



# Disseminating the World Health Organization (WHO) Guideline on health policy and system support to optimize community health worker programmes

# Background

*By fully harnessing the potential of community health workers, including by dramatically improving their working and living conditions, we can make progress together towards universal health coverage and achieving the health targets of the Sustainable Development Goals.”* DR  
**TEDROS ADHANOM GHEBREYESUS,  
DIRECTOR-GENERAL, WORLD HEALTH  
ORGANIZATION (WHO).**

# Webinar Objectives

- Familiarize participants with the new WHO *CHW Guideline* particularly the major recommendations intended to guide national policies pertaining to CHWs.
- Stimulate sharing of country-level perspectives on the CHW guideline implications.
- Highlight additional, selected resources pertinent to CHW programs that may be of interest to the audience

# Speakers



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For more information, please visit  
**[www.mcsprogram.org](http://www.mcsprogram.org)**

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# WHO guideline on health policy and system support to optimize community health worker programmes

Dr Giorgio Cometto

Coordinator, Health Workforce Department, WHO

WHO-USAID Maternal and Child Survival Program-CORE Group Webinar

15 February 2019

# Introduction

## Background

- Growing body of evidence supports CHW effectiveness for a range of *promotive*, *preventive* and *curative* health services, contributing to reducing inequities in access to care.

## Challenges

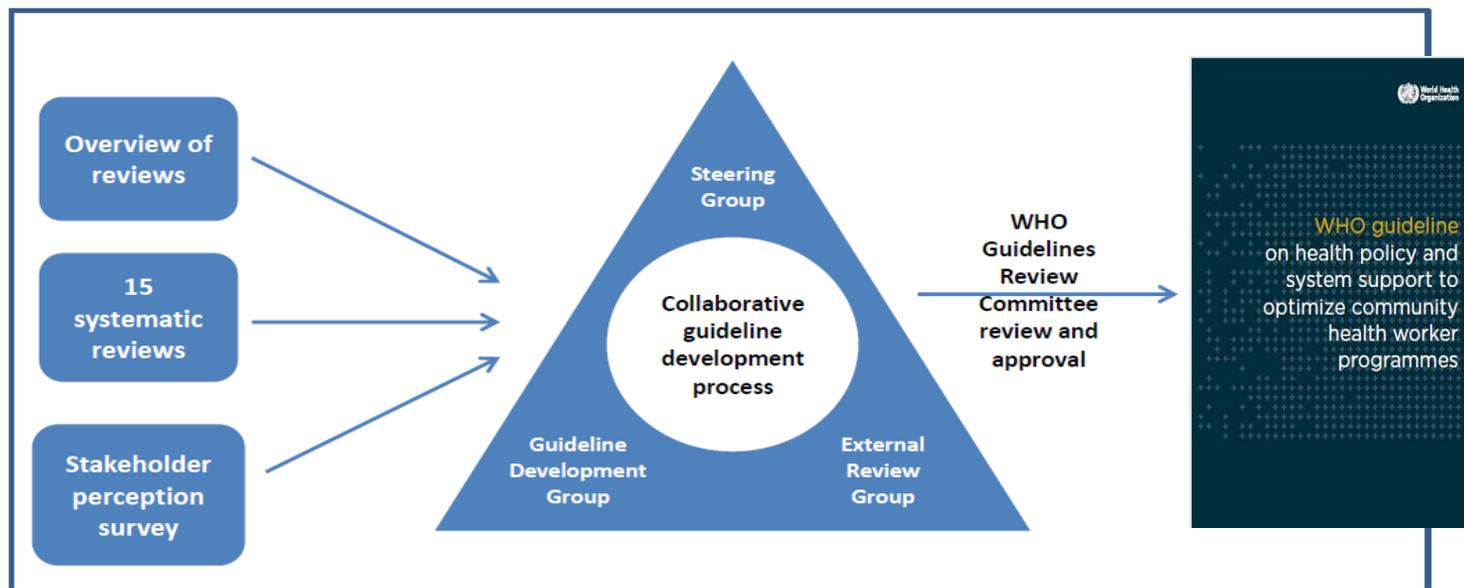
- Health workforce shortages and maldistribution.
- CHW integration in health systems and communities varies – typically inadequate.
- Best practices are not shared or implemented consistently.
- Evidence-based policy adoption is uneven.



# Rationale & objective

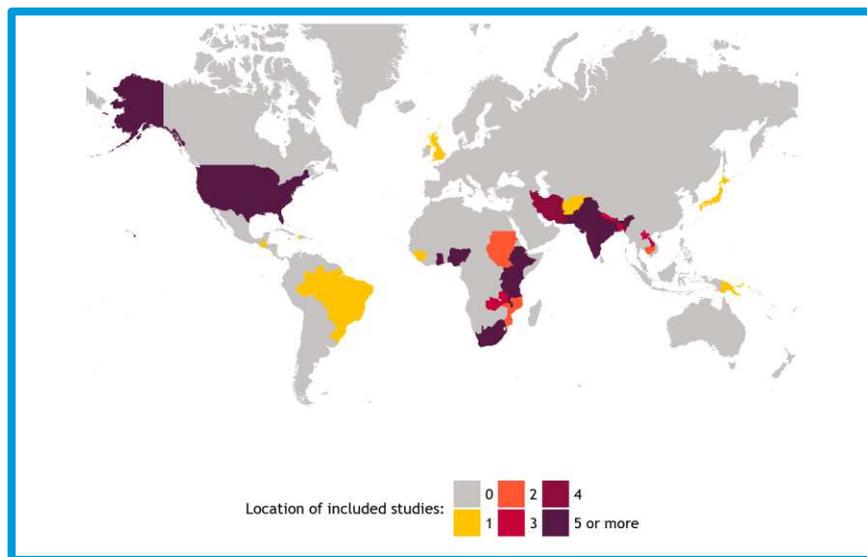
- **Who?** National governments and their partners
- **What?** Identify management systems and strategies for CHW programmes.
- **Where?** Countries at all levels of socio-economic development, adapted to context.
- **When?** Integrate guideline recommendations within human resources for health planning and financing.
- **Why?**
  - Harness potential of CHWs to strengthen primary health care.
  - Expand equitable access to priority health services.
  - Contribute to job creation and economic agenda.
  - Evidence shows it's feasible, even in low- to middle-income countries.
- **How?**
  - Provide recommendations to scale up, integrate, optimize design and performance, and sustain effective CHW programmes.
  - Contribute to progressive realisation of universal health coverage.

# Methodology

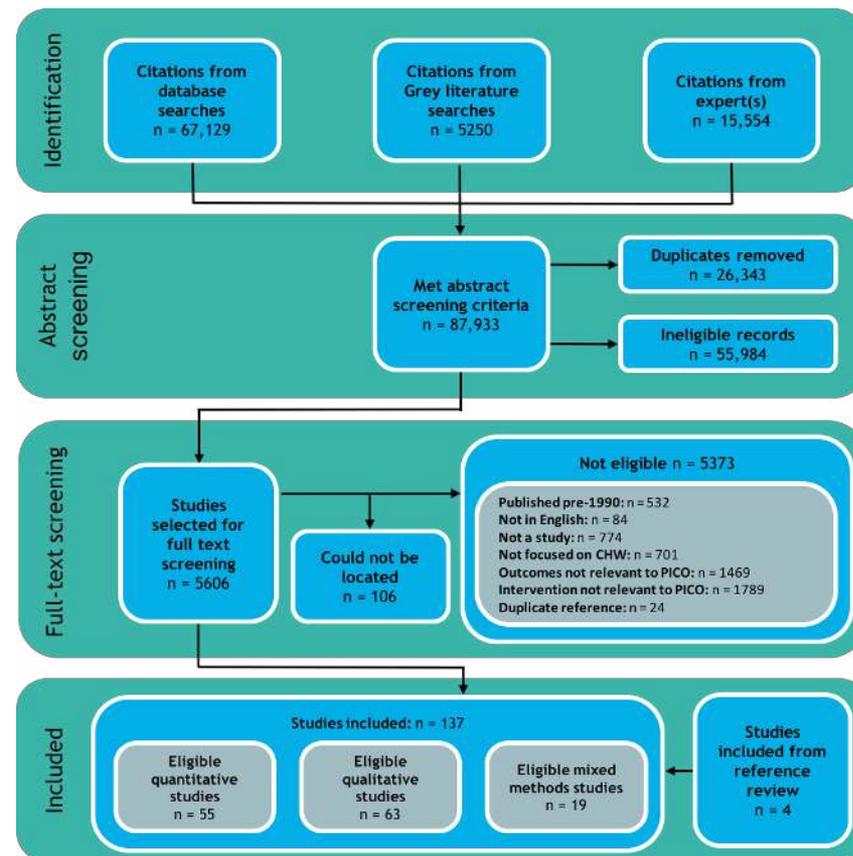


- Multi-sectoral approach.
- WHO GRADE guideline development method: recommendation strength reflects degree of confidence that desirable effects outweigh undesirable effects.
- Each recommendation includes background, rationale, evidence summary, interpretation and implementation considerations.

# Evidence sources



Geographical distribution of included studies across the 15 systematic reviews on the PICO questions

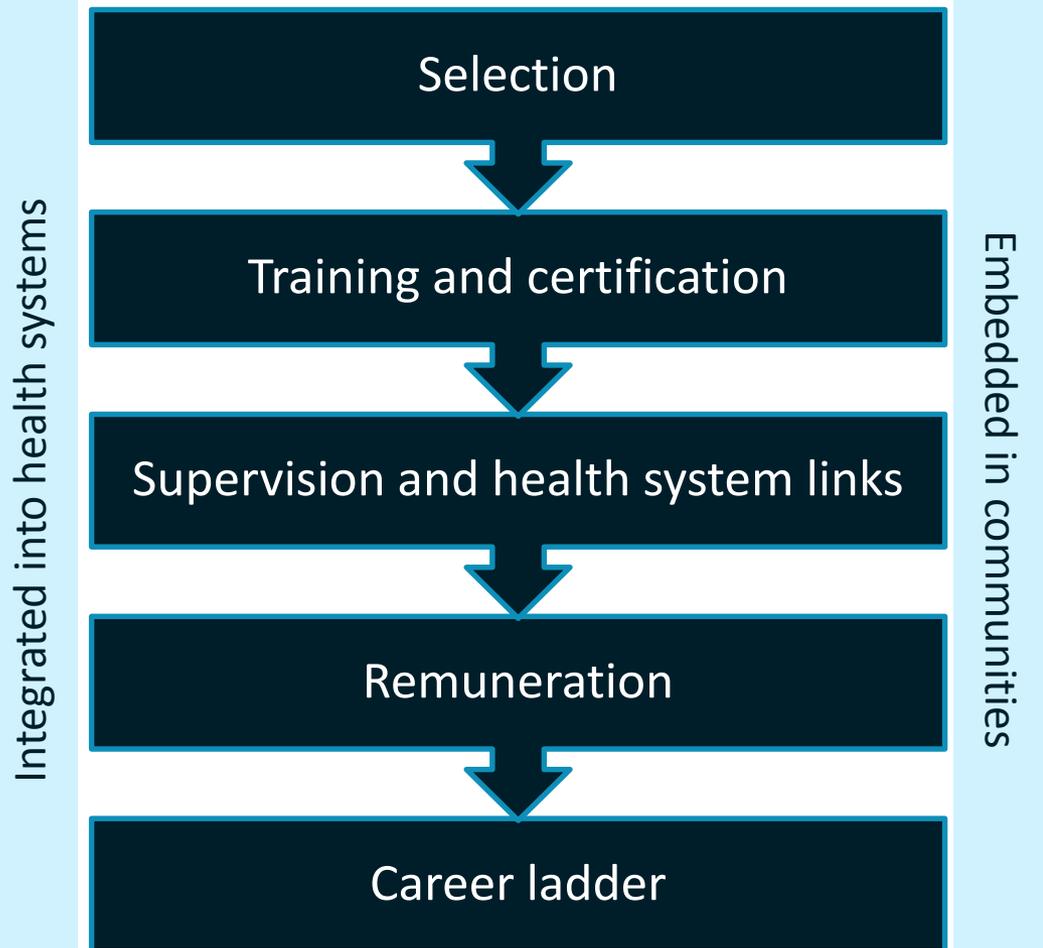


PRISMA diagram of studies assessed by the systematic reviews

	Recommendations	No. of studies	Quality of Evidence	Recommendation strength
<b>Selecting, certifying &amp; training CHWs</b>	1 Selection	16	Low	Strong
	2 Pre-service training duration	8	Low	Conditional
	3 Curriculum to develop competencies	2	Moderate	Conditional
	4 Training modalities	9	Very low	Conditional
	5 Formal certification	4	Very low	Conditional
<b>Managing &amp; supervising CHWs</b>	6 Supportive supervision	13	Very low	Conditional
	7 Remuneration	14	Very low	7A Strong 7B conditional
	8 Contracting agreements	2	Very low	Strong
	9 Career ladder	1	Low	Conditional
<b>Community embeddedness and system support</b>	10 Target population size	5	Very low	Conditional
	11 Collection and use of data	14	Very low	Conditional
	12 Types of CHWs	0	Very low	Conditional
	13 Community engagement	43	Moderate	Strong
	14 Mobilization of community resources	2	Very low	Conditional
	15 Supply chain	9	Low	Conditional

*Conditional:* Low evidence quality OR applying to certain groups, settings OR closely balanced results.

# Evolving roles & career pathways



- Guideline lays foundation for CHW programmes embedded in health systems.
- Multisectoral approach with health, education, labour, youth and finance ministries creates shared objectives.
- Supervision underscores health system links and mentoring.
- Emphasis on CHW rights and dignity envisions career pathways.
- Community engagement and integration.

## Selection

- Specify minimum educational levels.
- Require community membership and acceptance.
- Consider personal capacities and skills and apply appropriate gender equity to context.

## Pre-service training duration

- Base on CHW roles and responsibilities.
- Consider pre-existing knowledge.
- Factor in institutional and operational requirements.

## Curriculum to develop competencies

- Train on expected preventive, promotive, diagnostic, treatment and care services.
- Emphasize role and link with health system.
- Include cross-cutting and interpersonal skills.

## Training modalities

- Balance theory and practice.
- Use face-to-face and e-learning, and conduct training in or near the community.

**Offer competency-based formal certification upon successful completion of training**

## Supportive supervision

- Establish appropriate supervisor-CHW ratios.
- Train and resource supervisors to provide meaningful, regular performance evaluation and feedback.
- Use supervision tools, data and feedback to improve quality.

## Remuneration

- Provide a financial package commensurate with the job demands, complexity, number of hours, training and roles that CHWs undertake.
- Include financial resources for CHW programmes in health system resource planning.

## Contracting agreements

- For paid CHWs, establish agreements specifying roles, responsibilities, working conditions, remuneration and workers' rights.

## Career ladder

- Create pathways to other health qualifications or CHW role progression.
- Retain and motivate CHWs by linking performance with opportunities.
- Address regulatory and legal barriers.

## Target population size

- Consider population size, epidemiology, and geographical and access barriers.
- Chart expected CHW workloads, including nature and time requirements of services provided.

## Collection & use of data

- Enable CHWs to collect, collate and use health data on routine activities.
- Train CHWs and provide performance feedback based on data.
- Minimize reporting burden, harmonize requirements, and ensure data confidentiality and security.

## Types of CHWs

- Adopt service delivery models comprising CHWs with general tasks.
- Consider complementary role for CHWs with more selective and specific roles, based on policy objectives and population health needs.

## Community engagement

- Involve communities in selecting CHWs and promoting programme use.
- Engage community representatives in planning, prioritising, monitoring and evaluation.

## Community resource mobilization

- Identify community needs and develop required responses through CHWs.
- Engage and mobilize local resources through CHW involvement.
- Encourage CHWs to support community participation and linking to health system.

## Supply chain

- Ensure health system supply chain includes adequate, quality commodities for CHWs.
- Develop health system staff supply chain management capacities, including reporting, supervision, team management and mHealth.

# A career ladder



## Education

- Girls' education
- School health club

## Volunteer role

- Health promotion
- Selection by community



## CHW training

- Certification



## Remuneration

- With community support
- Contribute to jobs, economy

## Supervision

- Health system tie
- Training & career opportunity



# Research priorities

## Selection, education & certification

- Most effective pre-service education modalities to improve outputs and outcomes.
- Impact and optimal modalities of certification.

## Management & supervision

- Optimal monitoring and supervision to track performance.
- Remuneration level and modalities.
- Optimal supervision strategies.

## Systems integration & community embeddedness

- Optimal population target size entirely context specific.
- Strategies to mobilize community resources and participation.
- CHW workflow and linkages/ referral to health system.
- Long-term policy effect; cost-effectiveness.

# Guideline dissemination and use

## Phase 1

- Generate awareness and understanding

## Phase 2

- Foster commitment

## Phase 3

- Ensure uptake and transformation

## Phase 4

- Monitor and evaluate uptake and implementation

# What's next?

## Countries

- If CHW policies already aligned with guideline: share experience, data and best practices, engage in south-south exchanges and identify opportunities to advocate at regional level.
- If CHW policies not completely aligned OR no existing CHW policies: conduct policy review, engage relevant ministries and stakeholders and request technical assistance.

## Partners

- Harmonize support at global, regional and country levels.
- Align support activities with recommendations and national health system.
- Integrate guideline recommendations in technical products.

## Influencers

- Communicate benefits of adopting the recommendations, including return on investment.
- Identify event opportunities to share guideline recommendations.
- Encourage partners to adopt health policy and system support options to optimize programmes.

## Enablers of successful implementation

- Tailor CHW policy options to context.
  - Consider rights and perspectives of CHWs, and invite CHWs to take part in planning.
  - Embed CHW programmes in the health system , as part of a *diverse, sustainable skills mix*.
  - Harness demographic dividends by increasing employment for young people, especially women.
  - Resource and invest in CHW programmes as part of overall health strategy.
- 

*The role of CHWs should be defined and supported with the overarching objective of constantly improving equity, quality of care and patient safety.*

## Implementation: Key principles

- Starting point is identification of population and health system needs.
- Guideline is a menu of interrelated policy options to be adapted to context.
- Monitoring and evaluation of CHW programmes will yield shareable data and evidence to inform adaptation over time.
- CHWs should be part of integrated primary health care teams. Define their role vis-à-vis other health workers.
- Planning and policy dialogue should involve CHW voices and perspectives.
- Programmes should consider labour rights, working conditions and safety.

# Implementation: Operational design & implementation

## Programme design

- Design to be socially, culturally, politically and financially feasible.
- Plan health workforce holistically.

## Policy coherence

- Align with broader national health and health workforce policies.
- Retain internal coherence among policy recommendations.
- Articulate long-term vision for health system and possibly evolving roles for CHWs.

## Health system support

- Identify the institutional health system anchor for CHW programmes.
- Evaluate and strengthen system capacity to support CHW programmes.
- Leverage CHW programmes to spotlight broader system needs and opportunities.

## Financing implications

- Resource CHW programmes through long-term, dedicated financing.
- Align external support to domestic policy and overall system needs.

## Future of CHWs in Primary Health Care Agenda

- **1978:** Declaration of Alma-Ata
  - Recognised CHWs as a vital component of primary care.
- **2018:** WHO guideline launched to support governments and partners
  - To address immediate and pressing needs.
  - Based on evidence and considering CHW labour rights.
- **Future:** Evolution of health systems and epidemiological profiles
  - CHW education, certification and career ladder support employability of CHWs.



*“Improving the way WHO communicates is one of my priorities. We can produce the best guidelines in the world but there’s no point if nobody knows they exist.”*

– Dr Tedros Adhanom Ghebreyesus

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# Questions and Answers Session

## Part I

Moderator: Rachel Deussom, CORE Group Community  
Centered-Health Systems Strengthening Technical Working  
Group / Chemonics HRH2030 Technical Director

# WHO CHW Guideline webinar

15/02/2019

Mozambique Presentation

Dr Alexandre Boon – MCH specialist – UNICEF Mozambique



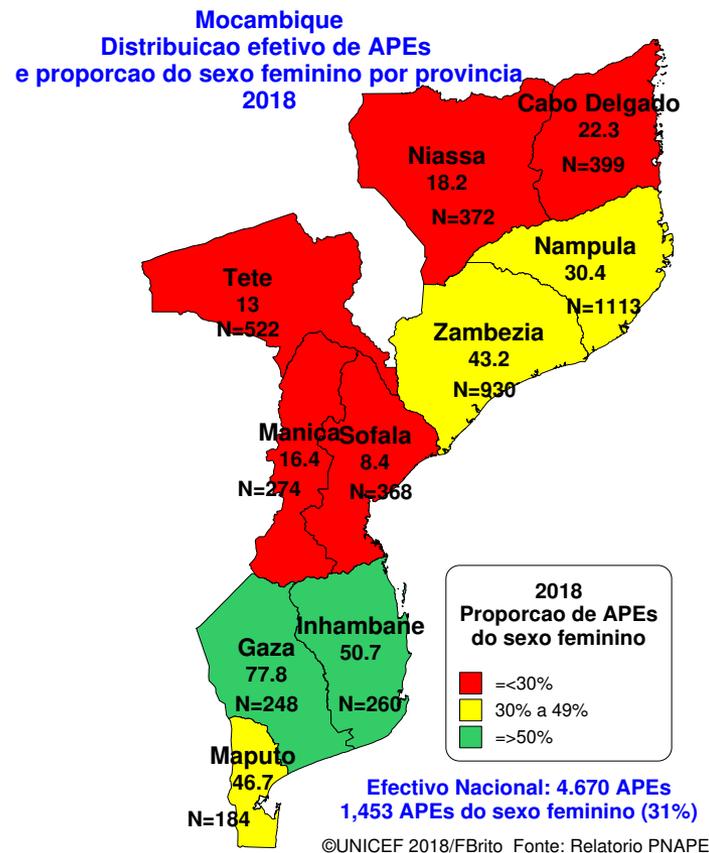
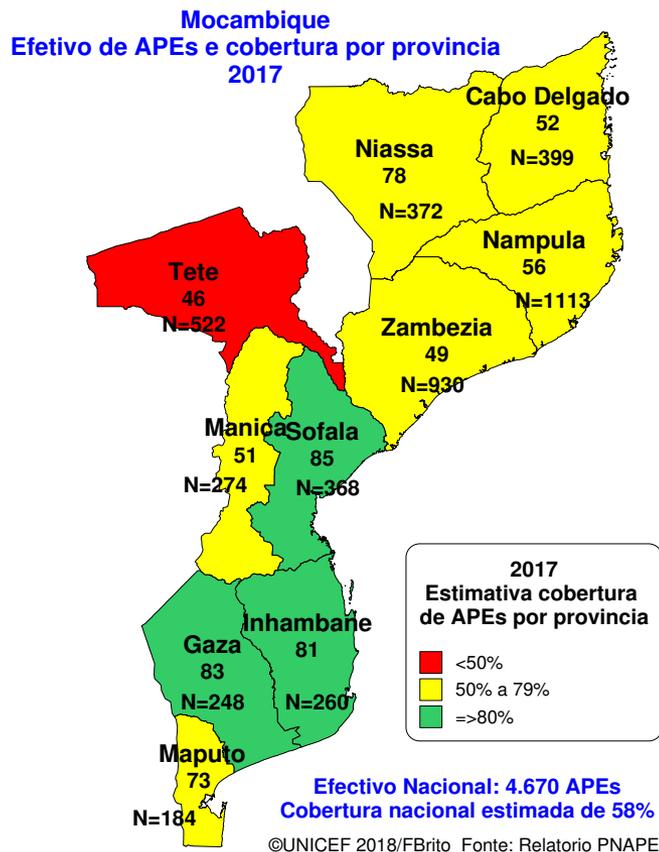
# Content

- Overview of Mozambique CHW program – slide 3 to 7
- Overview of Mozambique CHW program in line with WHO new recommendations – slide 8 to 15

# Historic and perspective of CHW in Mozambique

- **1976** – CHW creation 1 year after independence following 1975 Alma Ata summit
- **1978 to 1992** – 15 years of civil war – CHW abolished
- **2010** – revitalizing of CHW program – 25 CHW/district in 10 Provinces
- **2014** – revision of curriculum including many new MCH components
- **2015** – reaching the target of some 3650 APEs country wide
- **2015-16** – refresher course of CHW including new curriculum
- **2016** – start of expanding digital technology in one then a 2<sup>nd</sup> Province
- **2017 onwards** – new expansion of CHW with progressive expansion and stabilizing of digital technology in two Provinces (~700/3650 APEs)
- **End 2018** – reached 4,670 CHWs country wide (+34% from 2016) – 10 Provinces and 147 districts – some 5,8M people covered =~58% of HUs uncovered population
- **By 2022:** expansion of curriculum // community needs – aiming at full saturation with some 8000 CHWs as well as digital technology – contributing to achieving UHC

# Mozambique CHWs and Gender distribution 2018



## Contribution to Health services country wide - 2017

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Indicator	Health Units	APE/CHWs	Total	% realized by APE/CHW
Number of health services "points"	1.589	3.600		
Malaria Cases treated	8.742.149	917.768	9.659.917	9.5%
FP in the community	2.683.062	295.656	2.978.718	9.9%
Vitamine A	2.327.256	336.024	2.663.280	12.6%
Deworming	3.922.689	398.899	4.321.588	9.2%

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# Financing

- MOH assuming already: overall managerial structure – official contracting – flow and accountability of data integrated into DHIS-2 – drug supply – political recognition
- Different donors: UNICEF – USAID – DfID – Canada – EU
- Financial mechanisms:
  - State budget and administration
  - Through UNICEF: UNICEF – USAID – DfID – Canada – EU
  - GFF – Multi-donor TF; WB, USAID, DfID

# National Program perspective of the CHW program

Improve the coordination of different Community Health actors with the HUs



**Vision:** A unique integrated and complementary community platform having an impact in identifying at-risk situations, ensure referrals and integrated with the strengthening of PHC

## WHO Key recommendations 1 to 5: Selection, Duration of pre-service training, Competencies in curriculum for pre-service training, Modalities and Competency based certification

- CHW selection is done by the community –
  - Volunteers established in the community, age limit between 25 and 55y (though in practice no upper limit), education level grade 7 (read and write in Portuguese, basic maths) – lately emphasis on feminization in view of important MCH component
- Pre-service training of 5 months adjusted to curriculum
  - Mixed Portuguese and local languages – modular – pass rate 50% - mixed theory and practice – furnished with a full working kit – start including mobile technology
- Competencies covering areas of:
  - Health promotion and prevention; community mobilization; adherence to key MCH services (ANC, ID, PNC, EPI, VIT.A), FP, MN screening and referrals; TB and HIV adherence; diagnosis and treatment of common diseases (malaria, diarrhea, ARI)



## WHO Key recommendations 6 to 9: Supportive Supervision, Remuneration, Contracting Agreement, Career Ladder

- So far, the supervision was based more on community mobilization aspects → MCH component being added as a team approach
- CHW get a monthly subsidy paid usually on a quarterly basis, currently equivalent to 20US\$ - updating being considered
- There is an annual contract signed between the district health authorities and the CHW – conditions payment of subsidy
- At present there is no career ladder though the new strategic plan 2018-2024 emphasizes this need, by linking with Ministry of Education and MOH to offer opportunities

## WHO Key recommendations 10 to 13: Target population size, data collection and use, types of CHWs, community engagement

- The catchment area is between 500 and 2,000 people > 8 km radius from HU
  - In practice this differs: a few hundreds to ~ 5,000
- Data are collected though little attention given to direct usage –
  - Reflection on capacity to understand and explain data. Need to get to basics
  - Direct link CHW data from upSCALE with DHIS-2
- CHWs are one of several community health activists
  - Can't afford to cover the overall disease burden e.g HIV hence need for HIV activists
- Strong community engagement;
  - Recruitment, regular monitoring e.g on drug accountability, part of Community Health committees, are community educators/promoters e.g on hygiene – little on decentralized decision making

## WHO Key recommendations 14 to 15: Mobilization of community resources, availability of supplies

- So far more a TOP-DOWN approach on community resources mobilization
  - Opportunities within the new SP to leave more room for local problems identification – local resources are usually very scarce – evaluation and community data not yet into use – good linkage between community and HUs
- Supplies is based on a “push” system
  - Not very well responding to needs – research going on for gathering evidence on the best system; ?push-pull-mixed?
  - Future linkage between upSCALE and LMIS



### Community resources for health eq.

- identifying priority health and social problems and developing and implementing corresponding action plans with the communities;
- mobilizing and helping coordinate relevant local resources representing different stakeholders, sectors and civil society organizations to address priority health problems;
- facilitating community participation in transparent evaluation and dissemination of routine community data and outcomes of interventions;
- strengthening linkages between the community and health facilities.

## Innovations:

- CHWs and their Supervisors **upSCALE** digital technology
  - Currently 2 Provinces ~ 700 CHWs/4670
  - Expansion 2019 to 2021; plus 3 then 3 then 2 Provinces – full coverage

## Research:

- Barriers and facilitators to CHW feminizing
- In-depth analysis of the supply system
- upSCALE impact and CHW quality of care evaluation
- Cost-effectiveness of the upSCALE



## A aplicativo upSCALE do APE



### Possue sete modulos:

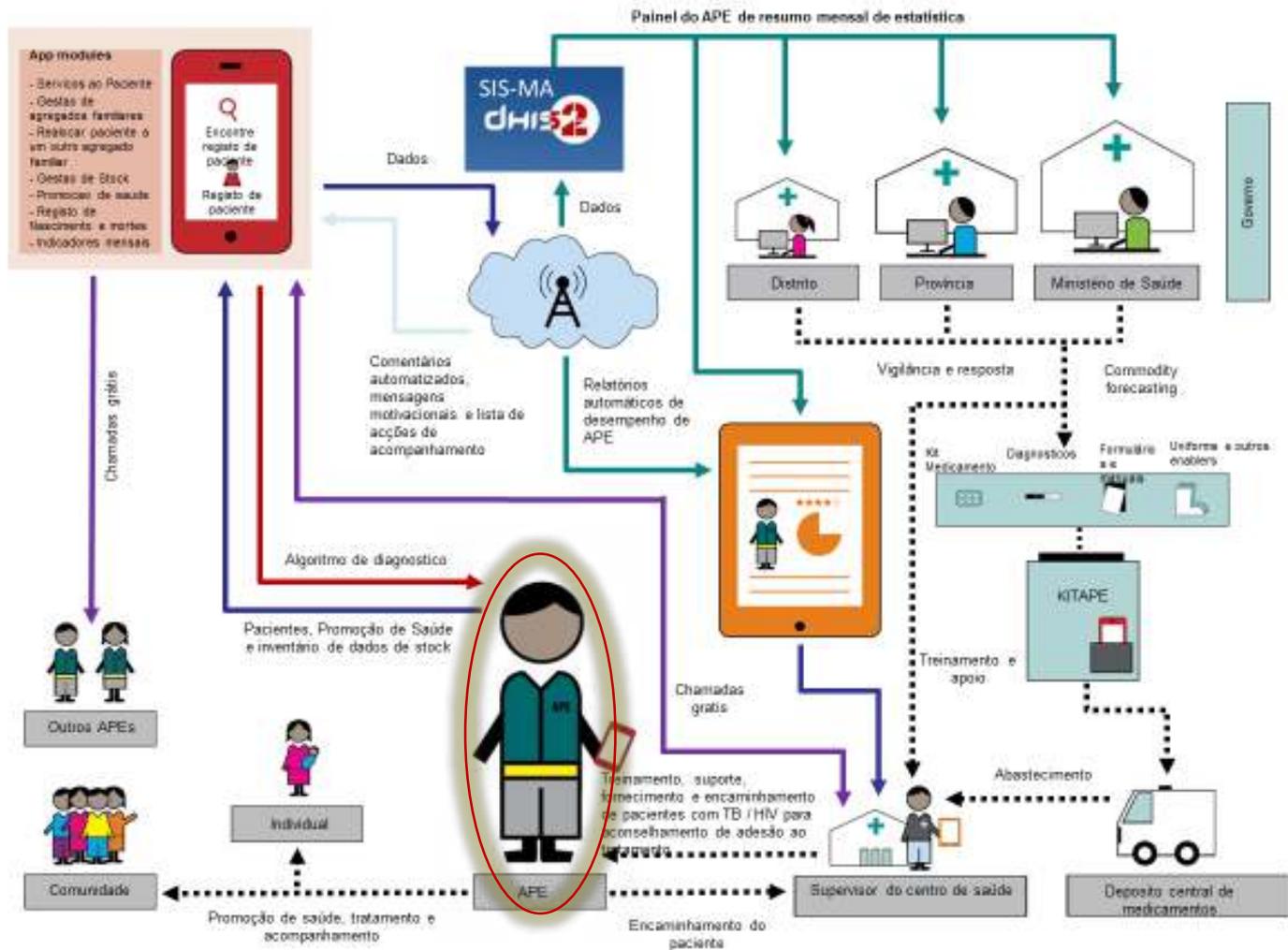
- Agregado familiar e pacientes;
- Gestao de informacao de agregados familiares;
- Realocar paciente a um outro agregado familiar;
- Gestão de Medicamentos;
- Palestras de saúde da comunidade;
- Registo de recém-nascidos e óbitos;
- Resumo mensal das actividades.

## Aplicativo do supervisor

### O aplicativo do supervisor no tablet tem os seguintes modulos:

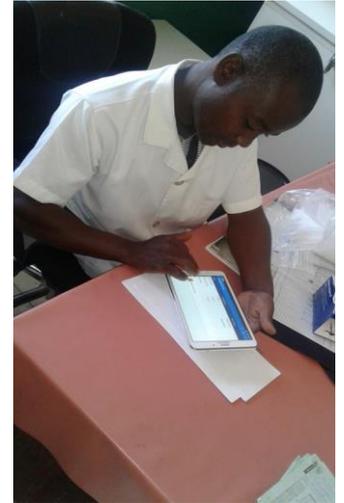
- ▶ Agendar visita de supervisão;
- ▶ Verificar o stock do APE;
- ▶ Rever as competências do APE;
- ▶ Ver os indicadores mensal do APE;
- ▶ Resolver os problemas técnicas da tecnologia.





# Towards more Institutionalizing

- MOH assuming already: overall managerial structure – official contracting – flow and accountability of data integrated into DHIS-2 – drug supply – political recognition
- Strategic Plan 2018-2024 proposes: more flexibility on responsibilities per socio-demographic and epidemiologic realities – career path and ladder – official recognition e.g NSSS – payment of subsidy



# WHO CHW Guidelines

## Liberia Snapshot

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**MINISTRY OF HEALTH**  
Republic of Liberia

# Background

- About 29% (1.2 Million) of Liberians live outside the reach of the current health system (>5km from the nearest health facility).
- This contributes to significant disparities in access to health services and to health outcomes for Liberians.
  - Skilled Birth Attendance at Delivery:  
50% Rural, 73% Urban
  - Child Vaccination 0–12 months fully vaccinated:  
49% Rural, 60% Urban
  - Infant Mortality Rate (per 1,000 live births):  
73 Rural, 66 Urban
- Available evidence suggest that the use of Community Health Workers can be effective in improving access to and coverage of health services particularly for women and child health outcome



Source: Liberia Demographic Health Survey 2013



**PANIC OVER KILLER VIRUS**  
**EBOLA: WORLD GOES ON RED ALERT**



# POST-EBOLA RECOVERY STRATEGY: BUILDING RESILIENCY

## Health Sector Investment Plan 2015-2021

- Building a resilient health system to provide health security to the Liberian people
- Reducing risks due to epidemics and other health threats
- Accelerating progress towards universal health coverage
- Includes the **creation of a National CHA Program** as part of a “fit for purpose” health workforce and contribution towards sustained community engagement

## Health Workforce Program

- Developed as a building block of the Investment Plan to highlight the creation of a **National CHA Program**, along with investments in pre-service training investment and health management, as part of the MOH’s commitment to revitalizing the health workforce—a core component of a resilient health system



**Liberia’s journey to achieve Universal Health Coverage and the Sustainable Development Goal 3.**

# Launch of National Community Health (NCHA) Program

July 24, 2016

Fragmented community health volunteer programs



A professionalized, high-quality, unified CHA program

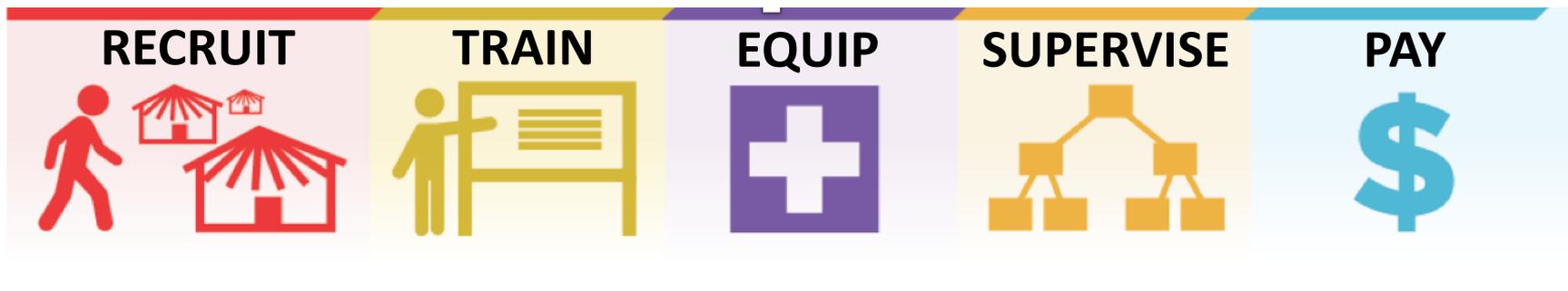


# Coming Together Under a National Policy

The Ministry of Health's vision for Liberia's National Community Health Services is a coordinated national community health care system in which households have access to life-saving services and are empowered to mitigate potential health risks.

Source: Revised National Community Health Services Policy, 2016

Place a professional Community Health Assistant (CHA) in every remote community in Liberia



# NATIONAL COMMUNITY HEALTH SERVICES POLICY

## Core Objectives

1. Strengthen **community engagement** to contribute to the reduction of maternal neonatal, infant, and child morbidity and mortality
2. Increase **access to and utilization of a high-quality**, standardized package of essential interventions and services
3. Strengthen **support and governance systems** for implementation of community health services
4. **Build human resource capacity for community health services** via pre-service and in-service training
5. Develop robust **community-based surveillance and information systems** linked with National Health Monitoring, Evaluation and Research (HMER) systems

# Benefits of the Liberia NCHA Program

1	Health	<b>Reduce maternal and child mortality</b> through improved access to health care in communities and through referral to health facilities
2	Economic	<b>Job creation targeted at thousand of unemployed youth and women</b> and creation of career pathway for existing community volunteers
3	Social	<b>Empowerment of women through educational and career opportunities</b> as well as engagement and development of communities.
4	Household Productivity	<b>Caretakers, particularly women, are able to remain at home</b> rather than traveling long distances to seek care.
5	Youth Mobilization	<b>Employment opportunities available in their communities</b> that attract youth, especially young women to the health sector
6	Disease Surveillance and Response	<b>Connection of remote communities through extension of health services</b> can improve stability and reduce social disruption caused by future outbreaks
7	Cost-efficient and Time Saving	<b>Provides rapid, immediate life-saving services</b> while longer term health-system strengthening initiatives (training of professional staff, building of health facility) are ongoing

A large, weathered tree stump is the central focus of the image, showing concentric growth rings and a dark, charred surface. It is surrounded by dense, vibrant green foliage, including ferns and various leafy plants, suggesting a tropical or subtropical environment. The lighting is bright, highlighting the textures of the wood and the surrounding vegetation.

# WHO CHW Guideline Recommendations

## The Liberian context

# I. Selecting, Training and Certifying CHWs

<u>Category of Intervention</u>	<u>Guideline Criteria</u>	<u>Liberia Policy</u>	<u>Liberia Criteria</u>
<b>Selection</b>	<ul style="list-style-type: none"> <li>▪ Specify minimum educational levels</li> <li>▪ Require community membership and acceptance</li> <li>▪ Consider personal capacities and skills</li> <li>▪ Apply appropriate gender equity to context</li> </ul>		<ul style="list-style-type: none"> <li>▪ Ability to read &amp; write in English, add, subtract, and multiply</li> <li>▪ Community Health Committees (CHCs) select permanent member of the community to serve as CHA</li> <li>▪ Must be trustworthy and respected, able to perform CHA tasks, and a good mobilizer and communicator</li> <li>▪ Females should be given preference</li> </ul>
<b>Pre-Service Training Duration</b>	<ul style="list-style-type: none"> <li>▪ Base on CHW roles and responsibilities</li> <li>▪ Consider pre-existing knowledge</li> <li>▪ Factor in institutional and operational requirements</li> </ul>		<ul style="list-style-type: none"> <li>▪ 4 training modules cover all roles and responsibilities</li> <li>▪ Pre-tests measure existing knowledge; activities throughout curriculum allows CHAs to share experience</li> <li>▪ Training conducted by Master Trainers and Community Health Services Supervisors (CHSSs) - not currently institutionalized</li> </ul>

# I. Selecting, Training and Certifying CHWs

<u>Category of Intervention</u>	<u>Guideline Criteria</u>	<u>Liberia Policy</u>	<u>Liberia Criteria</u>
<b>Curriculum to Develop Competencies</b>	<ul style="list-style-type: none"> <li>Train on expected preventive, promotive, diagnostic, treatment and care services</li> <li>Emphasize role and link with health system</li> <li>Include cross-cutting and interpersonal skills</li> </ul>		<ul style="list-style-type: none"> <li>Training Package               <ul style="list-style-type: none"> <li>Module 1: Disease Prevention and Control</li> <li>Module 2: Reproductive Health</li> <li>Module 3: Child Health</li> <li>Module 4: Special Services</li> </ul> </li> <li>Community Health Services Supervisors (CHSSs) conduct CHA training to link CHAs and health facilities</li> <li>Community engagement, coordination, mobilization, communication, and other cross-cutting skills strengthened</li> </ul>
<b>Training Modalities</b>	<ul style="list-style-type: none"> <li>Balance theory and practice</li> <li>Use face-to-face and e-learning</li> <li>Conducting training in or near the community</li> </ul>		<ul style="list-style-type: none"> <li>4 training modules each ~10 days with practicals in-between</li> <li>Continued Clinical Education videos on digital health tools will allow for ongoing e-learning</li> <li>Decentralization theoretical training per county with community practicals</li> </ul>
<b>Formal Certification</b>	<ul style="list-style-type: none"> <li>Offer competency-based formal certification upon successful completion of training</li> </ul>		<ul style="list-style-type: none"> <li>Informal certificate given to CHAs upon completion of training</li> <li>No formalized certification given</li> <li>Curriculum is currently objective-based, not competency-based</li> </ul>

# I. Selecting, Training and Certifying CHWs

Recommendations for Liberia:



Map current curriculum objectives to competency-based curriculum



Offer competency-based formal certification upon successful completion of training



## II. Managing and Supervising CHWs

<u>Category of Intervention</u>	<u>Guideline Criteria</u>	<u>Liberia Policy</u>	<u>Liberia Criteria</u>
<b>Supportive Supervision</b>	<ul style="list-style-type: none"> <li>▪ Establish appropriate supervisor-CHW ratios</li> <li>▪ Train and resource supervisors to provide meaningful, regular performance evaluation and feedback</li> <li>▪ Use supervision tools, data and feedback to improve quality</li> </ul>		<ul style="list-style-type: none"> <li>▪ Community Health Services Supervisor (CHSS) trained to provide supervision and coaching to no more than 10 CHAs</li> <li>▪ CHSSs are professional health workers (i.e. RN, PA, etc.) who serve as the link between CHAs and the health facilities</li> <li>▪ CHSSs spend 80% of their time in the field supervising CHAs and 20% in the health facilities</li> <li>▪ CHSSs supervise each CHA twice a month; County Health Teams perform monthly supervision; National MOH performs quarterly supervision – all with standardized tools</li> </ul>
<b>Remuneration</b>	<ul style="list-style-type: none"> <li>▪ Include resources for incentives in health system resource planning</li> <li>▪ Provide a financial package commensurate with the job demands, complexity, number of hours, training and roles that CHWs undertake</li> </ul>		<ul style="list-style-type: none"> <li>▪ CHAs work 20 hours per week and receive \$70 per month</li> <li>▪ CHSSs work 40 hours per week and receive between \$270 – \$310 per month, dependent on distance from Liberia’s capital</li> <li>▪ Payment mechanisms: mobile money, bank transfer, or cash</li> <li>▪ National CHA Program is donor-dependent</li> </ul>

## II. Managing and Supervising CHWs

<u>Category of Intervention</u>	<u>Guideline Criteria</u>	<u>Liberia Policy</u>	<u>Liberia Criteria</u>
<b>Contracting Agreements</b>	<ul style="list-style-type: none"> <li>▪ For paid CHWs, establish agreements specifying roles, responsibilities, working conditions, remuneration and workers' rights</li> </ul>		<ul style="list-style-type: none"> <li>▪ CHSSs sign formal contracts for 1 year</li> <li>▪ CHAs sign bonding agreements for 1 year</li> <li>▪ CHSSs are gradually becoming absorbed as civil servants who are supported by the GOL's payroll</li> <li>▪ CHAs are not currently civil servants and are donor supported</li> </ul>
<b>Career Ladder</b>	<ul style="list-style-type: none"> <li>▪ Create pathways to other health qualifications or CHW role progression</li> <li>▪ Retain and motivate CHWs by linking performance with opportunities</li> <li>▪ Address regulatory &amp; legal barriers</li> </ul>		<ul style="list-style-type: none"> <li>▪ No formal career pathway for CHAs, but policy calls for the development of one</li> <li>▪ Performance-based incentives are not standardized, but piloted by some implementing partners</li> </ul>

# II. Managing and Supervising CHWs

## Recommendations for Liberia:

- ✓ Develop sustainability plan to transition NCHA Program implementation from partners to the Government of Liberia
- ✓ Integrate NCHAP costs (i.e. payment, supplies, and trainings – currently donor-dependent) into Liberian health care budget
- ✓ Develop career ladder for CHAs
- ✓ Link CHA performance with motivation/opportunities
- ✓ Develop formal contracts for CHAs



# III. Health System Integration & Community Support

<u>Category of Intervention</u>	<u>Guideline Criteria</u>	<u>Liberia Policy</u>	<u>Liberia Criteria</u>
<p><b>Target and Population Size</b></p>	<ul style="list-style-type: none"> <li>▪ Consider population size, epidemiology, and geographical and access barriers</li> <li>▪ Anticipate expected CHW workloads, including nature and time requirements of the services provided</li> </ul>		<ul style="list-style-type: none"> <li>▪ CHAs serve populations living more than 5kms from the nearest health facility (29% of the population) in both rural and peri-urban settings</li> <li>▪ 1 CHA covers a catchment area up to 350 people</li> <li>▪ CHAs work 20 hours per week and cover communities by foot</li> <li>▪ CHSSs work 40 hours per week and are provided motorbikes for supervision</li> </ul>
<p><b>Collections and Use of Data</b></p>	<ul style="list-style-type: none"> <li>▪ Enable CHWs to collect, collate and use health data on routine activities</li> <li>▪ Train CHWs and provide performance feedback based on data</li> <li>▪ Minimize reporting burden, harmonize requirements and ensure data confidentiality and security</li> </ul>		<ul style="list-style-type: none"> <li>▪ CHA data is collected by CHSSs, aggregated, and entered into Community Based Information System (CBIS)</li> <li>▪ CBIS indicator trends are reviewed at Quarterly Review Meetings to provide performance feedback and make data-driven decisions</li> <li>▪ Digital Health initiative ongoing to streamline data collection</li> </ul>
<p><b>Types of CHWs</b></p>	<ul style="list-style-type: none"> <li>▪ Adopt service delivery models comprising CHWs with general tasks as part of integrated primary health care teams</li> <li>▪ CHWs with more selective tasks to play a complementary role based on population health needs, cultural context and workforce configuration</li> </ul>		<ul style="list-style-type: none"> <li>▪ CHAs are trained with a standardized package including promotive, preventive, and curative services to populations beyond 5kms</li> <li>▪ MOH developing Community Health Promoter (CHP) cadre to provide promotive and preventive services within 5kms of a health facility</li> </ul>

# III. Health System Integration & Community Support

	<u>Guideline Criteria</u>	<u>Liberia Policy</u>	<u>Liberia Criteria</u>
<b>Community Engagement</b>	<ul style="list-style-type: none"> <li>▪ Involve communities in selecting CHWs and promotion programme use</li> <li>▪ Engage relevant community representatives in planning, priority setting, monitoring, evaluation and problem-solving</li> </ul>		<ul style="list-style-type: none"> <li>▪ Community Health Committees (CHCs) select CHAs and regularly meet for priority setting, planning, and monitoring</li> <li>▪ 1 CHC member attends Health Facility Development Committee (HFDC) meeting at health facility</li> </ul>
<b>Mobilization of Community Resources</b>	<ul style="list-style-type: none"> <li>▪ CHWs to identify community needs and develop required responses</li> <li>▪ CHWs to engage and mobilise local resources</li> <li>▪ CHWs to support community participation and links to health systems</li> </ul>		<ul style="list-style-type: none"> <li>▪ CHCs engaged for community mobilization and health projects</li> </ul>
<b>Supply Chain</b>	<ul style="list-style-type: none"> <li>▪ Ensure CHWs have adequate and quality-assured commodities and consumables through the overall health supply chain</li> <li>▪ Develop health system staff capacities to manage the supply chain, including reporting, supervision, team management, and mHealth</li> </ul>		<ul style="list-style-type: none"> <li>▪ CHA supplies are aggregated with health facility requisition</li> <li>▪ 20% of health facility drugs are earmarked for National CHA Program and stored at the health facility in a separate locked box</li> <li>▪ Restock is done based on consumption, not a kit system</li> <li>▪ CHSS led CHA restocks during regular supervisions, stored in locked CHA box</li> </ul>

# III. Health System Integration & Community Support

Recommendations for Liberia:

✓  
✓  
✓  
✓  
Continue digital health rollout to improve performance based on data

Validate Community Health Promoter policy to strengthen access to populations within 5kms of a health facility

Improve community engagement and resource mobilization

Strengthen supply chain (i.e. drug availability, distribution, and storage)



# WHO CHW Guidelines - Liberia Fidelity

Recommendations for Liberia:



**Recommendation Fidelity: 10 / 15**



**Areas to Improve: 5 / 15**



**Recommendation Gaps: 0 / 15**



## Dissemination and Support

- Embark on in-country guideline dissemination
  - Stakeholders forum for CHW Guideline dissemination
- Mid-Term Policy Review Slated for May/June 2019
  - WHO involvement and support to align policy revisions with CHW Guidelines

THANK  
YOU



# Questions and Answers Session

## Part 2

Moderator: Rachel Deussom, CORE Group Community  
Centered-Health Systems Strengthening Technical Working  
Group / Chemonics HRH2030 Technical Director



## Selected CHW-related resources

- [Landscape Analysis of National CHW Programs in 22 USAID Priority Countries for MCH](#) 
- CHW Reference Guide & Case Studies
  - [Reference Guide: Full version](#)
  - [Reference Guide: Condensed version](#)
  - [Case Studies: Full version](#)
  - [Case Studies: Condensed version](#)
- [CHW AIM Tool: Updated Program Functionality Matrix for Optimizing Community Health Programs](#)
- CHW Coverage and Capacity (C3) Tool
  - Coming soon [here!](#)
- [Guideline on health policy and system support to optimize community health worker programmes](#)
  - [CHW Guideline: Selected Highlights](#)
  - [Lancet Global Health Abstract](#)
- [Community Health Systems Catalog \(USAID/APC\)](#)
- [Community Health Planning and Costing Tool \(Unicef/MSH\)](#)
- [USAID Community Health Framework and the Community Health Toolkit](#)