CHW "Principles of Practice"

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

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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
MDGs	Millennium Development Goals
NGO	Non-Governmental Organization
pMTCT	Prevention of Mother to Child Transmission (of HIV)
WHO	World Health Organization

Contents

Introduction

Non-governmental organizations have long been involved in community health programming 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, diverse cadres of trained health volunteers have emerged with different titles and responsibilities, according to the existing health infrastructure and needs, or 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 programs 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 [1, 2].

We commonly take the definition of the terms CHW very broadly, and the 2005 Cochrane review of CHW defined them 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"[3]. 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 programs 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 programs have been regarded with some scepticism within the global health community, and there have been lingering concerns around their effectiveness, and the quality and sustainability of the programs themselves, given the rapid turnover and consistent investment of resources needed to sustain activities. Throughout the late 1970's and 1980s, in the wake of the Alma Ata declaration, CHW programs were considered the centrepiece of the "Health for All" agenda, but after substantial investments in training, these efforts were found to be lacking in some countries, suffering from high attrition rates and variable quality. Political and economic changes within these countries, corruption or inconsistent donor investment also affected implementation within countries. 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 programs [4, 5].

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 [3-6]. 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 shown to be successfully delivered at scale in Malawi, Ghana, Ethiopia and Senegal. [7]

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. [8] In these contexts, bridging these gaps effectively will require strong partnerships between government health authorities, NGOs, civil society and with the communities and CHW cadres themselves in order to ensure CHW programs are effective and sustained.

CHW Program Functionality

The USAID funded Health Care Improvement Project developed the CHW-Assessment and Improvement Matrix[9], which lists 15 programmatic components derived from evidence-based practices. This tool, along with the good practices is being used to define certain standards for CHW programming among various organizations including some CORE Group members. The CHW AIM tools provides a benchmark against which to assess country CHW guidelines and implementation in the field, which can be used in partnership discussions with local and national government stakeholders to orient partners towards program strengthening activities.

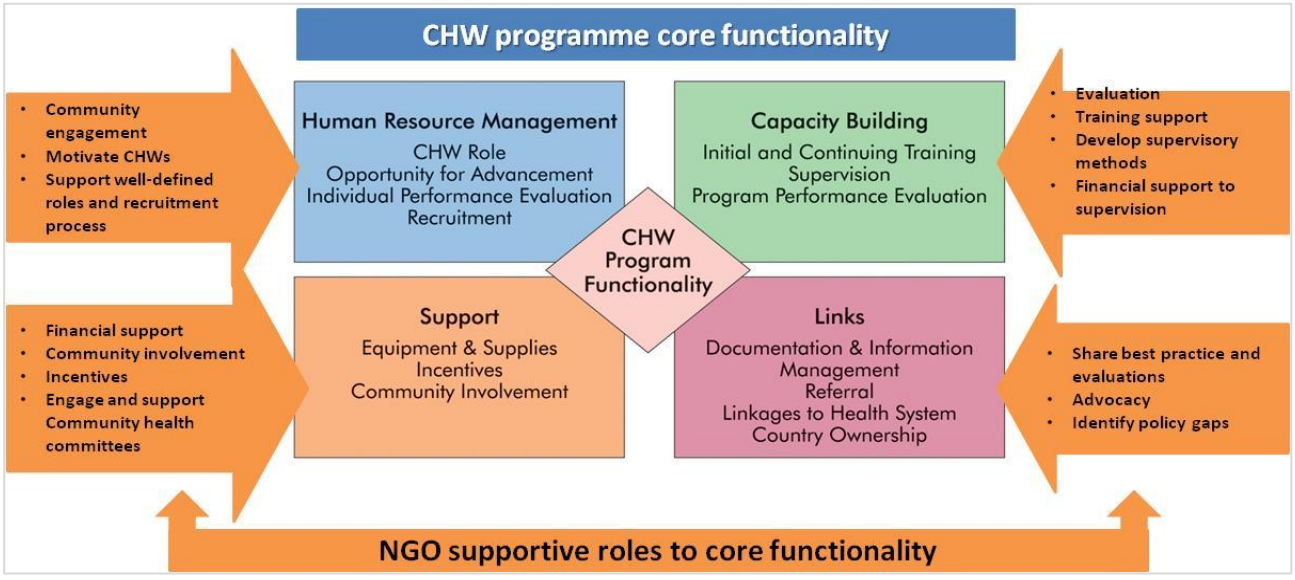

Figure 1. CHW AIM functionality Matrix and NGO Support Mechanisms

Figure 1 shows the CHW-AIM matrix with the 15 functionality elements, and the orange arrows show some ways in which NGO approaches are being used to strengthen functionality. Weaknesses have been observed in all 15 components, but are most commonly in ongoing training, inadequate supervision, lack of supplies and sustainable supply chains, and poor connectivity between CHWs and health centres, and the communities they work for. 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 programs are more advanced NGOs may be more focused in advocacy or evaluation. CHW AIM provides a framework for approach development all aspects of programming from household level to

health system integration into consideration, while allowing for the flexibility required for NGO-led programming to respond to diverse circumstances and community needs.

Recent evidence reviews from research and country experiences of scaling up CHW programs and international meetings, has resulted in greater understanding of how to ensure CHW programs are quality, sustainable and successful [2,4,5,9]. Furthermore, task-shifting and health systems strengthening initiatives require NGOs and donors to engage with governments through long-term partnership approaches, to ensure sustainable programming [10].

CORE Group (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 programs, reflecting their grass-roots origins and community-driven development, have diverse approaches for CHW engagement. These Principles of Practice for Community Health Worker Programming 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 with diverse programming approaches, then provide a clear framework relevant to specific cadres of CHWs, which reflects the underlying principles of good partnership for ethical and long-term investments in those CHW priority countries and contexts.

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 programs 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 when it comes to planning for national and international scale-up of CHWs.

- **Mosaic training systems**

NGOs and civil society organizations support CHW trainings often do so using curricula which are diverse in content and expectation of CHWs. This has resulted in a mosaic distribution of CHW programs 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 partners in operation, CHW programs 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 program 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, there may be a need for a tailored and more intensive CHW strategy to address specific population needs and epidemiology, which can be built into scale-up plans.

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

In recent years some governments have introduced financial and non-financial incentives to reduce attrition rates and improve program quality. Most countries lack a guiding policy around motivational strategies at a national level, results indifferent cadres or NGO-led projects receiving different levels of incentives. Often, the best financed programs 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 work through longer term projects financed for 10-15 years, tend to have lower annual budgets and as such are unable to match these incentives. As described above, multiple NGOs can introduce competing incentive packages causing conflicts of interest. Long-term development programs and grant-funded projects, as well as different NGOs operating in a geographic region should have unity on the issue of incentives and avoid the possibility of neighbouring communities and CHWs being subject to different methodologies and standards.

- **Direct implementation 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 implementation is necessary to ensure access to life saving interventions, and CHWs can have an important role in ensuring frontline services during disasters[11]. Contexts which are fragile or where state services are suffering poor functionality or corruption are also areas where NGOs and FBOs are essential, sometime only providers of services. Programs 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[12]. 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, for long-term planning 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 programs 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 project assistance ends, supplies and services collapse, CHWs run out of the buffer stocks with no functioning replacement system and community health delivery ceases to function.

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

In the era of HIV vertical programs throughout the 1990s many projects responded to the crisis by setting up rapid-acting vertical HIV treatment and testing programs. 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 multiple agencies are operating and reporting in different ways. Many countries, especially those with weaker health systems, require strengthening in the management and collection of health information for quality monitoring. Field supervision of CHWs is a rare luxury in countries with severe health workforce shortages. What is frequently lacking across projects is the consistent assessment of quality against appropriate standards and defined competencies. While the ideal would be to have qualified health personnel conducting regular quality supervision, the reality is that this gap is often filled by NGO staff, peer CHWs or not at all. Innovative methods for supervision can have an important role here. Mobile technologies, when coordinated with the MoH, offer a possible solution to improving local data management. Other lower tech solutions include working with communities to establish data boards and other types of publically displayed health scorecards. The establishment of CHW peer supervision gatherings has proven successful in some countries.

Scope and Objectives

- **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 programs 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 regional authorities the Principles could be adapted to advocate for decentralized CHW management allowing for development of locally relevant strategies under centralized policies.

Summary

The grassroots evolution of CHW cadres and their roles in diverse projects and organizations has led to a mosaic of implementation within and between countries. The effect is that minimum standards,

processes, quality and coverage, as well as long-term sustainable health systems strengthening approaches fail to be consistently established. This diversity is similar to that created in the era of vertical HIV programming prior to the 'Three Ones' call in 2004, in which donors, NGOs and developing country governments agreed to promote one action framework that provided the basis for coordinating the work of all partners; one national coordinating authority with a broad-based multi-sector mandate, and one country level monitoring and evaluation system[13]. 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 are established under a unified system. In order to scale up CHW programs 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 CORE Group 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.

CHW Principles of Practice

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 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 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 role in supporting CHW research, and for the development of appropriate low-tech innovations, judiciously taking to scale evidence-based cost-effective solutions made available in the public domain through partnership approaches.

Concurrent Works and Synergies

The resurgence in interest in scale up of CHWs to achieve the MDGs for health has led to a number of initiatives aiming to maximise the possibilities afforded by the plethora of evidence for CHWs potential impacts. The Global Health Workforce Alliance (GWHA) conducted a study of current CHW program evidence and a global consultation involving program managers, policy makers and experts in Montreux, Switzerland in 2010[1], from which 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 [8, 10]. They expanded this work conducting an in depth case study review of experiences[4]. In 2012, USAID led a review of current thinking and evidence on CHW programming at the CHW Evidence Summit[5]. The key messages promoted in these documents are the foundation for

these guiding principles, combined with the use of other key related resources and guidelines that have been developed to apply specifically to the action of NGO-led programs.

Recently, GHWA has moved forward a synthesis paper of recent evidence and thinking on CHW programming, summarizing the key findings on typology, selection, training, supervision, evaluation standards, certification, deployment patterns, in-service training, performance and impact[4]. In the development of this work four events took place to discuss CHPs focused how to harness the value of these cadres towards achieving related MDGs promoting evidence based and sustainable approaches to national level scale-up. The resulting synthesis paper calls for action around a set of common themes meant to increase collaboration between entities working on CHP initiatives, highlight positive partnership approaches and policy changes, and the need for a global research agenda to focus on sustainability and effectiveness. Synergies with the GWHA reflected in the Principles of Practice include highlighting the following key issues:

- Targeting partnership approaches for those HRH crisis countries for which CHW scale-up is high priority;
- Creation of a framework of action for greater collaboration and multi-stakeholder approaches among partners through multi-stakeholder approaches at both an international and national level;
- Emphasising national and regional level coordination processes led and backed by a nationally led coordinating body or process;
- The use of evidence-based approaches applied in scale-up through contextually adaptation;
- The recognition of CHW cadres and integration in the health systems under unified policies;
- The role of national level consultations and the role of 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 addresses specifically actions of non-governmental organizations, operating locally and internationally who are developing methods and innovations and engaged in advocacy activities related to CHW programming. We present specific guidance at how we can work together at various levels to deliver common goals and reduce those working practices that may currently be hinder progress in global CHW scale up.

Principle 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 roles and performance of different cadres.

There are still some health workforce crisis countries which do not formally recognise CHWs in health policy, although many have worked towards policy solutions in recent years. Health workforce crisis countries need to consider fast-tracking supportive legislation formalising the roles, performance, scope of practice, activities and minimum standards to 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. 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 National CHW policies and guidelines as part of a community participation or engagement strategy for organizations and regional health authorities which stipulate modes of operation of community health workforces.
- Integrate CHWs fully into national health plans and health system strengthening initiatives, accounting for existing needs, expected social benefits, local values and preferences.
- Countries should define the roles and the necessary competency levels required both for new cadres and for those which are 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 adaptation, adoption and regular updating of national policies to rapidly assimilate new evidence-based recommendations understanding how they affect functionality, scalability and sustainability. Support task-shifting of functions as close to the community as possible given evidence and safety considerations such as the prescribing and dispensing of key 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.
- 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"[14]

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 programs. As such, whether intentionally or not, NGOs may operate with little state intervention, and actual country ownership is not practically fostered. NGOs take diverse approaches to promote country leadership in their own projects, and are limited by program or financial requirements and contextual constraints. Often 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 programs 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.

Recommendations

Advocacy:

- Specialist departments or coordinating bodies should be established at both national and sub-national levles, 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 programs 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 program standards.

Programming:

- Partner-implemented CHW programs 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 program delivery should support country leadership and coordination of state and non-state iimplementers 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 clarificaiton. .

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 programs led by NGOs and the private sector. Recruitment of technically skilled staff for these programs 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[15], 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 programs support provision of core supplies for consistent program functionality.
- Work with existing public service staff to provide technical support to programs 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 programs 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 program 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.

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 have inadequate means to meet the salary costs of existing staff, or to deploy motivational strategies for retention of staff in under-resourced and isolated areas. Financial incentives for CHWs are seen as unsustainable, and in many places the contribution of CHWs may not be sufficiently valued by policy makers. There is also concern that introducing a financial gain component will detract from community-building spirit inherent in volunteerism as the backbone of civil society. 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. 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." Attrition seriously affects the quality and sustainability of community health interventions. There is growing evidence that significant quality improvements can be made through motivation and support strategies which promote good performance, long term retention and nurturing 'careerism' among CHWs.[16]

Some higher resourced countries have begun providing salaries for CHWs to positive effect, such as Brazil and Madagascar[16]. Others are promoting the provision of incentives from implementing agencies to meet the required costs. However, where a unified policy on incentives is not in place, competitive or unsustainable incentives schemes can 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 context or culture 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 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 the same stipend 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 events.

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 programs 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* – While CHWs may occasionally receive rewards or gifts in kind for their work 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 CHW as a 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 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. 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. 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 trainings 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 programs, 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 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 are becoming more interested in generating outcome and impact level data such as intervention coverage and changes in population health. 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. Supervision methods often focus on quantitative collection of basic data elements such as stocks and case load, then analysed remotely. 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.

Recommendations

Advocacy

- Advocate for agreement on quality assurance systems and core indicators appropriate to context, and develop systematic competency-based methods to monitor and improve quality and coverage of services 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.
- Advocate for the inclusion of quality and performance and outcome level monitoring indicators in HMIS data collection, with improved collection systems and automated reporting to enable data from diverse programs to be easily assimilated and used by health managers.

Programming:

- Ensure continuous support supervision, and skills mentoring are prioritized within all existing and new CHW programs with well supported and appropriate 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.

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.

Principle 7. Maximise NGOs roles in supporting CHW policy research, and for the development of appropriate low-tech innovations, 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 programs, 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 (REF). 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 programs 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 and 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 innovations 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 of 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.

Partnership:

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

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