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Image: United States government work

Report

Unlocking the community health workforce potential, post-Ebola: what models and strategies work?

Wednesday 10 – Friday 12 February 2016 | WP1447

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The Ebola pandemic of 2014-16 demonstrated the crucial role of the community health workforce in preventing, responding to, and effectively treating health emergencies. As the West Africa region rebuilds its health systems after Ebola, countries and communities have identified a need to develop strategies and plans to embed the role of the community health worker (CHW) as a foundation of an effective healthcare system.

There is strong evidence of the impact CHWs can have on health outcomes for their communities. Justification for investment in CHWs has been well established, but there remain questions about how to find the resources to do this sustainably. Real and practical challenges to building and supporting a strong community health workforce persist- challenges that existed before Ebola, but in many cases have become even worse.

Health systems recovering from the impact of Ebola have limited resources and depleted workforces. In many cases, international and domestic resources are restricted to specific diseases, and breaking free from the constraints of vertical project interventions to horizontal programmes is not simple. Governments, donors and non-governmental organizations (NGOs) are working to collaborate and adopt whole-system approaches, but this process takes enormous skill, effort, and compromise. Government leadership at national level has never been more important. Thinking about how each and every stakeholder supports health workers takes new thinking and new approaches. It means thinking systemically about what motivates and supports the health worker as a professional and as an individual.

With this in mind, the aim of the “Unlocking the community health workforce potential, post-Ebola: what models and strategies work” meeting was to develop clear ways forward for Ebola-affected countries in developing a strong community workforce; to share lessons learned from countries with strong community health systems; and to align the needs of Ebola-affected countries with global efforts to develop and support CHW programmes in a highly complex set of interrelated

environments.

The meeting built on the health information systems (HIS) meeting led by the West Africa Health Organization, which took place in May 2015 in Ghanaⁱ; as well as the ‘(Re)Building health systems in West Africa: what role for ICT and mobile technologies?’ meeting held at Wilton Park in June 2015.ⁱⁱ The core messages from that meeting were the importance of government leadership; the need for user-centred design in technology and programs; the need for high-quality training for health workers; incentives aligned to need and performance; and the essential role of collaboration, particularly with the private sector.

This conference – again drawing together both public and private sector leaders – specifically aimed to foster better coordination; to build determination across sectors for a paradigm shift in approaches; to build bridges between technology communities and those who need to manage those systems on a daily basis; and to put the health worker at the centre of all stakeholder thinking.

“(The) acute crisis of Ebola may be over but sustained crisis and emergency still exists”

Key points

- **It will take courageous, resilient and ambitious people to deliver a paradigm shift towards sustainable health worker presence and practice.** Strong political leadership at a national level will need to be integrated with strong regional and local management and coordination. Without this, most efforts will fail. CHWs need opportunities to express clearly what they need and trust that they will be heard. Facilitating such a dialogue requires skilled health, policy, and technology experts who think and act in a way that responds to the needs of health workers and their communities. In particular, CHWs need strong, empathetic supervisors to train, mentor, and reward them, and to help motivate and monitor performance.
- **National policy provides the framework, but implementation happens locally.** Policies need to be in place at a national level that connect CHWs with a wider health system with flexibility to adapt to local conditions. This can only happen if national policies respond to national ownership, leadership, and best practices; and if international donors and partners support these policies
- **Technology makes systems stronger when it serves the needs of the CHW, not the other way around.** When a CHW is supported by good systems and appropriate technologies, she has access to the processes, data, and information she needs. Data can allow CHWs to make decisions and see the impact of their work. Mobile devices can provide access to training resources and job aids. Technology should respond to what CHWs need, and this requires bridging a communication gap between tech and health.
- **Nothing will change without the right partnerships in place.** The development of and continued support for a strong community health workforce can only be enabled by effective partnerships and collaboration. Long-term

ⁱ USAID-WAHO Technical Workshop: “Data Harmonization in Ebola-affected and Neighbouring Countries—Strengthening Health Information Systems in the West Africa Region”

ⁱⁱ (Re)Building Health Systems after Ebola Report: <http://mpoweringhealth.org/wp-content/uploads/2015/07/WP1409-Report.pdf>

partnerships need to be formed at many levels – developing and sustaining partnerships takes significant effort but pays off.

Key trends and drivers affecting community health workforce development

- **Growing demand for national leadership and national policy.** National governments, donors, ICT firms and the private sector see national and local ownership as essential. Until now there has too often been a misalignment of donor and national government objectives that has hampered national governments' abilities to set agendas. National governments "...know what needs to be done" and setting these priorities down in policy can serve as a platform to guide innovation.
- **Continued need for decentralization, local ownership and engagement.** National leadership does not mean central control of all aspects of a programme - decentralised engagement and ownership remain essential. Decentralisation mitigates against the risk of too much central control; limited ability to contextualize; stifled innovation; lack of creativity; and sapped dynamism. Local coordination and ownership allow programmes to engage communities and last over time. The government's role is to set the quality standard, then create the enabling environment necessary for good programmes. How to do this is not the same everywhere, as health system challenges vary by country and within countries.
- **Need to both standardise *and* customise approaches.** There is a growing need to think about and share a common high level conceptual framework (the 'why, what and how') that decision-makers can use to understand the role of the CHW within the broader community ecosystem. A framework can help decision-makers access common language which in turn can help inform policy. USAID, with partners, has developed a conceptual framework and toolkit, and case study examples which can be used by Ministries of Health, donors and implementing organizations.ⁱⁱⁱ

"(The) Government decided it had to be done, and it was therefore done"
- **Increased emphasis on programme sustainability.** Because resources are scarce, sustainability must be considered up front. Donors and national governments are unwilling to keep reinvesting in projects that are not financially viable. The private sector will not invest in short term efforts. Breaking the current cycle of unsustainable efforts means moving away from project thinking towards thinking about investments across the health system.
- **Rationale for investment in CHWs.** A clear business case for investing in the development of strong CHW cadres is emerging. CHWs triage for the whole health system, and provide cost-saving preventive care. Increasingly, investing in CHWs is seen as a smart investment strategy.

"We can't afford not to invest in CHWs"
- **Growing need for accelerated learning at both a personal and programme level.** Rapid iterative learning is a key feature of successful programmes. A faster and more systematic learning cycle, supported by appropriate technology, will help programmes adapt quickly as they roll out. Technology also enables more individualised learning pathways, responding to a CHW's particular needs and helping a CHW improve the services she delivers. The public sector can

ⁱⁱⁱ USAID Community Health Framework: http://mpoweringhealth.org/wp-content/uploads/2015/11/USAID-Community-Health-Framework_Version-1-0_October-28th-2015.pdf

learn from the private sector and its ability to create systematic approaches to developing and delivering national programs.

- **Growing need for CHW recognition and reward.** Setting tangible objectives, monitoring performance, reporting and reviewing on progress, aligned to greater clarity of the role of CHWs, increases their motivation and performance. Commitment to these approaches, together with a better understanding of the role of a CHW as first line emergency responder (as shown by the response to the Ebola crisis) will help shape more effective community health workforce development .
- **A better understanding of what it means to be ‘community health worker-led’.** Whilst national leadership and policy are important, all partners are starting to see that in reality “*CHWs don’t work for us, we work for them*”. We need a collaborative approach to help them to do their jobs and improve health outcomes.
- **Continuing scepticism on the return and sustainability of investing in CHWs.** While the trends outlined above indicate a progressive direction, some countries or individuals in Ministry of Health departments remain sceptical about the role of CHWs, especially in comparison to the value placed on existing higher-cadre health workers. Investing in CHWs means competing for scarce health resources allocated for development of clinical officers, midwives and other high level health workers, and this competition could grow. There is also scepticism about the role that donors and international organizations play, with questions raised as to whether these significant actors in global health are truly invested in creating sustainable programs with a defined end point.

Key components of a successful community health worker programme

- **National leadership, national policy, and a national programme with enough resources for implementation and development.** True political leadership at a national level is a crucial component of a successful programme, and goes together with a general move away from reliance on donor funding to make programmes happen. Ghana, for example, secured funding for its CHW programme by finding resources from within the Ministry of Employment rather than the Ministry of Health, demonstrating a new way of working across government departments.
- **Decentralised community coordination, practice and engagement.** Countries see the importance of local community engagement to the success of programmes. Successful CHW programs require clear plans, structures and coordination mechanisms as well as local devolution of responsibility for day-to-day decision making. To ensure this happens, partnerships with clear roles and responsibilities are key.
- **Aligned and supportive donors and partners.** Other actors who support CHWs (donors, international organizations, civil society, and others) need to respond to government leadership by aligning their work to national priorities, communicating with national and local leaders, and coordinating amongst themselves.

“(The) problem is not just one of financing, but of coordination.”
- **Systemic and systematic workforce development.** Well-planned training, development, supervision and mentoring are crucial to ensure CHWs are supported, work effectively, and are motivated. The system needs to focus on the training and support that an individual CHW needs. This ‘whole person’ approach can be significantly supported by the appropriate use of technology; for example, mobile technology can be used to capture data that enables

recognition of good performance. (Participants highlighted the importance of using this data for management and reward, not for punishment.)

- **Recognising and rewarding CHW contributions in a way that they value.** CHWs need to know their work is appreciated – this can be shown by providing learning opportunities, job aids, certificates of recognition, and training. Expressing thanks and recognizing the value of their work help to motivate CHWs. There are different models of rewards in operation; the sustainability and desirability of paying CHWs remains open to discussion, with examples of both volunteer and paid models. Some countries see volunteerism as a fundamental feature that enables real community engagement and sustainability. Others have decided that establishing both the principle and resources to ensure CHWs are paid are necessary to ensure that programmes are successful in the long term. Hybrid versions exist too, as in Rwanda, where CHW co-operatives receive performance-based rewards from the government for successful health service delivery. A portion of these funds are reinvested in locally based income generating activities.
- **Appropriate use of volunteers.** It was clear that most, if not all, primary health care models continued to have some volunteer elements and participants agreed that the understanding and defining the relationship of volunteers to CHWs in each setting is key. Aligning any new programme within the health system and existing community structures was noted as essential for success, rather than creating parallel or entirely new processes. This includes understanding the role of traditional healers and other existing sources of health care and information.
- **Standardized curricula with local adaptation.** There is a tension between standardisation of training curricula and technology, and dynamism at a local level that allows adaptation to local context. However, there is some agreement that it is possible to have a common platform which allows training content to be reused and supports modifications to make that content useful and relevant in different local contexts.

Building a supportive ecosystem for CHWs

- **Key elements and approaches:** Some simple-sounding but extremely hard to execute elements are needed to create a supporting ecosystem. They include:
 - National ownership and leadership (for example, both Rwanda and Malawi's programmes were started by the national initiative, and not by donors);
 - Planning, control and monitoring mechanisms;
 - A clear vision, plan, and regular co-ordination meetings that include reviewing and approving action plans;
 - Ongoing oversight and management supported by the right information and systems to enable decision making;
 - Incentivising of staff and volunteers either by payment or other forms of recognition;
 - Devolution of responsibility for local engagement, coordination and action; and
 - Training, supervision and mentoring for CHWs and health workers at all levels.
- **A clear CHW policy supported by financing** needs to be in place as a minimum. The policy must align to or grow from the current programmes already in place to build upon past efforts and successes. Through an aligned implementation plan a government can demonstrate how it will manage and

supervise CHWs, taking into account the whole package of work CHWs undertake and not just day to day activities.

- **How CHWs are supervised is critical** –supervision has to take into account all CHWs’ responsibilities, rather than looking at a single disease or service delivery area. Monitoring and motivating CHWs requires collection and use of good quality data on activities and performance. This will include meetings at health centres or with supervisors, and considering how supervision will be integrated into health workers’ duties.

“You can’t really operate a programme without data”

- **Integration into strong health systems.** The wider healthcare system plays a vital role in supporting CHWs through existing facilities and systems. CHWs need to be able to refer clients to functioning, well-staffed health facilities. Data collected by CHWs needs to be input into the existing HIS and CHWs need to receive information adapted to their needs. Good examples of practice include: a registry of CHWs that includes their mobile phone numbers, and can send them regular SMS messages; a tracking system for pregnant mothers; finance management systems in place at health centre level; and performance indicators reporting from a local into national Health Management Information Systems (HMIS).

Setting the standard: enablers, barriers and opportunities for health worker training

- **Key enablers for setting a high standard for health worker training:** These enablers include alignment between partners, donors, private sector, local agents and government; an integrated training curriculum that has the support of government; and institutional capacity within systems to mitigate high staff or volunteer turnover. Training should be focused on learner needs and be designed for performance, with effective monitoring and evaluation key to learning and adapting fast in role. The individual needs the right environment and support for learning; from tutors, peers, and through access to data and feedback about their work and recognition for training. Initial training should only be the first part of an ongoing process including continuous ongoing training, supervision, and personal engagement. Training content should use openly available and adaptable resources.^{iv}
- **Key barriers:** These include lack of alignment between partners and government in the aims of a CHW programme. In a reliance on funds and support, governments can give partners too much independence and at times take advice that is poorly aligned with national priorities. In addition, vertical programs and inconsistent or unsustainable incentives lead to high attrition of CHWs, as well as duplication of effort in CHW training. Low literacy, lack of access to technology and cultural elements can pose barriers to training, although these challenges can be mitigated through strong curricula and trained, supported trainers. A lack of clear shared objectives between governments, donors, training institutions, and the private sector leads to inconsistent financing, low adherence to national policies, and limited or no sharing of what happens in programmes, leading to poor institutional knowledge of what works, what doesn’t work, and why.
- **Key opportunities include:** Strong supervision and mentoring, with appropriate levels of autonomy and support for supervisors. Use of data provides an opportunity to reward CHWs and monitor good practice. By curating training

^{iv} Openly available resources are available on the mPowering ORB platform (www.health-orb.org)

quality-assured content, evidence-based tools can be adapted to local context and provide training to health workers at regional or national scale. Effective training techniques supported by technology (such as training in small doses, training in work settings, and other evidence-based adult learning techniques) provide optimal training outcomes, particularly when training programs are adapted to CHWs' work, the setting in which they will work, and local health needs.

How ICT and mobile technology contribute to CHW development

- **Information and communication technology (ICT) is particularly valuable in two ways:** creating feedback loops that support continuous learning for CHWs and supervisors about activity and performance; and creating networks both at a technical level, but also of groups and individuals. Both feedback loops and networks are relevant to CHWs as they often work in rural communities without regular access to peers or supervisors.
- **ICT also creates the conditions in which data can be captured** and mined for additional insights that were originally not anticipated. By capturing rich data, a repository of information is created that can be used to provide feedback to CHWs, alert them to new trends or outbreaks, and strengthen national strategic planning.
- **For ICT to be successful it has to start with the user** (using the Principles for Digital Development¹). It is personal: to work, it needs to work at an individual level. Technical solutions should be useful to CHWs, and designed as a service for that individual, not as a goal on their own. User-centred design requires technologists to understand CHWs' day-to-day work and needs. When talking about ICT, it is important to remember that most frontline health workers do not have access to a computer - but they do to a mobile. Health decision makers and ICT experts need to have a robust discussion about what works and where ICT can support CHWs. This requires at least some common understanding of technical language.
- **Technology is only as good as the objective it serves.** It is essential to map what needs to be done and only then find the appropriate technology to support the process. Government officials are already inundated with mHealth applications and systems. Many of these are developed without reference to basic health protocols. There needs to be a new way to think about how health related content is managed for training and education. It is important not to tie a particular solution for a CHW to the technology – the technology changes. Planning should allow for – indeed expect – that technology solutions will change. Ensuring that infrastructure and systems are interoperable is a key enabler for this to work.
- **Infrastructure can pose a challenge, but does not preclude technology.** Technology helps reach people and communities that previously had little or no access to connectivity. For example, cash can now reach people by mobile faster than through most traditional channels, even for people who are off-grid. Even where network coverage does not exist, this should not hold back innovative thinking, as strategies exist to provide offline access to information, and ICT infrastructure is expanding rapidly.
- **Real concerns exist about security** for countries adopting new wide scale registrations of people and workers. There are some concerns about the potential for mobile operators to use individual location data in a way that could influence health insurance or for commercial purposes.

National strategies and structures work best when ...

- **Workforce structure is carefully considered throughout the health system**, including clear lines of reporting and responsibility between and across tiers and cadres of health workers. Resources and processes are mapped. Systems are in place to manage key practical processes such as HR and (where applicable) payroll. There is a clear articulation of roles and shared expectations, including clear boundaries of what CHWs can and cannot do. This is often dependent on their skills; availability of commodities; suitability of local facilities; and the scale of behaviour change they are trying to support at a local level.
- **Donor and partner programmes align with national policy owned by the government.** This provides dual support for capacity building within government and health workforce. Achieving this needs a champion with political will, and a clear focus from the government. Governments can identify areas where they step back and create an enabling environment for the private sector and NGOs. Gaining donors' support and thinking about sustainability needs precise costing models which are supported by carefully looking at how CHWs integrate with existing health facilities and community leaders.
- **Strong capacity is built within governments to create policies and oversee technical assistance.** Capacity building should reach all levels of decision-makers in the government. As government capacity increases, governments need to adopt and own successful programs- partners must put aside their business interests and step out at the right point.
- **A clear coordination and management process is institutionalised** including establishing technical working groups; a monitoring and evaluation framework using data that can be used for decision making; and action plan for areas for improvements.
- **Training materials draw on the existing evidence base and reuse and repurpose content** in a way that is suitable for the local context. Government ownership of training materials was seen as a way to increase their use by partners. Currently, donors do not incentivize the re-use of existing training content, and training partners do not sufficiently take advantage of existing materials in their training programs- this needs to be acknowledged and sharing needs to be facilitated and encouraged.
- **Community engagement takes place.** This can include community based forums (e.g. smart health camps) and we should also understand the critical role that civil society has to play in improving the health of populations. Civil society engagement is recognized to be vital to achieving the Sustainable Development Goals – evidence suggests that supporting active civil society engagement promotes equity and access to improved health service delivery and health outcomes. The new Global Strategy in support of *Every Woman Every Child* calls for the engagement of all sectors of society to end preventable deaths of women, children, and adolescents and ensure that all can thrive and reach their potential.
- **Partnerships more broadly are embedded as part of the process.** Having successful partnerships also includes having empathy for CHWs and the implementers of a programme to ensure enough time is devoted to up-front planning as it is to achieve (fast) results.

Steps to (re) building the community health workforce

- **Consider the whole health system and CHWs' role within that** rather than just addressing CHWs or projects supporting them in isolation. This will potentially include involving the Ministries of Health, Finance, Employment and

Communications, among others. Considering the health system as a whole needs close examination of the existing structures to understand their capacities and constraints- including workforce strategy and technology integration. Define the community workforce and be very specific about different cadres and roles. Review and update national health sector plans to ensure they are fit for purpose and updated in light of Ebola.

- **Set about really understanding the needs of the CHW** and what is required to support her in her role. This is a two-way conversation. It requires community involvement and feedback. This should result in user and provider-centred models that take into account local context (including literacy, access to technology, health priorities).
- **Create an enabling structure and environment** that includes a policy and plan that thinks about sustainability from the outset; national strategy is set as a guide, with regional adaptation permitted, based on cultural and other differences; with decentralised organisation; an iterative process of progress measurement; a reporting and learning cycle built in; and budget line items are clear and understood by decision makers.
- **Create standards for training, performance, and incentives.** Provide guidance for curriculum and platforms for training, which can be modified based on local needs but feeds into common competencies and a common assessment of training effectiveness. Develop a standard for performance measurement, including competencies and performance indicators defined for each level of CHW cadre as well as a clear career path. Define context-appropriate compensation and motivation strategies to ensure equity across groups of CHWs.
- **Create and sustain the right partnerships** needed: these include the donors, private sector (such as mobile network operators), NGOs, community and CHWs. Governments should lead partnerships and provide policies to guide partners' activities. This will require champions to foster political will. There should be a ministry focal point for CHW strategy implementation. All partners should contribute to an iterative learning strategy, with standardized measurement and documentation.

Scaling up plans and solutions

- **Vital questions to ask when assessing CHW programs include:** Is there a CHW policy in that country? What is the budget environment and cost of investing in CHW cadres (sustainably)? What are the strengths and valued add of that system/results? What is the (current and desired) patient experience? What are the opportunities to engage with stakeholders and other community workers?
- **The outcomes of strong CHW programs include:** Better integration of community health into larger health system; endorsement and support of CHWs by the community; more preventive health management; CHWs are better trained; CHWs are better supported; CHWs are better equipped to use data; improved quality and encounters of care; lower morbidity and mortality.
- **Performance can be better managed through:** Improved supervisory models and monitoring tools; a scorecard used to identify and acknowledge good work as a motivational tool; integration of community and client feedback; clearly defined roles and responsibilities for CHWs and their supervisors; and real-time feedback.
- **Support to achieve these outcomes can include:** Data being used to incentivise good performance; improved used of mobile-friendly educational tools

and job aids; use of technologies to target supervision more effectively to those CHWs who most need support; development of interoperable information systems that enable data to flow two-ways; payment or compensation of CHWs— not necessarily with cash, but in a way that motivates them.

- **Partnerships are crucial and can be formed around key functions including:** Capacity building for quality training; funding - aligning donors to government priorities; use and interoperability of technology; M&E and reporting. These partnerships need supporting by the right conditions including: strong government leadership; the courage and patience to build trust including transparency and accountability; flexibility; setting plans that are not too rigid, enabling adaptation as progress is made; a common understanding around common goal; and complementarity (everyone playing a defined and respective role).

Additional Considerations

- **Big contextual challenges include centralization, medicalization, and democratisation.** Our world is highly medicalized, but we need to be able to say that some things can be de-medicalised. Many decisions are centralized to national levels, but we need to help support decentralisation. Information is still in the hands of few, but technology provides an unprecedented opportunity and we need to democratise.
- **International aid needs to be shifted to support national and local priorities in a collaborative way.** Donors recognise that past models will not stand up to new challenges, and there are high levels of pressure on whether aid is spent right. Governments need to have leadership commitment, but they are balancing the need to rebuild health systems with addressing poverty; competing internal priorities; living with political instability; and coordinating many NGO projects. NGOs themselves are working in a landscape that is changing so rapidly, and they are not alone in this space which sees growing presence of social entrepreneurs and the private sector. The private sector wants to be contributing to society and have this seen as doing it as their core work. Members of academia want to be involved in a more robust way.
- **Big opportunities exist.** The SDGs have created a new set of goals forcing us to see the world in an integrated way. Resources in the private sector are becoming increasingly available, and their volume dwarfs traditional development assistance. Partnerships are the only way to solve complex health problems and this relies on the public sector finding shared value² with the private sector.
- **Leadership in community health is essential to support CHWs.** This will require unity of purpose among partners with strong leadership. By defining the outcomes and working back from there, we can understand what leads to improvement, and influence other sectors to do the same. Countries need to define the workforce that is needed in communities; and build leadership for community health at community and district levels.
- **Our shared vision** is a strong community health workforce where every community health worker has the tools and technologies they need to be inspired; every CHW is motivated to be the leaders for their community and create whole bigger than sum of the parts; training, continuing discussions, and M&E increase the rate at which people learn so that health workers and partners are able to manage any future challenges.

Vinny Smith with Lesley-Anne Long and Carolyn Moore

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Wilton Park reports are brief summaries of the main points and conclusions of a conference. The reports reflect rapporteurs' personal interpretations of the proceedings – as such they do not constitute any institutional policy of Wilton Park nor do they necessarily represent the views of the rapporteur.

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¹ The Principles for Digital Development can be found using this link <http://digitalprinciples.org>

² Link to Shared Value Article in HBR: <https://hbr.org/2011/01/the-big-idea-creating-shared-value>