

Toward Harmonization: Community Health Policy and Program Trends

Data from the Community Health
Systems Catalog



Advancing Partners & Communities

Advancing Partners & Communities (APC) is a cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. APC is implemented by JSI Research & Training Institute, Inc. in collaboration with FHI 360. The project focuses on advancing and supporting community programs that seek to improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning. APC provides global leadership for community-based programming, executes and manages small- and medium-sized sub-awards, supports procurement reform by preparing awards for execution by USAID, and builds technical capacity of organizations to implement effective programs.

For more information

Please visit the Community Health Systems Catalog at www.advancingpartners.org/resources/chsc

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Table of Contents

What is APC?	2
The Community Health Systems Catalog	4
Approach and Definitions of Terms	7
Leadership & Governance	9
Health Financing	11
Human Resources for Health	14
Service Delivery	36
Health Information Systems	49
Supply Management	54
Cross cutting Areas	61
Key Takeaways	65
Considerations for Harmonizing Community Health Systems	66



What is APC?

The Advancing Partners & Communities (APC) project is funded by the United States Agency for International Development (USAID). Since 2012, it has operated globally to support community programs that seek to improve health outcomes, especially related to family planning.

APC provides global leadership for community-based programming, executes and manages small- and medium-sized sub-awards, and builds capacity of organizations to implement effective programs.

APC designs and applies practical tools and approaches to advance knowledge, planning and implementation for strengthened, integrated and aligned community health programs.





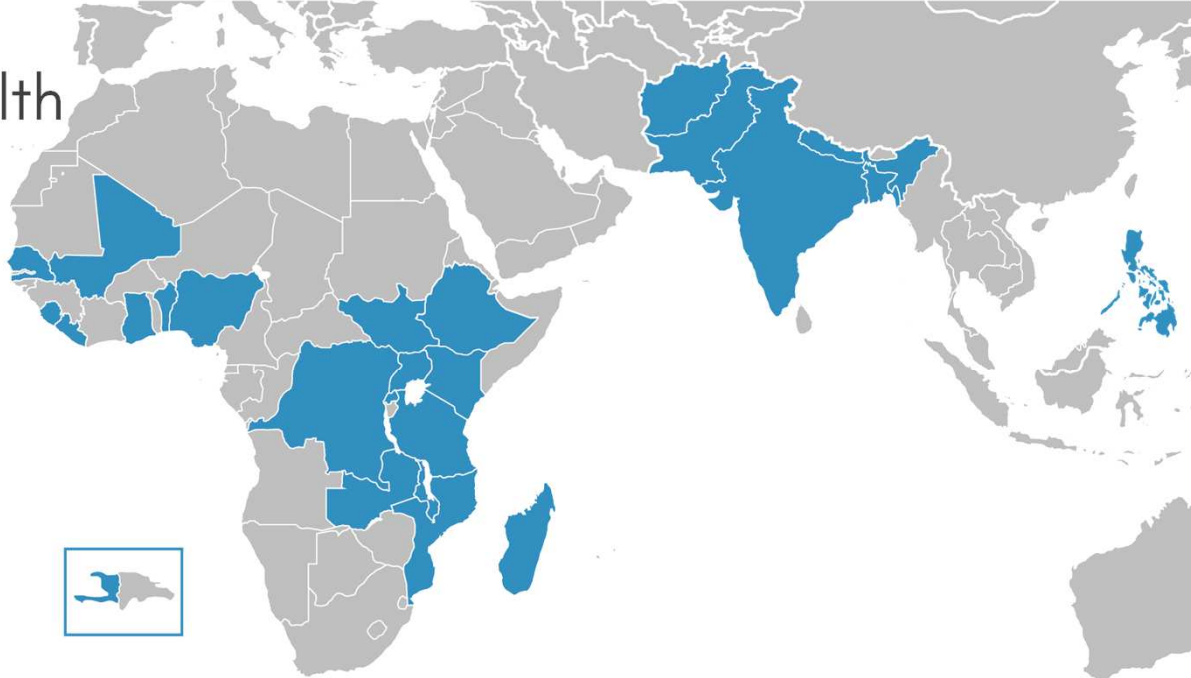
Supporting a Harmonized Approach to Community Health

With a vision towards universal health coverage and commitment to the Sustainable Development Goals, global efforts have been underway to develop a common framework to harmonize and reduce fragmentation in community health programs. In 2013, the World Health Organization (WHO) called for a “3 Ones Approach”: One National Strategy, One Coordinating Body, One Monitoring & Evaluation Framework, to align community health programs.

Many countries recognized that fragmentation was limiting their ability to strengthen and expand community health services and committed to harmonization efforts. However, few resources and information were available to help guide their policy design and scale-up strategies.

In 2014, APC developed the Community Health Systems (CHS) Catalog to address information gaps, advance the WHO’s vision, and help ensure the inclusion of community-based family planning within national agendas. In 2016–2017, APC updated the CHS Catalog and expanded it to include additional health areas such as nutrition and maternal, newborn, and child health.

The Community Health Systems Catalog



The [Community Health Systems \(CHS\) Catalog](#) is a resource that provides information on community health programs, workers, and interventions for the 25 countries deemed priority by USAID's Office of Population and Reproductive Health. It comprises a compilation of 25 country profiles developed from a desk review of community health policies, strategies, and related documentation.

This document summarizes country trends drawn from the CHS Catalog and highlights interesting and relevant findings about the global community health policy landscape.

25 FOCUS COUNTRIES

Afghanistan	India	Pakistan*
Bangladesh	Kenya	Philippines
Benin	Liberia	Rwanda
Democratic Republic of the Congo (DRC)	Madagascar	Senegal
Ethiopia	Malawi	Sierra Leone
Ghana	Mali	South Sudan
Haiti	Mozambique	Tanzania
	Nepal	Uganda
	Nigeria	Zambia



Amy Lee/CCP, Courtesy of Photoshare

Using the CHS Catalog and this Document

Before the CHS Catalog, guidance for community health systems was not widely available and had never been synthesized across countries. The information in the CHS Catalog and this summary document serves several purposes:

- Provides **an overview of community health systems** across 25 countries to contribute to policy and program planning, research, and general interest in community health topics.
- Showcases a range of **innovative community health models**, including which types of health workers can provide specific services. This data can inform country-level policy and program design, which is crucial as countries strategize to scale up community health programs and achieve national goals (e.g., Sustainable Development Goals, FP2020 commitments).
- Advances the dialogue on **task-sharing and -shifting** by facilitating comparison of community health worker (CHW) interventions across cadres and countries.
- Highlights where **policy guidance** may be incomplete, unclear, and/or outdated.

Considerations for Use

- The CHS Catalog (and therefore the cross-country data presented in this document) synthesizes available policy guidance for each country's community health system between 2016 and 2017. Thus, it captures a **snapshot in time**.
- Because the CHS Catalog documents content from community health policies, it does not necessarily reflect implementation realities, experiences, or lessons. Rather, it distills **policy inputs** that guide program implementation.
- Because informal CHW cadres tend not to be mentioned in policy, they are not included in the CHS Catalog. However, **informal cadres can play significant roles** in reaching last-mile communities, so their contributions should not be overlooked.



Approach and Definition of Terms

What is a 'community health provider'?

The definition of a CHW varies within and across countries, and over the years has evolved to mean different things. There is also a range of CHW roles. In some places, CHWs may only promote healthy behaviors, while in others they may provide curative health services. Some focus on a single health area; others deliver a more comprehensive package of products and services. CHWs may work in the community, from a community-based facility, or both. Thus, variations in CHW definitions and scopes apply worldwide.

Because there is no single adopted definition of CHWs across countries, the CHS Catalog and this document use a broader term, 'community health provider,' for all cadres, from community health volunteers with only basic training to more skilled, facility-based community health specialists. Country-level consultants and other local experts identified which cadres to include in the CHS Catalog based on this wide interpretation. This document uses specific cadre names when referring to individual countries.

What does 'policy' mean?

For the purpose of the CHS Catalog, APC applied a broad definition of 'policy' that includes national and subnational-level policies, strategic plans, training curricula, and other documents that guide the development of a country's community health system.

How are data presented?

The CHS Catalog summarizes data across:

25 countries

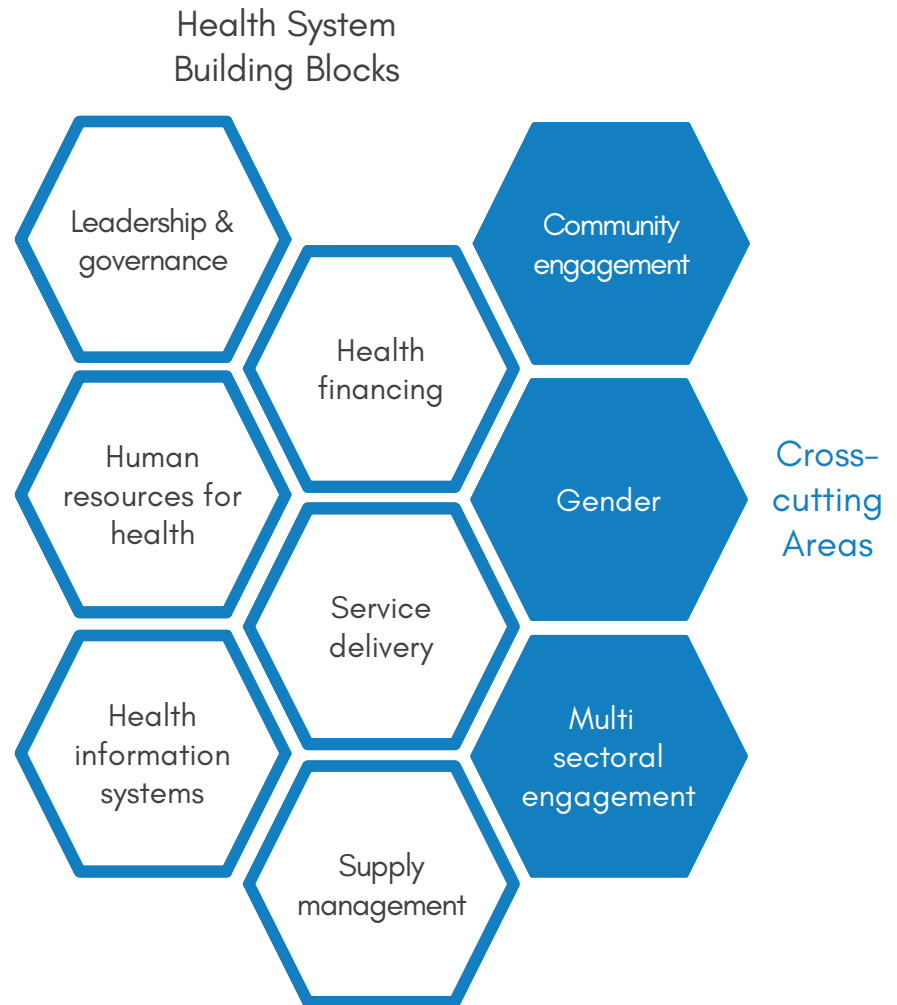
89 community health programs

60 community health provider cadres

Policies Guide a Country's Community Health System

The CHS Catalog and this summary document use the WHO's health system building blocks as a structural framework for presenting community health systems guidance. Community engagement, gender, and multi-sectoral engagement are cross-cutting themes that emerged across many policies and have therefore been added to the framework.

The CHS Catalog synthesizes information from approximately 100 main policies that guide community health across 25 countries, an average of four per country. At the conclusion of data collection in mid-2017, 63 policies had been developed since 2012, and 32 since 2015.





Anouk Delafortrie/EC ECHO

Leadership & Governance

Strong leadership and governance are key to ensuring organized, robust, and resilient community health systems that are accountable to the people they serve.

The CHS Catalog captures policy guidance on who leads and manages community health systems at various levels of the public health system in each country. The next page provides a brief overview of this information.

Leadership & Governance

Countries have diverse approaches.

The 25 CHS Catalog countries take different approaches to planning, managing, and overseeing community health systems.

Some countries, such as [Pakistan](#), have highly decentralized systems with different community health policies and structures at the subnational levels. Others, such as [Ghana](#) and [Tanzania](#), have central structures that are responsible for policy development and oversight, while subnational levels are primarily responsible for implementation. In certain countries, like [South Sudan](#), NGOs play a significant role in community health activities.

Clear guidance is important for accountability.

National policies and strategies often designate a large collection of actors to plan, manage, and coordinate community health activities at each level of the health system. Representative stakeholder categories are highlighted below.

Often, actors have overlapping responsibilities, sometimes due to overly general, vague, or conflicting guidance. Clear and comprehensive policies are critical for clarifying roles, avoiding duplication, streamlining implementation, and ultimately ensuring accountability at all levels of the system.





Robin Hammond/World Education International

Health Financing

Health financing is a broad and complex component of a health system. However, national community health policies do not consistently capture detailed information on financing, and obtaining community health specific information from country health financing documents is time consuming and costly.

Therefore, the CHS Catalog collates only basic financing information, such as community health funding sources and examples of community based financing schemes, which this section presents.

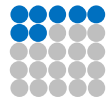
Health Financing

COMMUNITY-BASED FINANCING

Across the 25 CHS Catalog countries, national and subnational governments, donors, NGOs, out-of-pocket fees, private sector stakeholders, insurance schemes, and communities finance community health programs. Some governments plan to assume greater financial responsibility of large-scale community health programs as donors phase out support over time.

Community-based financing schemes are often touted as part of a sustainable approach to improve economic empowerment, equity, and access to health care.

How available is policy guidance?



At least 7 countries include guidance for community-based financing within their policies. In the other 18 countries, community-based financing schemes may exist, but policies do not explicitly describe them.

What does available guidance say?

Countries have various community-based financing approaches. The next page provides several examples.



Kate Holt/Maternal and Child Survival Program

Health Financing

COUNTRY EXAMPLES



Robin Hammond/AEI

Rwanda uses a performance-based financing system to incentivize high-quality service delivery. Community health providers are organized into collectives that retain 30% of the performance-based payments they receive. They invest the other 70% into income-generating activities, such as dairy farming and real estate development. Profits are divided among the collective's members, allocated to support its operations, and placed into a national reserve fund operated by the Ministry of Health to finance future community health endeavors.

Community-based financing holds potential for more equitable, accessible, and sustainable health care.



Robin Hammond/AEI

Madagascar has a cost-recovery system that deposits drug sale profits and community contributions into an equity fund. This fund is intended to resupply drugs and cover the cost of certain drugs that qualified community members can receive for free.



Erin Doherty/AEI

In **Nepal**, a community group manages a fund that gives community health providers low-interest loans for income-generating activities.



Robin Hammond/WEI

Human Resources for Health

Community health providers have received considerable attention in recent years as countries develop, harmonize, and strengthen strategies to reach last mile and marginalized communities to achieve universal health coverage and other national health goals.

This section presents characteristics of 60 community health provider cadres working across the 25 countries. It outlines policy guidance on definitions, scopes of service, and types of program and systems inputs required to support them.

Human Resources for Health

DEFINING COMMUNITY HEALTH PROVIDERS

Countries define community health providers and incorporate them into their community health systems differently. Often, community health providers within a single country represent a hybrid of categories:

- Unpaid versus paid
- Informally versus professionally trained
- Community-based versus facility-based
- Providing services in one health area versus providing services in many areas through an integrated approach

MULTI-TIERED MODELS

In many countries, several types of community health providers work together. [India](#), [Kenya](#), and [Mali](#) use **dual or multi-tiered models** in which one highly skilled cadre provides more complex interventions, such as administering immunizations, and coordinates with one or more lower-level cadres, which focus on health education and community mobilization.



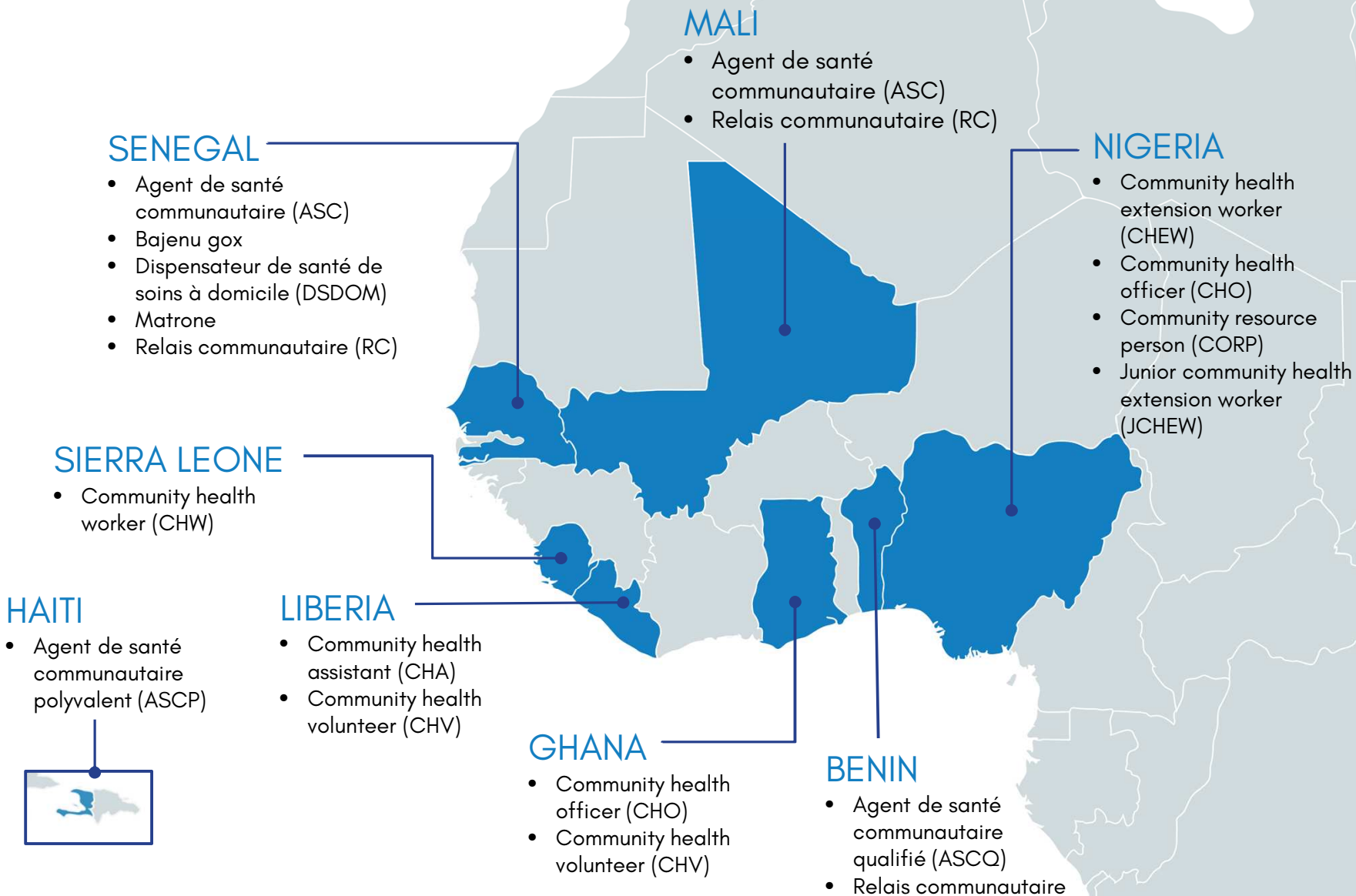
MANY ROLES

In some countries, a single community health provider may **have many roles** with discrete or overlapping duties. In the [Philippines](#), a *barangay health worker* may also be trained as a *barangay nutrition scholar*.

The following maps show the 60 cadres, averaging 2-3 per country, that the CHS Catalog captures.

Human Resources for Health

WEST AFRICA AND THE CARIBBEAN



Human Resources for Health

EAST AFRICA

SOUTH SUDAN

- Community health worker (CHW)
- Community midwife (CMW)
- Home health provider (HHP)
- Maternal and child health worker (MCHW)
- Traditional birth attendant (TBA)

ETHIOPIA

- Health extension worker (HEW)

UGANDA

- Community health extension worker (CHEW)
- Village health team (VHT)

KENYA

- Community health assistant (CHA) / Community health extension worker (CHEW)
- Community health volunteer (CHV)

RWANDA

- Agent de santé maternelle (ASM)
- Binome

TANZANIA

- Community health worker (CHW)

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CENTRAL AND SOUTHERN AFRICA

DRC

- Relais communautaire (RECO)

MALAWI

- Community-based distribution agent (CBDA)
- Community home-based care volunteer (CHBCV)
- Community leader for action on nutrition (CLAN)
- Health surveillance assistant (HSA)
- Natural leader
- Peer educator
- Village health committee (VHC)

ZAMBIA

- Community-based distributor (CBD)
- Community health assistant (CHA)

MOZAMBIQUE

- Agente polyvalente elementare (APE)

MADAGASCAR

- Agent communautaire (AC)

Human Resources for Health

ASIA

AFGHANISTAN

- Community health worker (CHW)

PAKISTAN

- Community midwife (CMW)
- Lady health worker (LHW)

NEPAL

- Auxiliary health worker (AHW)
- Auxiliary nurse midwife (ANM)
- Female community health volunteer (FCHV)

THE PHILIPPINES

- Barangay health worker (BHW)
- Barangay nutrition scholar (BNS)
- Barangay supply point officer (BSPO)
- Community health team (CHT)

INDIA

- Accredited social health activist (ASHA)
- Anganwadi worker (AWW)
- Auxiliary nurse midwife (ANM)

BANGLADESH

- Community health care provider (CHCP)
- Family welfare assistant (FWA)
- Health assistant (HA)

Human Resources for Health

BENEFICIARY RATIOS

Many countries grapple with how many beneficiaries each community health provider should cover.

How available is guidance?



All 25 countries specify coverage ratios for at least one community health provider cadre. However, there is no clear guidance for 9 cadres in 5 countries.

UNDERSTANDING DEFINITIONS

Countries use different units of measurement to express beneficiary ratios: number of **people**, **households**, **couples**, **facilities**, **neighborhoods** and/or **villages** per community health provider.

The diversity of definitions makes cross-country comparisons difficult. Furthermore, even within country policies, ratios are sometimes expressed differently for different cadres, resulting in unclear, unstandardized guidance.

What does available guidance say?

The two most common ways to express ratios are in terms of *people* and *households*.

The number of **people** per community health provider ranges from **235** to **7,500**.



The number of **households** per provider ranges from **12** to **250**.



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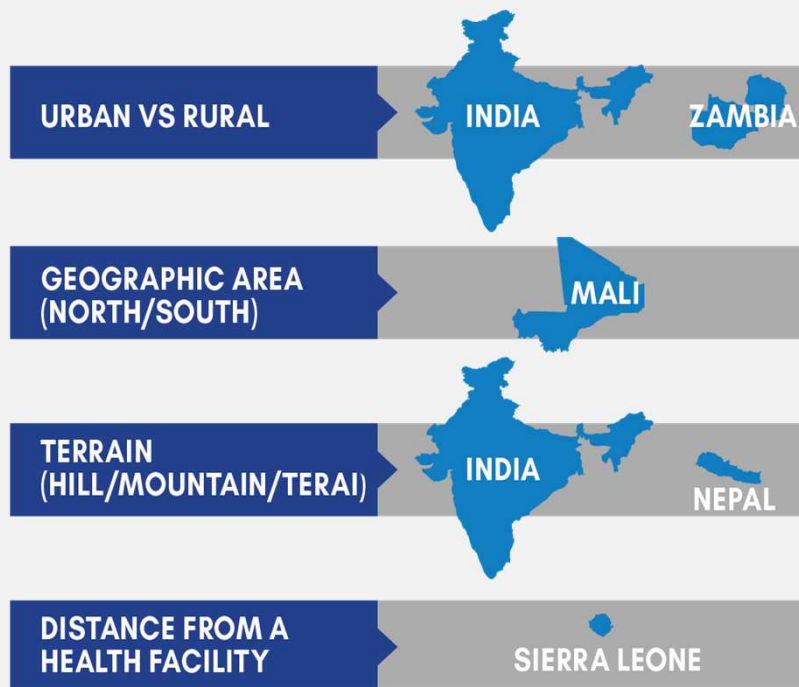
BENEFICIARY RATIOS

What does available guidance say? (continued)

Often, countries express beneficiary ratios as a range. Factors that influence the beneficiary ratio include a community health provider's scope of practice, local disease burden, terrain, and proximity to a health facility. Country examples are indicated on the right for each factor.

Factors that influence the beneficiary ratio

Country examples



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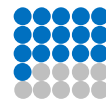
ENUMERATION

Often, policies fail to specify the number of community health providers that exist in the country and/or the number required to reach optimal coverage.

- Enumerating the **community health providers** in a country helps to identify potential coverage gaps.
- Determining or projecting the **number of community health providers that a country requires** is critical for planning and budgeting for program inputs such as training, supervision, incentives, commodities, and materials, as well as for program scale-up.



How available is guidance?



16 countries document the number of community health providers that *currently exist* in their country.



10 countries have complete information on the number of community health providers they *require*.



8 countries document *both* the number of community health providers that exist and the number required for all cadres: **Afghanistan, Ethiopia, Haiti, India, Nepal, Pakistan, Rwanda, and Sierra Leone.**

What does available guidance say?

In 7 of the 8 countries that document both existing and required numbers, there are not enough community health providers to reach intended coverage. **India**, however, has a surplus of auxiliary nurse-midwives, but shortages of the other two cadres, as shown in the next page.

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COUNTRY EXAMPLE: INDIA

India has comprehensive information on the recommended and actual number of community health providers in each of its three cadres.



Human Resources for Health

SELECTION CRITERIA

Selection criteria for community health providers can help establish fairness in the selection process and standardization across programs, districts, and regions. Criteria also ensure that providers have the desired qualities and skillsets.

How available is guidance?



All countries except Bangladesh provide selection criteria for at least one of their community health cadres. Overall, policies include selection criteria for 51 of 60 community health provider cadres.

What does available guidance say?

Common selection criteria are described on the right.



CHOSEN BY COMMUNITY

34 cadres in 22 countries
Community members, groups, committees, and/or representatives convene to select a community health provider.



LITERACY

33 cadres in 22 countries
Literacy is especially critical for cadres who perform case management, manage stock, and complete reports. Some countries require certain cadres to pass a written test (Haiti, Liberia, and Nepal); others only state a preference for literacy (Sierra Leone and South Sudan).



GENDER

31 cadres in 16 countries
13 cadres are female-only, such as midwives and others who can access households more easily as women. For 7 cadres, women are preferred over men to encourage female leadership. For 11 cadres, countries endorse selection of both women and men to promote gender equality.

COMMUNITY RESIDENCE



34 cadres in 22 countries
These providers must possess local knowledge that comes with living in the community. Local residence is a common criteria for lower-level cadres who conduct promotional activities. Community residence is not necessarily required for the more skilled cadres, such as CHOs in Ghana, who work from facilities.

AGE



33 cadres in 22 countries
Guidance for minimum age ranges from 18 to 25 years. Guidance for a maximum age ranges from 30 to 60 years. CLANs in Malawi must be "old enough to be respected."

EDUCATION LEVEL



26 cadres in 18 countries
Minimum education requirements range from primary school to advanced professional certifications in areas like midwifery and nursing, and largely depend on the provider's scope of practice.

Human Resources for Health

SELECTION PROCESS

There are a variety of ways to select a community health provider.

How available is guidance?



All 25 countries indicate the people and structures that should be involved in the selection process for at least one community health provider cadre.



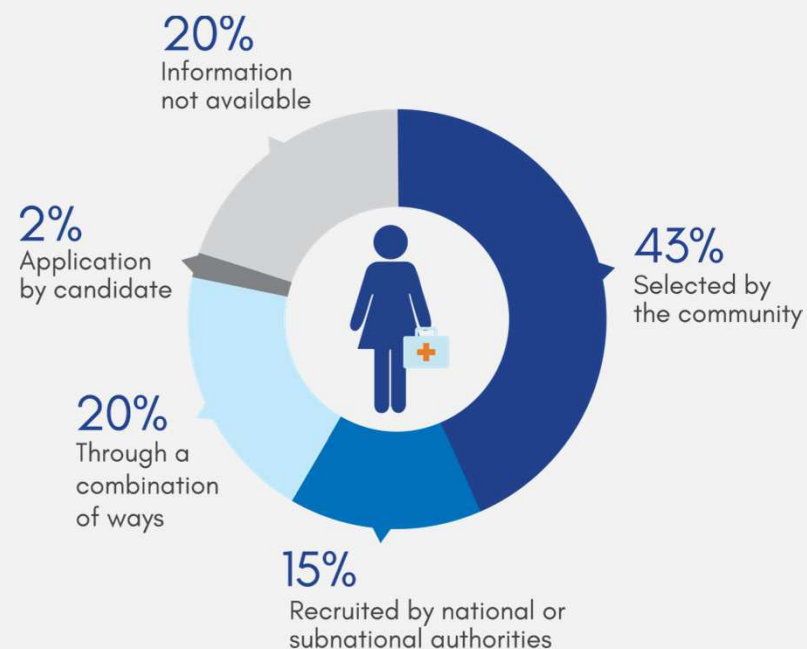
19 countries have guidance on the selection process for all cadres.

What does available guidance say?

For 48 of 60 cadres, policies specify the actors or structures responsible for selection. Community members are the most common actors responsible for selecting community health providers.

For some cadres, selection involves a combination of actors and processes. In Tanzania, CHWs apply to a training program with a letter of recommendation from their community.

While communities often play a role in selecting community health providers, selection processes are diverse



Human Resources for Health

TRAINING

Training is a key component of any investment to ensure that providers learn, practice, and retain the skills necessary to perform their tasks.

The CHS Catalog captures information on community health provider **training content**, **training duration**, and if they receive **refresher trainings**. The next four pages present this information.



Direct Relief

Human Resources for Health

TRAINING CONTENT

How available is guidance?



Information on **training content** is available for all cadres and is found across training curricula, job descriptions, and scopes of practice. Nationally-approved curricula are available for 44 of 60 cadres across **all countries except the DRC**.

In some instances, curricula are developed by NGOs or by subnational governments and may not be formally linked to the public health system. Curricula have yet to be developed for several newer cadres, such as ASCQs in **Benin**.

What does available guidance say?

Most community health providers are trained to perform **an array of functions across key health areas**. Some are trained in specialized subjects relevant to their context, such as home-based care for people living with HIV and surveillance for endemic diseases.

Although community health providers are typically trained to perform specific tasks, **countries are increasingly adding responsibilities to their scopes**, sometimes to reduce the workload of higher-level health workers. To prevent overtasking, countries should add responsibilities gradually and monitor scale-up carefully.

Common training content for community health providers

FUNCTIONS

- Advocacy
- Behavior change communication
- Case management
- Community mobilization
- Data management
- Disease surveillance
- Education and promotion
- Emergency preparedness and response
- Organization and management
- Referral and follow-up
- Supervision

KEY HEALTH AREAS

- HIV and AIDS
- Maternal, newborn, and child health
- Malaria and other communicable diseases
- Nutrition
- Reproductive health and family planning
- Tuberculosis
- Water, sanitation and hygiene (WASH)

OTHER HEALTH AREAS

- Adolescent health
- Dental health
- Disability assistance
- Eye care
- First aid
- Leprosy
- Mental health
- Neglected tropical diseases
- Noncommunicable diseases
- Traditional and folk medicine
- Violence prevention and care

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TRAINING DURATION

How available is guidance?

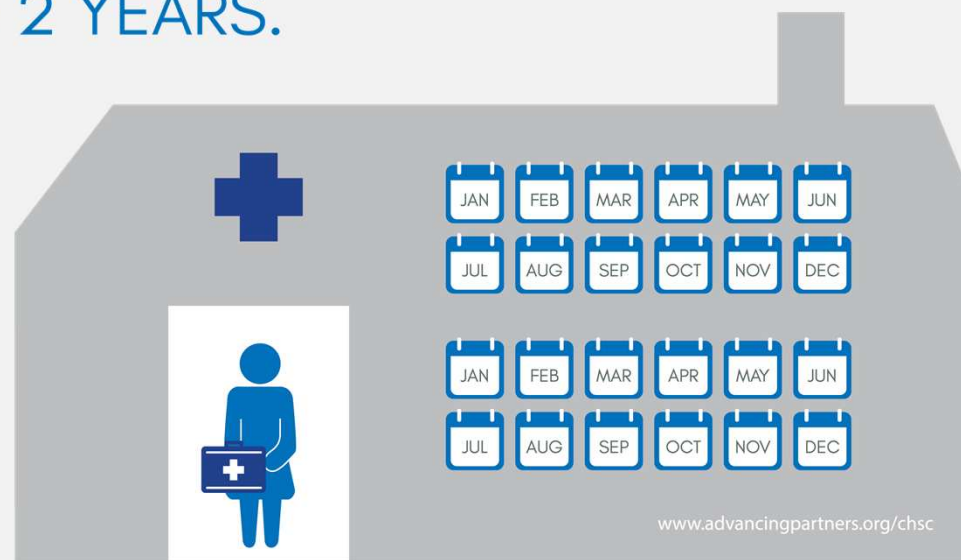


Policies specify guidance on **training duration** for 33 of 60 community health provider cadres. **13 countries** have information on training duration for all cadres.

What does available guidance say?

Training duration ranges from **2 days** to **2 years**, with a median of **6 weeks**. Duration varies by the number and complexity of the provider's responsibilities, training format, accreditation and if s/he has had previous relevant training.

Across 25 countries, community health provider training ranges from **2 DAYS** to **2 YEARS**.



Human Resources for Health

REFRESHER TRAININGS

How available is guidance?



Policies mention conducting **refresher trainings** for 29 of 60 cadres across 19 countries. **11 countries** have information for all cadres. However, guidance is often vague about how often refresher trainings should happen, for how long, and who will lead them.

What does available guidance say?

Refresher trainings generally last between **2 and 6 days**. They typically occur on an as-needed or periodic basis. Guidance is more detailed for some cadres, such as HEWs in **Ethiopia**, who are supposed to receive refreshers every two years.



Human Resources for Health

TRAINING

The range of training guidance reflects the incredible diversity of community health providers and the tasks for which they are responsible.

Adapting global guidance and standards for training may be helpful in many respects but should be balanced with context-specific factors, such as the provider's scope of service, supervision structure, remuneration, and position within the larger health system.



Human Resources for Health

REACHING COMMUNITIES

Investing in community health providers can improve access to health education, products, and services by reaching underserved communities.

The CHS Catalog documents how community health providers reach their clients with information and services, per available policy guidance.

How available is guidance?



All countries have guidance for how community health providers should reach clients.

What does available guidance say?

Community health providers reach clients through the methods below. More than three-quarters of the 60 cadres use more than one method.

54 cadres across 25 countries travel by foot



39 cadres across 19 countries have clients come to them at a facility or their homes



30 cadres across 19 countries may use bicycles



16 cadres across 10 countries may use public transport



4 cadres across Ghana and the Philippines may use boats



In Senegal, ASCs and a range of other providers deliver services from community-owned and centrally located health huts. Other providers work from their homes, such as CMWs in Pakistan.

HSAs in Malawi receive instruction on bicycle assembly, maintenance, and proper use as part of their training.

In Ghana, community health providers can use rickshaws and are encouraged to develop creative ways to reach clients.

Some communities are accessible only by boat – particularly in the rainy season.

Human Resources for Health

SUPERVISION

Supervision is critical to community health provider performance and motivation.

How available is guidance?



Policies indicate community health provider supervisors across **all 25 countries** and cadres. However, the amount of information available for supervision processes and protocols varies.

What does available guidance say?

Supervision takes many forms, from technical to administrative to community oversight and accountability. Supervisors include staff from health facilities, NGOs, subnational health staff, other community health providers, and community groups and leaders. 49 cadres across **24 countries** have more than one supervisor.

Often, community health providers have more than one supervisor.



HEALTH FACILITY STAFF

45 cadres across **25 countries**



NGO STAFF

32 cadres across **17 countries**



COMMUNITY GROUPS OR LEADERS

28 cadres across **15 countries**



SUBNATIONAL-LEVEL HEALTH STAFF

23 cadres across **13 countries**



HIGHER-LEVEL COMMUNITY HEALTH PROVIDER CADRES

19 cadres across **10 countries**

Human Resources for Health

INCENTIVES

A combination of financial and nonfinancial incentives help motivate and retain community health providers. In recent years, countries have moved toward standardizing incentive schemes across community health programs.

How available is guidance?

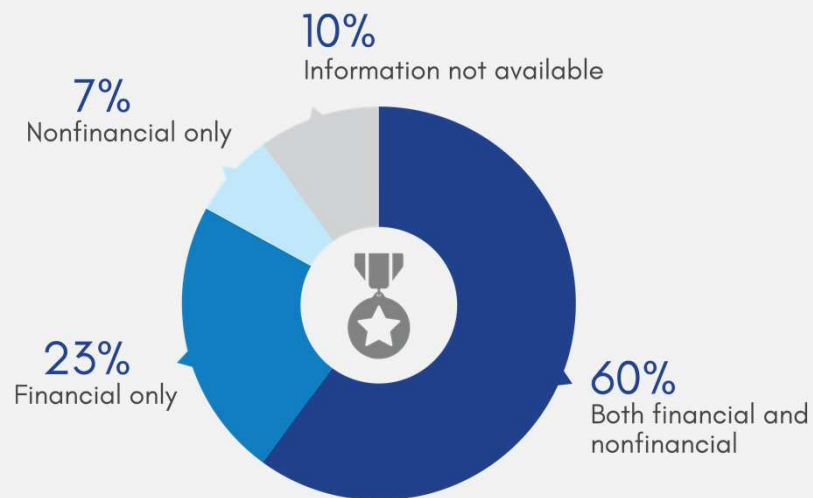


All countries provide guidance on incentives for most community health provider cadres.

What does available guidance say?

Most cadres receive a combination of financial and nonfinancial incentives. Due to the breadth of policy information across countries, findings on incentives are detailed in the following two pages.

Nearly 2/3 of community health providers across 25 countries receive a combination of financial and nonfinancial incentives



Human Resources for Health

FINANCIAL INCENTIVES

Some community health providers receive financial incentives as a living wage.

How available is guidance?



All countries have guidance on financial incentives for at least one community health provider cadre.

What does available guidance say?

50 out of 60 community health providers receive financial incentives, 3 do not, and information is unavailable for 7.

All countries provide at least one cadre with financial compensation, including salaries, per diems, cash payments, and performance-based incentives.

Guidance on Financial Incentives



PER DIEMS

21 cadres across 16 countries (e.g., VHTs in Uganda and ACs in Madagascar) receive per diems to cover expenses related to travel, meals, etc.



SALARIES

20 cadres across 15 countries (Bangladesh, Benin, Ethiopia, Ghana, Haiti, India, Kenya, Malawi, Mali, Nepal, Nigeria, Pakistan, Tanzania, Uganda, and Zambia) are salaried. Guidance on salary amount is available for 6 cadres and ranges from \$63 to \$157 USD/month.



PERFORMANCE-BASED INCENTIVES

17 cadres across 10 countries. For example, ASHAs in India receive payments for specific tasks, such as escorting women to facilities for delivery and ensuring completion of a child's immunizations.



OTHER CASH PAYMENTS

24 cadres across 13 countries receive payments including cash awards, allowances, stipends, and salary top-ups. CHWs in Sierra Leone and CHAs in Liberia receive monthly stipends.

Human Resources for Health

NONFINANCIAL INCENTIVES

In many countries, programs give community health providers nonfinancial incentives to motivate them and recognize their contributions.

How available is guidance?



23 countries have guidance on the types of nonfinancial incentives community health providers should receive.

What does available guidance say?

Two-thirds of cadres receive at least one type of nonfinancial incentive. Common incentives include formal social recognition, apparel such as t-shirts and hats, opportunities for career advancement, and free or discounted health care.

Guidance on Nonfinancial Incentives



FORMAL SOCIAL RECOGNITION

33 cadres across 21 countries receive awards, acknowledgement during ceremonies, and specially dedicated holidays.



OPPORTUNITIES FOR CAREER ADVANCEMENT

12 cadres across 10 countries (e.g., VHTs in Uganda may engage in apprenticeship training at health facilities).



ID BADGES

11 cadres across 5 countries



T-SHIRTS

10 cadres across 9 countries



FREE OR DISCOUNTED HEALTH CARE

8 cadres across 6 countries



OTHER

28 cadres across 14 countries (e.g., in-kind payments; preferred access to loans; scholarships for their children; free legal services; tickets for pilgrimages to holy sites; life insurance; living quarters; annual leave).



Veronique de Viguieré/JSI

Service Delivery

Service delivery encompasses a range of health services, interventions, and channels to improve health care access.

The CHS Catalog collates information on over 100 primary health care interventions that community health providers may provide, per policy guidance. It does not, however, include information on how and whether policy guidance translates into program implementation. Information on service delivery is presented in this section.

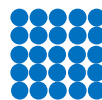
Service Delivery

OVERVIEW

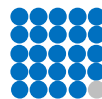
Most countries have policy guidance for community services in most key health areas.



How available is guidance?



All 25 countries have guidance for community health providers on key family planning, maternal, newborn and child health, nutrition, and WASH interventions.



24 countries have guidance for community health providers on key tuberculosis interventions. Sierra Leone has none for CHWs.



23 countries have guidance for community health providers on key HIV and AIDS interventions. Benin and Rwanda do not have guidance for their cadres.

What does available guidance say?

Most community health provider cadres offer services across a range of health areas. Several cadres provide services in only one health area, such as family planning, nutrition, or HIV and AIDS.

The following section presents information on selected health interventions that community health providers can provide, per country policy guidance.

Service Delivery

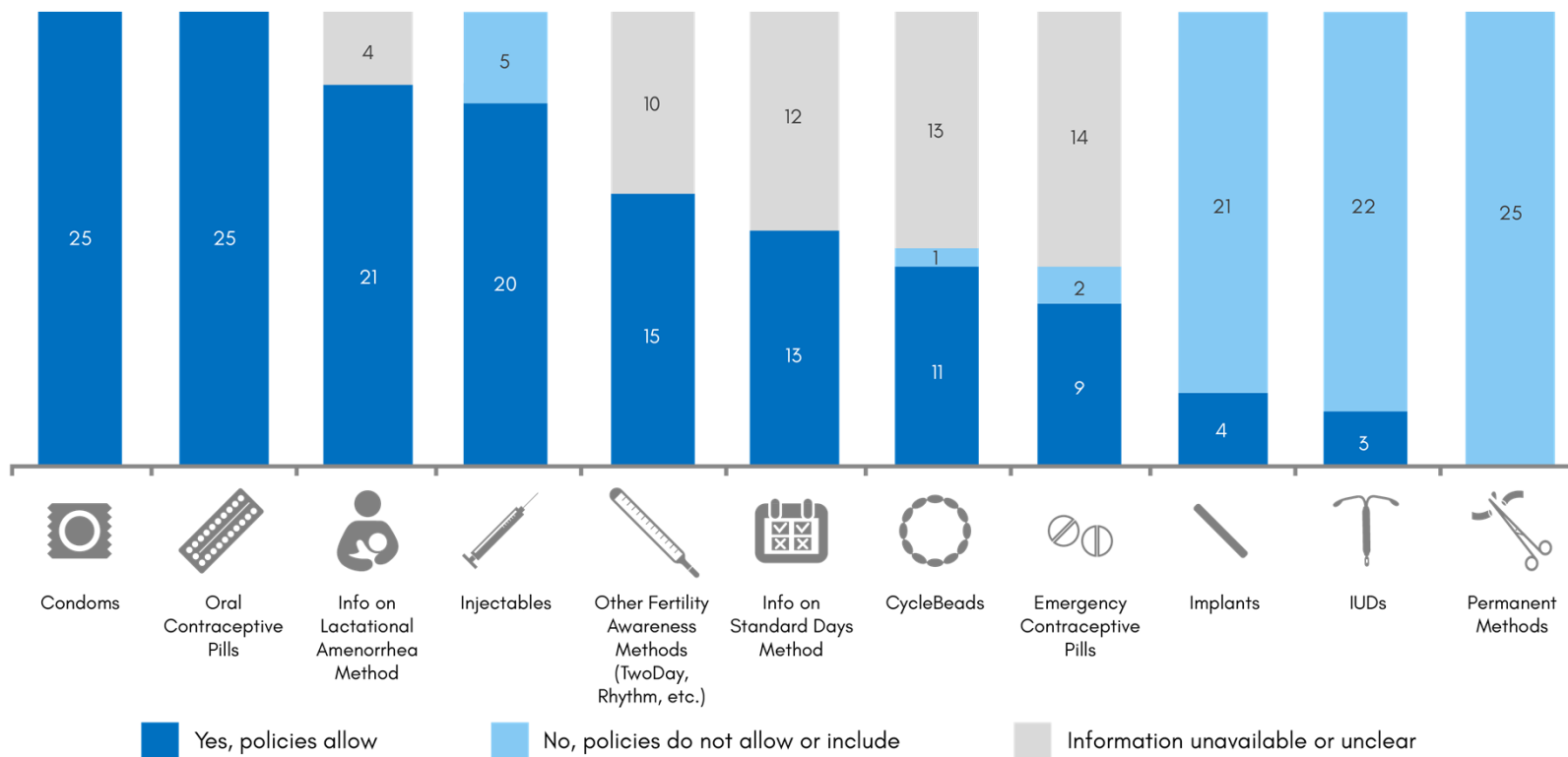
POLICY GUIDANCE: FAMILY PLANNING

The CHS Catalog contains guidance on **11 family planning methods** provided at the community level across 25 countries.

The graph below shows the number of countries in which: 1) policies allow at least one cadre to conduct each intervention; 2) policies do not allow any cadres to provide each intervention; and 3) there is no or unclear policy guidance for each intervention.

These data can help identify gaps and opportunities to advocate for community-based provision of specific family planning methods.

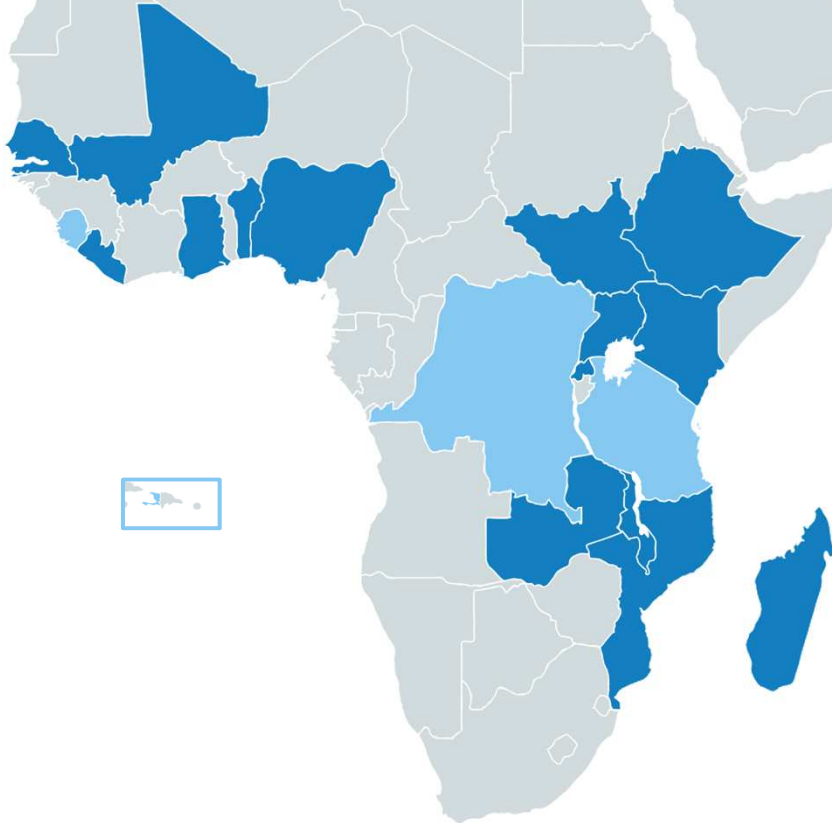
The next two pages provide further details for injectable contraceptives and emergency contraceptive pills.



Service Delivery

POLICY GUIDANCE: INJECTABLES

20 countries allow at least one community health provider cadre to administer injectable contraceptives, and **5** do not.



Across these **20 countries**, 33 cadres may provide injectables, and there are plans for at least another 3 cadres to pilot or provide the method in the future.

The **5 other countries** (DRC, Haiti, the Philippines, Sierra Leone, and Tanzania) may be piloting community-based injectables, but recent policies have not captured this information.

Service Delivery

POLICY GUIDANCE: EMERGENCY CONTRACEPTIVE PILLS

9 countries allow at least one community health provider cadre to provide emergency contraceptive pills, and **2** do not.

Information is unclear or not provided in **14** countries.

Across these **9 countries**, 17 cadres may provide emergency contraceptive pills.

Other countries may have general guidance for the provision of emergency contraceptive pills, but recent and available community health policies do not reflect this information.

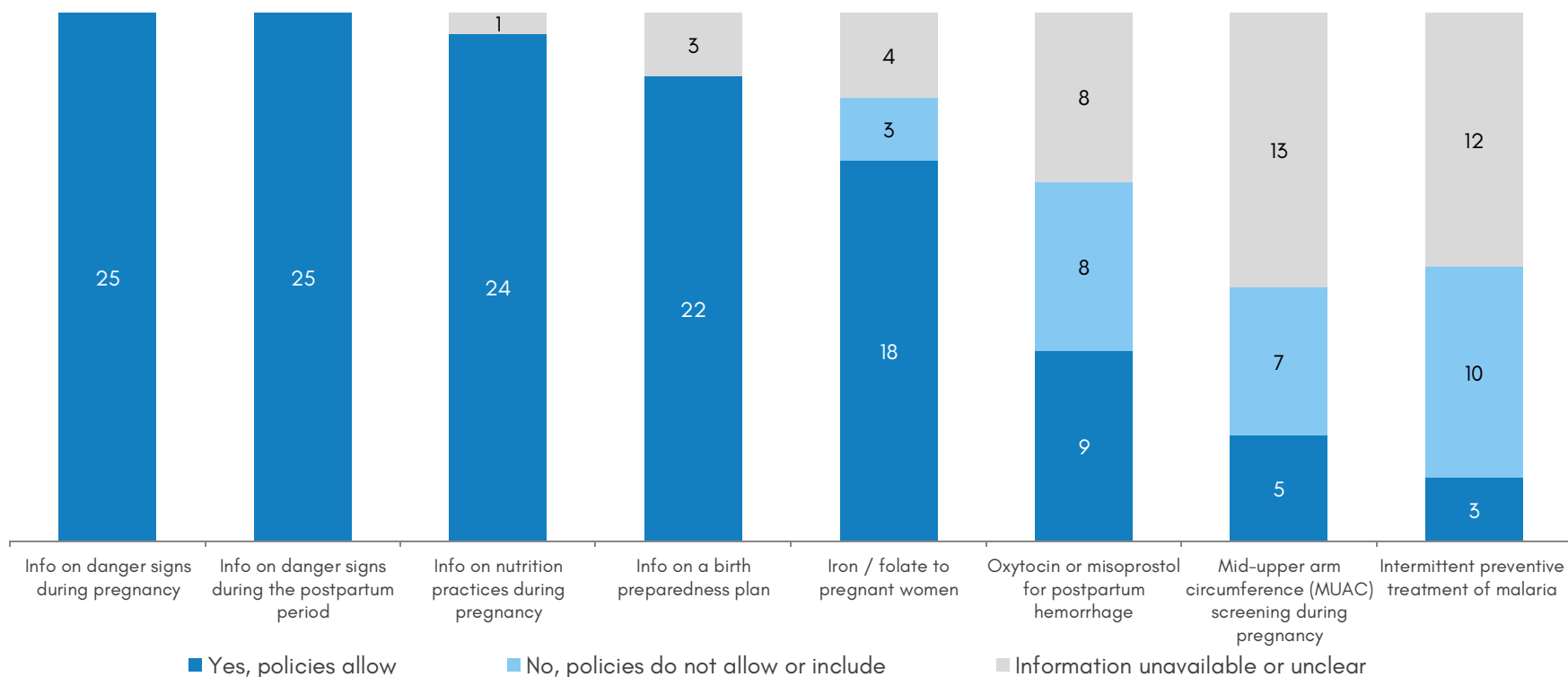
Service Delivery

POLICY GUIDANCE: MATERNAL HEALTH



The CHS Catalog contains guidance for **23 maternal health interventions** provided at the community level across 25 countries.

The graph below provides information on **8 of these maternal health interventions**. It shows the number of countries in which: 1) policies allow at least one cadre to conduct each intervention; 2) policies do not allow any cadres to provide each intervention; and 3) there is no or unclear policy guidance for each intervention.



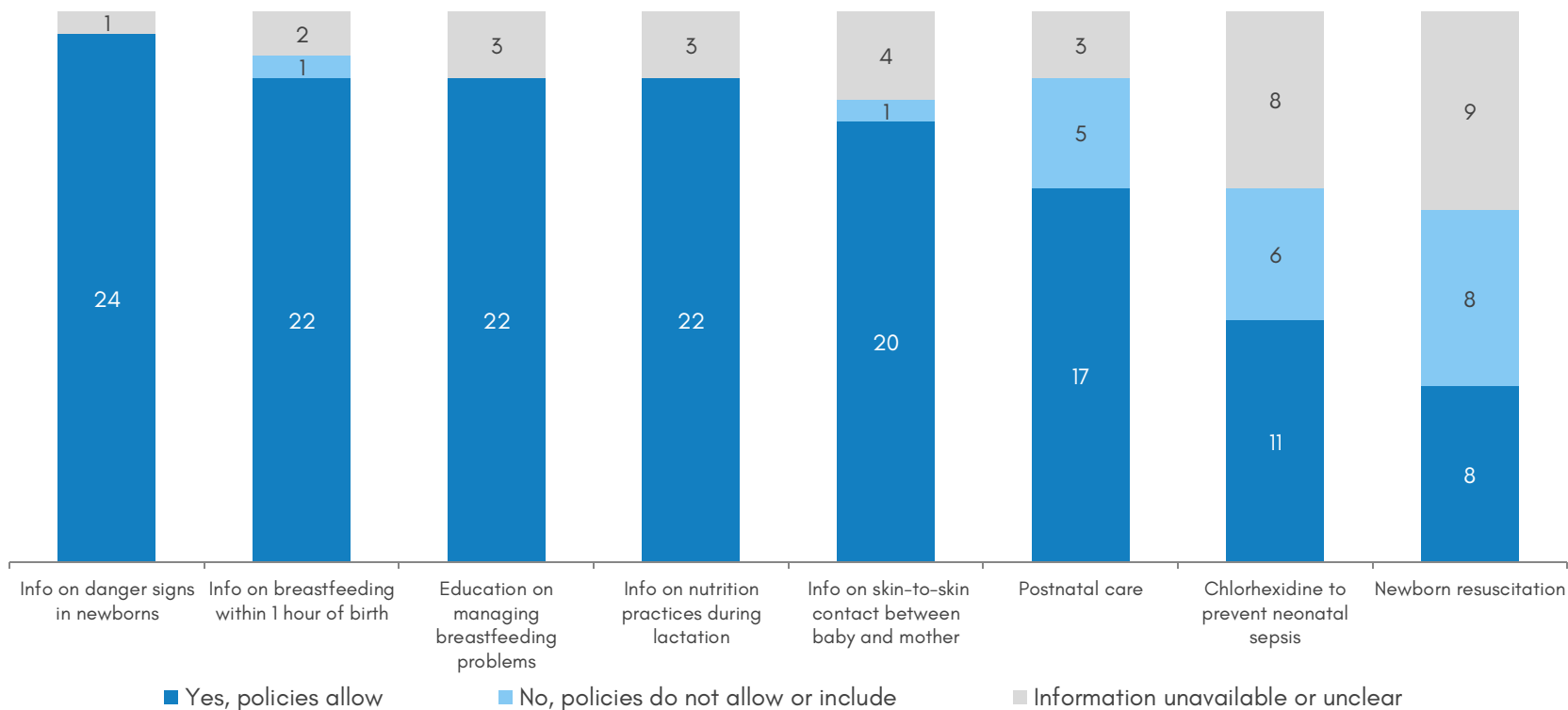
Service Delivery

POLICY GUIDANCE: NEWBORN HEALTH



The CHS Catalog contains guidance for **28 newborn health interventions** provided at the community level across 25 countries.

The graph below provides information on **8 of these newborn health interventions**. It shows the number of countries in which: 1) policies allow at least one cadre to conduct each intervention; 2) policies do not allow any cadres to provide each intervention; and 3) there is no or unclear policy guidance for each intervention.



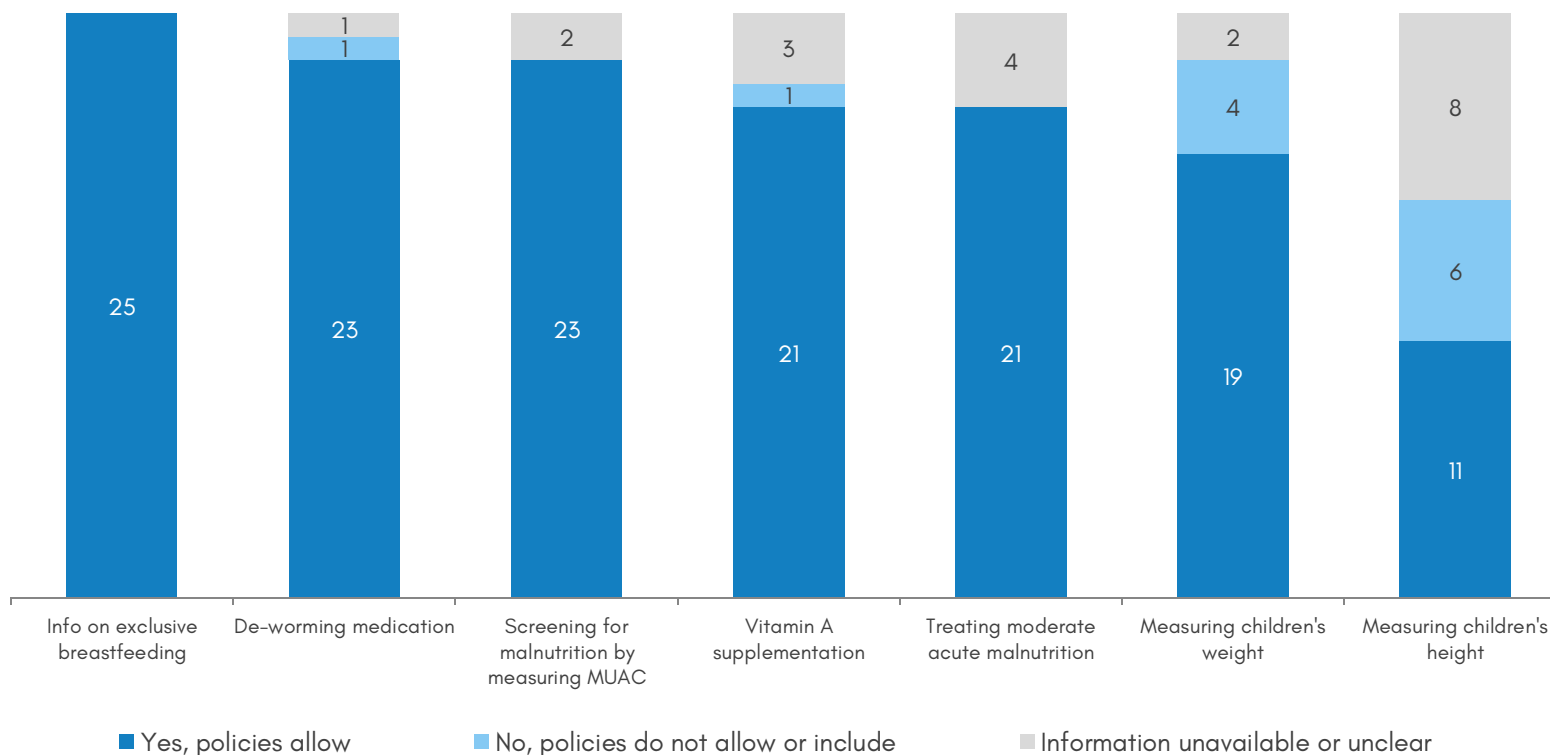
Service Delivery

POLICY GUIDANCE: NUTRITION



The CHS Catalog contains guidance on **37 nutrition interventions** provided at the community level across 25 countries.

The graph below provides information on **7 of these nutrition interventions** that target children under 5 years of age. It shows the number of countries in which: 1) policies allow at least one cadre to conduct each intervention; 2) policies do not allow any cadres to provide each intervention; and 3) there is no or unclear policy guidance for each intervention.



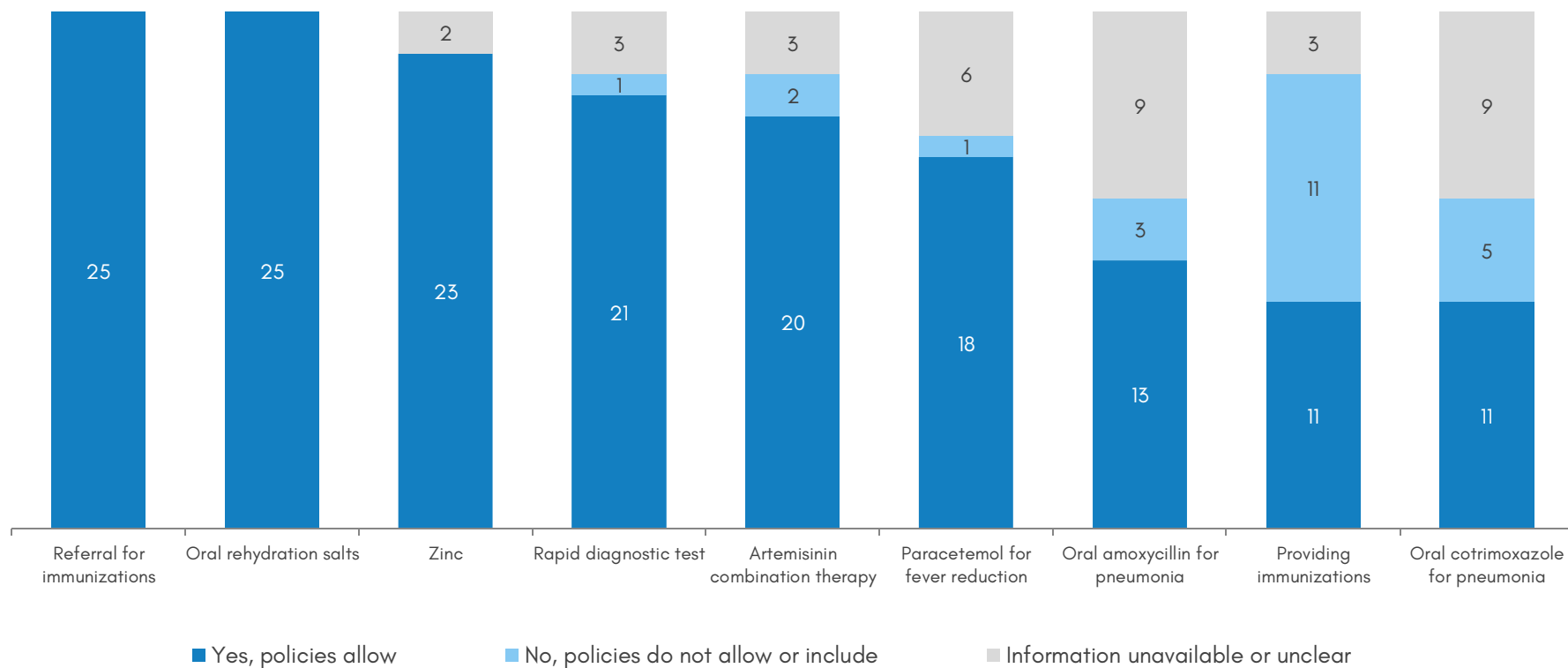
Service Delivery

POLICY GUIDANCE: CHILD HEALTH



The CHS Catalog contains guidance on **43 child health interventions** provided at the community level across 25 countries.

The graph below provides information on **9 of these child health interventions**. It shows the number of countries in which: 1) policies allow at least one cadre to conduct each intervention; 2) policies do not allow any cadres to provide each intervention; and 3) there is no or unclear policy guidance for each intervention.



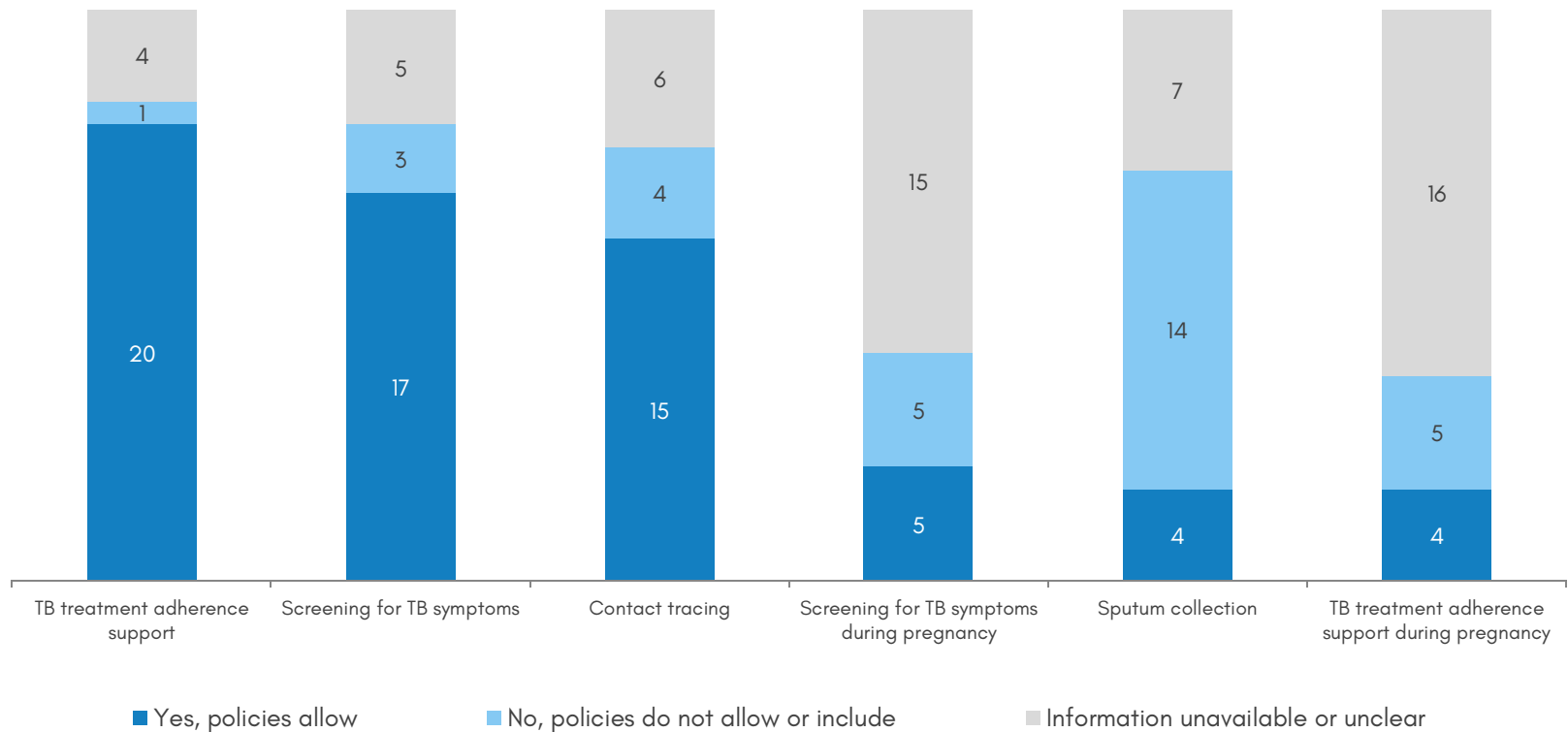
Service Delivery

POLICY GUIDANCE: TUBERCULOSIS



The CHS Catalog contains guidance on **11 tuberculosis interventions** provided at the community level across 25 countries.

The graph below provides information on **6 of these tuberculosis interventions**. It shows the number of countries in which: 1) policies allow at least one cadre to conduct each intervention; 2) policies do not allow any cadres to provide each intervention; and 3) there is no or unclear policy guidance for each intervention.



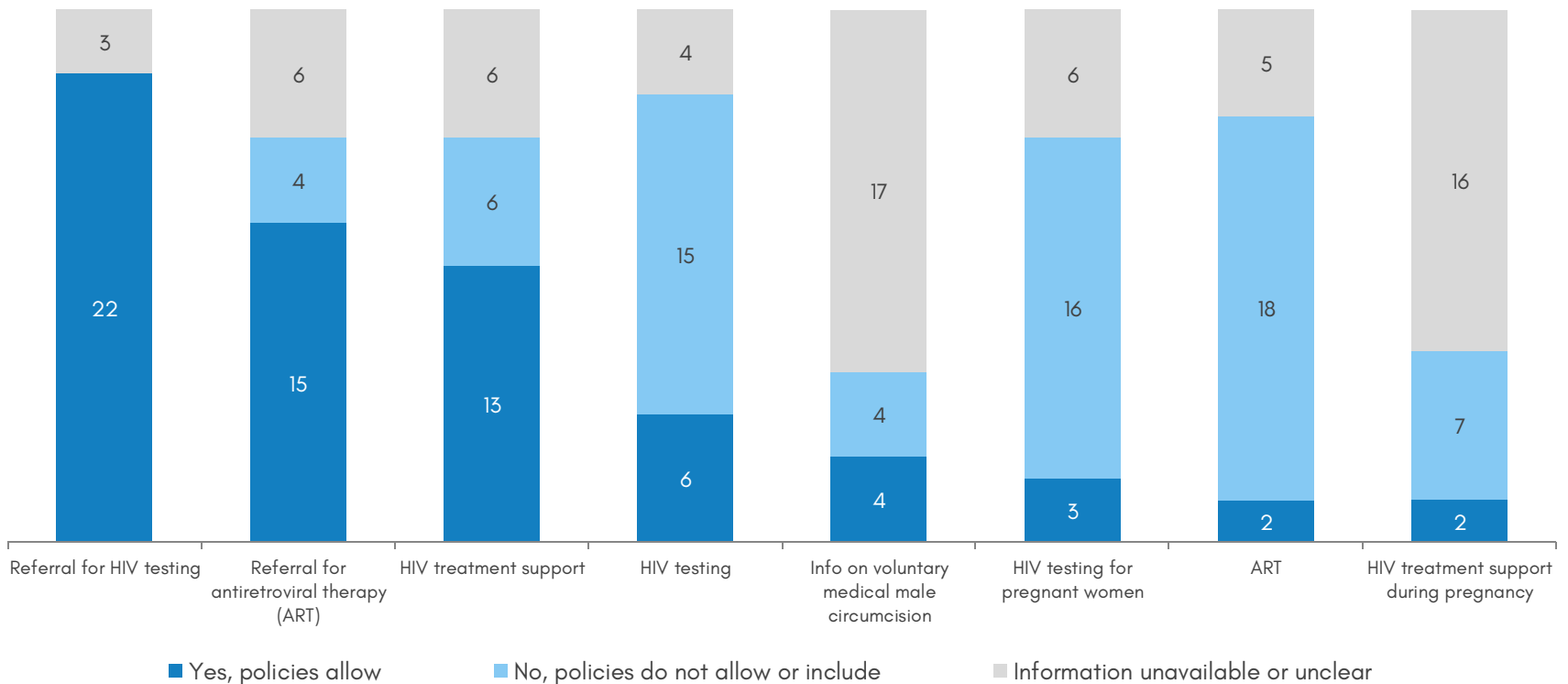
Service Delivery

POLICY GUIDANCE: HIV AND AIDS



The CHS Catalog contains guidance for community-based delivery of 15 HIV and AIDS interventions across 25 countries.

The graph below provides information on 8 of these HIV and AIDS interventions. It shows the number of countries in which: 1) policies allow at least one cadre to conduct each intervention; 2) policies do not allow any cadres to provide each intervention; and 3) there is no or unclear policy guidance for each intervention.



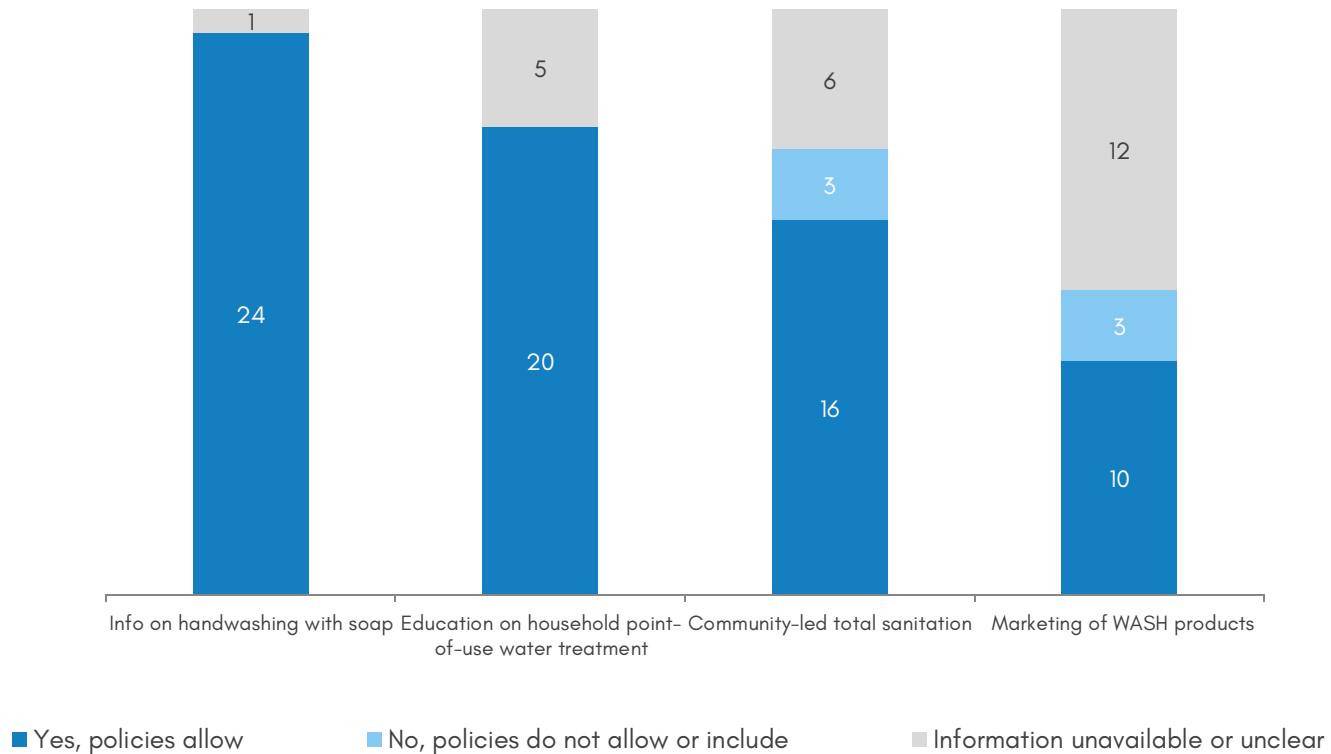
Service Delivery

POLICY GUIDANCE: WATER, SANITATION AND HYGEINE



The CHS Catalog contains guidance on 4 WASH interventions provided at the community level across 25 countries.

The graph below shows the number of countries in which: 1) policies allow at least one cadre to conduct each intervention; 2) policies do not allow any cadres to provide each intervention; and 3) there is no or unclear policy guidance for each intervention.



Service Delivery

REFERRALS

Referral systems help connect community members to the formal health system. Community health providers often refer clients to a higher tier of the health system. Ideally, clients should be counter-referred so community health providers can ensure continuity in care and support.

How available is guidance?



All countries include guidance on community-based referrals.



17 countries include guidance on counter-referrals.

What does available guidance say?

Community health providers refer clients mainly to health centers, but sometimes to hospitals or specialized facilities if needed. In 17 countries, policies direct community health providers to refer clients to a higher level of the system.

In **Tanzania**, CHWs refer clients to the public health facilities to which they are linked. They may also refer laterally (e.g. to parasocial workers, for legal services, and/or to NGO health providers).

In **Malawi**, community-based distribution agents refer clients to health surveillance agents (HSAs) for services they do not provide, such as injectable contraceptives. HSAs refer clients to health facilities for services like implants and IUD insertion.



Health Information Systems

Health information systems are critical for monitoring health system performance and collecting data for planning and quality improvement.

This section presents information from the CHS Catalog on community health data systems, including if community health providers collect data, the tools they use, if this information is integrated into national data systems, and how data are shared with the communities they serve.

Health Information Systems

DATA COLLECTION

Community health providers collect data to track and monitor health indicators, behaviors and practices, and service provision. Ideally, data inform decision-making and are integrated into district, regional, and national health information systems.

How available is guidance?



All 25 countries provide guidance on routine data collection.

What does available guidance say?

Policy guidance directs community health providers to collect and monitor data on:

- Health behaviors and practices
- Case management and routine services delivered
- Information provided during health education and outreach activities
- Life events such as births and deaths
- Commodity management
- Disease outbreaks, such as cholera, measles, and Ebola



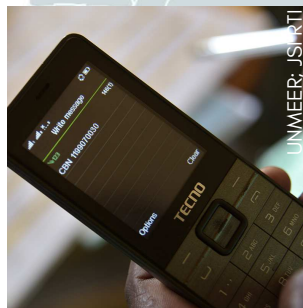
Health Information Systems

COUNTRY EXAMPLES



Pandemics, such as the Ebola outbreak, have prompted countries to use community health providers to help strengthen disease surveillance. In [Sierra Leone](#), CHWs now have a surveillance register to track suspected cases of diseases like cholera, measles, Guinea worm, as well as Ebola.

In [Rwanda](#), CHWs may record data through a real-time text message system (RapidSMS) on events such as confirmed pregnancies; births; deaths; immunizations; antenatal, postnatal and newborn care visits; case management; child nutrition and growth monitoring; and life-threatening emergencies.



Data collection tools are often tailored to the needs of community health providers who have low levels of literacy. In [Afghanistan](#), policies direct CHWs to use pictorial data recording and reporting tools, and each health post maintains a tally sheet of CHW household visits and the services provided.

Health Information Systems

DATA SHARING AND USE

Ideally, communities access and use the health data generated at the community level to continuously monitor their health status, the services received, and to make programmatic adjustments.

How available is guidance?



17 countries have at least general guidance for sharing and using community data at the local level.

What does available guidance say?

In at least 6 countries, policies indicate that community committees or groups should be directly involved in data analysis and/or decision-making.

In other countries, community health data is supposed to be collated at the facility or higher levels of the health system and routinely shared with communities; however, many countries do not specify a mechanism through which to do this.



In Senegal, policies direct community health providers and representatives to hold **planning and evaluation meetings** at community-based health huts and service delivery sites, with the support of facility-based nurses and health committees. These meetings give communities and providers the opportunity to discuss and address bottlenecks to available services, based on community health data.

Health Information Systems

DATA INTEGRATION

As countries aim to extend and strengthen high-quality health services to last-mile communities, they have increasingly focused on strengthening information systems, including at the community level.

How available is guidance?



21 countries have policies that mention integrating the data collected by community health providers into the national health management information system.

What does available guidance say?

Most countries have policies that recognize the importance of integrating community health data into national health information systems. At the same time, they often acknowledge pervasive fragmentation and challenges to doing so. Some policies indicate that data integration is still at nascent stages or has yet to begin.



Karen Kasmauski/MCSP



Supply Management

Supplies, commodities, and medicines are crucial to service delivery at every level of the health system.

The CHS Catalog identifies guidance on how community health providers access and restock supplies, navigate stockouts, and manage medical waste, which this section summarizes. It also provides a list of selected medicines, commodities, and supplies included in the latest national essential medicines list for each country.

Supply Management

ACCESSING SUPPLIES

Community health providers are often responsible for providing medicines, commodities, supplies, and other materials as part of their tasks. Policies may guide processes on how they may obtain supplies.

How available is guidance?



24 countries have guidance for how community health providers should restock commodities, medicines, and equipment. Afghanistan does not indicate how providers resupply after they receive initial starter kits.

What does available guidance say?

Providers are directed to restock supplies at a variety of places and in different ways. Most commonly, they go to a health facility for this purpose. In 10 countries, community health providers obtain supplies through a combination of strategies, listed at right.

Community health providers use different strategies to access supplies



AT A HEALTH FACILITY

18 countries



FROM A SUPERVISOR

6 countries



THROUGH SUPPORT OF AN NGO

6 countries



AT A SUBNATIONAL OFFICE

3 countries



THROUGH A COST-RECOVERY SYSTEM

2 countries



DELIVERED TO THEM

1 country (in Malawi, supplies are transported to HSAs or the health facility with which they are associated).

Supply Management

STOCKOUT MANAGEMENT

Stockouts or interruptions are common, particularly at the community level, and can erode trust in the health system. Some countries have established protocols for community health providers to access emergency stock to reduce disruptions in community programs.

How available is guidance?



8 countries have guidance for how community health providers can access emergency back-up supplies.

What does available guidance say?

- In [Ethiopia](#), [India](#), [Madagascar](#), [Nigeria](#), and [Zambia](#), guidance directs community health providers to borrow stock from nearby health facilities.
- In [Ghana](#), community health providers are supposed to access buffer stock from subnational health offices.
- In [Uganda](#), VHTs are directed to borrow stock from neighboring VHTs.
- In [Sierra Leone](#), CHWs may access buffer stock from NGO partners.

Shortages and stockouts at higher levels of the health system are likely to be felt most at the community level. Local contingency plans may mitigate some supply issues, but stockouts may be difficult to avoid.

Poor guidance in many countries affects service delivery and may also discredit community health providers and the overall health system. Establishing clear protocols provides options or permission for community health providers to manage stockouts and reduce programmatic disruptions through other means (e.g., by borrowing from other CHWs), at least in the short term.



Supply Management

WASTE MANAGEMENT

Guidance for community health providers on how they should safely and correctly dispose medical waste is critical to preventing the spread of disease, injury, pollution, and litter.

How available is guidance?



15 countries have guidance for how community health providers should dispose medical waste. In some countries, like [Tanzania](#), training curricula mention waste management but do not provide any details.

What does available guidance say?

Typically, policies guide community health providers to segregate types of waste (biomedical, sharps, plastics, etc.), place them in appropriate containers, and regularly bring them to a designated health facility or other location for incineration, burial, or transport to a higher-tier facility for disposal. Some policies directly mention following WHO guidance.

Policies in [India](#), [Malawi](#), and [Pakistan](#) direct community health providers to dispose of medical waste themselves through incineration or burial.



Supply Management

NATIONAL ESSENTIAL MEDICINES LISTS

The CHS Catalog documents whether or not the latest Essential Medicines List in each of the 25 countries includes certain medicines, commodities, and supplies necessary for key interventions in family planning, maternal, newborn, and child health, HIV and AIDS, tuberculosis, diarrhea, malaria, and nutrition.

The following pages present this information, summarizing content from the Essential Medicines Lists below.

COUNTRY	LIST
Afghanistan	National Essential Medicines List of Afghanistan (2014)
Bangladesh	National Drug Policy with Essential Drug List and OTC List (2016)
Benin	Generic Essential Drugs by Therapeutic Class and Corresponding Specialties (2009)
DRC	National List of Essential Medicines (2010)
Ethiopia	National Essential Medicine List (2014)
Ghana	Essential Medicines List (2010)
Haiti	National List of Essential Medicines (2012)
India	National List of Essential Medicines (2015)
Kenya	Kenya Essential Medicines List (2016)
Liberia	Essential Package of Health Services (2011)
Madagascar	National List of Essential Medicines and Health Inputs in Madagascar (2014)
Malawi	Malawi Standard Treatment Guidelines (2015)
Mali	National List of Essential Medicines (2012)
Mozambique	National List of Essential Medicines (2016)
Nepal	National List of Essential Medicines (2011)
Nigeria	Essential Medicines List, 5th Revision (2010)
Pakistan (Punjab province)	National Essential Medicines List of Pakistan (2007)/Essential Package of Health Services for Primary Health Care in Punjab (2013)
The Philippines	Essential Medicines List (2008)
Rwanda	National List of Essential Medicines for Adults, 6th Edition; National List of Essential Medicines for Paediatrics, First Edition (2015)
Senegal	National List of Essential Medicines and Products of Senegal (2013)
Sierra Leone	Sierra Leone Basic Package of Essential Health Services (2015)
South Sudan	Southern Sudan Essential Medicine List (2007)
Tanzania	Standard Treatment Guidelines and National Medicines List for Mainland Tanzania (2007)
Uganda	Essential Medicines and Health Supplies List for Uganda (2016)
Zambia	Zambia Essential Medicine List (2013)



David Rockkind/USAID

Supply Management

NATIONAL ESSENTIAL MEDICINES LISTS

Country	CycleBeads	Condoms	Emergency contraceptive pills	Implants	Injectables	IUDs	Oral contraceptive pills	Calcium supplements	Iron/folate	Misoprostol	Oxytocin	Tetanus toxoid	Chlorhexidine	Cotrimoxazole	Injectable gentamicin	Injectable penicillin	Oral amoxicillin	Tetanus immunoglobulin	Vitamin K	
Health area	FAMILY PLANNING						MATERNAL HEALTH						NEWBORN AND CHILD HEALTH							
Afghanistan		+			+	+	+	+	+	+	+	+	+		+	+	+		+	
Bangladesh		+	+	+	+	+	+	+	+		+	+	+	+	+	+	+	+	+	
Benin	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
DRC	+	+	+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Ethiopia		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Ghana		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Haiti		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	
India		+	+			+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Kenya		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Liberia		+	+	+	+	+	+	+	+		+	+	+	+		+	+	+		
Madagascar		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Malawi		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Mali	+	+	+	+	+	+	+		+	+	+	+	+	+	+	+	+	+	+	
Mozambique		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Nepal		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Nigeria		+		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Pakistan		+	+	+	+	+	+		+		+	+	+		+	+	+	+	+	
Punjab province		+	+		+	+	+	+	+	+	+	+	+		+	+	+		+	
The Philippines					+		+	+	+	+	+	+	+	+	+	+	+	+	+	
Rwanda		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Senegal	+	+	+	+	+	+	+	+	+	+	+	+		+	+	+	+	+	+	
Sierra Leone		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
South Sudan		+	+		+	+	+	+	+		+	+	+		+	+	+	+	+	
Tanzania		+	+	+	+	+	+		+	+	+	+	+	+	+	+	+	+	+	
Uganda	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	
Zambia		+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+		+	

Supply Management

NATIONAL ESSENTIAL MEDICINES LISTS

Country	Antiretrovirals	Isoniazid (for preventive therapy)	Oral rehydration salts	Zinc	Artemisinin combination therapy	Insecticide-treated nets	Paracetamol	Rapid diagnostic tests	Albendazole	Mebendazole	Ready-to-use supplementary food	Ready-to-use therapeutic food	Vitamin A
Health area	HIV & TB		DIARRHEA		MALARIA			NUTRITION					
Afghanistan	+	+	+	+			+		+	+			+
Bangladesh	+	+	+	+	+		+		+	+			+
Benin	+	+	+	+	+		+		+	+			+
DRC	+	+	+	+	+	+	+		+	+		+	+
Ethiopia	+	+	+	+	+		+		+	+			+
Ghana	+	+	+	+	+		+		+	+			+
Haiti	+	+	+		+		+		+	+			+
India	+	+	+	+	+		+		+	+			+
Kenya	+	+	+	+	+		+		+			+	+
Liberia	+	+	+	+	+		+			+			+
Madagascar	+	+	+	+	+	+	+	+	+	+		+	+
Malawi	+	+	+	+	+		+		+	+	+	+	+
Mali	+	+	+	+	+		+		+	+			+
Mozambique	+	+	+	+	+		+		+	+		+	+
Nepal	+	+	+	+	+		+		+				+
Nigeria	+	+	+	+	+		+		+	+			+
Pakistan	+	+	+	+	+		+		+	+			+
Punjab province		+	+	+	+		+			+			+
The Philippines	+	+	+	+	+		+		+	+			+
Rwanda	+	+	+	+	+	+	+	+	+	+			+
Senegal	+	+	+	+	+	+	+	+	+	+			+
Sierra Leone	+	+	+	+	+	+	+	+	+				+
South Sudan	+	+	+	+	+		+		+	+			+
Tanzania	+	+	+	+	+		+		+	+			+
Uganda	+	+	+	+	+		+	+	+	+		+	+
Zambia	+	+	+		+		+		+	+			+



Cross-cutting Areas

National community health policies highlight various topics that cut across the health system building blocks. Gender, community engagement, and multi sectoral approaches to improving health are among the most prominent.

The CHS Catalog captures key information on these cross cutting areas, documented in this section.

Cross-cutting Areas

COMMUNITY ENGAGEMENT

Countries have increasingly focused on community ownership to help ensure longer-term sustainability of community-based health programs, and consequently have involved **community groups** and **civil society** in programming. Ideally, policies provide clear guidance on the roles they can play and how their work might enhance the health of their communities.

How available is guidance?



All **25 countries** mention the roles of community groups in community health.



23 countries mention the roles of civil society organizations.

What does available guidance say?

Guidance for the roles of civil society organizations and community groups is incredibly diverse and varies in comprehensiveness. Policies frequently outline community group composition, retention, selection, scopes of work, training, incentives, and other areas.



Guidance for Community Groups

- 23** countries define a **scope of work** for community groups.
- 21** countries include information on group **composition** and **reporting** responsibilities.
- 19** countries include information on group member **selection** and their roles in **monitoring and evaluation**.
- 15** countries describe community group roles in **health service quality improvement**.
- 10** countries define how community groups can be **incentivized**.



Cross-cutting Areas

GENDER

Many countries include gender considerations and recommendations within their community health policies and strategies to enable gender equity and equality in accessing health services and improving health indicators.

How available is guidance?



20 countries include gender content in community health policies.

What does available guidance say?

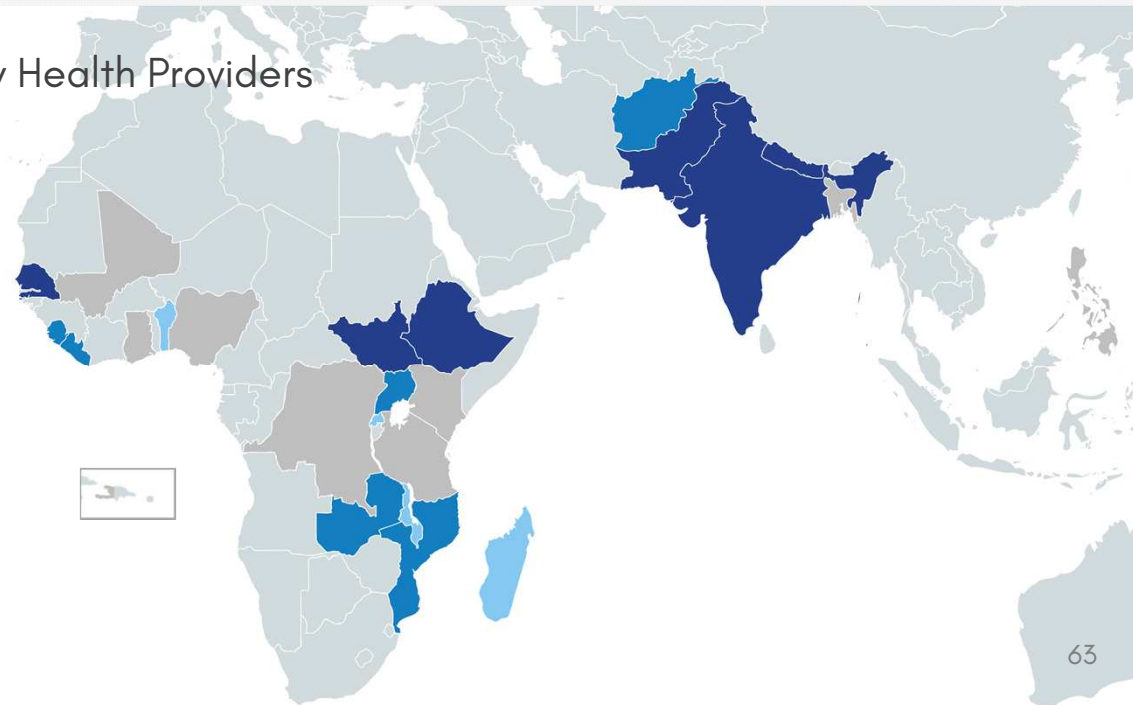
Policies mention gender in a myriad of ways, including:

- acknowledging challenges for women seeking health care
- addressing and preventing gender-based violence
- ensuring female representation in community groups and in community health management
- prioritizing selection of female community health providers

Few countries, however, have community health guidance on how to address gender inequities in health.

Guidance on Gender for Community Health Providers

- 9 countries have female-only community health provider cadres.
- 6 countries have community health provider selection criteria that give preference to women.
- 4 countries explicitly state that community health providers can be male or female.
- 9 countries do not have gender-specific guidance for selecting community health providers.



Cross-cutting Areas

ENGAGING OTHER SECTORS

Community health programs often have connections to other sectors to reach a wider client base, leverage resources, and achieve greater overall health impact. Multi-sectoral approaches to improving community health are found both at national and subnational levels.

How available is guidance?



At least 19 countries have a community health program that is linked to one or more additional sectors and described in policies.

What does available guidance say?

The education sector is most often linked to community health programs; 58 of the 89 community health programs are linked to the education sector. Many of these programs have developed or implemented health curricula in schools.

40 community health programs are linked to the private sector, often to support public sector collaboration with private clinics or partnerships to diversify or supplement community health financing.

Only 7 programs do not mention linkages to other sectors.



EDUCATION

A number of programs incorporate general health promotion messages into student lesson plans on topics like good nutrition, malaria prevention, and warning signs of respiratory or diarrheal diseases. Schools are also a common place to conduct immunization and nutrition campaigns.



FINANCE

Ministries of Finance support budgeting and planning processes for community health programs and allocate funds for implementation.



AGRICULTURE

A number of community health programs have partnerships with nutrition and agriculture programs to promote food security. In Senegal, a nutrition program brings in agricultural sector representatives to teach people how to plant and manage community gardens.

PRIVATE



Private sector partners, such as local and international NGOs, faith-based organizations, and for-profit companies and providers, work with the public sector to plan, implement, finance, and otherwise support community health programs. In Bangladesh, private community residents donate land for community clinics, while the government funds clinic construction, supplies, personnel, and management. In other countries, private sector actors may furnish resources such as medicines or cell phones to community health providers.

OTHER



Additional sectors that programs are linked to include environment, sanitation, social protection, transportation, and media, among others.



Natasha Kanagat/ISI

Key Takeaways

This snapshot of the global community health policy landscape illustrates that:

1. **Greater alignment and clarity of terminology is needed to inform the global conversation on community health providers.** The CHS Catalog captures the breadth and diversity of tasks, skills, and characteristics of the community health workforce across countries and regions. Efforts to develop more consistent definitions, such as the forthcoming WHO CHW Guidelines, should provide policymakers, program planners, implementers, and donors more consistent language to better convey information about best practices, experiences, and lessons in community health.
2. **Community health funding should align with the growing number of community health provider responsibilities.** Although countless studies demonstrate community health providers' vast capabilities and the many benefits of task-sharing, experience also shows that they are overtasked and overburdened, and often lack training and support to ensure high-quality performance. As their responsibilities increase, adequate financial investment in community health programs is key to ensuring they have sufficient training, supervision, mentorship, commodities, and supplies, etc. Community health policies and strategies must include budget items to support providers and other community health system inputs.
3. **Comprehensive and well-designed policies are the foundation for optimal program implementation.** The CHS Catalog reveals that community health information is often scattered across policies, and even when countries do have community health-specific policies, they are often vague, contradictory, or incomplete. Furthermore, implementation plans for these policies at the national and subnational levels are not always developed. Therefore, it is critical to design policies and implementation plans that are comprehensive, detailed, adequately financed, informed by the on-the-ground realities and include the voices of individuals these programs are meant to serve.



Considerations for Harmonizing Community Health Systems

1. Support efforts to fill policy gaps, such as those the CHS Catalog data has highlighted, which include:
 - Insufficient information about how community health programs are to be financed in the long term.
 - Unavailable or incomplete data on the actual and planned numbers of community health providers.
 - Few details on how informal community health provider cadres relate to the formal health system.
 - Disparate or inconsistent information on community health provider training.
 - Lack of substantive guidance for how community data should be used, shared, and integrated into national health information systems.
 - Incomplete or little information about certain community-based interventions. For example, family planning guidance is lacking for provision of emergency contraceptive pills and education on natural family planning methods.
2. Consider using a [human-centered design approach](#) to include community members and other subnational health actors in the policy design process. Active engagement at the local level can help ensure buy-in for implementation and ultimately reduce bottlenecks in program scale-up.
3. Develop a clear plan to roll out community health policies and strategies effectively, and ensure they reach those responsible for implementation. Policy dissemination is not a standalone process but part of larger implementation efforts that include stakeholders at all levels of the health system, including the communities that will benefit.

Further Information

Visit the APC CHS Catalog webpage at www.advancingpartners.org/resources/chsc to access 25 detailed country profiles, a list of key community health policies and strategies, a downloadable dataset, and several infographics.





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