Governing Large-Scale Community Health Worker Programs

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Key Points

Improving how community health worker (CHW) programs, and health systems more broadly, are governed is increasingly recognized as important in achieving universal access to health care and other health-related goals. Governing comprises the processes and structures through which individuals and groups exercise rights, resolve differences, and express interests. The process of governing involves ongoing interactions among ***actors,*** such as health care decision-makers, community representatives, and agencies, and ***structures***, with regard to the laws, resources, and beliefs within which these actors operate. Because CHW programs are located between the formal health system and communities and involve a wide range of stakeholders at local, national, and international levels, their governance is complex and relational. In addition, CHW programs frequently fall outside of the governance structures of the formal health system or are poorly integrated with it—making governing these programs more challenging. In the past, poor governance has undermined the planning and management of programs and the delivery of services. This chapter discusses the following key questions that decision-makers need to consider in relation to governing CHW programs:

- How, and where within political structures, are policies made for CHW programs?
- Who, and at what levels of government, implements decisions regarding CHW programs?
- What laws and regulations are needed to support the program?
- How should the program be adapted across different settings or groups within the country or region?

INTRODUCTION

In this chapter, we consider and discuss a number of relevant questions regarding the governance of community health worker (CHW) programs. This chapter is intended to be read alongside Chapter 12 on community participation in CHW programs.

WHAT IS MEANT BY "GOVERNING" IN THE CONTEXT OF HEALTH SYSTEMS?

Governing in the context of health systems can be seen as being concerned with "political, economic, and administrative authority in the management of health systems."[1] Governing comprises "the complex mechanisms, processes, and institutions through which citizens and groups articulate their interests, mediate their differences, and exercise their legal rights and obligations."[2] As this definition suggests, governing involves ongoing interactions and relationships between ***actors,*** such as health care decision-makers, community representatives, associations, and agencies, and ***structures,*** including the laws, policies, resources, and beliefs within which these actors work.[3] Governing is therefore a process rather than a static set of policies and structures. Consequently, this process is closely linked to context and may change over time as societies, health systems, and CHW programs change and evolve. Moreover, governing in the context of health systems may often overlap with management, which is sometimes seen to be more concerned with running or implementing programs.[4]

Governing health services can also be conceptualized in terms of inputs, processes, and outputs.[5] Governance inputs include how and by whom the institutions governing the health system are constructed and managed. This includes "participation," or the stakeholders involved in defining and designing health policies; and "consensus orientation," or the extent to which government officials collaborate with or involve other stakeholders in setting goals and formulating policies for health. The processes of governance concern how administrative procedures and rules governing the health sector are implemented. This includes transparency, accountability, monitoring, and control of corruption. Finally, governance outputs can be seen as the benefits that should result from the implementation of governance rules and processes within a health system. Different political systems may emphasize different governance outputs, but these may include measures of how well the health system responds to population needs, equity of access to health services, and efficient use of health resources.

WHY IS GOVERNING AN IMPORTANT ISSUE FOR CHW PROGRAMS?

Decisions on the type of structures established for governing CHW programs, who will be involved in governing (i.e., the actors), and how these will relate to the wider health and political systems are political. These decisions are important, as they will affect a range of other processes in these programs, including day-to-day accountability, and will ultimately impact performance and sustainability. Some of important decision parameters include:

- Extent to which the CHW program is part of the formal health system
- Extent to which CHWs are formally recognized as a cadre within the health system
- Extent of decentralization of authority for governing CHW programs and for their management
- Scale of the program
- Roles that key stakeholders, including communities and/or service users, have in governing the programs
- How, and by whom, resources are obtained and administered

Also important is the extent to which CHWs are organized, for example, through a union or health provider organization. Different decisions on these parameters, in response to specific contexts and needs, may result in different models for governing CHW programs. For example, in relation to the health system:

- Some programs are not part of the formal facility-based health system, but have structures that provide good links to this system (e.g., the Accredited Social Health Activists [ASHA] CHW program in India and the Building Resources Across Communities (BRAC) CHW program in Bangladesh.
- Some programs are integrated with the formal health system and are well-supported within it (e.g., the Family Health Teams in Brazil, the Health Extension Worker [HEW] program in Ethiopia, and the CHW program in Venezuela).
- Some programs are centrally driven with national guidance, but implemented through separate structures (e.g., CHW programs in South Africa, which are currently largely implemented through NGOs, but within parameters established at the national level).

These varied models for governing CHW programs have implications, in turn, for how programs are financed and funded; how and by whom CHWs are selected and trained; how CHWs are supported and supervised; how CHWs are paid; and how communities are involved; among many other issues. We discuss the implications of these differing configurations in more detail below.

Improving how CHW programs, and health systems more broadly, are governed is increasingly recognized as important in achieving universal access to health care and other health-related goals. The concept of "good governance" is now used widely and can be understood as the interactions between relevant stakeholders and processes that enable monitoring, transparency, and accountability and that lead to public value and the common good.[6] Improving on how CHW and other health system programs are governed requires a range of enabling factors. For example, clear goals and priorities for the CHW program; appropriate structures for implementing, coordinating, and integrating the program; standards regarding the selection and training of CHWs; data on how well these programs are performing; mechanisms for motivating CHWs and their supervisors; and meaningful involvement of, and accountability to, the range of stakeholders linked to these programs, including local communities and recipients of CHW care. Governing CHW programs, therefore, requires financial and other resources, and how these resources are managed will, in turn, impact the extent to which good governance can be achieved.[7, 4] Table 1 provides a summary of governance principles within health care.

Table 1: Health systems governance principles[2]

GOVERNANCE PRINCIPLE	EXPLANATION
Strategic vision	Leaders have a broad and long-term perspective on health and human development, along with a sense of strategic directions for such development. There is also an understanding of the historical, cultural, and social complexities on which that perspective is grounded.
Participation and consensus orientation	All men and women should have a voice in decision-making for health, either directly or through legitimate intermediate institutions that represent their interests. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively. Good governance of the health system mediates differing interests to reach a broad consensus on what is in the best interests of the group and, where possible, on health policies and procedures.
Rule of law	Legal frameworks pertaining to health should be fair and enforced impartially, particularly the laws on human rights related to health.

GOVERNANCE PRINCIPLE	EXPLANATION
Transparency	Transparency is built on the free flow of information for all health matters. Processes, institutions, and information should be directly accessible to those concerned with them, and enough information is provided to understand and monitor health matters.
Responsiveness	Institutions and processes should try to serve all stakeholders to ensure that the policies and programs are responsive to the health and non-health needs of its users.
Equity and inclusiveness	All men and women should have opportunities to improve or maintain their health and well-being.
Effectiveness and efficiency	Processes and institutions should produce results that meet population needs and influence health outcomes while making the best use of resources.
Accountability	Decision-makers in government, the private sector, and civil society organizations involved in health are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organization and whether the decision is internal or external to an organization.
Intelligence and information	Intelligence and information are essential for a good understanding of health system, without which it is not possible to provide evidence for informed decisions that influences the behavior of different interest groups that support, or at least do not conflict with, the strategic vision for health.
Ethics	The commonly accepted principles of health care ethics include respect for autonomy, nonmaleficence (a principle of bioethics that asserts an obligation not to inflict harm intentionally), beneficence (actions to benefit others), and justice. Health care ethics, which includes ethics in health research, is important to safeguard the interest and the rights of the patients.

WHAT KEY QUESTIONS DO DECISION-MAKERS NEED TO CONSIDER REGARDING GOVERNING CHW PROGRAMS?

Because CHW programs, to varying degrees, are located between the formal health system and communities, and can involve a wide range of stakeholders at local, national, and international levels, their governance is often complex and relational. CHW programs frequently fall outside of the governance structures of the formal health system or are poorly integrated with it, making governing these programs more challenging. In addition to the previously discussed topics, this chapter outlines key questions that decision-makers need to consider for governing CHW programs, and illustrates the options for governing with examples and case studies from programs in the field. These key questions are:

- How and, where within political structures, are policies made for CHW programs?
- Who, and at what levels of government, implements decisions regarding CHW programs?
- What laws and regulations are needed to support the program?

How should the program be adapted across different settings or groups within the country or region?

Table 2 summarizes the sub-questions for each of the main questions above. Tables 3 and 4 provide a cross-country comparison of issues in the governing of the overall CHW programs and policies that affect individual CHWs. These are based on case studies of Brazil, Ethiopia, India, Pakistan, and South Africa. We refer to examples from these tables in the main text. These tables also include additional material that complements and illustrates the issues raised in the main body of the chapter.

How, and Where within Political Structures, Are Policies Made for CHW Programs?

CHW programs experience a number of challenges in relation to policy processes. For example:

- Policies to govern these programs may be lacking if the program is seen to be peripheral to, or outside of, the formal health system or if it has developed out of programs initiated by nongovernmental organizations (NGOs), community-based organizations (CBOs), or civil society organizations (CSOs).
- Existing policies may not be "fit for purpose"; for instance, CHW program functioning may be hampered if a national Ministry of Health (MOH) department decentralizes primary health care (PHC) management to the regional or district level, but does not put in place policies that allow managers at those levels to manage and disburse funds to the CHW program itself and its staff.
- It may be difficult to ensure program consistency, for example, in terms of tasks and responsibilities, across a region or country where there are multiple players involved, including local and international NGOs and agencies and government health services. A national CHW policy framework may be needed to achieve this consistency.

It is therefore important to consider how and where policies for CHW programs are made, and the implications of this for developing and running the program. These policy decisions (such as whether to develop a volunteer-based or fully remunerated CHW program) need to be distinguished from implementation decisions (such as the timetable for continuing education of CHWs within a particular district or province).

Key issues to consider for CHW programs include the following:

- Where are policy decisions made?
- Who are the stakeholders involved in defining and designing these policies (participation), and to what extent is this done in a collaborative manner (consensus orientation)?
- Are there important historical legacies that may shape CHW policymaking?
- How might wider health and political systems goals in a particular context influence how CHW programs are governed?

Where Policy Decisions Are Made

Authority to make policy and operational decisions regarding CHW programs is located at different levels of government within different countries, depending on the country's constitutional or legislative arrangements or historical policy legacies (see below). In some countries, such authority may be located with the national ministry or department of health. In other countries, regional or provincial departments of health or legislatures may have authority to develop health policies, or such authority may have been delegated by the legislature or the MOH to an independent body, such as a CHW Commission. Each of these scenarios has different benefits and drawbacks, as follows:

- When policy authority is located at the national level, it may be easier to achieve consistency of approach for CHW programs across a country. However, policymaking may be very removed from the day-to-day running of CHW programs and may therefore not be very responsive to challenges as they are experienced.
- When policy authority is delegated to an independent body, it may facilitate more rapid and responsive policy development since these decision-makers have a clear focus on the CHW program. However, policies made by this body may not be well-aligned with other policies developed by the MOH or other government ministries.

Those wishing to develop or change policies governing CHW programs need to consider[2]:

- Where are laws and regulations relevant to health initiated?
- Do laws need to be initiated by cabinet or parliament? Can other stakeholders initiate laws or regulations through other mechanisms?
- Who can initiate such laws and regulations? Do laws need to be initiated by a government minister or a ministerial permanent secretary?

In addition, consideration needs to be given to what provisions there are locally for accountability and support. For example, what recourses citizens have if they feel that they not being treated respectfully, or if CHWs are not carrying out their duties adequately? This is addressed in more detail in Chapter 12.

Box 1: Governance within the Brazilian Family Health Program, where policy decisions are made[8]

In Brazil, the new constitution adopted in 1988 reinforced the role of state (provincial) and municipal governments in implementing public policies, while the central government had the role of issuing the main guidelines for implementing public policies. Later legal provisions shifted more responsibility for the management and organization of health services over to municipal governments, while at the same time, emphasized the technical and financial role of the central government and the states. Municipalities have the authority to decide whether to implement the Family Health Program. Once a decision to implement is made, the local government determines the organization of the program in their municipality, for example, specifying the number of family health teams they want to establish and selecting the areas to which these teams will be assigned.

The positive effects on the program resulting from such a process of implementation appear to be more local ownership of the implementation and improved local management of the program. On the other hand, the process could lead to unprepared and uncommitted local management, as well as heterogeneity of implementation.

Box 2: Governance of programs supported by the National Rural Health Missions in India[8]

The three tiers of governance (i.e., government, state, and *panchayats*) in India pose challenges for a range of government programs, including for carrying out certain functions of the National Rural Health Mission (an initiative of the Ministry of Health and Family Welfare to strengthen rural health services). An evaluation from 2009 reported that transfers of funds to lower levels of governance were being held up at the state levels. The evaluation proposed direct disbursement of funds from the central government to the *panchayats* as a solution to this problem. However, it was noted that this change may be difficult, given that health is defined as a state responsibility in the constitution of India. The evaluation suggests that individual states would like to gain more autonomy from the center. However, states are reluctant to devolve the necessary powers to govern CHW programs to the *panchayat* level, where primary health centers and sub-centers are located. Similar tensions were reported between the central government and the states in relation to program financing.

Who, and at What Levels of Government, Implements Decisions Regarding CHW Programs?

Stakeholders Involved in Defining and Designing these Policies and to What Extent Is this Done in a Collaborative Manner

A range of stakeholders may have roles in defining and designing CHW policies. The extent to which there is wide participation in this process may depend on the orientation of the political system within a particular context, the formal and informal power stakeholders are able to exert, and the attitudes of those driving a particular policy process.

Which stakeholders are involved in CHW policymaking, and how these stakeholders are involved, have important benefits and drawbacks for programs:

- When it is not clear who has final responsibility for policymaking, decisions may not be made or may be much delayed.
- When policy decision-making is dispersed across a range of stakeholders, important inconsistencies may develop across program policies. For example, CHWs may have authority to deliver antibiotics for neonatal sepsis in one region of a country but not in another; or may be compensated differently among regions, as is the case for example with India's ASHA Program.
- Involving a wide range of relevant stakeholders in CHW program policymaking may help to build consensus, consistency, and buy-in regarding these policies. This, in turn, may facilitate implementation of CHW policies. However, it may be difficult to achieve such consensus, and decision-making may, as a result, be very prolonged, or may fail to keep pace with changes encountered by the programs on the ground.

Questions that need to be considered in relation to stakeholder involvement include[1]:

- Who are the key stakeholders for policies related to community health services?

  In addition to the national Ministry or Department of Health, this may often include other ministries or departments, such as Finance, Education and Training, Employment, Public Works, etc.; provincial or regional ministries or departments of health; CSOs; professional organizations, such as doctors' or nurses' unions; regulatory authorities, such as bodies that register health care professionals; private sector organizations, such as private clinics; national and international NGOs, who may employ or manage CHWs or other elements of the health system; CHWs themselves; communities where CHWs are working; and donors, including bilateral and multi-lateral organizations and private foundations.

- *To what extent are these key stakeholders consulted and involved in policymaking for community health services? To what extent is there a consensus orientation, in which state authorities cooperate with other stakeholders in policy development?*

  There may be a trade-off between involving a very wide range of stakeholders and involving a narrower group of stakeholders. The former may maximize input and buy-in to the policy but may result in no one stakeholder having overall responsibility for policy development, leading to delays and indecision. The latter approach may make the policy process more manageable, but may reduce buy-in or may result in policies that are not aligned with related policies in other governments departments or sectors.

- *How are inputs solicited from stakeholders?*

[1] Adapted in part from [2]

There are a range of ways in which this may be done, including convening a national or regional policy dialogue,[9-11] requesting written inputs, and holding public consultations. Important challenges include:

- Having a leader or champion who has motivation, the necessary experience with CHW programs, and the credibility with stakeholders to take forward a consultation process. The leader also needs to have the authority to adapt the policy based on the inputs received.
- Having resources for and commitment to a consultation process.
- Having skills to synthesize inputs received in ways that advance the policy process.

- How are the varied objectives, motivations, and views of different stakeholders reconciled within the policy process?

  Stakeholders may have very different views in relation to a particular policy question, based on their constituencies. For example, an international donor may lobby for a "vertical" CHW program for a particular health problem, such as providing treatment support for people living with HIV/AIDS. However, the national department of health may favor a more integrated model, in which CHWs are part of the PHC team in each primary care facility, as more useful and appropriate in the setting. At the same time, the nurses' professional association may be concerned to limit the range of tasks that CHWs are permitted by policy to undertake because they want to protect their profession's scope of practice.

  Those leading and managing the policy process need to decide if the views of stakeholders will be made available publicly, the extent to which consensus is desirable or possible, and what mechanisms will be used to address the different views and objectives of different stakeholders. Mechanisms that may be used include involving key stakeholders in drafting a policy and facilitating dialogue on a draft policy.

Important Historical Legacies that May Shape CHW-Related Policymaking

In addition to being constrained by existing laws and regulations, policymaking for CHW programs may also be shaped by historical legacies. These legacies may include previous and current policies, experiences, and practices. For example, a CHW program may have been established with the specific purpose of improving equity of access to health care for historically marginalized groups, such as populations living in geographically remote areas of the country. The Brazilian Family Health Program, for instance, has its antecedents in a regional program, established to respond to a severe drought (see Table 3, row 3). The model developed in this setting has shaped the program across the country.

Programs may also be shaped by specific health system legacies: for instance, CHW policies may need to take into account an existing nurse auxiliary cadre or a program based on salaried CHWs, or may need to absorb an existing network of community health volunteers. Efforts to establish a national CHW policy framework in South Africa, for example, were influenced by the absence of a national CHW program and the presence of a large number of small-to-medium-sized programs, largely managed by NGOs, in which CHWs had different scopes of practice and levels of training (see Table 3, rows 2 and 3).

Historical legacies are important as they may determine stakeholders' views of and reactions to policies. These legacies may also constrain what is possible; for instance, it may be difficult to make substantial changes to CHWs' existing scopes of practices, such as introducing curative tasks to a program focusing on health promotion, or to the types of recipients targeted, for example, from women and children to everyone in the household or from rural to urban households.

Questions that need to be considered here include:

- Are there important health system legacies, in relation to governance, financial, or delivery arrangements[2], that may shape CHW-related policymaking?
    - It may be very challenging to establish community-led systems for governing CHW programs in a health system in which governance and financial management are highly centralized and in which there is little experience with more decentralized forms of governing. Similarly, it may be difficult to put in place policies to expand the roles of CHWs if these roles are likely to be seen to overlap with those of another cadre.

- *Are there important political system legacies, in relation to institutions, interests, or ideas[3] that may shape CHW-related policymaking?*

  Issues to be considered here include whether there is a constitutional mandate to decentralize the management of programs to district level; whether important funders of a CHW program, such as the Ministry of Finance or international donors, will support a policy change; and whether there is a body of research that may provide support for shifting the way in which a health service is delivered.

- *To what extent are these historical legacies in alignment with the planned policy? What scope is there for re-shaping the policy or bypassing these legacies?*

  Decision makers involved in governing CHW programs need to consider how these historical legacies may impact a planned policy. A number of tools are available, such as a SWOT (strengths, weaknesses, opportunities, and threats) analysis, which may be useful in approaching this assessment in a systematic way.[12-14]

Wider Health and Political System Goals May Influence How CHW Programs Are Governed

How CHW programs are governed may be influenced by the particular goals or benefits (sometimes called governance outputs) that have been prioritized within a specific health or political system. CHW and other health policies may be assessed by decision-makers in relation to the extent to which they help to achieve these goals or outputs. Such goals may include improved equity, improved responsiveness to population needs, greater efficiency in the delivery of services, more decentralized services, increased employment, or greater involvement of the private sector in the delivery of services.

There are a number of ways in which wider health and political system goals may influence how CHW programs are governed. Firstly, it may be difficult to develop CHW program policies and governance processes where these do not align with wider goals. For instance, developing structures to allow CHWs to work more closely with private sector providers, such as drug dispensers, may not be feasible if such arrangements are not seen as legitimate or important within the wider health system. Similarly, the governance of CHW programs may be neglected if there is a shift in goals in the political system toward increasing the number of providers with

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[2] Governance arrangements are concerned with political, economic, and administrative authority in the management of health systems, as noted above. Financial arrangements include funding and incentive systems, while delivery arrangements include human resources for health, as well as service delivery.

[3] Drawing on political science theory, the term "institutions" is used here to refer to both the formal and informal structures and processes of policymaking (constitutional rules, structures through which decision are made, and features of the policy process, such as the level of transparency). The term "interests" concerns the stakeholders who shape a policy and their views on whether the policy will have benefits or drawbacks for them or others. The term "ideas" refers to the values and knowledge held by stakeholders, including those in government and civil society, and comprises information from both research and experience. [12–14]

higher levels of training, such as nurses and doctors. In contrast, ways of governing CHW programs that align closely with political system goals, such as the decentralization of services, may be easier to develop and implement.

Secondly, health and political system goals may drive the development, or indeed the demise, of a CHW program. In many settings, programs have been developed or scaled up to help achieve the goal of improved equity in access to health services. In Ethiopia, the HEW program aims to improve access to care for rural populations particularly (see Table 3, row 3). In South Africa, efforts by the first democratic government to improve equity and quality in PHC prioritized nurses as the lead cadre and viewed CHWs as giving second-rate care. Consequently, funding and support for CHW programs declined and many programs ceased to function[15] (see Table 3, row 3).

Questions that need to be considered in relation to health and political system goals include:

- What goals are emphasized currently within the health and political system in a particular context?
- To what extent will CHW-related policies help to achieve these goals, and how can this be demonstrated within the policy process?
- What changes need to be made to proposed CHW policies to better align them with relevant governance goals?
- Where CHW-related policies diverge from prioritized governance goals, how can this be justified and advocated for within the policy process?
- Are there role players with political influence who can advocate for CHW programs?

There are a number of ways, both formal and informal, in which these questions may be considered. Those governing CHW programs can reflect on the goals of the program, and those of the wider health and political system, and the extent to which CHW policies will help to achieve these wider goals. Wider consultations, such as deliberative dialogue processes,[10] may be useful in identifying current and future health and political system goals, in considering how CHW policies align with these, and in assessing how the governing of CHW programs may need to shift in order to support important health and political system goals. A number of policy analysis tools are available that may be useful in this process.[16-19]

Additional Factors to Consider Regarding Who Implements Decisions and at What Levels of Government

After a policy decision has been made, the next key challenge is transforming this policy into practical actions. Policy implementation is challenging in most settings for a range of reasons, including the complexity of the health system. The process of implementing policy decisions may involve multiple levels of government, as well as other stakeholders, and the coordination and management of complex processes. Such complex processes may include: 1) limited financial resources or difficulties in disbursing resources to the levels where they are needed, 2) deficits of other resources, including human resources for health care delivery and management, 3) competing priorities within and beyond the health system, and 4) challenging physical environments, such as very remote communities. The implementation of decisions regarding CHW programs may, therefore, take place in an unsystematic way or be slowed by a range of obstacles. Careful and systematic planning is needed to ensure that CHW program policies are implemented as intended.

Questions that can be considered by policymakers when planning the implementation of policies for CHW programs include: [4]

- What factors might affect the successful implementation of the policy? In what ways can potential barriers be overcome or minimized and facilitators harnessed?
- Is there a clear implementation plan for the policy that includes the objectives to be achieved, adequate resources, and a timeframe, and that addresses important barriers and facilitators? There are additional issues to be considered here:
    - What is the extent of decentralization for the implementation of CHW policies? Which stakeholder(s) will lead and which level(s) of government and other agencies need to be involved?
    - What strategies should be considered in planning implementation of the policy in order to facilitate the necessary changes among health care recipients, health care professionals, organizations, and the health system?
    - How will implementation of this policy affect the day-to-day running of ongoing CHW (and other) programs?
    - To what extent will communities and CSOs be involved, and how will this be operationalized? (See Box 3 below and Chapter 12 on relationships with communities.)
- How will implementation ensure that key governance goals, such as equity, participation, and accountability, are maximized?
- How will implementation of policies be monitored and evaluated to ensure that their objectives are met? (Also see Chapter 4 on planning for CHW programs.)

Box 3. Community involvement in CHW program implementation in Zimbabwe[8]

Studies analysing the implementation of the Village Health Worker (VHW) program in Zimbabwe provide in-depth analysis of why such local citizen bodies may have failed to stimulate meaningful community involvement. These studies suggest that the government, while attempting to redirect resources to the village level, developed an increasingly large bureaucracy that reinforced centralization of power, and local citizen bodies became extensions of the central government structures. People's representation was supposed to be mediated through village and district committees. However, these structures were regarded by communities as remote and as a part of civil service structures that were accountable to the government, and not to poor people within communities. Effective popular mobilization in the planning and development of the VHW program was seen to have declined inversely in relation to the bureaucratization of the program.

WHAT LAWS AND REGULATIONS ARE NEEDED TO SUPPORT THE PROGRAM?

The governing and implementation of CHW programs may be shaped or constrained by existing laws or regulations[5] in relation to, for instance, the organization of health services, human resources, drugs, technologies, and financing. As noted above, these "policy legacies"[20] may include regulations regarding the kinds of health care providers who can prescribe and dispense

[4] Adapted from [2,13]

[5] A law can be defined as "a rule of conduct or action prescribed or formally recognized as binding or enforced by a controlling authority" (From: www.merriam-webster.com/dictionary/law Accessed 26 June 2013). A regulation can be described as "A law on some point of detail, supported by an enabling statute, and issued not by a legislative body but by an executive branch of government" (From: www.duhaime.org/LegalDictionary/R/Regulation.aspx , accessed 26 June 2013).

different types of medications. These legacies may also include laws regarding the disbursement of funds from health departments to community structures that may be responsible for supporting CHWs.

Further, CHW programs may experience challenges if laws and regulations that are needed to enable effective program functioning are not put in place in a timely manner or if existing laws and regulations are not amended as needed. For example, regulations in Brazil regarding the need to advertise civil service posts nationally were changed to help ensure that CHWs employed by the Family Health Program came from the community in which they were to work.[21] In South Africa, it has been argued the functioning of CHW programs was hampered by poor regulation that limited the rights of CHWs and contributed to low pay levels.[22]

Appropriate legal and regulatory frameworks are, therefore, needed for large-scale programs to function effectively.[23] These need to address issues related to CHWs, such as selection and remuneration, as well as issues related to the wider health system, such as governance structures for PHC. As such, those developing and scaling up CHW programs need to consider which existing laws and regulations need to be taken into account and whether changes to them are needed to ensure the effective governing of the program and its implementation as intended.

Questions that should be considered in relation to laws and regulations:

- Which laws and regulations are relevant to the governing and scale-up of CHW programs?
- How are these laws and regulations translated into rules and procedures that may affect program implementation in the field, and who has responsibility for this?
- Will any changes be required to these laws and regulations to allow the program to be scaled-up as intended? Will any new laws and regulations be needed?
- Where laws or regulations need to be promulgated or amended, which government bodies would be responsible for leading this process? Which other bodies would need to be involved in this process? Are there key laws or regulations that may act as critical barriers or bottlenecks to policy implementation and that should be priorities for promulgation or amendment?
- What is the likely timeframe for these legislative or regulatory processes?
- Can scale-up be implemented in parallel to changes in laws and regulations?

HOW SHOULD THE PROGRAM BE ADAPTED ACROSS DIFFERENT SETTINGS OR GROUPS WITHIN THE COUNTRY OR REGION?

For CHW programs operating at scale, there may be tension between, on one hand, adopting a fairly standard approach to the governing of programs and to their implementation and, on the other hand, trying to ensure that the program is tailored to the needs of different settings or groups. The former approach may allow for more rapid scale up and may require fewer resources. The latter approach, while more resource intensive and more difficult to implement, may help to ensure that the program is seen as useful by local communities and health services, may be more sustainable,[24, 25] and may have a greater impact in the medium to long term.

There are a number of reasons why programs may need to be adaptable. Firstly, different population groups within a country may have very different health and therefore program needs. Secondly, programs may need to be adapted for particular local contexts, such as remote areas with poor physical access where operational challenges differ dramatically from more densely populated urban areas. Thirdly, CHW programs may need to be adapted to local or regional health system arrangements, such the availability of other health care providers in the

area, the presence of private drug sellers or other sources of drugs, or the extent of private sector health care provision.

Questions that need to be considered:

- Is the program targeted toward specific groups or settings in the country or region?
- Are there important differences across groups or settings in the country or region that may affect the roll-out of the program and that may require its adaptation?
- If the program is to be adapted:
    - What are the specific needs of these groups or settings; what barriers do these groups experience in accessing the program; and what challenges might be encountered in adapting the program to their needs or setting?
    - Which are the core elements of the program that should be retained across settings or groups and which elements can be adapted to address specific needs?
    - To what extent does adaptability need to be built into the program policy?
    - Which entities will have responsibility for adapting the program in response to local needs?
    - Will the adapted program need to be piloted before it is scaled up?

ADDITIONAL CONSIDERATIONS

Other issues that may be important to consider in relation to governing CHW programs at scale include the requirements that scale-up of the program might impose on the health system (including managers, health care providers, and users) and on other sectors. Factors affecting the sustainability of the program, and ways in which national, regional, and international stakeholders can be mobilized to support a national CHW program. These issues are discussed further in the chapters on relations with the health system (Chapter 11), on financing (Chapter 12), and on planning (Chapter 3).

CONCLUSIONS

Governing CHW programs can be complex because of the location of these programs between the formal health system and communities, and the involvement of a wide range of stakeholders at local, national, and international levels. CHW programs frequently fall outside of the governance structures of the formal health system or are poorly integrated with it.

The most appropriate and acceptable model(s) for governing CHW programs depends on the community, on local health systems, and on the political context of the program. Policymakers and other stakeholders in each setting need to consider what systems are currently in place and what might work in their context, and develop a locally tailored governance approach.

Where community or local participation is well-established, models of community governance and accountability may be appropriate and useful for CHW programs. Where local participation in governance is not well-established (e.g., because governance of the health and political systems are highly centralized) or is weak, stakeholders need to explore other mechanisms for accountability.

It is challenging to include a very local participatory structure for governing a CHW program within a large-scale program, and there are few sustained examples of this. For large-scale programs, formal local governance structures, such as elected local government councils, may

need to be relied on. Stakeholders need to consider how to organize CHW program governance in such contexts.

Ultimately, local participation in governing CHW programs is difficult to achieve at scale without substantial resources, adequate planning, and sustained attention to maintaining these local structures. Stakeholders must consider what resources are needed and how these can be made available.

Table 2: Governing CHW programs – key questions and sub-questions

KEY QUESTIONS	SUB-QUESTIONS
How, and where within political structures, are policies made for CHW programs?	*Where are policy decisions made?* ▪ Where are laws and regulations relevant to health initiated? Do laws need to be initiated by cabinet or parliament? Can other stakeholders initiate laws or regulations through other mechanisms? ▪ Who can initiate such laws and regulations? Do laws need to be initiated by a government minister or a ministerial permanent secretary? *Who are the stakeholders involved in defining and designing these policies (participation), and to what extent is this done in a collaborative manner (consensus orientation)?* ▪ Who are the key stakeholders for policies related to community health services? ▪ To what extent are these key stakeholders consulted and involved in policy making for community health services? To what extent is there a consensus orientation in which government authorities cooperate with other stakeholders in policy development? ▪ How are inputs solicited from stakeholders? ▪ How are the varied objectives, motivations and views of different stakeholders reconciled within the policy process? *Are there important historical legacies that may shape CHW-related policy making?* ▪ Are there important health system legacies in relation to governance, finance or service delivery that may shape CHW-related policy making? ▪ Are there important political system legacies in relation to institutions, interests or ideas that may shape CHW-related policy making? ▪ To what extent are these historical legacies in alignment with the planned policy? What scope is there for re-shaping the policy or bypassing these legacies? *How might wider health and political systems goals in a particular context influence how CHW programs are governed?* ▪ What goals are emphasized currently within the health and political system in a particular context? ▪ To what extent will CHW-related policies help to achieve these goals, and how can this be demonstrated within the policy process? ▪ What changes need to be made to proposed CHW policies to better align them with relevant governance goals? ▪ Where CHW-related policies diverge from prioritized governance goals, how can this be justified and advocated for within the policy process? ▪ Are there role players with political influence who can advocate for CHW programs?

KEY QUESTIONS	SUB-QUESTIONS
Who implements decisions regarding CHW programs, and at what levels of government?	▪ What factors might affect the successful implementation of the policy? In what ways can potential barriers be overcome or minimized and facilitators harnessed? ▪ Is there a clear plan for implementation of policy decisions that includes the objectives to be achieved, adequate resources, and a timeframe, and that addresses important barriers and facilitators? ▪ How will implementation ensure that key governance goals, such as equity, participation and accountability, are maximized? ▪ How will implementation of policies be monitored and evaluated to ensure that their objectives are met?
What laws and regulations are needed to support the program?	▪ Which laws and regulations are relevant to the governing and scale up of CHW programs? ▪ How are these laws and regulations translated into rules and procedures that may affect program implementation in the field, and who has responsibility for this? ▪ Will any changes be required to these laws and regulations to allow the program to be scaled up as intended? Will any new laws and regulations be needed? ▪ Where laws or regulations need to be promulgated or amended, which government bodies would be responsible for leading this process? Which other bodies would need to be involved in this process? Are there key laws or regulations that may act as critical barriers or bottlenecks to policy implementation and that should therefore be priorities for promulgation or amendment? ▪ What is the likely timeframe for these legislative or regulatory processes? ▪ Can scale-up be implemented in parallel to changes in laws and regulations?
How should the program be adapted across different settings or groups within the country or region?	▪ Is the program targeted toward specific groups or settings in the country or region? ▪ Are there important differences across groups or settings in the country or region that may affect roll out of the program and that may require its adaptation? ▪ How will the program be adapted, if this is needed?

Table 3: Cross-country comparison of CHW program governance[6]

	KEY GOVERNANCE CONSIDERATIONS	RELEVANCE AND IMPORTANCE OF THE ISSUE	COUNTRY				
			BRAZIL FAMILY HEALTH PROGRAM	PAKISTAN LADY HEALTH WORKER PROGRAM	INDIA ASHA PROGRAM	SOUTH AFRICA WARD-BASED PRIMARY HEALTH CARE (PHC) OUTREACH TEAMS	ETHIOPIA HEALTH EXTENSION PROGRAM
Inception year (as a national program)			**1994**	**1994**	**2005**	**2011**	**2003**
Cadres	Is there one or are there several cadres?	Historical experiences, both negative and positive, may shape views and responses. Diversity and unclear boundaries can lead to conflict among cadres and/or gaps in provision	Community Health Agent (CHA)	Lady Health Worker (LHW)	Accredited Social Health Activist (ASHA)	Community Health Worker	Health Extension Workers (HEWs) Health Development Army (HDA, formerly called Community Health Promoters, or CHPs) Various other CHW cadres including Community-Based Reproductive Health Agents (CBRHAs) and HIV lay counselors
Size of the program	Is this a national or small-scale local program?	Size and scope of program impacts on the complexity of governing the program	236,000 working in 33,000 family health care teams	100,000	820,000 ASHAs have been selected (across 31 States and Union Territories)	Prior to project initiation there were around 72,000 CHWs, attached to various NGOs and programs	>34,000 HEWs; >100,000 CHPs in 15,000 *kebeles* (communities)

[6] The information in this table is drawn from the case studies in the Appendix at the end of this guide.

	KEY GOVERNANCE CONSIDERATIONS	RELEVANCE AND IMPORTANCE OF THE ISSUE	COUNTRY				
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Inception year (as a national program)			**1994**	**1994**	**2005**	**2011**	**2003**
Historical legacies	Are there important health system legacies in relation to how programs are governed, and in terms of key players and specific institutions, financial or delivery arrangements that may shape CHW policy-making? To what extent are these historical legacies in alignment with the planned policy? What scope is there for building on or re-shaping the policy or bypassing these legacies?	Historical legacies may define, constrain or facilitate CHW policies. Policy may be shaped by previous experience or existing practices. Legacies will determine what actors think of policy and how they will enact and react to it	The program has its antecedents in a regional program in Ceará State, where it emerged from an emergency response to a severe draught. [26]	In 1993 Pakistan established the Prime Minister's Program for Family Planning and Primary Health Care that employed CHWs to provide primary health care services in their communities. The program subsequently only employed female CHWs and the Lady Health Worker (LHW) program was developed in 1994.	ASHAs are the most recent incarnation of community health workers (CHWs) in a long history of national and state-level CHW programs in India. In many states, the ASHA program built upon pre-existing CHW programs. The Chhattisgarh Mitanin CHW program, launched in 2003 as a precursor to the ASHA program, has retained the name "Mitanin" for their health workers but has otherwise been encompassed by the ASHA program.	South Africa has never had a large-scale, national community health worker program, but has had numerous smaller and larger CHW projects since the 1980s. In the 1990s and early 2000s these CHWs often worked as volunteers and single-purpose workers, with insecure funding. The present emerging national program builds on this "stock" of CHWs and their experience.	In the 1997/8 fiscal year the Ethiopian Federal Ministry of Health launched the National Health Sector Development Program (HSDP). This program shifted the health system's focus from predominantly curative to more preventive and promotive care and prioritized the needs of the rural inhabitants who constitute 83% of the Ethiopian population. The "Accelerated Expansion of Primary Health Care Coverage" and the Health Extension Program (HEP) was launched in 2003.

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Inception year (as a national program)			**1994**	**1994**	**2005**	**2011**	**2003**
Health system structure	How does CHW policy fit into wider health governance structures?	CHW programs in many settings remain peripheral to the rest of the health system. This undermines their legitimacy, hampers alignment of tasks and responsibilities, and may cut them off from mainstream funding sources.	There are three levels of health care provided in Brazil with strong emphasis on basic (primary) health care. This care is the entry point to more advanced care, but also has promotive and preventive components. Family Health Care Teams are the main service providers and are comprised of one doctor, one nurse, one auxiliary (assistant) nurse, and a minimum of four community health workers.	There are three tiers of governance in the Pakistani public health system: federal, provincial and district. Responsibility for health services rests with provinces, with the exception of a national Ministry of Regulation. The district level is responsible for allocation and supervision of LHWs. All tiers of government are involved in the LHW program, and LHWs are integral to service delivery of most community health initiatives in the country.	The rural public health system is designed from the village to the state level. In addition to an ASHA worker, each village should have an Anganwadi Worker (AWW). A multipurpose worker (MPW) and an auxiliary nurse midwife (ANM) are employed to conduct outreach to villages on a monthly basis. The MPW works out of the sub-center, a clinic that serves several villages. The ANM is based in the primary health center (PHC), a larger clinic that is to be open 24/7 and includes a doctor. Referrals can be made from there to the community health center (CHC) and district hospital.	South Africa introduced a district health system shortly after its first democratic election in 1994. The most recent health sector reforms, aiming at revitalizing PHC, have introduced community health services consisting of clinics, school health teams, specialist teams, and PHC outreach teams at community and household levels. First- level hospital care is rendered through district hospitals, and referrals take place from these to secondary and tertiary hospitals.	The Ethiopian health system is decentralized and has been reorganized into three tiers: (1) primary healthcare units comprised of a health center and five satellite health posts along with district/*woreda* hospitals; (2) zonal/general hospitals; and (3) specialized/referral hospitals.

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Inception year (as a national program)			**1994**	**1994**	**2005**	**2011**	**2003**
Structure of the program	How is the program integrated/aligned with the formal health system?	Signals how the program is located in the governance structures of health system.	CHAs operate as members of the family health care teams (*Equipo de Saúde Familiar*) that are managed by municipalities. These teams are based within the Family Health Program clinics and provide services to 600-1,000 families or a maximum of 4,500 people.	LHWs are attached to a local health facility, but they are primarily community-based, working from their homes. The homes of LHWs are named Health Houses, and emergency treatment and care are provided from these houses.	ASHAs are based in their villages but refer people to their local CHC and PHC. Village Health and Sanitation Committees (VHSCs), composed of village residents including the ASHA, also provide support for the ASHA's activities (see: Local Governance). Although service delivery varies by state, in general, ASHAs are expected to attend weekly meetings at their local PHC and make home visits in the community as needed. They work approximately 2 hours a day, four days per week.	The new system for the first time sees CHW as part of the system of service delivery. Similar to the Brazilian model, PHC outreach teams consist of 5-6 CHWs supervised by a nurse. They render services in households and communities, and refer patients to clinics as needed.	The aim of the HEP is to "provide equitable access to promotive, preventive and select curative health interventions through 30,000 government-salaried Health Extension Workers (HEWs), two per *kebele* (neighborhood), located at a health post. The HEWs, young local women with grade 10 education, are recruited by Kebele and Woreda Councils and given one year of training prior to employment with the Woreda Health Office.

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Inception year (as a national program)			**1994**	**1994**	**2005**	**2011**	**2003**
Employment status of CHWs	*Are CHWs employees of the state and/or appointed by communities?*	*Signals who CHWs are accountable to, and how firmly embedded they are in structures of the health system.*	State employees	State employees	Considered volunteers but receive a government stipend.	Employed by NGOs who in turn have service contracts with state health services at district level.	State employees
Program financing	*How are CHW programs financed?*	*How CHW programs are financed reflects both national and local priorities and is also a key governance mechanism.*	The Family Health Program is co-funded by states and municipalities, but regulated by the national government. The CHW program is an integral part of Family Health Program and thus funded as part of it.	The Pakistani government is the largest funder of LHW services, although the program has been underfunded since its inception. The vast majority (around 70%) of the costs are comprised of LHW stipends, drugs and contraceptives. 4% of overall costs are for training.	In 2006, the MoHFW stipulated that the program would cost US$185 per ASHA. This included the costs of selection, social mobilization, training, drug kits, identity cards and support for ASHAs through the PHCs and supervisors. It did not include the ASHAs' stipends, which were to come from the budgets of other MoHFW initiatives.	In the past, programs were largely funded from external grants. The new program will increasingly be funded through the health budget.	Financed by a mix of national and sub-national government entities, bilateral and multilateral donors, non-governmental organizations, private contributions, along with user fee revenues. At the local level, financing and planning are decentralized and the *woredas* receive block grants to cover HEP expenses.

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Inception year (as a national program)			**1994**	**1994**	**2005**	**2011**	**2003**
Program scale-up	*Will the program be taken to scale and, if so, how will this occur?*	*CHW programs generally aim to improve access to and quality of health care for remote and poor communities.*	In 1990 there were 78,805 CHAs and there are now over 236,000 CHAs that provide services to 98 million people within 85% of Brazil's municipalities.	A 2000 evaluation estimated that 150,000 LHWs were needed to obtain optimal coverage in the country. Since then there has been a consistent scale-up, to 90,074 in 2008. This increased LHW coverage in more rural and poorer areas, but the program still does not reach the most disadvantaged areas…	Initially (2005-2008) the ASHA program was a component of the National Rural Health Mission only in 18 "High Focus States" and in the tribal districts of other states. In 2009 the program was extended to cover the entire country. The target number of ASHAs is 888,650; 94% have now been selected.	The intention is to roll the program out nationally. Numerous pilot sites are operational at this stage and are being carefully monitored and evaluated.	There have been four HSDPs since its inception in 1997. Rollout has occurred in a step-wise manner, in which the speed was influenced by available resources for health posts and presence of eligible women to become HEWs.

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Inception year (as a national program)			**1994**	**1994**	**2005**	**2011**	**2003**
Local (community) governance	*How are communities involved in decision-making about CHW activities at local level? Are they involved in selection? Can they hold CHWs to account? Can they influence decision-making about funding, support, etc.?*	*Community acceptance and therefore community participation is considered central to any CHW program, but mechanisms of community participation in governing programs are often poorly developed and dysfunctional.*	Community governance functions through national, state and municipal health councils, over 5,500 municipal councils participating. Councils are comprised of 50% users, 25% health workers and 25% health managers and service providers. Health conferences are also held every four years to propose directives for health policies.	The selection committee for LHWs includes a person nominated by the local community, and potential LHWs are identified through local community structures were possible. Program planning, implementation and monitoring and evaluation also should include community participation. However, the extent to which this occurs varies.	ASHAs are to be selected by and accountable to the local village level government, called the Gram Panchayat, through a participatory process involving the whole village. After selection, ASHAs are to work closely with the Village Health and Sanitation Committee (VHSC). This committee is comprised of key stakeholders in the village.	All health districts have district health councils who have representation from civil society. Implementation is at an early stage and uneven throughout the country. Furthermore, community health committees are supposed to oversee the functioning of service delivery in communities and facilities.	There are active health committees involved in the selection and oversight of HEWs and they are involved in these activities with CHPs in some geographical areas. Additionally, the *kebele* council is supposed to be involved in every step of the HEP from program planning through to evaluation.

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Inception year (as a national program)			**1994**	**1994**	**2005**	**2011**	**2003**
Relationship with the formal health services	What are lines of reporting and accountability? What is the level of integration?	In many CHW programs, links with the formal health services are tentative and not well thought through. Professionals at the first formal level of service delivery (health centers, etc.) often resist engagement with and support for CHWs.	CHAs are managed by local nurses who spend half their time working in the local clinic. Thus, CHAs are closely integrated into formal health services. They also have strong referral systems in which they report any ill person within their catchment area to a nurse.	All LHWs are attached to a First Level Health Facility in the form of either a rural health center or a basic health unit. LHWs generally receive their supplies from these facilities, although there are challenges with insufficient staff and stock outs at local clinics.	Although ASHAs are supposed to be representatives of and accountable to the people, they receive their payments through the ANM at the PHC and are often treated as extensions of the health system.	CHWs are managed by nurses and structurally linked to the formal health services. Prior practices and experiences were very mixed and dependent on links between NGOs and health services. They were often dependent on personal relationships as well.	HEWs are full members of the formal health workforce. They staff health posts and are responsible for CHPs and model families. Many HEWs work in hard-to-reach and isolated areas, where supervision, supplies and referrals remain a challenge.

Table 4. Governance structures and mechanisms in relation to the definition, selection, training, support and remuneration of individual CHWs[7]

GOVERNANCE ISSUE	BRAZIL	PAKISTAN	INDIA	SOUTH AFRICA	ETHIOPIA
CHW Criteria	CHAs are adults who work in the community where they are from/ permanently reside. The only other selection criterion is completion of primary school.	LHWs are females who have a minimum of eight years of education. They also must be between 18 and 45-50 years old, reside in and be acceptable to/ recommended by their community, and preferably be married with children.	ASHAs are to have class eight education or higher and preferably be between the ages of 25 and 45. ASHAs are to be "daughter-in-law" of the village, i.e., married women (or widowed or divorced) so that they are likely to live in the village for the foreseeable future.	Criteria for selection vary, but in most cases, cadres who were active through NGOs prior to the introduction of a national program are being drawn on to continue rendering services.	HEWs are adult females who have completed 10th grade. HEWs are supposed to work in or close to their native community/ permanent residence.
Selection Process	CHAs are hired by their municipalities based on their demonstrated abilities while addressing simulated community problems during the selection process.	LHW are selected using a clearly delineated process. LHW posts are advertised and applicants are then interviewed and selected based on pre-set criteria by a selection committee.	Local governance structures and the wider community should be involved in ASHA selection. However, these selection processes are not always adhered to.	Selection processes vary widely, depending on the NGOs who contract with the CHWs.	There are active health committees that are involved in the selection of HEWs from the local community. CHPs are nominated and elected by the community or selected by HEWs and approved by the community.
Scope of Work	One of the goals of the Family Health Program is to promote community engagement and to analyze the community's needs. Thus, CHAs are expected to serve as the link between the Family Health Care Teams and the surrounding community. *Family Health Care Teams provide comprehensive care through promotive, preventive, recuperative, and rehabilitative services. Central services provided by CHAs include the promotion of breastfeeding, the*	LHWs are expected to link the community to formal health services and to be members of the community where they work. They also provide a range of community development services and participate in community meetings. The LHW program has evolved over time. LHWs' scope of services has grown from an initial focus on mostly maternal and child health; it now also includes participation in large health campaigns,	The government of India describes the ASHA's role as having three key components. First, ASHAs are to play an important role in achieving national health and population policy goals. Second, they are to act link rural people with the health system. Third, they are to serve as social change agents who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability	A PHC outreach team will initially be responsible for: ▪ Identifying and capturing details of people who live in the households in the catchment area and assessing those who are most at risk; ▪ Providing health promotion and prevention; ▪ Testing for HIV and screening for	HEWs are full-time employees who are supposed to split their time between health posts and the community. HEWs should spend at least 80% of their time in these community-based activities, although considerable anecdotal evidence suggests this is not the case. HEWs' main role is in health promotion, disease prevention, and treatment of uncomplicated and non-

[7] The information in this table is drawn from the case studies developed for this series of chapters (see Appendix 1).

GOVERNANCE ISSUE	BRAZIL	PAKISTAN	INDIA	SOUTH AFRICA	ETHIOPIA
	provision of prenatal, neonatal and child care, the provision of immunizations, and the clinical management of infectious diseases, including screening for and providing treatment for HIV/AIDs and tuberculosis. CHAs register the households in the areas where they work and are also are expected to empower their communities and link them to the formal health system.	newborn care, community management of tuberculosis and health education on HIV/AIDS.	of the existing health services. Anganwadi Workers (AWWs) provide basic child health information, medicine and nutritional supplementation to children younger than 6 years of age, pregnant and lactating women, and adolescent girls.	TB; ▪ Checking immunization status of children; ▪ Facilitating use of antenatal care early in pregnancy and use of contraception; and ▪ Responding to the local burden of disease.	severe cases of malaria, pneumonia, diarrhea, malnutrition and measles in the community. HEWs provide a range of services including: prevention/health promotion/health education role; support role for outreach work by health services; community-based distribution role that does not involve clinical judgment; clinical case-management role that involves exercising clinical judgment; ongoing care or support role to assist people with a chronic illness (e.g., HIV/AIDS); and participation or support role in campaign-type activities. They also provide immunizations, injectable contraceptives, basic first aid, as well as diagnosis and treatment of malaria, diarrhea and intestinal parasites.
Training	The national Ministry of Health –with Ministry of Education approval – is responsible for the training of CHAs in Brazil and trains them in regional health schools. CHAs receive eight weeks of training from local nurses, followed by four	LHWs are trained for three months on PHC in classrooms and then have one year of on-the-job training. This should include one week of training per a month for a period of 12 months and 15 days of refresher	ASHAs are to receive 23 days of training over their first year, based on five training manuals. They are then to receive 12 additional days of training each year thereafter. Two additional training modules have just been added to the training	The training existing CHWs have received varies widely, and has been provided by a wide range of NGOs and training providers. The MOH is now aiming to standardize training,	HEWs have more than one year of pre-service training conducted by trainers that were capacitated using a train-the-trainer approach. HEW training is a collaboration of the Ministry of Health and

GOVERNANCE ISSUE	BRAZIL	PAKISTAN	INDIA	SOUTH AFRICA	ETHIOPIA
	weeks of supervised field work. This includes training on home visits, how to conduct a family census, and then on specific priority health care interventions. CHAs receive monthly and quarterly ongoing education training during meetings. CHAs are also trained by nurses and state health secretariat staff in their local clinics; these trainers undergo an 80-hour training module.	training each year, although there is substantial variation in training patterns across provinces. The Federal Project Implementation Unit is responsible for approval of all LHW training and, with the Ministry of Health, develops training curriculum, organizes and coordinates training, and trains master trainers while Provincial and District Project Implementation Units are responsible for the local trainings.	regimen. ASHA training has in some states been outsourced to NGOs, and in other states is being conducted by health professionals within the public system. Training generally takes place in a cascading manner, by which state teams are trained and then pass on their training knowledge to district training teams. These district teams then pass on their training to block-level ASHA trainers. ASHAs are then to be trained at the block or sub-block level.	although this process is still awaiting finalization.	the Ministry of Education and occurs at 40 Technical and Vocational Education Training Schools. CHPs have a brief initial training that is conducted by the HEWs that is less than 3 weeks in length. Women from model families are given 96 hours of training on prevention of communicable diseases, family health, environmental and household sanitation, and health education.
Feedback and Supervision	CHAs are supervised by nurses and physicians from the local health centers. Supervisory nurses spend 50% of their time in these supervisory roles and the rest of the time staffing the local health center, a factor that has been identified as a critical component to the program's success.	Supervision is highly organized and tiered in the Pakistani LHW program. LHWs are each attached to a public health clinic and are supervised on a monthly basis by a LHW supervisor (LHS). There are two layers of supervision above the LHS. LHWs should have community-based supervision at least once a month in which supervisors meet with clients and with the LHWs in the community where the LHW works, review the LHW's work, and jointly make a work plan for the next month.	According to national guidelines, there is to be one ASHA Facilitator for every 20 ASHAs. The Facilitator is to help with the selection of the ASHA, run monthly ASHA meetings, establish a system to respond to ASHA grievances, accompany ASHAs on home visits, maintain records of ASHA activities, attend Village Health and Nutrition Days with the ASHAs, and attend monthly Block PHC meetings. The ASHA facilitator is supervised at the Block level by the Block Community Mobiliser, who is in turn supervised by the District Mobilization / Coordination Unit, which liaises with the state-level	Feedback and supervision is presently provided through NGOs but will in future be provided through the nurse supervisor attached to every outreach team.	HEW supervision appears to vary across the history of the program and geographical contexts. In 2005 HEWs had relatively high levels of supervision with an average of three supervisory visits over the course of nine months. There are supposed to be multiple levels of HEW supervision, including the *woreda* supervisory team that is comprised of a health officer, public health nurse, environmental/ hygiene expert, and a health education expert.

GOVERNANCE ISSUE	BRAZIL	PAKISTAN	INDIA	SOUTH AFRICA	ETHIOPIA
			ASHA resource center.		HEWs supervise other cadres such as CHPs, traditional birth attendants, and Community-based Reproductive Health Agents.
Compensation/ incentives	CHAs are salaried, full-time workers, but there is a large variation throughout the country in their salary. CHAs are supposed to earn at least the national minimum wage of ~US$112 each month.	LHWs receive a salary of about $343 per year and are not supposed to engage in any other paid activity, although some do. The LHW stipend is often the only source of family income and is a critical family support.	Although ASHAs are considered volunteers, they receive outcome-based remuneration for facilitating institutional deliveries, immunization, family planning (surgical sterilization) and toilet construction. More recently, an incentive of US$4.60 (Rs.250) has been established for providing home- based newborn care. Facilitating institutional deliveries is the most common activity for which ASHAs receive payments. ASHAs are also compensated for training days, attending meetings, and additional health-related activities. The amounts vary from state to state.	In most provinces in South Africa, NGOs receive funding from the MOH to contract with and pay CHWs. More recently, at least one province has decided to contract with CHWs directly and put them onto the government payroll. Salaries are approximately at the national minimum wage.	HEWs are regular employees with a regular salary and benefits. A range of non-financial incentives have been effective with CHPs, including formal recognition, ongoing mentorship, certification, and community celebrations.
Career opportunities	No structured opportunities for career advancement for CHAs exists.	The LHW Program offers professional advancement opportunities for LHWs. LHWs can receive additional training to serve as a LHS, which is an incentive for good performance.	Career advancement within the program for ASHAs is limited.	The issue of career development is not addressed in the new policy, but in several provinces pilots are underway to provide career paths into professions such as nursing and social work.	HEWs who enroll in additional training can qualify as registered nurses.

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