Community Health Worker Reference Toolkit

A Toolkit for integrating CHWs into the formal healthcare system
ACKNOWLEDGEMENT

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The content of the toolkit was provided and validated by experts across Africa. The list of these experts can be found in the appendix section of this document. The contribution of these experts is much appreciated.

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# ABBREVIATIONS AND ACRONYMS

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>AMREF</td>
<td>African Medical and Research Foundation</td>
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<td>ARI</td>
<td>Acute respiratory tract infection</td>
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<td>AU</td>
<td>African Union</td>
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<td>BCC</td>
<td>Behaviour change communication</td>
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<td>BI</td>
<td>Bamako Initiative</td>
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<td>CBHC</td>
<td>Community-based health care</td>
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<td>CBIS</td>
<td>Community-based information system</td>
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<td>CBO</td>
<td>Community-based organization</td>
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<td>CBT</td>
<td>Competency-based training</td>
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<td>CBWs</td>
<td>Community-based workers</td>
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<td>CHEW</td>
<td>Community health extension worker</td>
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<td>C-IMCI</td>
<td>Community level integrated management of childhood illnesses</td>
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<td>CORAT</td>
<td>Church Organizations Research Advisory Trust</td>
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<td>CORP</td>
<td>Community-owned resource person</td>
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<td>DDC</td>
<td>District Development Committee</td>
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<td>DHMB</td>
<td>District Health Management Board</td>
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<td>DHMT</td>
<td>District Health Management Team</td>
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<td>DRC</td>
<td>Democratic Republic of Congo</td>
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<td>ECD</td>
<td>Early childhood development</td>
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<td>ECN</td>
<td>Enrolled community nurse</td>
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<td>EH</td>
<td>Environmental health</td>
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<td>EPCHS</td>
<td>Essential Package For Community Health Services</td>
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<td>FBIS</td>
<td>Facility-based information system</td>
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<tr>
<td>FHFE</td>
<td>Family health field educator</td>
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<td>FP</td>
<td>Family planning</td>
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<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>GOK</td>
<td>Government of Kenya</td>
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<td>HC</td>
<td>Health centre</td>
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<td>HDC</td>
<td>Health development committee</td>
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<td>HE</td>
<td>Health education</td>
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<td>HFC</td>
<td>Health facility committee</td>
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<td>HHs</td>
<td>Households</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>HMIS</td>
<td>Health management information system</td>
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<td>HSR</td>
<td>Health sector reform</td>
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<tr>
<td>IEC</td>
<td>Information, Education And Communication</td>
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<td>IMCI</td>
<td>Integration And Management Of Childhood Illnesses</td>
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<td>KEPH</td>
<td>Kenya Essential Package for Health</td>
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<td>KEPI</td>
<td>Kenya Expanded Programme of Immunization</td>
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<td>KHSSP</td>
<td>Kenya National Health Sector Strategic Plan</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>NCDs</td>
<td>Non-Communicable Diseases</td>
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<tr>
<td>NHIF</td>
<td>National Health Insurance Fund</td>
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<tr>
<td>PLWHA</td>
<td>People Living With HIV/AIDS</td>
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<tr>
<td>SCCHC</td>
<td>Sub-County Community Health Coordinator</td>
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1.0 INTRODUCTION

Amref Health Africa in collaboration with the African Union (AU) and intra-health is carrying out a campaign to make Community Health Workers (CHWs) available and accessible everywhere within Africa. The campaign is also advocating for the CHWs to be recognized and remunerated for the work that they carry out. Amref Health Africa given the evidences has noted the important role played by Community Health Workers (CHWs). Further, the organization noted the multiplicity of individuals who provide some sort of care, health promotion and health advocacy in communities and the difficulty of putting all these players under one umbrella of CHWs. The amorphous nature of these players means that they cannot be trusted to provide a full package of CHW services. It also means they cannot be certified and supervised; more importantly, they cannot be remunerated for the work they do.

It is for this reason that Amref Health Africa regional office compiled a toolkit to clearly outline the definition, qualifications, career path, service delivery and health promotion roles, supervisory structure and accountability systems for CHWs. The toolkit is intended to advocate for qualified CHWs to be integrated into the health workforce and remunerated adequately.

1.1 Background

Community health workers (CHWs) close the gap between communities and the formal health system. They have a very important role in referral, health promotion and prevention at community level. Their effective involvement leads to significantly better health outcomes. CHWs provide health education and referrals for a wide range of services, and provide support and assistance to communities, families and individuals with preventive health measures and gaining access to appropriate curative health and social services. They create a bridge between providers of health, social and community services and communities that may have difficulty in accessing these services. In short, community health workers save lives. One reason why African countries failed to achieve health related Millennium Development Goals (MDGs) was because of the lack of allocation of financial and human resources for health, including community health workers.

Current high attrition rates for CHWs, pose a serious threat for people accessing health services. The attrition rate varies, but is sometimes up to 77% per annum. One study in Senegal found attrition rates of 30% over nine months. Another research found a 50% rate over two years in Nigeria. From country to country, and even within the same country, there exists a variety in CHWs roles, trainings and services. In some communities, CHWs provide health education messages; in others, they provide higher-level services such as dispensing life-saving commodities. Partly because of voluntarism and often time-bound community health projects, retention of CHWs has become a mounting challenge. Non-Governmental Organizations (NGOs), such as Amref Health Africa, a leading NGO in this area, often fill gaps to empower communities in remote areas to access health care services. However, this is not a sustainable solution for everyone everywhere, particularly when there is no scale up of good practices at the national level.

There is an urgent need for a campaign to recognize and remunerate CHWs, as key players within

communities in addressing health issues. However, without proper policies in place, the attrition rate will continue to escalate. Remuneration is a key factor in addressing attrition of CHWs as it gives income stability and commitment to work. Paying community health workers saves lives!

1.2 Historical perspectives of CHWs

The principles agreed at Alma-Ata Declaration on primary health care (PHC) in 1978, apply just as much now as they did then. A review of thirty years since the Alma-Ata declaration, found that CHWs in national programs achieved large mortality reductions of 63% and 36% respectively. Health for all by the year 2000 and the health related MDGs were not achieved. Lack of political prioritisation of health, structural adjustment in the 1980s and 1990s and austerity policies are some of the root causes of missed global health targets. Austerity led to significant reductions in public spending for health for decades, often resulting to inadequate health systems, leaving the poor and vulnerable in remote areas behind without adequate access to health.

One of the few countries which achieved the health related MDGs is Tanzania. Tanzania is training CHWs as part of the formal health system. Another good practice is Ethiopia, where health outcomes have improved significantly since the inception of the Health Extension program (HEP). HEP is an innovative community based health care delivery system aimed at providing preventive health care services. It was introduced in recognition of failure of essential services to reach communities in remote parts of Ethiopia. HEP services have been customized to meet the needs, demands and expectations of the pastoralist, agrarian and urban population. HEP led to an increase in health extension workers to 50% of the national health workforce. The other 50% being doctors, nurses and midwives. The Ethiopian model of CHW is successful because of strong support from the executive. It is anchored in laws and policies and implemented in a structured way. The Accredited Social Health Activists or ASHAs in India are also sometimes referred to as good practice. It is India’s mission to have female ASHAs trained and working in every village in the country. They are selected from the village itself and accountable to it.

One crucial lesson from the Ebola crisis, was the lack of CHWs to help prevent and end the epidemic. Ebola is a scourge that takes hold in places with under-financed and fragmented health systems that lack effective CHW system support. The potential rapid spread of communicable diseases across countries and continents is compounded by approximately 100,000 daily flights around the global per day. Thus a lack of trained and remunerated CHWs poses a significant threat for global health. While non-communicable diseases do not threaten global security, the increase in such diseases in low- and middle-income countries threatens to overwhelm fragile health systems unless rapid investments are made in disease prevention and health promotion.

Achieving Universal Health Coverage (UHC) is target 3.8 of the health-related Sustainable Development Goal (SDGs).

CHWs play a key role in achieving UHC. UHC encompasses: availability of health services; physical accessibility in terms of reasonable reach of health facilities; financial affordability and ability to pay for these services, for example through public health insurance schemes to pool risks, and acceptability: willingness to seek quality essential health care services. Another prerequisite for achieving UHC is SDG target 3C that aims to substantially increase health financing and the recruitment, development, training and retention of the health workforce especially in developing countries especially in the least developed and small island states. Realizing the health related SDGs will not be possible without CHWs becoming an integral part of sufficiently resourced health systems.

WHO is currently developing CHW guidelines, which are scheduled to be ready in 2017. These guidelines should provide an evidence-based model for educating, deploying, remunerating and managing CHWs to optimize their performance and contribution to the health system. This will help governments to improve the design and implementation CHW programs to enhance their contribution to achieve UHC.

The vision of WHO’s report Workforce 2030 is that by 2030 all communities should have access to trained and supported health workers with a minimum core set of competencies. At least 10 million additional health workers in low- and middle-income countries need to be trained and deployed to achieve this. This global shortage could grow to 13-18 million by 2035. To prevent this, requires effective policies at national, regional and global levels and adequate investment levels. The health sector is one of the most labour intensive sectors. Recently the UN High-Level Commission on Health Employment and Economic Growth (HEEG) stated that new investments in the health workforce will create jobs and drive economic growth and increase global health security. The returns on investment in health are estimated to be 9 to 1, and around one quarter of growth between 2000 and 2011 in low-income and middle-income countries is estimated to have resulted from improvements to health. Investing in skills and expanding health employment will also contribute to the economic empowerment of women and youth.

The one million CHW Campaign, which has a partnership base of over 150 organizations from United Nations agencies, civil society, the private sector, and academia, was launched in January 2013 at the World Economic Forum in Davos. The mission of the campaign is to accelerate the attainment of UHC in rural sub-Saharan Africa by supporting governments, international partners, UN agencies, and national stakeholders dedicated to community health worker scale-up in the context of health systems strengthening. The campaign supports African Ministries of Health (MOHs) in planning for CHW scale-up in the context of health systems strengthening.

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9 http://www.who.int/hrh/resources/glob-strat-hrh_workforce2030.pdf
11 http://1millionhealthworkers.org/
The objective of the Health Strategy of the African Union (AU) is to strengthen health systems performance, increase investments in health, improve equity and address social determinants of health to reduce priority diseases burden by 2030\textsuperscript{12}. Also, article 14 of the (Maputo) Protocol to the African Charter\textsuperscript{13} (2005) ensures the right to health of women, including sexual and reproductive health is respected and promoted. Despite AU governments pledging in Abuja\textsuperscript{14} in 2001 to commit 15 percent of their annual budgets to public health spending, nearly one-third of African countries have reduced health expenditure.

A human rights-based approach to health provides the strategy and solution to address and rectify inequalities, discriminatory practices and unjust power relations, which are often at the heart of inequitable health outcomes. As such, UHC is a means to promote the right to health. The International Covenant on Economic, Social and Cultural Rights (ICESCR) adopted in 1966\textsuperscript{15} and ratified by all countries, formulates the “…right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” In many countries the right to health is guaranteed in national constitutions\textsuperscript{16}. Moreover, the right to health includes certain components, which are legally enforceable\textsuperscript{17}. Also, the WHO Constitution enshrines “…the highest attainable standard of health as a fundamental right of every human being.”\textsuperscript{18} Governments have the obligation to ensure the right to health for all, through progressive realization, which includes providing sufficient budgetary allocations when available.

1.3 Process of development of the toolkit

The process of development of the CHW toolkit used the following steps

Step 1: Documents review: The team conducted an extensive desk review of the available published literature which provides one of the largest pools of evidence gathered on CHW hiring, training, supervision, integration, and evaluation. It also looked at policies, practices, programme and research studies related to human resource management practices used with CHWs at the national and local level. The search also looked at the ministries of health websites and institutional libraries, using search engines such as PubMed and Google Scholar.

Step 2: Stakeholder consultation: Each country office identified consultants to assist with the process in Kenya, Uganda and Zambia. The key informant interviews targeted different categories of respondents. The key informants included Head of Community Health and Development Unit (CHDU), Community health ambassadors, County Health Executives, members of the County Health Management Team and County Community Strategy Focal Persons (CCSFP), Community health extension workers in the three counties visited.

13http://www.achpr.org/instruments/women-protocol/#14
15http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx
16http://worldpolicycenter.org/policies/does-the-constitution-guarantee-citizens-the-right-to-health
18http://www.who.int/mediacentre/factsheets/fs323/en/
**Step 3: Participatory stakeholder workshop:** A participatory stakeholder’s workshop was carried out in the month of March 2017. The workshop involved key stakeholders from the representative’s staff and consultants from the three Amref offices in Kenya, Uganda and Zambia, National leaders working on CHW implementation in the countries and leadership of Amref health in Africa. The main aim of the workshop was to validate the toolkit and incorporate their inputs to build a consensus on the Amref Health Africa’s position regarding the advocacy toolkit.

### 1.4 CHW Toolkit Overview

The CHW Toolkit assists the assessment, improvement, and planning of CHW programs by deepening understanding of the elements of successful programs and the use of best practices as an evidence-based approach to improvement. The toolkit is framed around ten key themes that describe the definition, entry level, age, gender, recruitment, training, scope of work, supervision, career progression, entry level and remuneration of CHWS.

### 1.5 Target Audience

The advocacy toolkit targets the following:

- Regional and sub-regional intergovernmental bodies – Africa Union, EAC, ECSA, SADC
- UN Bodies – WHO, UNICEF, UNFPA, UNAIDS
- Donors – Bilateral, Foundations, etc.
- Ministries of Health, Finance, Labor and Civil Service
- Parliamentary Health Committees
- Health professional associations
- Health regulatory bodies
- Celebrities
- CHWs and community leaders and members

### 1.6 Objectives

The general objective of the toolkit is to sensitize the governments to recognize the contribution of CHWs towards achieving health related sustainable development goals. This will then enable governments to recognize and remunerate CHWs within the health system workforce.

Specifically it will be used to ensure that

1. By 2022 there will be a growing body of evidence and consensus among policymakers stating that investing in CHWs guarantees positive health outcomes, which are crucial to achieve SDG3.
2. By 2022 there will be substantially increased numbers of CHWs who are adequately remunerated by governments and supported by defined salary levels.
3. By 2022 countries will have integrated CHWs into the formal health workforce, supported by policies with up-to-date registries, standardized national training curriculums and accreditation frameworks as part of meeting the Work Force 2030 targets.
4. By 2022 countries will have increased health budget allocations for human resources for health and allocated an appropriate percentage of the national health budgets to CHWs.

5. By 2022 the focus countries will have developed a social accountability mechanism to evaluate performance of CHWs at community level.
2.0. KEY COMPONENTS OF THE TOOLKIT

2.1 Definition of a community health worker

2.1.1 Current situation

Community health workers are known by many different names in different countries. The umbrella term “community health worker” (CHW) embraces a variety of community health aides selected, trained and working in the communities from which they come. A widely accepted definition was proposed by WHO:

*Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers (WHO, 1989)*\(^{19}\)

There have been other definitions of community health workers for instance; the American Public Health Association has the following definition:

“A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.”\(^{20}\)

A review of definitions by 3 African countries indicates that most definitions agree with that of the WHO but add some specific elements. In Kenya for instance, community health workers are known as community health volunteers (CHVs) and the role of a mobilizer, promoter of development and motivator of positive change. In Uganda, the common term used is Village Health Team which refers to a group according to the national strategy but has been used synonymously to refer to the individual member\(^{21}\). The Uganda definition generally agrees with the WHO definition. In Zambia, the definition states CHWs pay status (paid or Volunteers) and mentions the fact that they should have an experience of the lifestyle of the beneficiaries.

Thematic analysis of the WHO definition derives the following themes: Residence, selection criteria, period of training, support sources, whether or not they belong to health system. The American association of public health places them at frontline of the health system, places them in public health system, mentions issues of trust and understanding of the community (soft values), includes cultural relevance and competence, and assigns them a role in improving quality and access in the health services, alludes to their ability to link people to social services, provide health education/promotion and capacity building community services (ref).


\(^{20}\)https://www.apha.org/apha-communities/member-sections/community-health-workers

The Kenya definition adds to the WHO definition the role of CHWs being Change agents (ref). Uganda and Zambia agree with the WHO definition, describing them as lay or paraprofessional, paid or volunteers who have the same experiences with the community they serve (ref) and have a link to the community health system.

2.1.2 Our stand
A Community Health Worker is a community member with an in-depth understanding of the community values, culture and language who is selected by the community through a participatory process; has undergone standardized and accredited training and qualified/certified to provide a defined package of health promotion and services at community level; has formal linkages to the health system; and is recognized and remunerated as part of the health workforce.

2.1.3 Implementation mechanisms
i. The African Union should establish a definition of the CHW in the African context and engage governments to review and adapt the definition as well.
ii. Countries should review the definition of CHWs based on the context considering the elements above.
iii. CHWs should be included in the national schemes of service, the health system workforce and the national public service by law.
iv. There should be a review of the health Sector Policies, Strategies and implementation guidelines to include a comprehensive definition of CHWs.

2.2 Entry level into service for CHWs
2.2.1 Current situation
There is varying standards regarding education qualification entry level for community health workers. Most countries have a set minimum depending on the contexts. The minimum entry level ranges from simply ability to legibly write (Uganda MOH (2010). VHT strategy) and read to at a certificate of education (completed lower secondary education). Literature suggests that variation is also dependent on the expected roles of the CHEW and the community to be served. In Zambia, entry in to Community Health Assistants service requires one to hold a high school diploma and passing grades for at least two subjects on their secondary school graduation exams. In Ethiopia, CHWs need to be Female high school graduates are recruited and trained for one year (candidates must have completed grade 10 in school. In pastoralist communities, the community health worker should have at least standard 8 educations is expected.

23 Health Extension Workers in Ethiopia: Improved Access and Coverage for the Rural Poor, NejmudinKedir Bilal, Christopher H. Herbst, Feng Zhao, Agnes Soucat, and Christophe Lemiere 54 24. The Health Extension Program in Ethiopia, the World Bank, Netsanet W. Workie and Gandham NV Ramana
2.2.2 Our stand

We recommend that for an individual to be selected as a CHW, they should have an entry education qualification that allow him/her to understand the roles and the diverse health challenges of the community, be able to communicate and report to the health system and to grow in the service without education level being a barrier. Completion of secondary school therefore is recommended as a minimum but communities without such individuals should be allowed the exception.

In addition, Amref Health Africa recommends that soft values should be included in the selection criteria but should be assessed at entry. These values should be accepted to the communities that they serve including but not limited to exemplary, honest, trustworthy, respected, willing to serve the community etc.

2.2.3 Implementation mechanisms

A review of the community health strategy implementation guidelines to reflect the eligibility criteria.

2.3 Age of CHWs

2.3.1 Current situation

The question of who CHWs were and are in terms of age, finds many different answers in the literature that reflect the diversity of CHW programmes. The comments on age are even less frequent in the literature, although mature age (between 20 and 45 years) and often married status are reported to be a criterion in a number of cases (Ofosu-Amaah, 1983). Examples are the Church of the Brethren initiative in Nigeria (Hilton, 1983), the Somalia and Kenya VHW programmes (Kaseje et al., 1987a; Bentley, 1989), and a Safe Motherhood initiative in Uganda (Kasolo, 1993). In the case of a Peruvian project, the age of health promoters ranged from 19 to 57, with an average age of 29, (Brown et al., 2006).

A review of literature from the three countries indicate that while the age bracket for the Community Health Worker is not clear, all the counties are in consensus that CHWs should be of mature age of 18 year and above.

In Kenya, community health context studies by (Alam, Tasneem, & Oliveras, 2012) (Couinihan, et al., 2012) (Kaburu, 2016) (Crispin, et al., 2012) (Olang'o, Nyamongo, & Aagaard-Hansen, 2010) have shown that older Community Health Workers perform better that their younger counterparts. This is attributed to the high attrition rate among the younger CHWs which could be explained by a number of factors: Younger people are more likely to leave when they get promising careers while on the other hand older CHWs stay on due to fewer household responsibilities. Similar views were also expressed during discussions with stakeholder who noted that younger CHVs are harder to retain than their old counterparts. Additionally, persons of very young age are perceived to have no experience and little knowledge not only by older members of the society but by their age mates as well.

In Uganda VHTs are supposed to be at least 18 years old, and there is no stipulated maximum age limit so long as one is willing to serve the community, and could read and write a local language. In Zambia the “Community health integrated care handbook” for Zambia, the age of entry to community health work, is 25 years and above.
However, the age of exit is not well defined. This is consistent with other contexts in developing countries, where the age of entry for CHWs was above 20 years of age\textsuperscript{24} with some recruited at 30 years and above.

2.3.2 Our stand
Considering the current situation, we recommend that that the CHWs should have a minimum age of 18 years and above.

2.3.3 Implementation mechanisms
Review the health Sector Policies, Strategies and implementation guidelines to include the exit age of Community Health Care Workers- This should be based on the jurisdiction of the community members.

2.4 Gender of CHWs
2.4.1 Current situation
WHO defines gender as the socially constructed characteristics of women and men – such as norms, roles and relationships of and between groups of women and men. The preferred Gender for CHW usually depends on the type of intervention that the community volunteers are meant to carry out (11, 13, 24). In most of the reviewed studies however, female CHWs were preferred on the premise of them being closer and more willing to share problems For instance MNCH interventions will most times tend to favour young adults, due to traditional perceptions of them having sufficient experience in sexual and reproductive health related issue. It varies from society to society and can be changed.

CHW-Prasad Muraleedharan: Most countries have largely relied on females as CHWs. Although both men and women are employed at grass-roots level, there is a collective impression (particularly amongst policy makers) that female workers are able to deliver care more effectively than male workers at community level. While this may be true of maternal and child health (MCH) related services, the role of male workers in the control of epidemics (in the past) such as cholera, small-pox, plague, at the community level has been substantial across countries. However, there has been an explicit policy-shift in India to replace male health workers by female workers at community level (GOI, 1997).

2.4.2 Our stand
Amref Health Afirics's position is that of gender equality and as such a Community Health Worker can be male or female.

2.4.3 Implementation mechanism
There is need for policy guidelines on gender and social inclusion to guide the recruitment community health workers

2.5 Community participation in selection of CHWs

2.5.1 Current situation

Whether and how communities are involved in selection of CHWs will largely depend on issues of governance, the role of formal health services and particularly forms and structure of broader community participation, which will be discussed below. The most common approach employed by organizations to initiate CHW selection has been the setting up of village health committees (VHCs), which then are responsible for selecting CHW/CHW candidates (Knowles, 1995; Kaseje, 1987b; Daniel & Mora, 1985; Diallo, Ly & Sakho, 1995; Ghebreyesus et al., 1996; Kaseje, 1987a and b; Bamisaiye et al., 1989; Kaseje, 1986; Mitchell, 1995; Opoku, 1997; Sepehri & Pettigrew, 1996; Tumwine, 1993). Little detail is available on the finer details of selection processes and how the VHCs were constituted – although issues of domination through village elders and issues of gender inequities are raised repeatedly.

In some cases, as in Somalia, existing village committees were used to play the role of VHC (Bentley, 1989). However, most studies report only that CHWs were chosen or selected “by the communities themselves”. Community recognition and appreciation of the work of CHWs can have a snowball effect as communities demand more services and the MOH is able to respond with additional training and support. This is the ultimate goal of many CHW programs. In Mozambique, where activists have worked for many years, their roles seem to have matured, and communities seem to accept their work to a high degree. Community members now approach activists for family planning services and other types of support (Snetro 2000).

When sevikas in Nepal were asked why they continued their volunteer work, they said, “Our neighbors won’t let us resign; they insist we continue because their children’s health depends on us” (Taylor 2000). Several programs have mentioned the support of the community as an incentive for CHWs. Trust, prestige, mobility, and social interaction are other factors that are favorably mentioned (Walt et al.; Kaseje 1987; Lysack and Krefting 1993; Ruebush 1994). Many CHWs volunteer because they enjoy serving the community.

2.5.2 Our stand

Governments will work in collaboration with the community in the identification and vetting of candidates to be recruited as CHWs.

2.5.3 Implementation Mechanisms

- Inclusion of the recommendations in the National Human resources for health Policy
- Development of guidelines and strategies for CHWs selection/recruitment & Deployment

2.6 Scope of training for of CHWs

2.6.1 Current situation

CHWs undergo training using basic modules that may include but are not limited to, first aid and treatment of minor ailments, household mapping, health education and health promotion, record keeping, community mobilization, and danger signs for referral.
The technical modules such as NCDs, FP, MNCH, WASH, Nutrition practices, iCCM, HIV, TB. Countries may differ in training needs especially for technical modules. Their training duration ranges from as short as 5 days to as long as one year.

2.6.2 Our stand

CHWs should be trained using a standardized and accredited curriculum

2.6.3 Implementation Mechanisms

1. A legal framework that positions CHWs in the countries health care system and elucidates how their integration in the health care system addresses gaps in HRH (i.e. they should be included when you are defining your health system)
2. Must be included in the national health policies and strategies /in every technical area
3. Institutionalization of their curriculum by accredited institutions
4. Task shifting Policy briefs i.e. WHO policy allowing them to treat malaria, provide injectable contraceptives, etc

2.7 Scope of work for CHWs

2.7.1 Current situation

Their scope of work according to the Alma Ata Declaration includes home visits, environmental sanitation, provision of water supply, first aid and treatment of simple and common ailments, health education, nutrition and surveillance, maternal and child health and family planning activities, communicable disease control, community development activities, referrals, record keeping and collection of data on vital events (Ofosu-Amaah, 1983 cited in Bhattacharyya, Winch, LeBan & Tien, 2001, p.12).

2.7.2 Our stand

CHWs should focus on the following: health promotion including social mobilization, provide integrated management of common illnesses, do disease surveillance, refer patients to health facilities and generate and report health information through community based health management information systems. They bridge the gap between community, health facilities and the whole health system contributing to universal health coverage.

Examples of service coverage of CHWs:

- Integrated Community Case Management (iCCM)
- Integrated Management of Childhood illnesses (IMCI)
- Family Planning
- Disease outbreaks and global health security
- Non Communicable Diseases
- Water Sanitation and Hygiene
- Nutrition
2.7.3 Implementation mechanisms
1. There must be clear job description and terms of reference for their work
2. There must be a performance appraisal mechanism
3. Policy briefs that are country specific
4. Documentation of best practices

2.8 Supervision of CHWs

2.8.1 Current situation
Supervision of CHWs is supposed to happen but it doesn’t happen. It is expected to be done by the in-charge /and CHEWs. Supervision process should include obtaining feedback and suggestions for improvement. Many health professionals lack knowledge on supportive supervision as they are used to the traditional approach that relies on ‘policing’ and penalties.

2.8.2 Our stand
Community health workers provide the first direct link to a health facility where the health system governance structure is defined and the supervisor is designated to oversee their work.
This could be a community nurse, a public health officer or any other health worker of a similar cadre. There is always a committee made up of community members which acts as the governance body for community health and provides accountability for the work of CHWs.

2.8.3 Implementation Mechanisms
We need to advocate for a policy on appropriate supervision structure for CHWs. Clear strategies and procedures for supervision and the activities with which supervisors will be charged should be well defined. There should be supervision checklist/guidelines as well as Reporting and recording tools.

2.9 Career progression for CHWs

2.9.1 Current situation
Career progression for the community health workforce is dependent on the category of the CHW, the unpaid and the paid. The unpaid CHWs, who provide voluntary services, have no career pathway (1-4). These cadres have largely remained at the same level despite having many years of experience. However, the salaried CHWs (CHEW/CHAs/HEWs) have a career pathway/progression. For instance, in the case of Kenya and Ethiopia, there are schemes of service defining career progression, while in Zambia, the salaried community Health assistants have no career progression pathway.
It is not clear how the volunteer CHWs will progress in their career as there is no structured framework for their progression. In the case of the CHAs and CHEWs in Zambia and Uganda who are salaried, it is also not defined how they will progress from their certificate level of training to any other level for career development.
2.9.2  Our stand
There is need for governments to open up career progression pathways where none exists for the purpose of retention and motivation. Further, career progression will broaden their scope and improve the quality of work that would facilitate task shifting. The governments should establish a way for CHVs appraisal depending on the qualification and use it as a basis for integrating them into the system for career growth.

2.9.3  Implementation mechanisms
The current strategies should be revised to include career progression for the CHWs. There is need to come up with structured recognized legal framework for career progression e.g. having scheme of services for CHWs. The government should put in place an all-inclusive scheme of service and policy guidelines that includes the community level workforce.

2.10  Civil service job entry level
2.10.1  Current situation
The salaried CHWs have a structured entry into the civil service. For instance the Kenyan scheme of service for CHEWs defines their entry into the civil service. However, the CHVs have no structured framework for entry into the civil service. It is not clear how the CHVs should be absorbed into the civil service because there are no structured guidelines or policies on how this should happen.

2.10.2  Our stand
The governments should put in place policy and regulations to absorb CHWs into civil service. Level I CHWs should enter the civil service at the lowest level.

2.10.3  Implementation mechanisms
There is need for the governments to institutionalize and legalize the entry of the CHWs into the civil service. The governments should also revise existing policies and strategies to pave way for CHWs absorption into the civil service. Position papers, policy briefs and relevant laws or regulations for community health services are used to advocate for CHWs integration and absorption into the civil service. Revised policy strategies and schemes of service for unpaid CHWs.

2.11  Remuneration of CHWs
2.11.1  Current situation
Generally, as volunteers, CHWs do not receive a salary but are sometimes are motivated by monetary and non-monetary incentives. In some settings, the paid CHWs have a salary based on a structured scheme. In addition, CHWs in some countries operate through a formalised structure that is being encouraged to register their Community Unit structure as a Community Based Organisations (CBOs) that facilitate opportunities to establish Income Generating Activities (IGAs) that enhance retention and sustainability of the workforce. The mechanism for the remuneration of unpaid CHWs now and into the future remains unclear.
2.11.2  Our stand
The CHWs should be remunerated to motivate and retain them in the health system. This should depend on the civil service salary structure. They should receive salaries and benefits based on the job groups they are placed in.

2.11.3  Implementation mechanisms
There is need to institutionalise and provide in law the remuneration of unpaid CHWs. Case studies, documented reports and publications stating the evidence that return on investment or cost benefit reports of investing on community health workers produce gain on health outcomes. Scheme of service in the public sector. Policy guidelines on remuneration of community health workforce. Proposed harmonized guideline for payment of community health workforce.
REFERENCES


Annex 1: **LIST OF CONTRIBUTORS**

1. Prudence K  
   Amref Uganda
2. Choolwe Jacobs  
   Consultant, Amref Zambia
3. Grace Kibanja  
   Consultant, Amref Uganda
4. John Paul Oyore  
   Consultant, Amref Head quarters
5. Robbert Athewa  
   Amref Kenya
6. George Oele  
   Amref Kenya
7. Salim Ali Hussein  
   Head, Community Health, Ministry of Health, Kenya
8. Paul Agina  
   Amref Kenya
9. Anne Opil  
   Amref Kenya
10. Agatha LLyod  
    Amref Zambia
11. Hillary K Kipruto  
    World health Organisation
12. Dona Anyona  
    Amref Head quarters
13. Joachim Osur  
    Amref head quarters
14. Dorcus Indalo  
    Amref Kenya
15. Charles Oyaya  
    Consultant, Amref Kenya
16. Emily Kaburu  
    Consultant, Amref Kenya
17. Yeshitilia Hailu  
    Amref Ethiopia
18. Happiness Oruko  
    Amref Kenya
19. Patrick Karugusi  
    Amref Uganda
20. Mary Munyao  
    Amref Kenya
21. Onesmus Okwogo  
    Amref Kenya
Annex 2: **SAMPLE LETTER THAT YOU CAN USE TO WRITE TO YOUR LEGISLATOR**

(Month) (Day) (Year)
The Honorable (First name) (Last name)  
(Room Number),  
Address

RE: (state the topic or include the bill number, author and subject if you are writing to support or oppose a particular legislative bill)

Dear (Assembly Member/Senator) (Last name):

According to the American Public Health Association, a CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs/peer supporters provide four key functions in chronic disease management: assistance in daily management, social and emotional support, linkages to clinical care and community resources, and ongoing support over time. Evidence indicates that, CHWs/peer supporters have made clinically significant impacts on the improvement of health outcomes. When integrated with primary healthcare and closely supervised, CHWs/peer supporters can enhance team-based, patient-centered care by complementing the work of healthcare professionals.

CHWs/peer supporters help primary care providers understand the real problems that clients face on a daily basis. They are the ones that clients trust to help them solve problems and figure out how to implement their clinical care plans. In fact, there are potential ways in which CHWs/peer supporters can satisfy all six of the core chronic health home services (Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support Services, Referral to Community and Social Support Services) in direct or indirect roles.

I strongly urge you to support the important work of Integrating CHWs in the health system and have them receive a salary due to the significant benefits to the population. This is an issue that resonates deeply with many of your constituents, and the country at large hence we would be excited to have your support.

Sincerely,

SIGN YOUR NAME
Print your name
Street address
City, State, Zip code