Integrating community health workers into health systems

A step-by-step policy implementation guide

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ISBN 978-92-4-011029-8 (electronic version)
ISBN 978-92-4-011030-4 (print version)

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Cataloguing-in-Publication (CIP) data. CIP data are available at **https://iris.who.int/**.

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Acknowledgements

The development of this community health worker (CHW) policy implementation guide was conceptualized by Giorgio Cometto and supported by Onyema Ajuebor, under the leadership of James Campbell, Health Workforce Department, World Health Organization (WHO).

WHO is grateful to Maryse Kok (Liverpool School of Tropical Medicine, United Kingdom of Great Britain and Northern Ireland) and Caroline Whidden (independent consultant) for drafting the original document and several iterations. Review contributions were also received from the following colleagues in the WHO Health Workforce Department: Juana Paola Bustamante, Laurence Codjia, Khassoum Diallo, Catherine Kane, Agya Mahat, Michelle McIsaac and Pascal Zurn. The following WHO regional colleagues also contributed to the review of the policy guidance at various stages of its development: James Asamani and Champion Nyoni (WHO Regional Office for Africa), Benjamin Puertas (WHO Regional Office for the Americas), Ibadat Dhillon (WHO Regional Office for South-East Asia), Yana Andersen and Sulakshana Nandi (WHO Regional Office for Europe), Samir Garg and Masahiro Zakoji (WHO Regional Office for the Western Pacific).

WHO is grateful to the following individual experts for peer reviewing the document: Ochiawunma Akwiwu-Ibe (independent public health and community health systems strengthening expert), Rohina Joshi (University of New South Wales, Australia), Tracy Kobukindo (Last Mile Health), Caroline Masquillier (University of Antwerp, Belgium), Lucia M Mupara (Partners In Health), Elvira Muratalieva (University of Geneva, Switzerland), Saidy Eliana Arias Murcia (Universidad El Bosque, Colombia), Abimbola Olaniran (London School of Hygiene and Tropical Medicine, United Kingdom), Sudha Ramani (India Primary Health Care Support Initiative, India), Tuutaleni Shilyomunhu (Ministry of Health, Namibia) and Jospeh Zulu (University of Zambia, Zambia). Conflict of interests declarations were obtained and managed according to WHO policy.

Finally, WHO is grateful to the Susan Thompson Buffett Foundation for providing the funding that supported the development of this product.

Abbreviations

CHW community health worker

DAK digital adaptation toolkit

HLMA health labour market analysis

ISCO International Standard Classification of Occupations

NGO nongovernmental organization

PHC primary health care

TWG technical working group

WHO World Health Organization

Executive summary

This guide presents steps that policy-makers, planners, managers and their partners should undertake when considering a national or subnational policy initiative to integrate community health workers (CHWs) into health systems. The guide was developed as a result of requests from Member States in the 2019 World Health Assembly Resolution 72.3 on CHWs, and builds on the *WHO guideline on health policy and system support to optimize community health worker programmes* (*2018*), *Health labour market analysis guidebook* (*2021*) and *National health workforce accounts: a handbook* (*2023*).

It integrates and complements this prior body of work with the aim of provide a sequencing and prioritization of policy actions to formalize and integrate CHWs in health systems.

The methodology involved the review and validation by a selected group of global experts in CHW programmes. Although this guide is laid out as a series of steps, integrating CHWs into health systems is an iterative, non-linear process. Users should apply the guide flexibly, based on their context and goals, considering which steps correspond and respond to their situation.

Step 1: Assess the national context and state of CHW programmes

Situate CHW integration within the broader health, social, technological, cultural, political and economic context, and assess the current state of CHW programmes in the country and health system.

Step 2: Conduct a stakeholder analysis and engagement with actors involved in PHC and CHW programmes

Map stakeholders in primary health care (PHC) and CHW programmes, their roles and interests and involve them throughout the process of integration. This includes government ministries and agencies, subnational government, development partners, CHW employers, CHWs and other health workers, and community leaders and representatives.

Step 3: Determine the governance structure for CHW integration

Determine the institutional anchor of CHW integration and establish a multidisciplinary technical working group (TWG) of key stakeholders. The TWG would ideally be integrated within or linked to the health workforce governance structures that cover all health occupational groups within the country or setting. Leverage local or community-level governance structures and mechanisms throughout the process of integration.

Step 4: Define the vision, goals and timeframe of CHW integration

Determine the extent to which CHWs will be integrated into the health system, and over what timeframe. Articulate this in a national CHW policy aligned with other policies and regulations across health, development, labour, gender and other sectors.

Step 5: Ensure sustainable financing of CHW integration

Develop a sustainable financing strategy, with all components of CHW integration fully costed. Identify needs requirements, resource gaps and, if needed, policy options to create or increase fiscal space for health and the CHW workforce, ideally through domestic sources.

Step 6: Design the integrated CHW programmes

Adequate policy design requires making key decisions, conducting analytical evidence reviews, and engaging in policy dialogue with key stakeholders across the following functions:

- Planning CHW scope of practice and needs quantification.
- CHW selection, education and certification.
- CHW management and deployment.
- Support for CHWs from the health system and community.

Step 7: Adapt CHW integration in the context of emergencies

As health systems may face shocks and stressors due to conflict, climate change, epidemics and other crises, ensure alignment with national or subnational disaster management plans and consider a framework for flexibility and action that allows integrating CHW roles and responsibilities within emergency preparedness, response and recovery.

Step 8: Monitor and evaluate CHW integration

Integrate CHW data into existing health information systems and assess the health workforce inclusive of CHWs, the implementation fidelity of CHW integration policy and CHW programme performance on PHC and universal health coverage indicators.

Introduction

Community health workers are a diverse and heterogenous occupational group with various typologies and characteristics, and a variable level of formalization and integration in health systems. Despite these variances, CHWs often operate at the margins of health systems, without being duly recognized and adequately supported and rewarded for the crucial role they play. The reasons for this are complex and multifactorial, but include the imbalance of occupational power, the sometimes voluntary and non-structured nature of service provision by CHWs, and the highly gendered landscape of CHW programmes *(1,2).*

In 2018, WHO published an evidence-based global guideline on health policy and system support to optimize CHW programmes *(3)*, recommending their formalization and support by health systems in order to maximize CHW contribution toward universal health coverage and to uphold their basic labour rights. In 2019, WHO Member States noted in World Health Assembly Resolution 72.3 on CHWs, that the integration of CHWs in health systems was uneven, among several challenges affecting the occupational group. Member States then requested WHO to further strengthen the implementation of the CHW guideline in this regard. As countries strive toward this objective, as well as to move beyond dependence on official development assistance for health to support recurrent costs for their CHWs, this resource aims to guide formalization and integration of CHWs in national health workforce planning, education, management and information systems.

This CHW policy implementation step-by-step guide aims to facilitate the implementation of the CHW integration policies at country level by policy-makers, planners and managers in ministries of health, employers, education institutions and development partners. It articulates the rationale, prioritization and step-by-step sequence of analysis, policy dialogue and decision-making needed to facilitate and optimize the integration of CHWs into national health systems.

Methods

This guide has been developed integrating the recommendations of the *WHO guideline on health policy and system support to optimize community health worker programmes (3)*, as well as relevant technical elements of the WHO *Health labour market analysis guidebook (4)* and the WHO *National health workforce accounts: a handbook* (second edition) *(5)*. The guide also received review inputs from national and global experts in community health, including from governments, United Nations agencies, nongovernmental organizations (NGOs) and academia.

Conflict of interests declarations were obtained and managed according to WHO policy. No significant conflicts of interest were declared by peer reviewers.

How to use this guide

The integration of CHWs entails the deliberate and dynamic process of ensuring that CHWs are included within health service delivery structures and covered by the overarching management, administration and support mechanisms that govern other health workforce occupational groups across core functions including planning, education, certification of training, remuneration, management and supervision.[1]

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[1] WHO deliberately uses the term “integration” while noting that other terminologies appear in the literature and policy discourse. The commonly used term “professionalization” (of CHWs) is not consistent with the ILO International Standard Classification of Occupations (ISCO), where CHWs are not part of the “health professionals” grouping. The term “formalization” covers only some aspects (e.g. recognition and certification) and is therefore narrower than “integration”.

The integration of CHWs in health workforce planning and management, in PHC service delivery and in broader health sector strategies and financing mechanisms should be country and context specific. The application of this step-by-step guide therefore needs to be based on the country context, including the extent to which CHW-related policies and CHW integration into the health system already exist and the level of integration desired. Working towards the integration of CHWs into the health system is an iterative, non-linear process and the sequence of the steps presented in this guide may differ by country. In addition, the guide is not exhaustive for every context, but provides a succinct overview of the steps that planners, policy-makers, managers and their partners should consider.

Structure

The guide addresses planners, policy-makers, managers, employers, educators and development partners. It comprises eight sections (see Fig. 1) that refer to actions and policy decisions that need to be taken when integrating CHWs into health systems.

The first five sections lay the foundation by presenting steps to assess the context and key stakeholders, determine the governance and financing structures, and articulate the policy goals. Sections six and seven discuss the key decisions and considerations for adapting the WHO guidelines to the design of integrated CHW programmes. Finally, section eight addresses ongoing monitoring and evaluation of CHW integration.

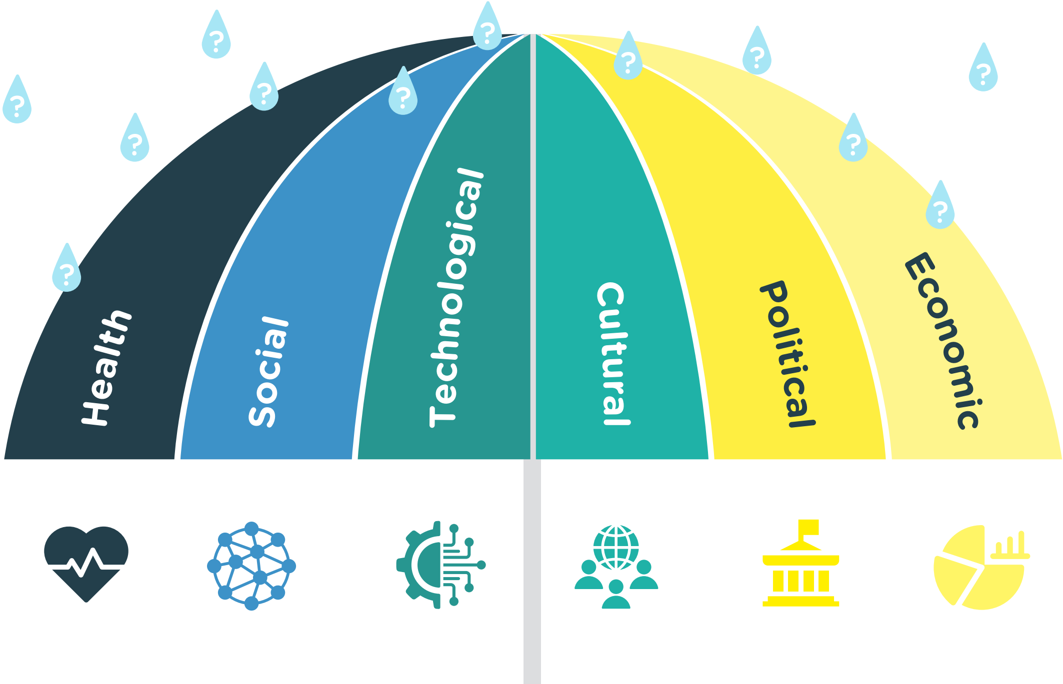
Fig. 1 Action steps and policy decisions for integrating CHWs into health systems

Assess the national context and state of CHW programmes

The relevance, feasibility and implementation modalities of CHW integration into health systems need to be understood within the broader health, social, technological, cultural, political and economic context. Contextual factors can facilitate or hinder implementation, mechanisms of effect and outcomes of CHW integration. Thus, policy-makers should assess the national and subnational context and current state of community health programmes through answering questions, such as:

- What is the level of economic development and social inequality, including gender inequality, throughout the country?
- What is the level of urbanization and state of infrastructure and access, including roads, health facilities and digital tools, infrastructure and connectivity throughout the country?
- What are the social norms and values that come into play in PHC?
- What is the epidemiological situation of the country, the main population health needs and burdens of disease, and how are these distributed? How are social determinants of health shaping access to health services and health outcomes?
- How is health care, especially PHC, financed, governed, managed and delivered?
- What is the role and current state of CHW programmes in the country, in policy and in practice, and how do they vary between localities or population groups?
- What are the political, economic and fiscal windows of opportunity for, and threats to, CHW integration?
- Is there political will for CHW integration?

Fig. 2 Broader social context for integration of community health workers into the health system



Step 2

Conduct a stakeholder analysis and engagement with actors involved in PHC and CHW programmes

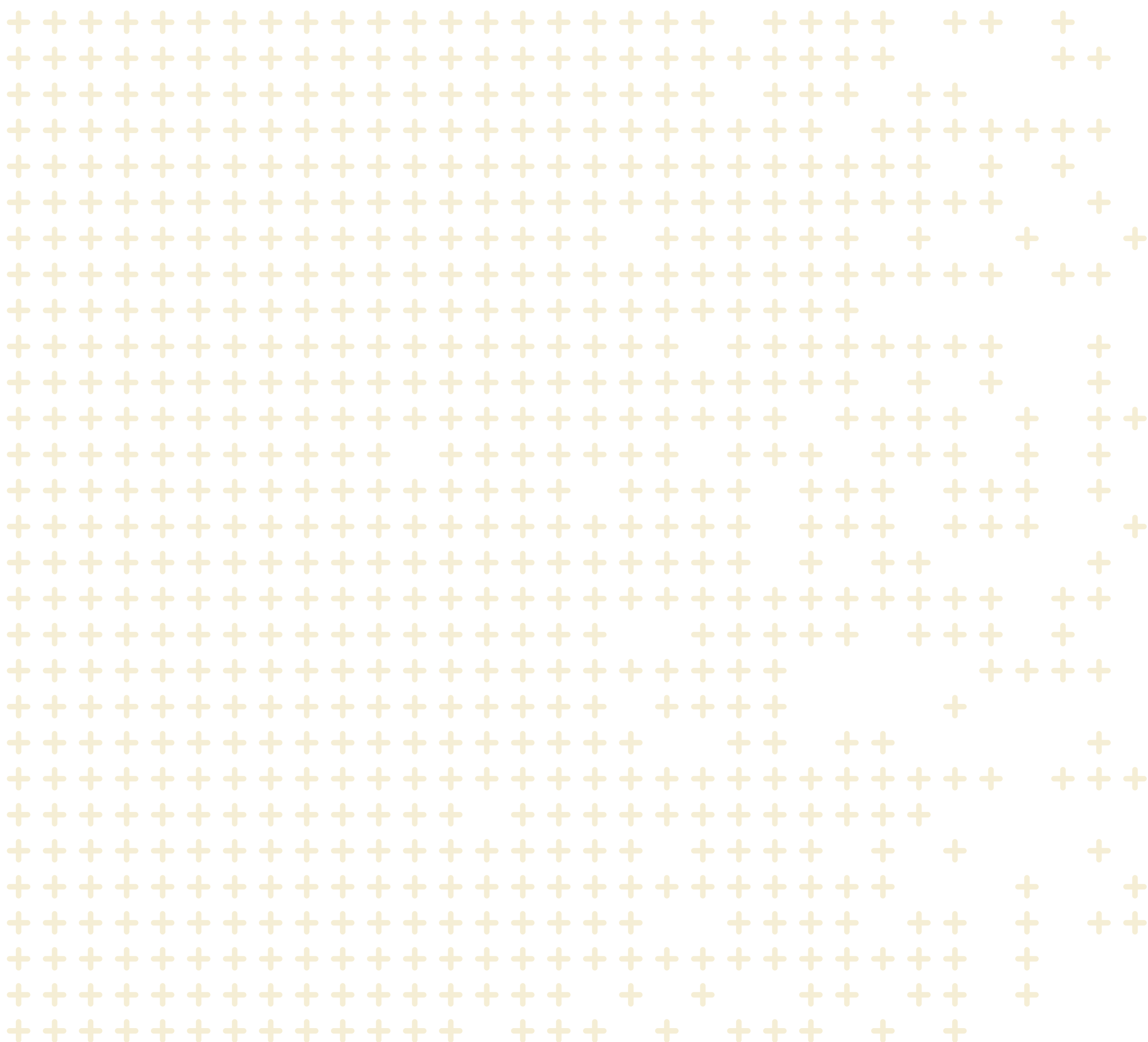
Understanding the context and identifying relevant stakeholders in PHC and CHW programmes, including their roles and interests, are critical to effectively engaging them for optimal buy-in and results. An engagement approach would ideally be participatory, dynamic and involve diverse actors (including health workforce coordination mechanisms) at community, local, subnational and national levels. The mapping could also explore the linkages between these stakeholders at the various levels. A stakeholder mapping can be part of a broader health labour market analysis (HLMA); a political economy analysis is one component of a HLMA (module 4) *(4)* that aims to track the position, behaviour and influence of actors on the health labour market. Who these individuals, institutions and interest groups are, their role and level of influence, and their positioning vis-à-vis the issue of CHW integration, will depend on the country context. Nevertheless, the following broad stakeholder categories are likely to be critical in any context and throughout the process of integration.

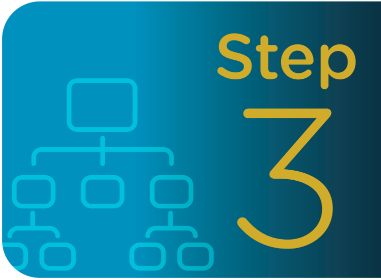
Fig. 3 Engage with stakeholders and determine a programme anchor

+ **Government ministries and agencies:** Delivery of health services, including at primary and community level, is inherently intersectoral, resting on collaboration between health and other sectors. Thus, it is important to adopt a whole-of-government approach and engage different ministries or government agencies at national and subnational levels. Besides ministries of health, health professional regulators and national public health agencies (or their equivalents), CHW integration requires cross-sectoral collaboration with other ministries or government agencies, e.g. education, finance, labour, water and sanitation, agriculture, environment, women, youth and internal affairs. The exact constituents of government participation may differ according to country and setting. Engaging national, subnational and local governments and authorities is beneficial to achieve CHW integration, especially in decentralized health systems.
+ **Development partners and other actors:** Existing CHW programmes may be funded, implemented and supported by a multiplicity of actors involving various partners of the national government, including NGOs and faith-based organizations (often the employers of CHWs), the private sector, donors, United Nations agencies, global health initiatives, universities and health education institutions and research institutes. A mapping of which financial, operational, technical and research partners are doing what and where in relation to CHW programmes in the context of their PHC operations, can inform policy dialogue. Reductions in official development assistance for health, including for CHW programmes, requires governments to consider how to progressively mobilize domestic financing to integrate CHW programmes in national payrolls, to the extent that this meets domestic policy priorities, in line with the Lusaka Agenda.[2]

[2] Launched in December 2023, the Lusaka Agenda outlines five key shifts for the long-term evolution of global health initiatives (https://futureofghis.org/follow_ups/lusaka-agenda-overview/).

- **CHWs and other health workers and their representatives:** As community health experts, CHWs can make a positive contribution through involvement in strategic decisions that affect them, including planning, implementation, monitoring and evaluation of CHW integration. Where CHW labour unions or associations or representatives exist, these should be consulted. Labour unions and associations of other health workforce occupations (e.g. nurses, doctors) could also contribute to ensure effective skills mix and clear delineation of roles and responsibilities within PHC teams *(6)*.
- **Communities:** Engaging communities throughout the process of CHW integration, including pre-programme consultation, community involvement in selecting CHWs and their activities, and community monitoring of CHWs are key to successful CHW initiatives. Community representatives can offer strategic contributions to decision-making, problem-solving, planning and budgeting to promote community ownership. The proactive and meaningful participation of all components of the community, including representation of vulnerable or marginalized groups, is key to ensuring community engagement is strong. Mapping and assessing existing resources, structures and mechanisms of community participation in health and CHW programmes, such as via community or village health committees, women's or youth associations, traditional health practitioners etc., can maximize their potential throughout the process of CHW integration.



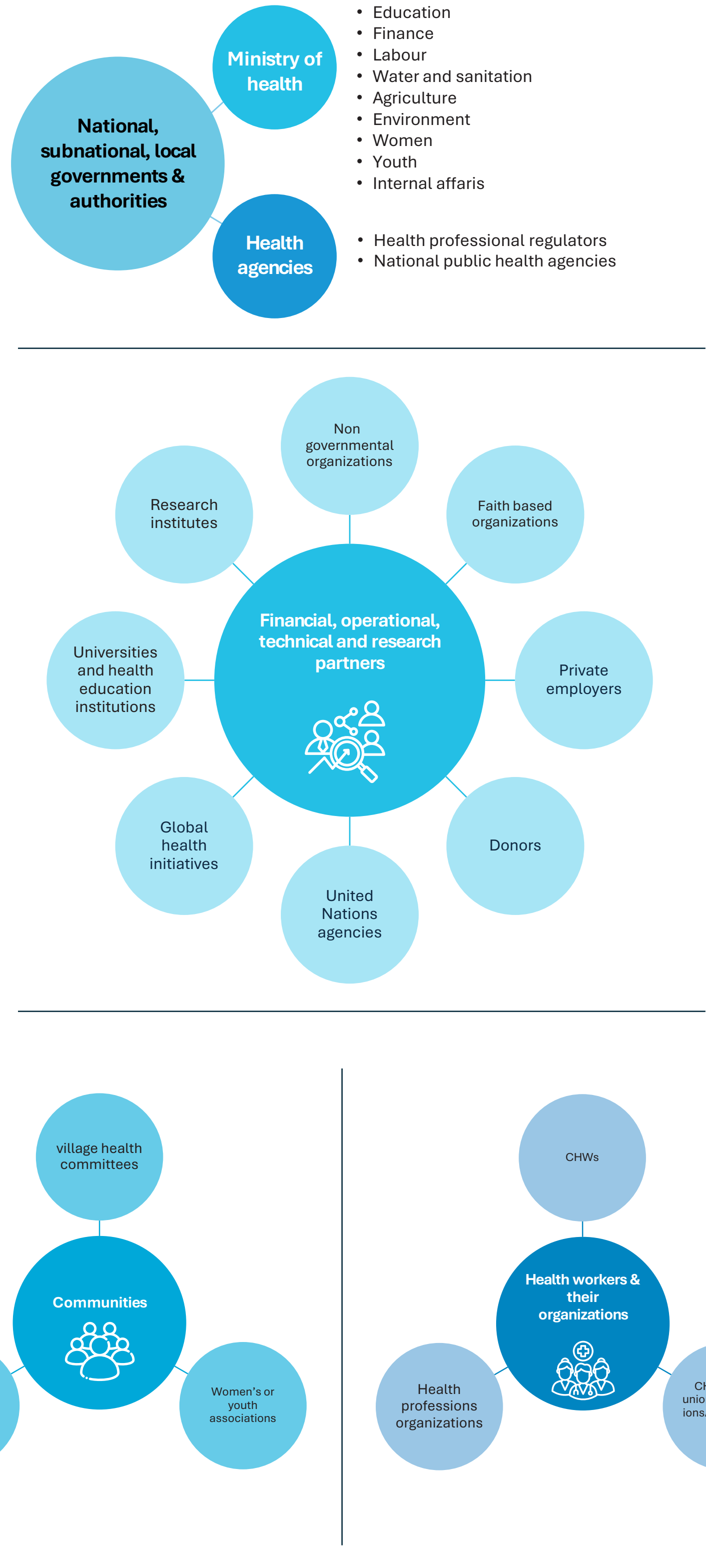


Determine the governance structure for CHW integration

Integrating CHWs into national health systems entails formalizing core functions in public policy, including CHW planning, selection, education, certification, deployment, remuneration, management, supervision and support. Achieving this requires visionary leadership, and clear delineation of roles and responsibilities. The initiative requires an institutional anchor to be identified from the beginning. In many cases, this will be the ministry of health *(7)* but it is equally important to determine the specific department of the ministry of health (e.g. health workforce, community health, PHC etc.) CHW integration falls under, as this has implications for implementation. The responsible institution might consider coordinating a multidisciplinary TWG of key stakeholders, including relevant CHWs and other health workers' representatives. The TWG would ideally comprises the expertise required to pursue the policy-making, implementation and monitoring and evaluation processes of CHW integration. Ensuring a dedicated secretariat function for the national TWG within the ministry of health would facilitate coordination, provide administrative support and strengthen CHW integration within the national health system. The TWG and its secretariat would benefit from integration within or institutional linkage to the health workforce governance structures that cover all health occupational groups within the country or jurisdiction. Subnational TWGs can be considered in decentralized health systems.

CHW integration policy and implementation should consider how to enable local agency in health and community development more broadly. Existing local or community-level governance structures and mechanisms should be identified and assessed to explore how these can be supported or strengthened to support CHW integration. In different countries these might include district-level health offices, local councils, community or village health committees, and traditional and religious structures.

Fig. 4 Identifying stakeholders and understanding roles of government, partners, health workers and communities



Step 4 Define the vision, goals and timeframe of CHW integration

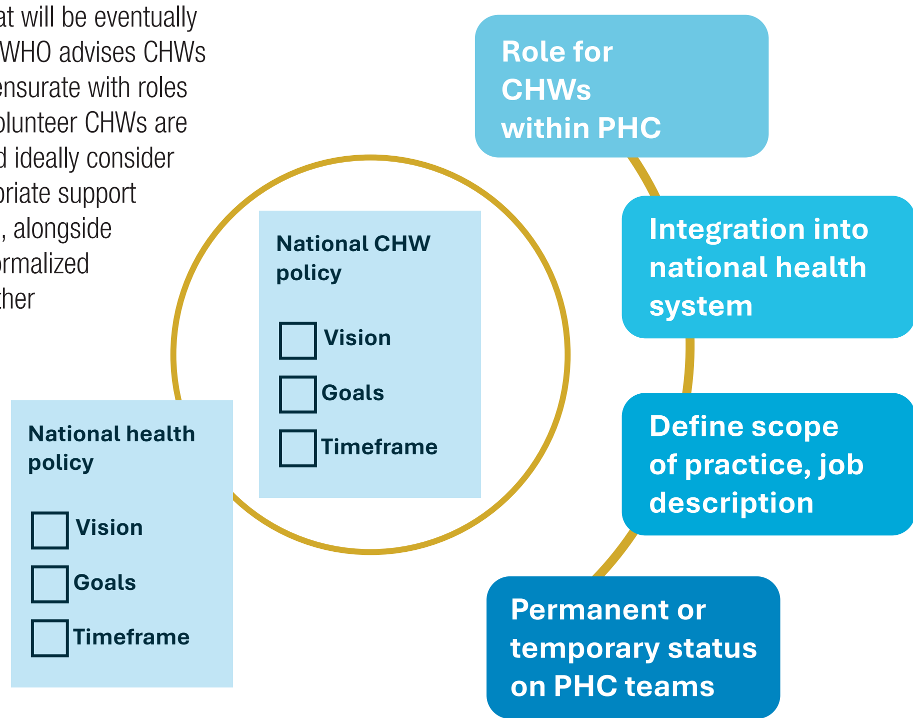
The vision, goals and timeframe of CHW integration need to be articulated in a national (or subnational) CHW policy or through a CHW section of a broader national health or health workforce strategy, policy or plan. This policy document should reflect the context/situation analysis, be developed (or adapted) in collaboration with CHW programme stakeholders, and aligned with national, regional and global commitments and goals. The policy should assess the gaps between the desired CHW vision, the current country CHW policy (including national community health policy or strategy documents), if available, and implementation of CHW programmes at subnational level.

Some fundamental aspects of the future CHW programme should be decided upon. Policy-makers' long-term vision and the role that they see CHWs playing in PHC will inform the extent to which CHWs will be integrated into the national health system, over what timeframe, and whether all or only a part of current CHWs will be integrated into the health system. CHW roles are determined by defining their scope of practice and through standardized job descriptions, including specifying how these may be adapted over time. It should be determined whether CHWs are intended to become permanent members of PHC teams, or if they will be a temporary occupational group that will be eventually replaced by other health occupations. WHO advises CHWs to be paid a fair remuneration, commensurate with roles and level of effort. In settings where volunteer CHWs are nevertheless prevalent, planning would ideally consider operational models that ensure appropriate support and oversight also for volunteer CHWs, alongside more structured integration for their formalized peers, and avoid any disparities or further fragmentation. CHW integration could take a phased approach in the short, medium and long term. In addition to policy or strategy documents, new or adapted legislation or regulations might be beneficial to integrate CHWs into the health system.

In order to develop these national (and/or subnational) policies, legislation and regulations to guide CHW integration, an analysis of relevant documents should include:

- The country's long-term health development plans.
- Documents on administrative decentralization and subnational governance.
- National health policies, strategies, plans, acts, frameworks and regulations, especially those pertaining to the health workforce, PHC and community health.
- National education, labour, gender, community development and social protection sectoral or subsectoral policies and frameworks.
- Regional and international conventions, such as the Sustainable Development Goals, Alma-Ata and Astana declarations on PHC and broader conventions or regulations on labour, human and women's rights.

Fig. 5 Align governance of CHW programmes with national health and CHW policies



Step 5 Ensure sustainable financing of CHW integration

Integration of CHWs into national health systems requires substantial investment in capital and recurrent costs, especially remuneration, supervision and system support. If a CHW programme is wholly or in large part externally funded, there is a need to determine the timeframe, modalities and the cost of transitioning CHWs to the national payroll or other domestic funding mechanism. All components of the CHW policy need to be costed and integrated in a holistic, sustainable financing strategy for the health workforce; the approach and its costing need to be elaborated in collaboration with the ministry of finance, employers, the private sector and other local funding partners. What this financing strategy looks like will depend on the country's macroeconomic context, health budgeting and spending patterns, and CHW integration plans and costs. A macroeconomic analysis of the health labour market (module 5 of the *Health labour market analysis guidebook*) *(4)* will identify opportunities and constraints to increasing investments in the health workforce. A political economy analysis will optimize the chances for successful design, adoption and implementation of CHW financing reforms *(8)*. Key questions to consider include:

- How are human resources for health, community health and CHW programmes currently financed? What is the breakdown of private, public and external sources of funding? What is the extent of out-of-pocket spending in health care? National health workforce accounts (NHWA) module 3 includes indicators on health workforce remuneration *(5)*.
- What is the nature of donor relationships? How do external sources of funding influence investments in the (community) health workforce? For example, NGOs may support CHW programmes in areas of technology, supply chain management and training. Are donor funding trends and priorities aligned with CHW integration plans? Is there a strategy or plan in place to transition from external to domestic funding sources over time?
- Is there a need for a CHW investment case to allocate more government funding to community health or attract investments from donors and other potential funders? A CHW investment case should articulate the long-term benefits and value for money of investing in CHWs, including improved health outcomes, reduced health care costs and increased community empowerment.
- What are the main macroeconomic constraints limiting the expansion of public health expenditure on human resources for health, such as wage bill ceilings, fiscal space, budget prioritization, public spending efficiency? What are the policy options to create or increase fiscal space for health and investment in the CHW workforce through domestic sources, such as increasing tax revenue?
- What are the power structures, the vested interests and the policy positions of the main stakeholders (see step 2), and the underlying political and institutional factors which could potentially affect CHW financing reform? How could these be influenced?

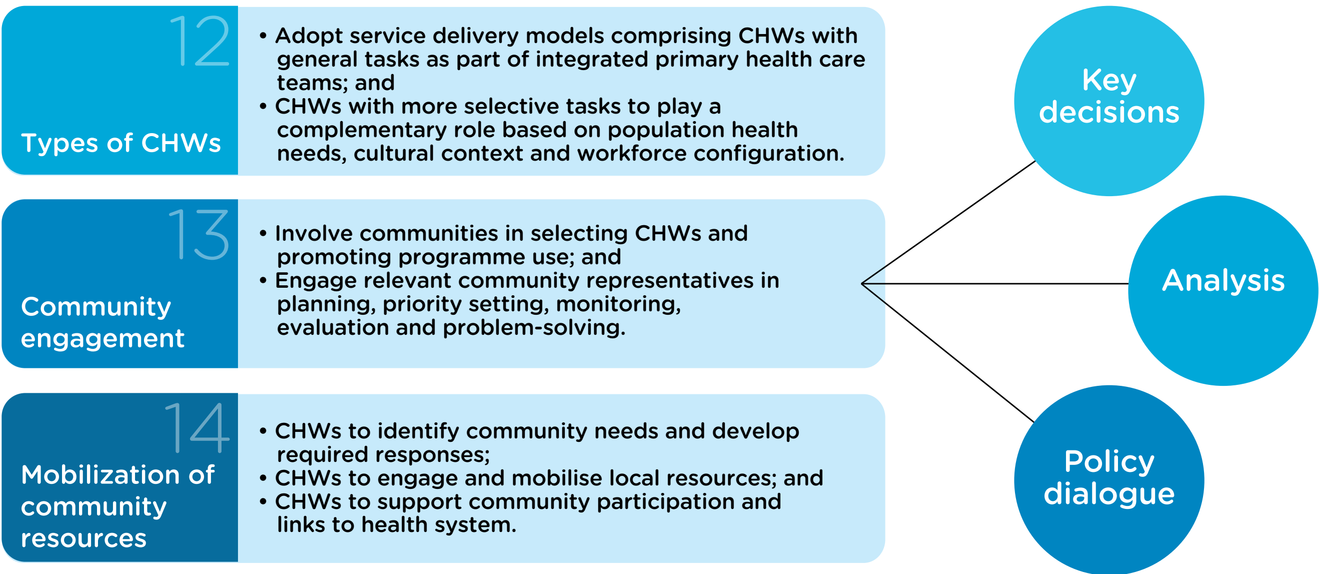
> *CHW integration into national health systems requires substantial investment in capital and recurrent costs, especially CHW remuneration, supervision and system support.*

Step 6 Design the integrated CHW programmes

6.1 Planning CHW scope of practice and needs quantification

Effective CHW integration hinges on clarity around their scope of practice, i.e. defining CHW roles, tasks and distribution in relation to other health workers. This will ultimately inform decisions about CHW deployment – who, how many, where.

Fig. 6 Key decisions, analysis and policy priorities to plan CHW scope of practice and quantify needs



WHO recommendations

Types of CHWs: Adopt service delivery models comprising CHWs with general tasks as part of integrated PHC teams, in which CHWs with selective tasks can play a complementary role (recommendation 12).

Community mobilization: Adopt strategies for CHWs to engage communities and to harness community resources (recommendations 13 and 14).

Target population size: Determine an appropriate target population size in relation to expected workloads, frequency, nature and time of contacts required (recommendation 10).

Key decisions

Types of CHWs: Determine on the role of CHWs along the spectrum from health service delivery to agent of social change, as appropriate to the context and in relation to other health and care workers. Identify CHW priority tasks or activities in terms of service delivery and community mobilization. Decide if there will be a single type of generalist CHW or specialized CHWs. Choose whether all, or which types or groups of CHWs in the country, will be harmonized under a national or subnational policy and integrated into the national or regional health system.

Target population size: Quantify the number of CHWs that will comprise the workforce and how they will be distributed. Identify the appropriate target population size given the CHW scope of practice.

Conduct analysis

+ What is the current stock of active CHWs? Specifically, how many CHWs exist, where are they deployed, who are they (characteristics), what do they do (types), are they engaged short or long term, and with which organizations are they affiliated? This information may need to be triangulated from multiple data sources at all levels and across partners, such as subnational registries,

NGO rosters, or CHW coverage and capacity analyses. Planners and managers should generate a CHW master list with aggregate data that can be integrated into NHWA and include a breakdown by CHW type, if relevant to the country context. Ideally, a labour market analysis inclusive of CHW data would be conducted to assess the current supply and demand of CHWs and its determinants (*Health labour market analysis guidebook* modules 7, 8), gendered dimensions (module 9) and potential mismatches (module 11), along with the types, distribution, density, entry and exit rates, etc. of other health workers *(4)*.

- What is a realistic and appropriate CHW workload, factoring in the package of services along with travel time, reporting requirements and population size of a typical catchment area? Consider conducting a CHW workload assessment to ensure CHWs are not overburdened, leading to burnout and/or compromised service quality and patient safety.
- What is the population density and distribution, and the physical access and infrastructure of CHW catchment areas, including roads and terrain, transportation options, health facilities and mobile phone/digital connectivity? Plan for the implications of such factors on providing CHW management and support.

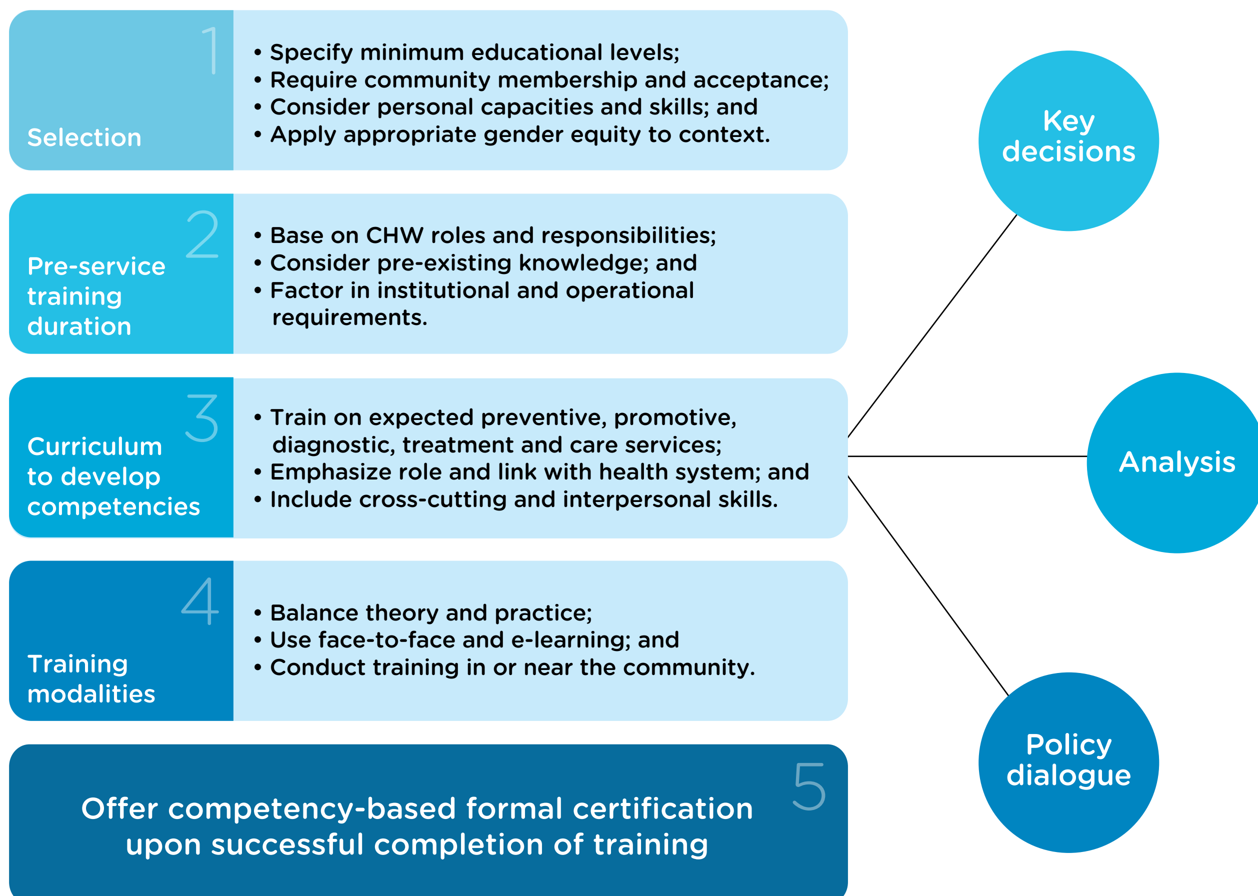
Policy dialogue focus

- When making decisions about CHW service delivery activities, the health issues and interventions for which there is evidence of CHW effectiveness should be mapped onto the country's disease burden and inequities (CHW guideline, annex 2 *(3)*; WHO *Global community health worker curriculum guide (9)*). In addition, the definition of CHW scope of practice should consider existing gaps in population and service delivery coverage at PHC level, which CHWs may be well placed to address.
- The definition of the CHW scope of practice could be informed by the ISCO definition of CHWs *(10)* (code 3253), relevant WHO guidance documents and national essential health services package.
- Regulatory implications of skills mix and PHC team models, with division of labour with other health workers need to be considered. Global guidelines and existing national regulatory approaches (laws and proclamations, rules and regulations, policies and guidelines) should be factored in. Revisions might be needed to accommodate extensions or changes to CHW scope of practice to ensure they are legally authorized to perform the tasks assigned to them.
- Communication plans about the CHW scope of practice can be considered, to ensure all stakeholders are aware of CHW roles and tasks.
- The CHW policy would ideally consider how an integrated CHW workforce fits within primary care teams and networks, in relation to other health and care workers and existing community structures, including facility-based health workers (e.g. nurses, midwives, doctors), community health governance structures (e.g. associations, committees) and other community-based actors (e.g. community health promoters, traditional complementary and integrative medicine practitioners, etc.). Interprofessional collaboration plans, with attention to information sharing and collaboration, could be developed.
- If a phased integration of CHWs on the government payroll is envisaged, implications for the role of different stakeholders in CHW deployment over the near, medium and long term will need to be considered.
- In the policy dialogue on CHW scope of practice, there should be internal coherence and consistency across different policies and programmes affecting CHWs, including essential health services package.

6.2 CHW selection, education and certification

CHW requisite competencies, selection criteria, the length, content and modalities of CHW education and training, and CHW certification prior to deployment largely depend on the decisions made in the CHW planning phase around CHW roles and distribution in relation to the health needs or disease burden of the community.

Fig. 7 Key decisions, analysis and policy priorities for CHW selection, education and certification



WHO recommendations

CHW selection: Select CHWs for pre-service education based on a minimum education level appropriate to the tasks, personal attributes and capacities, such as motivation, integrity, interpersonal skills, membership of and acceptability by the target communities – through community engagement in the selection process (recommendation 1A). Do not select CHWs based on age criteria and marital status (recommendation 1B).

CHW education and training: Determine the length of pre-service education based on competencies required according to role, pre-existing knowledge and skills, and expected conditions of practice (recommendation 2); include content on promotive and preventive services, diagnostic and curative services where relevant, and interpersonal and community mobilization skills (recommendation 3); and balance theoretical and practical modalities, blending face-to-face and e-learning, where feasible, with adequate attention to a positive training environment and faculty (recommendation 4).

CHW certification: Use competency-based formal certification for CHWs who have successfully completed pre-service training to improve CHW quality of care, motivation and employment prospects (recommendation 5).

Key decisions

Cross-cutting: Designate which ministry or government agency has primary ownership and ultimate responsibility for CHW selection, education and certification.

CHW selection: Identify the selection criteria for pre-service education of CHWs. If different types of CHWs are to be integrated into the health system, tailor the selection criteria per CHW type. Detail the CHW selection process: who is responsible, how will the community be involved, and the frequency of CHW selection.

CHW education: Determine a standardized CHW pre-service education length, content and modality (CHW curriculum). Where the training programme is being designed to produce different types of CHWs, include universal modules (i.e. modules encompassing the content all CHWs are required to be trained on), followed by role-specific modules depending on the type(s) or health service area(s) of CHWs to be trained *(9)*. Specify the competencies required of the trainers, establish a list of CHW training institutions authorized to deliver a nationally recognized CHW education programme, and detail how they will be accredited.

CHW certification: Designate the health professional body or council that will oversee CHW certification.

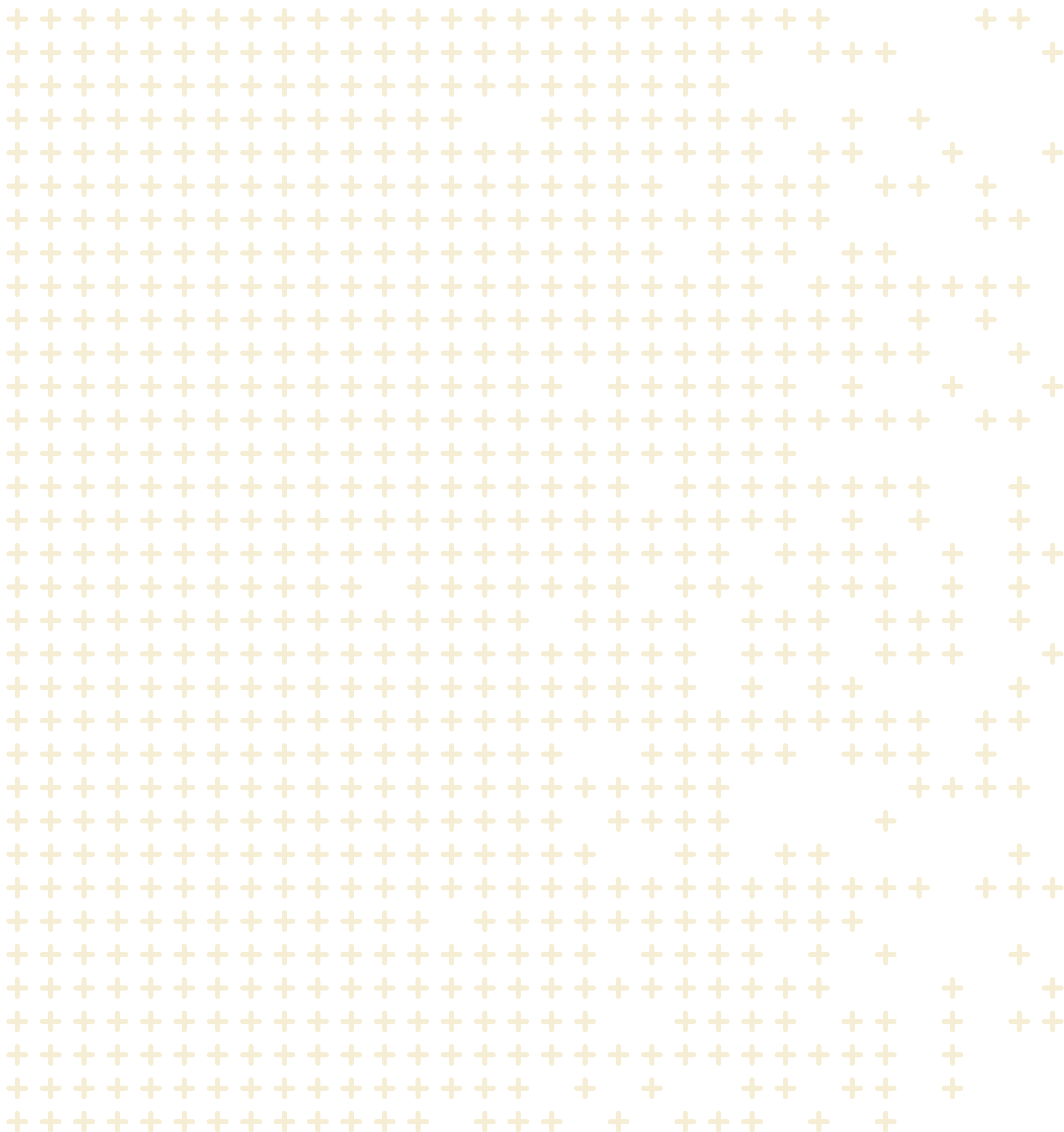
Conduct analysis

- Review the criteria on which CHWs are currently selected? Who is currently responsible for CHW selection? What are the levels and mechanisms of community engagement in CHW selection? What is the frequency of CHW enrolment in education?
- Which institutions currently train CHWs, and which have the mandate and capacity to do so? Who ensures the accreditation of CHW training institutions and their programmes/courses, and how? *(11)*. Ideally, this would be part of a larger assessment of the health education market (*Health labour market analysis guidebook* module 6) *(4)*.
- What is the current length, content and modality of pre-service education of CHWs? How does this vary across different types of CHW? What does in-service training of CHWs currently look like?
- Are CHWs currently certified? If yes, who is involved ? If not, what institution may be well placed to take on this additional mandate?
- How do CHW selection, education and certification vary across different types of CHWs or local contexts across the country? How is this different from what is intended in existing policy documents? For example, what profile of trainers is needed, and to what extent do they understand the principles and implementation of competency-based education, and any shifts that may be required from the status quo?

Policy dialogue focus

- When discussing selection criteria, social norms, cultural values and contextual preferences for community health care delivery and utilization should be considered. This will help determine the personal attributes and capacities of CHWs that promote acceptability and uptake of services in the country context.
- When discussing who is responsible for CHW selection and recruitment, community involvement needs to be considered. For example, if the vision is for CHWs to be eventually integrated into the health system as civil servants, their selection and recruitment might need to follow standard hiring processes of civil servants. In this case, specific mechanisms should be considered to ensure community involvement in CHW selection.
- When discussing the frequency of CHW selection and recruitment, the size of the required CHW workforce needs to be considered. In contexts of expansion of the CHW workforce, policy-makers might consider more frequent, phased rounds of CHW selection, enrolment in education and recruitment across the timeframe of CHW integration.
- In many countries, there is a mix of existing close-to-community health workers, inside and outside the health system, including CHWs, community health volunteers, traditional birth attendants, traditional, complementary and integrative medicine practitioners, etc. Should these practitioners be considered for CHW selection? How to ensure that the minimum education requirements for selection do not unfairly exclude or phase out those with years of practical experience and who demonstrated cultural and contextual competency (e.g. will mature entry be considered, and if so how)?
- If private sector entities are training CHWs, regulation should be considered to ensure standardization and quality of education and inclusive access.
- When discussing CHW training length, content and modality, the defined scope of practice, pre-existing knowledge and skills, and expected conditions of practice need to be taken into account. CHW curricula should be guided by requirements in the national context, while also reflecting international best practices and clinical and other health service protocols reflected in other WHO guidelines (see *WHO guideline on health policy and system support to optimize community health worker programmes* annex 3 *(3)*).
- In countries with different education institutions and curricula for CHWs, nationwide standardization of CHW curricula should be considered, so that all CHWs have a basic universal competency level.

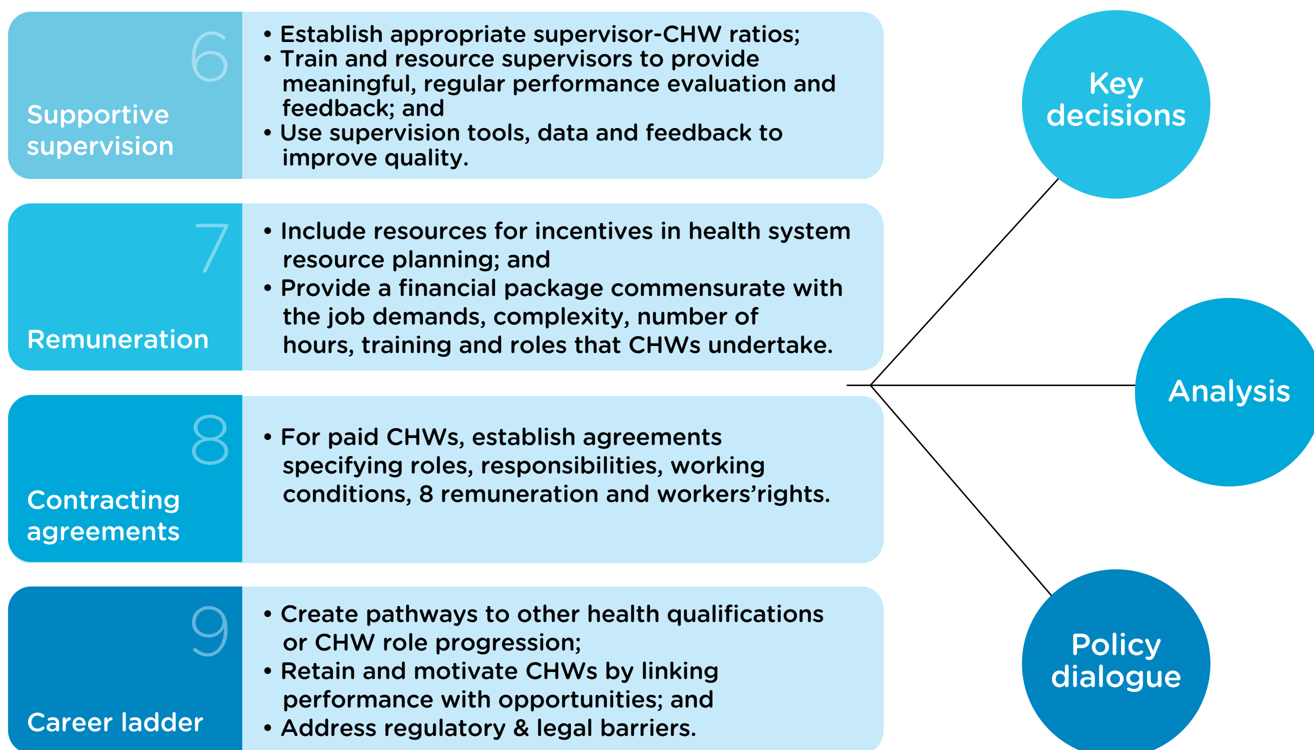
- CHW pre-service education plans should be considered alongside in-service training and supervision plans, as a continuum of CHW training.
- The regulatory implications of CHW certification need to be discussed. If CHWs are certified health workers, this means that they need to be registered by a health professional council. Professional councils can set standards for CHW entry into practice and for their roles in the health system, undertake action when such standards are violated, and set requirements for continuous education of CHWs.
- Policy-makers should adopt proactive policies that promote equity, diversity, inclusion and belonging in the processes of CHW selection, education and certification. This empowers the CHW workforce and minority groups and encourages acceptability of services by the target population. Power dynamics and social inequalities related to gender, sexual orientation, ethnicity, geography, language, health status, etc. should be considered.



6.3 CHW management and deployment

CHW human resource management and deployment should be integrated into the national and subnational health workforce planning and governance mechanisms. This includes CHW contracts, payment, supervision and career development opportunities.

Fig. 8 Key decisions, analysis and policy priorities for CHW management and deployment



WHO recommendations

CHW remuneration: Provide practising CHWs with a financial package commensurate with the job demands, complexity, number of hours worked, training and roles that they undertake (recommendation 7A); do not pay CHWs exclusively or predominantly according to performance-based incentives (recommendation 7B).

CHW contracts: Provide paid CHWs with a written agreement specifying role and responsibilities, working conditions, remuneration and workers' rights (recommendation 8).

CHW supervision: Adopt the following supportive supervision strategies: appropriate supervisor/supervisee ratio allowing meaningful and regular support; ensuring supervisors receive adequate training; coaching and mentoring of CHWs; use of observation of service delivery, performance data and community feedback; and prioritization of improving the quality of supervision (recommendation 6).

CHW career ladder: A career ladder should be offered to practising CHWs (recommendation 9).

Key decisions

CHW remuneration and contracts: Determine CHW contract terms, salary, and health and social benefits, including health insurance, accident insurance, pension, maternity cover, parental leave, vacation, etc. *(11).* If different types of CHWs are integrated into the health system, tailor CHW remuneration and contracts per CHW type. Decide which entity is the primary owner of CHW contracting and payment.

CHW supervision: Define the CHW supervision structure and approach: who will supervise CHWs, using what methods, at what frequency? Identify a desired supervisor – supervisee ratio. Decide on how and by whom supervisors will be trained. Select the institutional anchor at the local level regarding lines of reporting, supervision and support.

CHW career ladder: Outline a CHW performance management system, including performance indicators. Identify employment and academic career advancement opportunities for CHWs, including promotion and career ladder opportunities or pathways to acquire new qualifications through additional education and training.

CHW deployment: Identify who/which institutions will deploy (and manage) CHWs – consider the national government, subnational governments, NGOs, community health associations, or a mix. Determine how the community or district will be involved in the process of who gets deployed. Select mechanism to ensure consistency of local implementation and alignment with national policy.

Conduct analysis

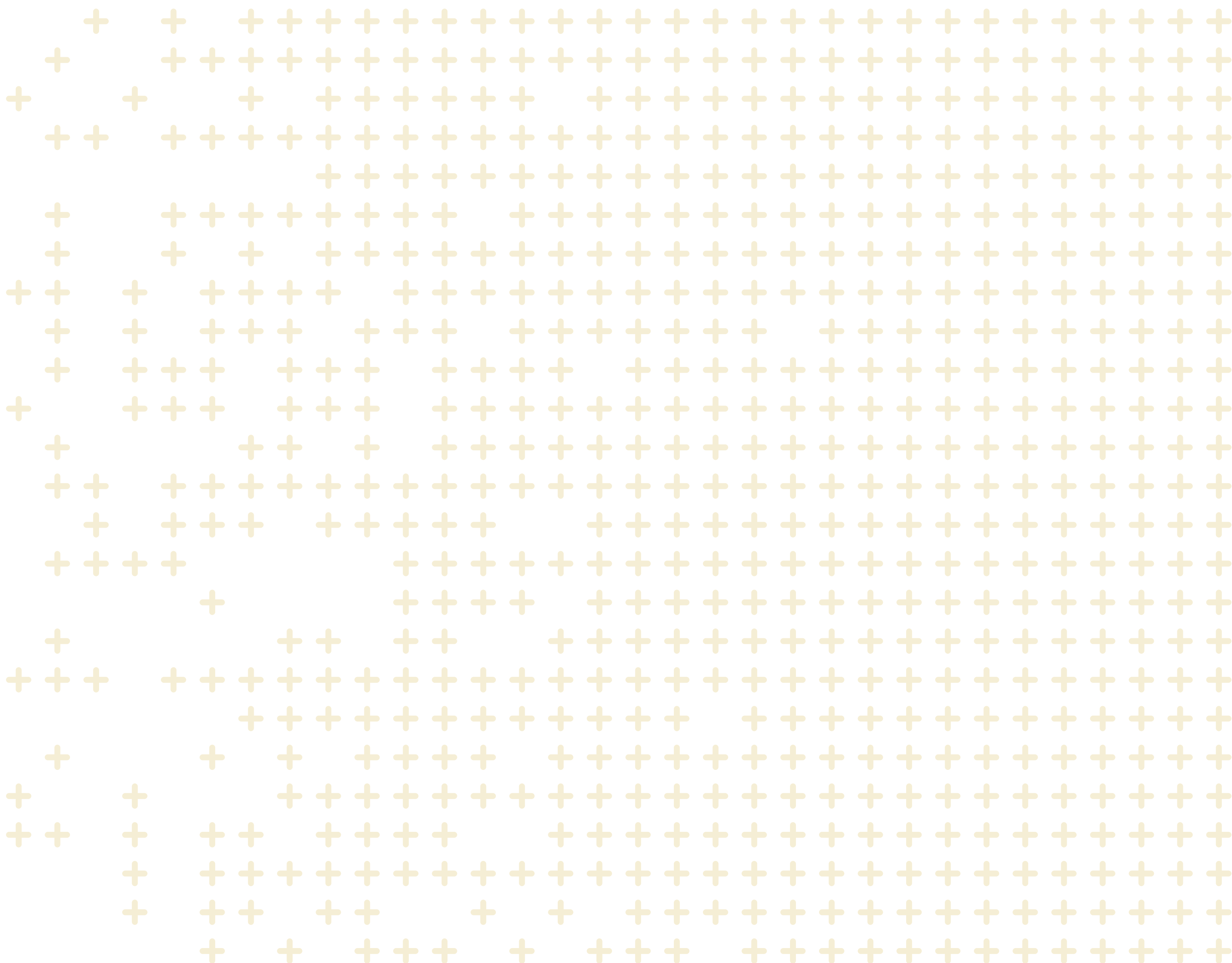
+ What are currently the terms and conditions of CHW employment, including salary, stipends or other incentives, and health and social benefits of CHWs? Do CHWs have official contracts with their employers?
+ Who supervises CHWs? With what frequency? What methods of supervision are employed (e.g. individual, group, peer supervision)? What is the supervisor to supervisee ratio? When and how are CHW supervisors trained and by whom?
+ Does performance appraisal of CHWs take place? What are the current opportunities for career advancement for CHWs? What are the opportunities and pathways to pursue further training to acquire higher level qualifications?
+ How does CHW remuneration, contracting, supervision and career advancement vary across different types of CHWs or local contexts across the country? How is this different from what is intended in existing policy documents?
+ What is the history of CHWs in the country, and what lessons have been learned regarding their roles and deployment?
+ What are current community health governance structures, mechanisms and resources that can provide opportunities to meaningfully involve communities in CHW planning, priority setting and deployment?

Policy dialogue focus

+ When discussing the terms and conditions of CHW employment, including salary, stipends, incentives and health and social benefits for CHWs, the CHW scope of practice needs to be considered, as well as a reasonable alignment with CHWs' preferences.
+ Mechanisms of payment that ensure CHWs receive their salaries reliably and on time need to be discussed, including by leveraging technology, as appropriate and feasible.
+ Existing guidance and data on the national health workforce, such as on health workforce spending and remuneration, employment characteristics and working conditions, dual practice, safeguarding health workers, etc., need to be considered.
+ A gender equity element should be factored in to ensure equitable access to employment, income and promotion opportunities; gendered power dynamics between CHWs and supervisors also need to be considered. Adopting appropriate safeguards to prevent gender-driven competition for economic reasons is highly encouraged to anticipate and mitigate the displacement of women from the CHW workforce when CHWs are formalized *(12)*.
+ CHW working conditions need to be aligned to national and international regulations, legislation, frameworks and principles on labour and employment, such as on working hours and conditions, minimum wage, social protection, workers' rights, etc., as applicable to the national context. It should also be discussed if CHW remuneration is part of or aligned with a national salary scale. As a preliminary step, harmonization of CHW remuneration across externally funded programmes could be considered; its alignment with national policies and salary scale would represent, in most contexts, a pre-requisite to consider eventual transition to the domestic payroll.
+ Discussions on the primary ownership or main responsibility for CHW contracting, as well as considerations for wage ceiling issues if the public sector is the employer.
+ Discussions on supervisors and supervision quality should focus on CHW supervisors' competencies, skills and time to conduct their tasks. For example, if diagnostic and curative tasks are part of the CHW scope of practice, supervisors should have adequate knowledge and skills to be able to supervise CHWs implementing these responsibilities. Furthermore, it is important for those supervising CHWs to have knowledge of and experience with CHW tasks and the realities of serving in the community setting (outside facilities). Supervisors should be trained and certified in all CHW training modules.
+ When discussing the supervision structure, approaches, frequency and supervisor to supervisee ratio, the geographic context should be considered. CHWs working in remote and hard-to-reach areas may require different approaches, such as utilizing technology for remote supervision or organizing periodic group meetings.
+ Performance management guidelines for CHWs should be developed, outlining roles and expectations, providing

feedback mechanisms and supporting continuous improvement. In addition, discussions should include the development of operational indicators to monitor CHW performance (e.g. number of household visits conducts, health education sessions delivered, referrals made) aligned with national monitoring and reporting mechanisms and processes.

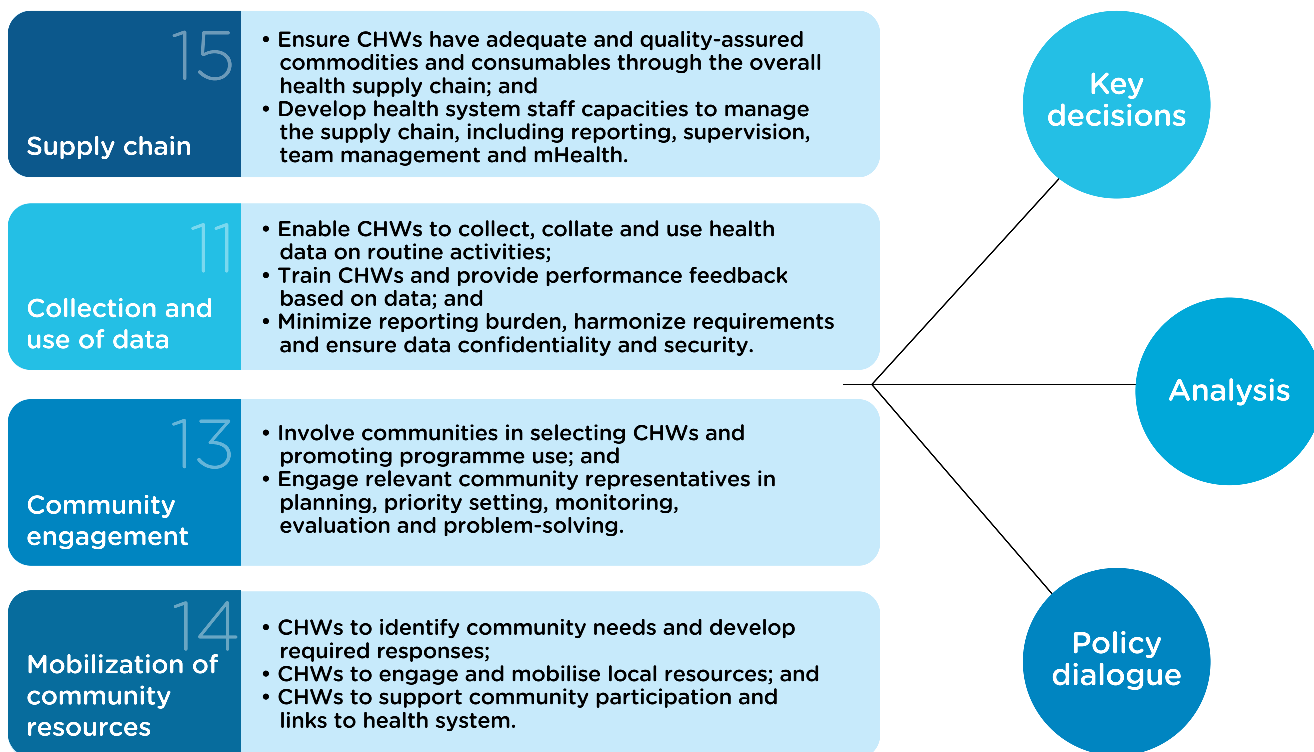
+ While WHO encourages fair remuneration for CHWs, proportionate to their roles, education and level of effort, in settings where volunteer CHWs are still prevalent, the discussion should include identifying operational models to ensure their adequate oversight, support and facilitation, alongside their formalized peers.
+ Career advancement opportunities for CHWs should be identified, including both employment (e.g. supervisor) and academic (e.g. diploma, progression to acquire additional qualifications) advancement pathways.
+ Best practices in human resource management and existing strategies on upward employment mobility need to be considered.
+ The level of administrative decentralization will determine who is responsible for CHW management. If different partners outside of government are involved in CHW deployment and management, standardization/harmonization of remuneration, contracts, supervision, and career advancement is desirable, especially where there are plans or expectations to eventually transition CHWs to the public sector payroll.
+ Discussion should include how and in what timeframe the government and its partners will ensure sustainable financing for the recurring costs of CHW remuneration and supervision.
+ CHW ability to organize and advocate for their own rights, working conditions and service or career development needs consideration. CHW integration and upholding their labour rights may benefit from the establishment or strengthening of CHW associations and/or unions. Grievance redressal systems should also be agreed and put in place.



6.4 Support for CHWs from the health system and community

The role of CHWs as an interface between health systems and communities requires integration with both. From the health system side, this entails, in addition to elements previously mentioned, CHW supply chains and data collection and use. From the community side, community engagement and mobilization of community resources are required.

Fig. 9 Key decisions, analysis and policy priorities from the health system and the community to support CHWs



WHO recommendations

Supply chain: Ensure adequate availability of commodities and consumable supplies, quality assurance and appropriate storage, stocking and waste management through integration in the overall health supply chain (recommendation 15).

Data collection and use: CHWs collect, collate and use health data on routine activities, including through relevant mobile health solutions, while respecting data confidentiality and security (recommendation 11).

Community support: Adopt strategies for CHWs to engage communities and to harness community resources (recommendations 13 and 14).

Key decisions

Referral: Identify mechanisms for CHW integration into existing or strengthened referral networks. Delineate division of labour and referral and counter-referral pathways between CHWs and other PHC team members to ensure continuity of patient care across community and facility settings.

Supply chain: Determine how the national supply systems can be extended to CHW commodities and consumables, as opposed to setting up a separate, independent supply chain(s), to support CHW integration and programme sustainability. Select the stocks, materials and tools to be included into the CHW kit to support CHWs, promote their acceptability in communities and improve quality of care delivered.

Data collection and use: Prioritize the data items or indicators for CHWs to collect, collate and use. Identify opportunities, mechanisms and tools for digitization of community health data systems to facilitate CHW integration and support.

Community support: Determine how community health governance structures, leaders and resources will support CHWs and will be supported by integrated CHWs. Define their roles in monitoring, supervising or assisting CHWs.

Conduct analysis

- What is the availability and functionality of existing referral networks into which CHWs will be integrated?
- What systems for forecasting and quantification need to be adapted to address the needs of CHWs and ensure timely supply of commodities and consumables, equipment and digital tools at community level? Map the existing supply chain, including storage facilities, transportation networks and inventory management systems. Identify bottlenecks and areas for improvement and extension into community settings.
- What is the quality and usability of existing health information systems, including the infrastructure and mechanisms of data collection, processing, feedback and informed decision-making? How can CHW data be integrated and supported to provide feedback to communities, CHWs, managers and policy-makers?
- Are there existing national or other relevant digital-related policy or framework tools such as digital adaptation toolkits (DAKs), and technology/software artefacts for CHW programmes?
- What is the level of digital literacy of community members and CHWs, as well as the availability and reliability of mobile phone/data networks, to ascertain the acceptability and feasibility of using digital tools for communication, data collection, performance feedback and supply chain management?
- What are current community health governance structures, mechanisms and resources, and which other close-to-community health worker groups exist (such as community relays, traditional health practitioners, midwives, etc.) that can provide support to CHWs?

Policy dialogue focus

- Policy dialogue should focus on the additional health system support needed to strengthen referral networks. This could include strengthening human resource capacity at referral centres (e.g. recruitment and retention, salaries, training, coaching and supervision, etc.), infrastructure, equipment, stocks and supplies at all levels of service delivery, transportation between sites, referral slips or closed loop digital technologies, etc.
- The physical, geographical and infrastructural barriers to connectivity between community systems, health systems and other connected systems need to be assessed. This includes distance, roads and terrain, transportation options, mobile phone networks, internet, etc. Stakeholders should discuss what infrastructure can be improved or what adaptations need to be made to ensure access by patients referred by CHWs to referral centres, and communications and linkages with resupply hubs, supervisors, etc.
- Operational procedures and mechanisms regarding the distribution and refilling of stocks, materials and tools in the CHW kit, clinical stocks (such as diagnostic tools, rapid tests, drugs, etc.), non-clinical materials (such as backpacks, uniforms or badges, rain gear, walking shoes, etc.), and mobile phones or digital tools should be considered.
- The use of national guidelines to harmonize data requirements and indicators in community health, including those specific to certain service delivery packages (e.g. integrated community case management), need to be considered.
- National and/or regional data protection regulations to ensure CHW patient confidentiality and data security should be considered. When deciding about the extent of digitization of community health data systems, protecting patient and health worker confidentiality, data security and minimizing the technological and reporting burdens on CHWs need consideration.
- Local governance capabilities and accountability mechanisms need to be considered when identifying opportunities to empower community structures.

Adapt CHW integration in the context of emergencies

Integration of CHWs contributes to strengthening the resilience of health systems all the way to the community level, aiding the delivery of essential public health functions, including prevention, preparedness, response and recovery from emergencies. As health systems around the world increasingly face shocks and stressors due to conflict, climate change, epidemics/pandemics and other crises, CHW integration should include a framework for action that awards them a role and equips them with competencies that enable them to effectively contribute to maintaining essential health and care services and essential public health functions during emergencies and contribute to response and recovery efforts. These actions should be part of the routine health system, health workforce (and CHW) management and not verticalized as a separate "emergency preparedness" agenda.

7.1 Key questions – prevention, preparedness, response and recovery in emergencies

Prevention

+ What measures need to be put in place to strengthen the CHW active surveillance linkages and reporting to the health system?
+ How existing public health risk assessment tools or mechanisms can better harness CHW competencies and experience?
+ How to improve emergencies risk awareness communication, and the corresponding social mobilization tools that are available to CHWs?

Preparedness

+ What prevention and resilience-strengthening activities should be incorporated into CHW routine roles and responsibilities, such as vaccination, infectious disease surveillance, case finding and reporting, community engagement and mobilization of community resources?
+ Can certain competencies already be incorporated into CHW pre-service education in anticipation of common crises, such as training modules on safety and security, disaster preparedness, prevention and response, risk monitoring and early warning, climate/environmental change and health, etc.?
+ What national or subnational financial and regulatory flexibilities permit rapid CHW deployment and action, their ability to adapt at local level, in the case of emergencies?
+ How can existing communication systems (e.g. mobile phone networks, community radio) be strengthened for effective information sharing and coordination during emergencies?
+ What structures are in place to enable rapid re-training, in-service training and supervision related to new CHW activities during an emergency? What digital tools can facilitate remote-based training or supervision?
+ What safeguarding policies, procedures and protocols are needed to protect CHW rights, security, and mental and physical health during calm times and in times of crisis *(13)*? How are these sensitive to the additional or unique vulnerabilities faced by certain CHWs, such as female CHWs?
+ What redundancies or buffer stocks are built into the supply chain system to ensure essential CHW commodities and supplies are available at local level in times of crisis?

Response

+ How has the emergency influenced the population demand and need for services, and the ability of CHWs and other health workers to provide them?
+ Do more CHWs need to be deployed? Do catchment areas need to be redrawn? Is there a need for more localized CHWs (e.g. only working in their own communities)? Does the CHW to population ratio need to be reconsidered in the context of the emergency?
+ What tasks or competencies need to be added to CHWs' scope of practice (e.g. specific health messaging, case detection, psychological first aid, surveillance, etc.), including tasks normally performed by other occupational groups? How can training on new tasks or competencies be organized?

Fig. 10 Identifying CHW tasks and roles in the context of emergencies

+ How can CHWs, CHW governance structures and local and national health authorities ensure coordination with NGOs, humanitarian organizations, disaster management agencies, security forces and other actors in a rapidly evolving situation?
+ How can the interface role of CHWs be leveraged to counter misinformation, distrust, fear, discrimination and stigma that can arise during times of crisis?
+ How do CHW management structures and system support need to be adapted in emergency settings to safeguard CHW rights, security and well-being (e.g. crisis pay, remote/peer supervision, mental health and psychosocial support)?
+ What additional infrastructure, technologies, equipment, commodities and supplies need to be deployed to protect CHW and patient safety, such as personal protective equipment, mobile clinics, secure transportation, water quality testing and purification kits, etc.
+ What new data need to be collected and how can they be used in surveillance or to improve the emergency response?
+ How can CHWs mobilize community resources to lead local action and enhance community self-organization during times of crisis?

Recovery

+ How can data collected by CHWs be used to review and recover from the emergency?
+ How can CHW roles and competencies be leveraged to rebuild trust following a crisis?
+ How can CHWs mobilize community action and resources to enhance localized recovery strategies?

7.2 Policy dialogue focus in emergencies

+ Clarifying the scope of practice of CHWs in emergencies preparedness and response.
+ Agreeing on coordination mechanisms (and the specific role of stakeholders and partners) for deployment, service provision and reporting in acute emergencies.
+ Safeguarding and personal protection for CHWs participating in emergency response activities.
+ Identifying appropriate and sustainable remuneration, incentives and indemnities for CHWs during acute emergencies which are compatible with remuneration and incentives for other occupations.

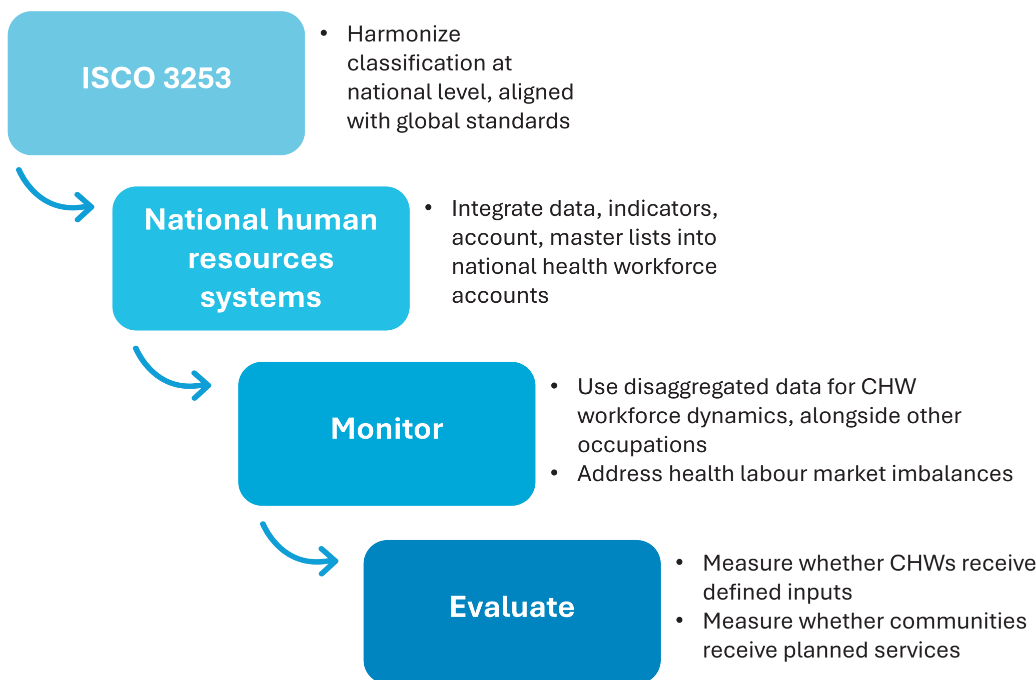
Monitor and evaluate CHW integration

Like any health system policy reform initiative, CHW integration relies on the availability, completeness and quality of data to assess whether implementation meets its policy goals. The *Global strategy on human resources for health: workforce 2030 (14)* recommends establishing or strengthening national health workforce information systems to assess implementation and effectiveness of health workforce policies. Efforts to integrate CHWs should be reviewed and revised periodically as contexts, health needs and priorities evolve.

A decision at national level across stakeholders should be taken to harmonize categorization of CHWs. As much as possible, this classification exercise should be linked to relevant regional or international standards, such as the International Labour Organization ISCO-08 classification. Following this, CHW workforce data, indicators and accounts should be integrated into existing health workforce information systems. Master lists generated during the planning process should be integrated into the NHWA as dynamic registries to track CHW stock, age structure, gender composition, education, distribution, flows, demand, capacity and remuneration. NHWA indicators can be disaggregated by occupation, enabling a specific analysis of CHW workforce dynamics. CHW workforce data should be continuously monitored alongside other health workers to address imbalances in the health labour market and inform overall health system planning, budgeting, procurement and service delivery.

The health management and health workforce information system should measure whether CHWs receive the training, management, health system and community support as intended in the policy, and whether communities receive CHW services according to plans. Monitoring and evaluating the implementation of CHW integration policy, requires assessing its different components (e.g. education, deployment, remuneration, supervision), institutional locus

Fig. 11 Steps to measure, monitor and evaluate CHW programmes



(e.g. employers, education institutions, regulators) and administrative levels (national, province, district, health catchment area). It is important to regularly collect data on CHW and community perspectives and experiences of CHW integration to iteratively improve implementation.

Routine (CHW collected) health data and CHW service delivery indicators could be disaggregated by service package (e.g. integrated community case management, tuberculosis activities, uptake of contraceptives, childhood immunization, etc.), to contribute to the national health management information system.

Research, monitoring and evaluation of CHW integration should also consider the ultimate goals of the policy (e.g. accelerating progress toward universal health coverage, reducing maternal, newborn and child mortality, etc.) and whether the policy achieves these goals over the short and long term. Research on CHW integration will require frameworks and methodologies that accommodate complexity, such as implementation science, mixed methods, and realist evaluation, documenting not only whether or not policy objectives were met, but also to what extent, how, from which perspective and enablers and barriers which can provide lessons learned across countries and jurisdictions and over time.

Conclusion

This step-by-step policy implementation guide provides policy-makers, planners, managers and their partners with a succinct overview of steps to consider in the integration of CHWs into national health systems. The recommendations, key decisions and issues for analysis and policy dialogue need to be adapted and contextualized to the reality of specific health systems to ensure optimal integration of CHW programmes and maximize their contribution toward attaining universal health coverage.

The foundations of effective CHW integration are:

+ Conducting a sound situation analysis of the stakeholders involved, population needs and health system requirements.
+ Taking key decisions on the governance structure, vision, goals, timeframe and sustainable financing.

Key decisions should be based on the objectives, context and architecture of the health system:

+ Planning the CHW scope of practice and needs quantification.
+ CHW selection, education and certification.
+ CHW management and deployment.
+ Support for CHWs from the health system and community.

The resulting policies on CHW integration should be part of broader national health and health workforce policies, governance and financing mechanisms.

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