficiencies at all levels, including those affecting facility and community based health workers at the front line of the health system. Partnerships must move beyond collegial collaboration to a more challenging synergistic cooperation which proactively addresses multiple and fragmented program efforts. Policies, plans and actions should be integrated and harmonized thereby leading to results greater than what would have been produced had each partner acted on its own. Synergies must be harnessed in ways that contribute to sustainable scale-up rather than increasing fragmentation and duplication between different short-term initiatives.

While CHWs in many countries have long been held in high regard within health teams as trusted providers, communicators, facilitators and enablers<sup>iv</sup>, there have also been experiences where CHW programs that are initiated have not been sustained over time. Governments, multilateral agencies and donors, together with international, national and local NGOs have recently returned to the potential of CHWs to assist in reducing the gap between local communities and local people on one side and facility based health services on the other.

What has received less attention is the need to develop and integrate CHW cadres with health systems and link CHWs roles with facility functions in a systematic and collaborative manner as part of an overall national HRH plan. Strategies are therefore needed at the national and global levels to build countries' capacity to develop, administer, manage, finance and sustain those community based interventions that are made possible through international partners.

## **3. Current CHW program challenges that need to be overcome**

### **Weak linkages to existing national coordinating frameworks**

Several national multi-partner coordination mechanisms exist, such as IHP+, SWAPs, national HRH plans and HRH Country Coordination and Facilitation (CCF) processes, yet with weak links to CHW program coordination. The same is true for health related coordinating committees related to HIV, such as National Aids Coordination mechanisms, Country Coordinating Mechanisms (CCMs) and also for some of the vertical initiatives and programs

targeting special result areas such as Maternal, Neonatal and Child Health (MNCH) services, eliminating Mother to Child Transmission (eMTCT), immunization, Sexual and Reproductive Health (SRH), malaria, TB, etc.

### Fragmentation

A broad range of initiatives and programs exist for community based service delivery, communication and demand creation, often funded by international partners and implemented by public and a wide variety of non-state actors. There is generally no formal global platform for partners in CHW support, no accountability mechanisms, and no repository of partner strategies or work plans that involve CHWs globally, nationally or locally. Fragmentation is a particular problem for CHW cadres due to the multiple waves of CHW programs through the last thirty years.

In most countries, health workers at the peripheral facility level are hired, managed and paid by district and local authorities. CHWs may be hired and trained by these same local authorities or by special programs and their implementer organizations. Faith based and NGO- related, private or community-based initiatives have their own contracts and arrangements for health workers in their programs. A legacy of parallel projects and programs are funded separately, delivering separately and reporting separately - often with little attention to how the programs link up with the facility based health workers and with the district health management team.

### Confusing typology

There is also no agreed typology for CHWs, but a large mix of labels and categories with widely different training and incentive systems, such as Extension Workers, Village Health Workers, Health Volunteers, Community Assistants, Health Aides, Health Promoters, Front Line Health Workers, Barefoot Doctors, Vaccinators, Peer Counsellors, Mentor Mothers, Peer Educators and Home Visitors. Some work broadly within primary care while others are more focused on a single disease or population.

### Friction in career and incentive structures

Priority programs with special donor support and a particular disease focus are often able to provide remuneration, special allowances or incentives for CHWs, uncoordinated with other CHW programs and initiatives in the same locations. In some settings CHWs are expected to volunteer, in others they are compensated with food and bicycles, and in others they receive monetary compensation with salary scales that are either tied to or are independent from the local or national standards. Differences in career prospects and training opportunities also cause friction across initiatives and between programs operated by different organisations. CHWs may not be recognized or regulated by the government. In addition, donor and INGO efforts may unintentionally undermine already weak or under-resourced governments and national institutions<sup>v</sup>.

### Missed opportunities in training

The education of CHWs presents challenges as well as opportunities. With notable exceptions, CHW education has rarely been integrated into the established health professional schools and health professionals are not generally trained for working with CHWs as members of the health team. These are missed opportunities. CHWs can benefit from interactions with the rest of the health team during their training and the considerable donor investments for improving pre-service education and in-service training systems for higher level health workers can also benefit CHWs.

### Insufficient attention to implementation science

Other elements that need to be brought to bear to increase the synergy of CHW programs and initiatives include the application of implementation science. Through the application of implementation science, CHW implementers can investigate and address major bottlenecks beyond the health system (e.g. social, behavioral, economic, management) that impede effective implementation<sup>vi</sup>.

## **4. Why a framework for synergies and a harmonized response is needed**

Although some countries have been able to ensure coordinated CHW programs within their national health systems through exercising national leadership, the reality on the ground in most countries calls for more deliberate action by all governments, donors and implementers - within and outside the public system.

Community based programs are often implemented under district level authority at the health facility and community level, or operated independently through NGOs. With the growing focus on scaling up CHW programs to support the formal health system, there is an urgent need for attention from the national and district level to address fragmentation and inefficiencies and to build synergies at the level of implementation.

Addressing the challenges of the HRH crisis requires collaboration from multiple sectors and stakeholders with complementary roles. Depending on the country setting, partners including the Ministry of Health, Ministry of Finance, Ministry of Education, Ministry of Planning, professional councils, schools, donors, NGOs, district governments and communities are often involved in making national HRH plans. However, many of these groups focus mainly on higher level cadres and on the central level of administration.

District level implementation and coordination and the voice of the CHW have generally not been included. In addition, the sharing of work-plans and data that occurs at the central level is rarely transmitted down to the implementation level. The complexity of community level stakeholders is often greater than at the national level.

Equally, the important space at the point of care that allows for flexibility and innovation and generates more quality delivery and demand must be preserved. Services provided by CHWs, both remunerated and voluntary, must be relevant to the specific local context and guided and underpinned by locally articulated need, community ownership and community action. Communities empowered for taking action on their own health and making health a local priority will improve acceptability and sustainability of health interventions.

Within the NGO community, efforts have been under way to address the challenges of diverse CHW programming approaches and to provide actionable steps for NGOs in the form of principles of good partnership coordination. World Vision, together with the CORE Group has developed a set of "CHW Principles of Practice"<sup>vii</sup>.

The "CHW Principles of Practice" highlight the necessity of working together to achieve common goals in a manner that is fully aware of the potential for duplication, and situate NGO and non-NGO related CHW programs within the wider context of the health system scale-up considerations and challenges.

These principles are not only relevant for NGOs, but also offer a platform for NGO alignment with the approach required for governments and partners in terms of synergies and harmonization in the scaling up of CHW programs. This includes performance management, quality improvement in regulation and supervision, workforce distribution and approaches to collaboration between public and non-state education and provider systems.

**Box 1: CHW "Principles of Practice"**

Work with national and regional health authorities and partners 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 program 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 CHW 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.

## 5. A Framework for synergies and harmonized response in CHW program implementation and scale up: The CHW Framework for Partner Action

### **Dealing with a crowded and fragmented environment**

Without taking steps to synergies through harmonized support and implementation, investments in CHW programs will not be efficient, not improve quality in the communication between the community and the health services, not be sustainable and not make optimal contribution to UHC. The proposed framework for harmonization and alignment of partner support to CHW programs aims to provide a basis for moving from fragmented efforts to synergies and joint action, on the ground as well as among partners at national and global levels.

Partners' commitments to harmonize must be anchored at the national level, based in principles that are agreed also at the global level. However, the focus for making the framework operational, with compliance and engagement from all partners, must be at the district and local level. Many CHW programs are implemented at the district level.

Equally, many of these programs are based on local initiatives or NGO implemented activities supported by international NGOs and different funding partners directly. Operational responsibility and authority for coordination, supervision and support of public sector CHW programs, is commonly decentralized to the district or facility level. Hence it seems feasible and indeed sensible to locate operational leadership for coordination of CHW programs at the district level, or below.

In order to be workable, the framework should *apply the principles agreed at national and global level to the operational level and translate these into responsibilities for all that are involved in CHW programs on the ground.* This includes public and non-state health managers, providers, trainers and health programs.

### **National leadership**

General guiding principles for the inclusion of community action and CHW programs within national health system plans should be established at national level. National decisions will necessarily be different given the role assigned to CHW programs in the country and the need to reflect local epidemiology and socio-cultural contexts. The CHW Framework for Partner Action presents principles that will serve synergies and mutual accountability based on shared commitments, but should be adapted and agreed for use in each country and not be seen as a blueprint,



Through application of the framework in ways that fits the country context, the national level authorities with the external partners have an agreed platform that will enable the district and facility level to lead the coordination of implementation, innovation and alignment of CHW programs. All implementers– including NGOs and community initiatives, should respond to and align with the leadership of the district and local authorities.

*The CHW Framework can meaningfully be structured around a “3-Ones” approach<sup>viii</sup> with three overriding principles for harmonization:*

- ***One national strategy as the shared basis for CHW program investment and alignment of all partners***
- ***One authority respected by all partners, clearly identified at national level and with appropriate delegation to district level***
- ***One monitoring and accountability framework as the basis for reporting and accountability by all partners***

Commitment from partners to support and comply with these overriding principles at country level will serve as the basis for global partners to harmonize their support to CHW programs, country by country as well as at the global level. Such commitment will imply that partners and stakeholders collaborate, share and monitor information, tailored to country context, in a way that demonstrates their individual and shared contribution as an integral part of their reporting system for program results. The most essential step towards achieving these changes is the development of a national framework, country by country, with road-maps or guidelines that can ensure joined up planning, monitoring and action by all involved on the ground, and that set priorities for dealing with knowledge gaps.

An overview of how these commitments could be implemented at national, district and local levels are presented in Table 1, and further discussed in Annexe 2 and in the Working Paper on the Monitoring and Accountability Platform.

**Table 1: CHW Framework for Partner Action: One strategy, One authority and One M&A platform**

**One National Strategy**

<p><b>National level</b> <i>Basis for national policy and recognition of CHWs in HRH plans and health system development collaborative structures</i></p>	<p>National CHW principles and guidelines integrated in HRH plans and as part of Health strategy for UHC. CHW typology, training curriculum and standards for recognition. Task shifting policies. Policy guidance for synergies across programs and for collaboration with non-state actors. Guidance on incentives and allowances. Links to existing national health, HIV and development coordination mechanisms. Clearing house for implementation research.</p>
<p><b>District level</b> <i>Basis for incorporating CHWs in district plans, inclusive of all CHW programs (both volunteer and remunerated), and for strategic synergies and alignment across partner supported initiatives</i></p>	<p>Application of National CHW policies and guidance, with flexibility to reflect local context and stimulate innovation for A-A-A-Q, recognizing the contribution of all CHWs to the district health system. Agreed platform for incentive, supervision and support structures (including village based structures). Inventory of all CHW programs in the district, with overview of access and effective coverage. Strategies for dealing with gaps and synergies across different programs .</p>
<p><b>Facility level</b> <i>Basis for operational synergies</i></p>	<p>Facility plan for including CHWs in the health team, ensuring supervision and support for different categories community based workers. Updated inventory of programs by location, type of services operators and CHWs. Strategies for action on barriers to synergies. Strategies for dialogue with community level mechanisms for CHW support</p>
<p><b>Community level</b> <i>Basis for community mobilization</i></p>	<p>Overview of CHW activities in the community. Strategies for integrating CHW programs and other extension workers in community development plans. Strategies to enhance synergies across programs and to strengthen effective communication, community support and response to demand</p>

**One National Authority**

<p><b>National level</b> <i>Basis for mutual partner commitments and agreement on principles for harmonization and synergies</i></p>	<p>Health Ministry and partners (including other ministries involved such as National Aids Authorities, Ministry of Local Government) agree to comply with the CHW Framework according to national policies and guidance. Health Ministry makes appropriate delegation of authority for operational coordination of CHW programs to district health authorities</p>
<p><b>District level</b> <i>Basis for district level authority to convene and coordinate, to implement principles for harmonization and synergies</i></p>	<p>Establish clarity in relationship between DHMT and District political and administrative authorities. District authorities and partners agree to comply with the CWF Framework as applied to the district plan, enabling synergies with other development efforts</p>
<p><b>Facility level</b> <i>Basis for a health team approach with partner collaboration in supervision and support</i></p>	<p>Authority from district level to convene all actors in the facility service area and create the platform for agreements by all to collaborate across programs, both public and non-state, including agreements on reporting, supervision, support, etc.</p>
<p><b>Community level</b> <i>Basis for local agreements</i></p>	<p>All CHW programs establish mechanism for accountability to Village health committee or other community structures</p>

**One Monitoring and Accountability Platform**

<p><b>National level</b></p>	<p>Joint reviews and consultations, using standardized indicators, based on reports from districts</p>
<p><b>District level</b></p>	<p>Managing the CHW Monitoring and Evaluation for district with reporting from all partners and consolidated reporting to national level</p>
<p><b>Facility level</b></p>	<p>Hub for managing reporting from all CHW partners and initiatives in the service area. Review and discuss with all actors</p>
<p><b>Community level</b></p>	<p>Reviewing progress and link to other community based accountability systems for health, HIV and development</p>

## Global level

Global level agreement among partners that support CHW programs along these principles will facilitate improved collaboration and dealing with key bottlenecks known to limit efficiencies and synergies across the programs at local, national and global levels. To ensure that CHW programs are responsive to working with other FLHWs in the context of national UHC and Health Workforce plans, these partners, including the health related UN agencies (H4+) together with donors, academic institutions and networks and international voluntary and private organizations, need to take stronger steps to collaborate across agencies and programs.

Significant barriers to harmonization and synergies are related to how donors and agencies design, fund and support CHW programs, through earmarked funding, vertical issue- and result-oriented programming and reporting. At the national and operational levels, these funding and reporting flows should be reviewed and structured in ways that facilitate harmonization and the necessary functional integration required to achieve efficiencies and optimize synergies across the different programs.

In compliance with the national framework as set out in each country, global partners will:

- a) Provide leadership from the highest level of agencies/organizations in support of CHW projects/programs with CHW components to:
  - design and fund programs and initiatives in ways that allow optimal harmonization and functional integration into national health plans; making CHW programs contribute to overall availability, accessibility, acceptability and quality in the health system
  - communicate scaling up of CHWs as one important element in the development of a functioning health team at the front line of health services, not as a stand-alone solution
  - direct agency/organizational focal points located at national level to optimize synergies across issue and result-oriented programs to achieve better value for the investment
  - direct global level technical departments to report on achievements and missed opportunities for synergies and harmonization
- b) Provide technical leadership to:
  - ensure that CHW programs are responsive to national HRH plans and not scaled up in isolation from the whole health team of community based and facility based workers at the front line of the health system
  - align the CHW program objectives towards achieving the UHC, MDGS and post 2015 agenda
- c) Collaborate across agencies and programs to:
  - track partner commitments

- exchange knowledge and learning, including documenting examples of success, generating and analyzing data, etc.
- standardize indicators
- harmonize advocacy messages to ensure that CHW projects are not promoted as standalone investments
- respond to needs for research and development in a way that maximize building research capacity and knowledge platforms in program countries
- contribute to development and use of communication technologies (ICT) that facilitate coordination and data sharing from the global level to the service delivery level and helping to overcome the problem of the lack of global, regional, and national collaboration and data sharing.

### **Financial sustainability**

Financial sustainability will be key to forging and maintaining synergies around activities, interventions, and CHW program areas. Donor-supported interventions that develop or strengthen CHW cadres in a targeted region/district of the country, or as a contribution at national level, have an expiration date.

Successful phasing of these activities into the primary health care system that will deliver community based services long term, require particular attention to sustainability from the start, as well as to the transition and exit stages. This applies to salaries and support for those CHWs that are being formalized as regular health workers in the public system. It equally applies to salaries and/or non-financial incentives for CHWs and other lay health workers in delivery systems that are supported by NGOs or by donor supported targeted interventions of a more vertical nature.

Technical cooperation needs to be designed so that it can fold into the national financial and administrative capacity when the intervention activity comes to an end.

## **6. Conclusion**

Based on an extensive consultation this paper proposes a set of generally agreed guiding principles to support countries and their partners in their efforts to:

- Harmonize donor support, based on commitments by all partners to collaborate at global and national level
- Build greater synergies across CHW programmes with communities, districts and countries, guided by national leadership, national strategies and nationally agreed systems for monitoring and evaluation with an accountability mechanism
- Improve efforts to integrate CHWs into the broader health system, when appropriate, and to give a particular focus on effective linkages between community

based and facility based health workers at the front line of service delivery, so that individuals receive the health services they need.

*This leads into the need for agreement on monitoring and evaluation systems that can guide and track data collection and reporting and progress towards alignment, efficiency and effectiveness through synergies and harmonization. This is the subject of the Working Paper on Monitoring and Accountability, which allows for monitoring and evaluation with an added provision for public reporting to maintain stakeholder accountability.*

## Appendix I: An illustration of synergies in CHW programs: HIV and PHC

There are many examples of functional integration and programmatic synergies under national leadership, such as is the case with community based HIV programs and MNCH/PHC programs in Ethiopia, Malawi<sup>x</sup> and Rwanda<sup>xi</sup>. To date, however, they remain largely unconnected to an overall strategic vision that all partners buy into as they relate to other countries. Donor's selective funding priorities and the debate on the pros and cons of integrating HIV, maternal and child, sexual and reproductive services when seeking to accelerate results, maintain isolated funding streams and reporting requirements.

As a basic element of national AIDS plans, HIV CHW programs have demonstrated their capacity to expand to fit the demand: for example mothers2mothers (m2m) is a facility-based service that reaches into communities both through direct service delivery and linkages with existing community based service groups. m2m, now has 589 sites working in seven countries, with 1457 mentor mothers trained in basic medical knowledge about HIV infection, treatment, and prevention; infant feeding; counseling methods; strategies for negotiating safer sex; nutritional advice; and essential peer education and psychosocial support<sup>xii</sup>. Emerging studies indicate that well-managed HIV CHW programs are also able to create demand and where communities have achieved a high comprehensive knowledge of HIV, people are more likely to seek and initiate treatment early<sup>xiii</sup>.

Given that HIV testing and treatment is now reaching the local health clinics through simplified treatment and Point of Care testing, and given the increase in the numbers of PLHIV with co-morbidities and chronic care needs, there are clear programmatic and financial gains to be made integrating HIV with local health services and community case management, and in particular integrating HIV CHWs programs with local MNCH/SRH/TB CHW services.

However, because of the nature of the evolution of the HIV CHW cadres, as well as other CHW cadres in many places they remain disconnected from the local health system. The history and experience of the HIV CHW has much to offer wider CHW programs. The challenge is to maintain the integrity of the evolving and adaptive community-based response that begins with the individual and has proven adept at holding the health system accountable for the provision of services that work for the individual, while at the same time integrating with a more formalized and centralized health system that can provide comprehensive health care.

As increasing attention is given to scaling up MNCH services, the tendency is to create parallel efforts from global to national and local levels, similar to what has been the case for HIV. In dealing with the shortages in the health workforce that affects these programs, the tendency is to seek for shortcuts through new vertical solutions. At the front line of the health system, this applies to the need for skilled birth attendants and community based

workers with a special focus on maternal or child mortality. For example as the push to reach the MDGs by 2015 led to great progress in maternal child health and disease control, it also created 'quick fix' solutions that were not able to be absorbed by country strategies or systems.

The Global Plan to eliminate new infant HIV transmission and keeping mothers alive (eMTCT) and the Global Strategy for women's and children's health are at the global level conceived as two separate tracks for scaling up access to services on the ground, while ultimately focusing on the same families and the same pregnant women. The same UN agencies (H4+) collaborate for each of the tracks, yet with parallel technical groups, funding streams and reporting systems down to the national level. At the national level, donor governments and non-state actors support additional parallel efforts, including also operational research and policy dialogue with decision-makers. Focal points for key partner agencies, such as UNICEF, WHO, UNFPA and UNAIDS have different priorities, according to their agency mandate and the links between the Global Plan and the Global Strategy may not be actively pursued.

It is a general observation by practitioners that the closer to the operational and implementation level of the health system, the easier it is to see the need for synergies, both by providers and users. This is very much the case for CHW programs, where local and district government, local health committees and district health management teams are better placed to notice opportunities for positive synergies as well as fragmentation, duplication, competition and gaps –in implementation, monitoring and reporting.

Rwanda and Malawi are two African countries that in particular ways illustrate national leadership for the use of CHW programs in ways that promote synergies coordination and integration.

**Table 1: Synergy factors in the national CHW programs in Rwanda and Malawi**

Contributing Factor for Synergy	Rwanda	Malawi
<p>The existence of a <b>solid policy, regulatory and organization framework that anchor community health workers within the public health system.</b></p> <ul style="list-style-type: none"> <li>• results in more structured recruitment, training, supervision, remuneration, compensation.</li> <li>• allows for deployment of multi-disciplinary CHWs manage the well-funded programs such as HIV, TB, malaria as well as MNCH,</li> </ul>	<p>Health programs build capacity and integrate all aspects of health care.</p> <p>In addition to building hospitals and clinics, Rwanda has trained 45,000 community health workers to provide in-home care and psychosocial support for HIV patients as well as basic primary care for the wider communities</p>	<p>The eMTCT program is fully integrated into the HIV/MCH programming, with complete integration of antenatal and postnatal care with HIV services in all service delivery sites in the country. Coordination is primarily provided through the MoH structures at national and district levels.</p> <p>Severe HRH issues led to the first Emergency HR Plan (EHRP) in 2004 and the second in 2010 which included CHWs as a key element of health and</p>

Contributing Factor for Synergy	Rwanda	Malawi
SRH, vaccination, nutrition, hygiene, and sanitation		HIV service delivery. Health Surveillance Assistants (HSAs) and CHWs are a key element of the eMTCT plan rollout of services.
<b>District health systems with strong planning and information systems</b> create a platform for building synergies across various programs at district/ community level.	CHWs are trained to diagnose and provide empirical treatment for HIV, malaria, pneumonia, and diarrhoeal disease.	The national eMTCT Plan is translated into district-level plans for all districts. The eMTCT plan includes detailed indicators and a monitoring framework that is linked to the overall national response, strategic information gathering and analysis systems.
<b>Common funding pool or plan</b> to support CHW work is more likely to promote synergies across several programs.	<p>The Rwandan Ministry of Health demands robust financial management, transparency, and accountability standards of all of its domestic and international partners. NGO and donor funds are channeled through government, allowing it to balance funding for priority and basic health service programs, including CHWs.</p> <p>The national government of Rwanda has instituted a CHW performance based financing strategy whereby CHWs form a cooperative. National funds, enhanced through World Bank funding support, are channeled to the cooperatives to allow them to develop income generating activities. The idea is that the money gained from these activities will then fund salaries, supplies, and other needs for the CHWs.<sup>xiv</sup></p>	<p>The eMTCT program in Malawi is fully supported (and substantially funded) by USG/PEPFAR and World Bank. Development partners are actively engaged in the design and implementation of the program.</p> <p>Future transition to government-owned capacity has not been considered in the Malawi's economic planning.</p> <p>"To date, the official costs of national CHW programmes in pioneering countries such as Malawi have not been estimated, partly because tracking unit costs is difficult and because methods for isolating the CHW subsystem from an integrated primary-health-care system have been elusive."<sup>xv</sup></p>
<b>Donors</b> can offer CHW programs funding conditional on integration.	SWAp has been used as a way to coordinate donors in resource-support to Ministry objectives with regards to HRH development. <sup>xvi</sup>	The SWAp is actually country-led but donor-monitored. It provides a good example of and innovative synchronization mechanism. <sup>xvii</sup>
<b>Political emphasis</b> on building synergies across various CHW programs forces	Financial incentives to coordinate care include a performance-based financing system that pays	H.E. The President of Malawi is the Minister responsible for HIV and has also launched a Presidential Initiative



Contributing Factor for Synergy	Rwanda	Malawi
stakeholders to create opportunities for building synergy across programs.	hospitals, clinics and community health workers to follow-up on patients and improve primary care. In the cases where partners have been reluctant to work in accordance with the National strategies, the government has chosen not to accept the funds or has asked the organization to leave the country.	on Safe Motherhood and Maternal Mortality. The eMTCT agenda has the highest possible level of political commitment and engagement.
Focus on <b>broad health and development outcomes</b> rather than a disease specific project outcomes	Rwanda emphasizes building a robust system of primary care. HIV and other disease programs must address associated conditions such as tuberculosis and malnutrition.	eMTCT/ART services are fully integrated in all ANC service sites, including HIV testing.
<b>Community demand</b> can force alignment and build synergies.		Community and social mobilization strategies and program activities (including efforts to increase male involvement PMNCH/HTC/eMTC) are critical elements of eMTCT plan and programming. They are also key elements of the Presidential Initiative on Safe Motherhood and Maternal Mortality.
CHW programs that include <b>home management of common illnesses</b> such as diarrhoea, malaria, pneumonia; distribution of health commodities such as bednets etc., position themselves for better linkages across interventions.	The Rwandan MoH emphasizes the role of CHWs of bringing health care into people's homes to reach those who otherwise might not receive care.	<p>HSAs and CHWs form a link between the community and formal health service delivery. Many live in the villages among the communities</p> <p>Tasks include:</p> <ul style="list-style-type: none"> <li>• Immunization</li> <li>• Growth monitoring</li> <li>• Disease surveillance</li> <li>• Water and sanitation</li> <li>• HIV counseling and testing</li> <li>• Family planning</li> <li>• Treatment of malaria, pneumonia and diarrhoea</li> <li>• MNCH home visits</li> </ul>

## Appendix II: A menu of roles and responsibilities to inform discussions on making the "CHW Framework" operational

### **A) At the National Level:**

National authorities, through strong national leadership, carry the responsibility for:

- establishing the policy and the principles to which all CHW programs adhere; articulated within national HRH plans and the overall health strategy.
- linking these policies and principles to existing national coordination mechanisms for health and HIV services,
- drawing upon relevant CHW stakeholder mechanisms to inform development of policy, establishing criteria and processes to establish typology relevant for the country, define and formalize cadres of CHWs within the public health system as salaried workers, including licensure, curriculum and standards, tasks and roles in the health team, as well as how formalized cadre of health workers will work together with other community based workers that do not meet the criteria for being formalized on the payroll of the national system
- providing guidance to all partners for incentives and compensation packages - such as in terms of a "minimum and maximum" incentives that align with national HRH incentives across all cadres.
- utilizing internationally standardized core indicators for monitoring and evaluation of CHWs and CHW programs under the CHW Framework. National observatories or relevant knowledge institutions are tasked to keep updated information of CHW programs in the country and to track progress, in collaboration with external partners as agreed at national level. Data, analysis, and program maps and documents should be made publically available.
- defining the scope of delegated authority for the District authorities to facilitate coordination of CHW program implementation in line with the national CHW policy, ensuring that there is space for district authorities to apply and adapt national guidance to the local context and engage with the different actors in CHW programs to follow up the principles through district level collaboration.
- enabling district health leaders to properly implement and monitor the CHW programs with the skills, budgets and resources needed.
- building on data and information gathered, develop and maintain a map of community-based services and develop a national CHW program research and innovation agenda to inform strategies for successful contribution of CHWs to UHC.

Multilateral and bilateral donors and NGO partners carry the responsibility for

- anchoring the CHW projects they support in the national CHW policy and HRH plans
- harmonizing and aligning programs to achieve synergies across different CHW programs and appropriate integration with all relevant element of the health system, in line with national efforts to achieve UHC
- sharing information on allowances and incentives in CHW projects they support and aligning these systems with national agreed principles

- supporting and respecting a shared monitoring and reporting system and ensuring that information from the CHW projects supported is made available
- sharing knowledge and learning, from within country and across country experiences in ways that build up the national knowledge base
- participating in national level meetings of stakeholders and partners convened by the national authorities to review progress, synthesize learning and identify knowledge gaps and research needs.
- Ensure planning and support for project/programme transition at the end of the funding period

## **B) At the District Level:**

The District Health Management team or other appropriate mechanism at district level

will:

- facilitate synergies and coordination of CHW programs in the context of overall health system development and UHC in the district on the basis of delegated authority from the national level,
- define expected CHW program contributions in the district health plan, inclusive of all programs operated in the district by all partners, and make the appropriate links to local government at district level and different types of extension services in other sectors
- identify priority actions, concrete measures for synergies across CHW programs and ensuring that support, supervision and supply systems are established
- dialogue with CHW programs partners regarding alignment and nurturing synergies in line with national principles and relevant to the local context and be informed of allowances and incentives used by different CHW programs in the district
- collect, process, and act on data and reports on CHW programs in the district and ensure compliance with the agreed monitoring and evaluation part of the CHW Framework
- establish accountability mechanisms for CHW programs that link to and communicate with local government authorities as part of the district plan, consolidate district reporting from all CHW programs and communicate to the national level
- clarify the role and responsibilities of the primary health care facilities in the district (public and non-state) to ensure that each front line health facility will include the community based CHWs in the health team, with supervision and two-way communication and support. Facility-based health workers may be providing support to services delivered by doctor/nurses or promoting linkages with community-based carers.
- include CHW projects in district level meetings on the district plan and its implementation and facilitate dialogue on improvements and problem solving in CHW contribution to UHC in the district, along the A-A-A-Q elements (availability, accessibility, acceptability and quality)

The district level partners will:

- anchor the CHW projects they support in the district health plan
- harmonize and align activities to achieve synergies across different CHW programs and appropriate integration with the district health system, whether operated by public or non-state actors
- share information on allowances and incentives in CHW projects they support and align these systems with district guidance, based on nationally agreed principles
- participate in the development of a shared monitoring and reporting system and make available information from the CHW projects supported
- share knowledge and learning, from within district and across district experiences in ways that stimulate innovation and best practices for all CHW projects in the district
- participate in district level meetings of stakeholders and partners as convened by district authorities to review progress, synthesize learning and identify knowledge gaps and research needs

C) At the Front-line Facility Level<sup>1</sup>:

- The facility based and community based workers in the communities served by the facility (public or non-state) will functionally work in interaction with each other as a mutually supportive health team
- The facility staff will serve critical functions in ensuring supervision, support and effective health team functions that are inclusive of all CHWs in the communities they serve. These responsibilities will be clarified in job descriptions and criteria for evaluation.
- Where there are both public and non-state operated facilities serving the same communities, collaboration across facilities in terms of CHWs will be established that assign supervision, support and reporting functions, if necessary facilitated by the district health authorities
- The facility in charge will convene consultations on how to align activities and optimize synergies across different programs that work through community based CHWs
- The facility will keep an updated inventory of the activities performed by CHWs in the communities they serve and receive regular reports in line with the agreed reporting system
- In those instances where there is no formal engagement with CHW programs, initiate efforts to establish a linkage
- Provide supervision and support on the provision and management of commodities
- The facility will meet regularly with the CHWs in the communities they serve, to address bottlenecks and opportunities and to identify where action by partners is necessary.
- Work with other facilities to define catchment areas to prevent overlap or gaps.
- CHWs will have access to relevant communication technology to ensure they can be properly supported and have access to the information they need to properly conduct their work.

The facility level partners that implement CHW projects will:

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<sup>1</sup> Context and resources will have an enormous influence on the types of activities and processes.

- make arrangements with the facilities that serve communities where their CHWs are based, to agree on how their CHWs will contribute into the health team and be supported
- share information about their program, including supervision and management of commodities, training, remuneration and activities, and ensure regular reporting in line with the agreed reporting system, not bypassing the facility when reporting to districts, national and partner program levels
- be available to meet with facility staff to address bottlenecks and opportunities and to identify where action by partners is necessary

#### **D) The Community Level:**

Many partners working with CHWs are based at the CSO/CBO level and may have limited facility engagement. They may or may not already be establishing engagement with health facilities. Exactly how the roles at the community level evolve will be context specific and depend on design of program.

Some of the ways that community groups and civil society might participate with the formal health system in improving community health services are:

- where the CHW programme is based in the community, ensuring that linkages to the health facility are established
- Participating in the selection and oversight of CHWs.
- In each community or village, CHW projects will contribute to a map or inventory of community based health initiatives to share with the local leadership
- Communities and community groups will be encouraged and empowered to work with CHWs, such as through a village health committee or other local government or community development structures.
- A representative of the village health committee should sit on Health Facility Management Committee
- Efforts to build synergies at this level should be focused on enhancing community support structures for CHWs and establishing responsive accountability to the people whose health care needs they serve.

Health facility case managers, with encouragement from District governments, will engage community groups, faith-based organizations, and civil society, particularly as the user-provider care collaboration becomes more prominent.

In addition, District governments will include community leaders in strategy discussions regarding community health outreach and CHW management. District government will also solicit partnership from community groups in community health surveillance, CHW support, and data collection.

To support community programs and community providers, national and regional governments should build in incentives that will encourage community involvement and linkages with the health centers and CHW activities.

<sup>i</sup> The authors have chosen to use the term Community Health Worker (CHW) recognising that, while it is not a perfect fit, it is understood to refer to the broad range of community-based health workers, facility-based workers who provide care in the community, and volunteers

<sup>ii</sup> Four consultations on CHWs and FLHWs in 2012:

1. Technical consultation on the role of community based providers in improving Maternal and Newborn Health (30 - 31 May 2012 - organized by Royal Tropical Institute, Netherlands)
2. Evidence Summit on Community and Formal System Support for Enhanced Community Health Worker Performance (May 31 and June 1 - convened by USAID Global Health Bureau in Washington DC)
3. Community Health Worker Regional Meeting (19 to 21 June - convened by USAID-funded Health Care Improvement Project, at Addis Ababa, Ethiopia)
4. Health workers at the Frontline – Acting on what we know: Consultation on how to improve front line access to evidence-based interventions by skilled health care providers (25-27 June, (convened by NORAD and coordinated by EQUINET at Nairobi, Kenya).

<sup>iii</sup> A synthesis of the consultation outcomes can be found at:

[http://www.who.int/workforcealliance/knowledge/resources/synthesis\\_paper/en/index.html](http://www.who.int/workforcealliance/knowledge/resources/synthesis_paper/en/index.html)

<sup>iv</sup> Kate Tulenko, Sigrun Møgedal, Muhammad Mahmood Afzal, Diana Frymus, Adetokunbo Oshin, Muhammad Pate, Estelle Quain, Arletty Pinel, Shona Wynd & Sanjay Zodpey. Community health workers for universal health-care coverage: from fragmentation to synergy; *Bull World Health Organ. Forthcoming.*

<sup>v</sup> Rifat A. Atun, Sara Bennett and Antonio Duran. When do vertical (stand-alone) programmes have a place in health systems? World Health Organization, Geneva, Switzerland, 2008

<sup>vi</sup> Lobb R, Colditz GA. Implementation Science and its Application to Population Health. *Annu Rev Public Health.* 2013 Jan 7. [Epub ahead of print]

<sup>vii</sup> Walker, P.; Downey, S.; Crigler, L.; LeBan, K. *CHW "Principles of Practice" Guiding Principles for Non-Governmental Organisations and Their Partners for Coordinated National Scale-Up of Community Health Worker Programmes.* April 2013. Washington, D.C.: CORE Group, World Vision International.

<sup>viii</sup> The "Three Ones approach" derives from an approach used in the AIDS response where countries had One National AIDS Committee, One National Plan, and One National M&E framework.

<sup>ix</sup> For further information see the related background paper: CHW Monitoring and accountability framework (MAF), co-authored by Allison Annette Foster (URC and USAID-ASSIST project), Kate Tulenko (USAID CapacityPlus) and Edward Broughton (URC and USAID-ASSIST project).

<sup>x</sup> Rasschaert F, Pirard M, Philips MP, et al. "Positive spill-over effects of ART scale up on wider health systems development: evidence from Ethiopia and Malawi." *J Int AIDS Soc* 2011; 14 (suppl 1): S3.

<sup>xi</sup> Price J, Asuka Leslie J, Welsh M, Binagwaho A. "Integrating HIV clinical services into primary health care in Rwanda: a measure of quantitative effects". *AIDS Care*; 2009; 21: 608–13.

<sup>xii</sup> McColl K. "Mentor mothers to prevent mother-to-child transmission of HIV". *BMJ.* 2012; 344:e1590.

<sup>xiii</sup> Ndawinz, Jacques D.A. et al., "Factors associated with late antiretroviral therapy initiation in Cameroon: a representative multilevel analysis", *Journal of Antimicrobial Chemotherapy*, Feb, 2013 – ahead of print.

<sup>xiv</sup> <http://allafrica.com/stories/201109230257.html>

<sup>xv</sup> McCord G, Liu A, Singh, P.; Deployment of community health workers across rural sub-Saharan Africa: financial considerations and operational assumptions; *Bull World Health Organ* 2012;91:244–253B

<sup>xvi</sup> Ortiz, Christine, Nadia Olson, Mark McEuen, Paul Dowling. 2008. *Primer: Ensuring Reproductive Health Commodity Security within a Sector Wide Approach.* Arlington, Va: USAID | DELIVER PROJECT, Task Order 1

<sup>xvii</sup> Mary Sibande Kumwanje; "The Role of Community Based Providers in Improving Maternal and Newborn Health: Community based RH Project-CRH-College of medicine, Malawi;" Presentation for Technical Consultation meeting 30<sup>TH</sup> - 31<sup>ST</sup> May, 2012; Royal Tropical institute, Amsterdam, The Netherlands