

FAQs - PMI Community Health Worker Payment Policy

On June 29, 2021, PMI officially announced a change in policy regarding use of PMI funds for payment of Community Health Worker (CHW) salaries and stipends, and PMI funds from any fiscal year may now be used to pay CHWs who provide community-based malaria case management services as part of the package of services they deliver.

With this change in policy, many questions have arisen from the PMI field-based teams and from other stakeholders on the expectations around the use of PMI funds for CHW payments, as well as the “how to” for beginning to pay CHWs, including how to support relevant ministries in establishing an enabling policy environment and implementation mechanisms. In this document, which complements PMI’s broader technical guidance, we begin to address some of these questions and to clarify the nuances around the adoption of this policy.

There are three sections to this document: [General Clarifications](#), [Recommendations and Requirements](#), and [Evidence and Resources](#), each of which will be updated as new questions are asked and answered, and as more PMI country teams begin to use PMI funds to contribute to CHW payments.

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GENERAL CLARIFICATIONS

What are PMI priorities for CHW support? Is the main focus payment? How does this all fit into broader health system strengthening efforts?

The second strategic focus in PMI's [2021-2026 strategy](#) is Strengthening Community Health Systems. USAID's *Vision for Health Systems Strengthening 2030*¹ defines a community health system as: *a set of local actors, relationships, and processes engaged in producing, advocating for, and supporting health in communities and households outside, but related to, the formal health system. Health and community systems are dynamic overlapping systems that independently contribute to improving health.*

The idea of investing in the systems -- not just the services -- community health workers deliver, underpins PMI's approach to community health system strengthening to improve access and quality of malaria prevention, treatment and care. One helpful framework for thinking about the components of systems are the 5 S's: selection (also related to another S: saturation), skills, supervision, supplies, and salaries². All of these system components are priorities for PMI and support for them should be conducted through the lens of broader health system strengthening to ensure that community health systems are integrated with and function as an extension of primary health care generally, wherein CHWs should be understood and incorporated as part of a country's health workforce and appropriately supported as such with the other systems components³. There has been much discussion around payment of CHWs, as this is a PMI policy shift and a newly allowable area for PMI investment. However, it should be stressed that PMI payment of CHWs is not prioritized over the other components of community health system strengthening, which continue to be a key focus of PMI. In fact, payment is synergistic with investments in other systems levers like supplies and supervision.

As with all of PMI's investments, decisions on how to prioritize the many local needs for CHW support and on how CHW payment systems should be established and monitored should be made in concert with the host country government, in alignment with local policy and in response to gaps (ie there is a present inability of the host country to undertake recurrent cost financing for CHW payment and other donors are not covering this cost).

Support for CHWs is not the only way PMI headquarters defines how PMI reaches the unreached. The best definition comes from the strategy itself, which is inclusive of but broader than CHWs:

“Reach the unreached: Achieve, sustain, and tailor deployment and uptake of high quality interventions with a focus on hard-to-reach populations.

¹https://www.usaid.gov/sites/default/files/documents/USAID_OHS_VISION_Report_FINAL_single_5082.pdf

² See <https://www.exemplars.health/topics/community-health-workers/cross-country-synthesis/recommendations> for more information. Other examples of guiding frameworks such as the WHO AIM tool are described and linked in the resources section of this document.

³ For more information see another set of [5 S's of health system strengthening](#) and USAID's own HSS vision: <https://www.usaid.gov/global-health/health-systems-innovation/health-systems/Vision-HSS-2030>

1. Achieve and maintain coverage of high quality interventions to reach the highest malaria burden, highest need populations in each country.
2. Tailor deployment of interventions for maximal impact, using the right tools, in the right place, at the right time.
3. Leverage data for decision-making and monitoring of progress and impact.”

Please refer to the PMI strategy for more information on how PMI aims to reach the unreached with a tailored set of interventions such as community case management, appropriate vector control and social and behavior change activities. While there may be many ways to reach the unreached, according to the context, CHWs are an important means of reaching the unreached as they are, by definition, working in communities and are crucial for extending the reach of essential supplies and services. However, they are not the only means, and country teams should use data to inform their decisions. This policy shift comes in a moment where there is global movement around revitalizing health system strengthening and primary health care. This is a strategic opportunity that requires both an enabling environment and tactical considerations, each of which are detailed later in this document.

Which cadres are we referring to? Can PMI pay any of them?

This policy refers specifically to CHW cadres whose package of services includes routine implementation of community case management for malaria. (See question below on integration.) Compensation of CHW cadres for specific campaign style activities may continue as it always has, with intentional thought to how campaign-style activities can be structured in a way that lends itself to the institutionalization⁴ of CHWs.

Is it a requirement that PMI start paying CHWs?

No. As stated in the original communication from the Coordinator on this policy shift, “ In settings where payment of CHWs is in line with government policy and resources are needed to implement the policy, PMI may have an important role to play.” Country teams should work with the Ministry of Health (MOH) and other relevant ministries and donor partners to determine whether and how to move forward on funding CHW payment and when adjustments to CHWs policies might be required. Additionally, there are very few settings where PMI could cover all of the cost of CHW payment without compromising other important priority PMI-supported activities. We expect PMI to catalyze actions (e.g. changes in MOH policies, creating leverage to encourage investments in CHW payment from other USG or non-USG funding sources) in support of CHW payment with the Ministry of Health and other local donors, but it is not likely that a PMI country budget would be able to cover all implementation costs.

⁴ More broadly, “institutionalization” of iCCM refers to effective iCCM programs that are ministry-led, adequately resourced and managed, and with long-term commitments of support from partners. A report from a WHO- and Unicef-led technical consultation on Institutionalizing iCCM to end preventable child deaths, including ten recommendations for institutionalizing iCCM programs can be found here: <https://apps.who.int/iris/bitstream/handle/10665/333541/9789240006935-eng.pdf>

What are sustainability and locally led development considerations related to CHW payment?

This of course is a big (and incredibly important) question without easy answers. While sustainability has been used as a justification to *not begin* to pay CHWs, the same criterion has not been applied to many other investments that PMI supports such as commodities. This shift in PMI's policy is in line with the global recognition that CHWs should be fairly paid for their work in delivering life saving services (see details on the WHO guideline on this from 2018 below in the section on evidence) -- and clear evidence that paying CHWs and enhancing other components of the systems to support them improves the delivery of malaria services and [accelerates elimination](#)⁵. The goal is for governments to strengthen their community health systems and ultimately work towards compensating all of their staff, including CHWs. But we also need to be realistic about the timeline in which it will be feasible for host governments to cover CHW payment with domestic resources and in many contexts a sustainable financing pathway/strategy will include a mix of funding sources including donors and blended finance (e.g., from multilateral / regional development banks), with increasing government financing over multiple years. That said, having a progressive costing and sustainable financing plan in place before moving forward with paying CHWs with PMI funds is required. PMI and other donors can collectively support governments to develop such a plan and can consider formalizing this plan through an MOU. It is not necessary that funding for the full plan needs to be secured prior to PMI paying CHWs, but that there must be a pathway so that the MOH, PMI and other donors can understand what gaps PMI funding is filling and what gaps remain. Efforts should be encouraged to coordinate a plan for sustainable financing of CHWs with other donors (e.g. Global Fund, PEPFAR, World Bank/Global Financing Facility) and technical partners (e.g. UNICEF, Financing Alliance for Health).

Understanding that PMI funds are appropriated on an annual basis, PMI encourages country teams to plan for a minimum of three years of support. If the PMI team does not have a clear plan for how this investment is aligned with MOH, other USG or other donor support and can sustained (within the country PMI funding envelope or including other resources) for a minimum of three years, it should work with USG, other donors, including multilateral development banks, and MOH partners to define a sustainable strategy to ensure that CHW payments are sustained with non-PMI resources. This will look differently depending on the context. For example, PMI could progressively increase funding over the first half of a plan as the government or other funding sources concurrently meet targets for complementary support, and then scale back over time with the expectation of domestic resources filling in. Another approach could be a strategy of donor matching for host government commitments. The Evidence and Resources section in this document contains further information on best practices and lessons learned in this area.

Further, the payment of CHWs with USAID resources is a clear example of investing locally, another

⁵ Landier et al., 2016. The role of early detection and treatment in malaria elimination. *Malar J* 15, 363 (2016). <https://doi.org/10.1186/s12936-016-1399-y>

focus of PMI's strategy and an important component of sustainability.

Can you explain the difference between salary, stipend and incentives? What is a salary supplement that was mentioned in the initial communication on the new policy?

“Incentives” is the broadest term, and this can be non-financial (e.g., community and health sector recognition), in-kind (e.g. equipment or other goods/special privileges), or financial (e.g. cash compensation for services rendered, allowance for transport or training, performance-based financial reward, direct and regular salary or stipend). What PMI's new policy is referring to is this last example of financial incentives: regular salary or stipend. While a salary is usually understood to be a regular payment through the government payroll, a stipend can be provided via a contract and paid by an implementing partner. It is differentiated from an ad-hoc or conditional payment tied to campaign activities that PMI has always been able to pay. The bottom line is that through either a salary or a stipend, CHWs may be paid commensurate with their work in line with government policies, which is PMI's goal.

The original communication on PMI's new policy contained the following language on USAID policy: *This change in PMI policy is consistent with USAID policy on salary payments in the ADS, which allows for payment of host country government salaries as part of a longer-term goal to achieve sustainable staffing approaches using non-USG sources. In addition, while PMI funds may not be used for salary supplements (i.e., top-ups), they may be used to support bonuses or incentives for CHWs who meet performance-based criteria that are directly linked to achieving program goals.*

This language is in reference to ADS 201 mau, which prohibits support of salary supplements for host government employees or anything beyond base salary compensation for a regular pay period worth of work. A salary supplement is a top-up (additional payment on top of existent salary) wherein a funder would increase what the government is already paying (for the same work) and run the risk of inflating salaries beyond what is sustainable for a government to continue to pay and/or cause the employee to prioritize certain activities. Salary supplement does not include cover of host government employee salaries (base compensation for base pay period's worth of work) and is allowable under USAID policy⁶.

How does this PMI policy relate to those from other donors?

New strategies from [Global Fund](#) and [World Bank/Global Financing Facility](#) highlight investing in community health systems, including payment, as a priority. Several global health philanthropies, including

⁶ See State Cable 11978 (April 15, 1988), which defines salary supplementation as follows, 'SALARY SUPPLEMENTATION OCCURS WHEN PAYMENTS ARE MADE THAT AUGMENT AN EMPLOYEE'S BASE SALARY OR PREMIUMS, OVERTIME, EXTRA PAYMENTS, INCENTIVE PAYMENT AND ALLOWANCES FOR WHICH THE HG EMPLOYEE WOULD QUALIFY UNDER HG RULES OR PRACTICE FOR THE PERFORMANCE OF HIS REGULAR DUTIES OR FOR WORK PERFORMED DURING HIS REGULAR OFFICE HOURS.' (para 3(b))

the Bill and Melinda Gates Foundation, ELMA Philanthropies, Mastercard and Buffett Foundations⁷, also have increasingly prioritized galvanizing payment of CHWs in recent years. Facilitating collaboration between these institutions and PMI is something the Community Health Team and Front Office can also support, as needed.

Will PMI only pay for community case management of malaria? In most countries, this is implemented through integrated community case management (iCCM), and CHWs have varying packages of services outside of iCCM. Does this mean that a CHW cannot be paid for pneumonia services? Is there a risk that non-malaria services will be de-emphasized?

The language on malaria case management was intended to differentiate routine case management activities from campaign style activities like net distribution and IRS, for which we already pay actors, including CHWs. It was not intended to distinguish payment for case management of malaria from case management of pneumonia and diarrhea. If a cadre implements iCCM , PMI may pay for the entire, regular salary or stipend for the CHW. However, in countries where MCH, HIV/TB, Global Health Security/Pandemic Preparedness and Response/COVID-19, or other streams of funding are available (as applicable to the government-defined package of services for the CHWs), it is highly encouraged for this support to be shared across funding elements to strengthen the integrated platform. Integration offers many opportunities to leverage PMI's resources in this area, both within iCCM services but also for other health services. For example, PMI's investments in community health workers have helped countries fight COVID-19. From Liberia to Thailand, community health workers looking for people with fevers have found people with COVID-19, tracked their contacts, promoted mask use, and educated about COVID-19 vaccines.

Noting that the timing of PMI country funding discussions for other streams of funding may not be aligned, it is important that country teams discuss coordination of support before these cycles begin, and continue these conversations throughout the funding cycle.

What considerations should we take into account when trying to accommodate these costs within fixed budget envelopes and amongst competing priorities?

We know that PMI country teams have to make difficult budget decisions each year. However, given the launch of PMI's 2021–2026 strategy, we are asking country teams to take a step back and look critically at their investments to see how they are contributing to the attainment of PMI's objectives, as well as

⁷ See, for example, the BMGF-funded [Exemplars](#) work on community health workers and [Mastercard's commitment to the Africa CDC](#), which includes support for training and paying community health workers.

broader MOH strategies. We know that CHWs are a critical lever in getting there. Examples of global and country investment cases for CHWs are provided in the Evidence and Resources section. As stated elsewhere in this document, where there is strong interest in using PMI funds to contribute to CHW payments, PMI country teams should work with the MOH, other donors, and stakeholders to determine if CHW payment can be a shared expense and to jointly identify how practical, sustainable systems can be developed to ensure that CHW payments are implemented in a manner which takes into consideration the many obstacles faced in delivering these payments. PMI HQ teams are also available to help country teams think through the potential risks and benefits of changing how PMI resources are prioritized.

RECOMMENDATIONS AND REQUIREMENTS

What are the global recommendations around paying for CHWs?

WHO's 2018 [guideline on health policy and system support to optimize CHW programs](#), **strongly recommends** (1) "remunerating practising CHWs for their work with a financial package commensurate with the job demands, complexity, number of hours, training and roles that they undertake;" and (2) "providing paid CHWs with a written agreement specifying role and responsibilities, working conditions, remuneration and workers' rights."

Are specific models of compensation recommended? What about performance-based models?

While the WHO guideline does not recommend any specific models of remuneration, the next part of the recommendation is a suggestion to *not* pay CHWs exclusively or predominantly according to performance-based incentives. This suggestion was due to their potential encouragement of certain activities associated with incentives and neglecting other responsibilities, moral hazard and mis- or over-reporting, and reported CHW dissatisfaction with performance-based incentive schemes. Recent [research](#) led by the Community Health Impact Coalition found that public-sector models or models with public-sector wage floors were the best models to institutionalize recommended CHW protection. Additional evidenced-based resources are available [here](#).

Are there any requirements about what needs to be in place in-country before PMI funds can be used to pay CHWs?

For PMI to be successful in supporting CHWs the following pieces need to be in place, each of which will be discussed in detail in the subsequent questions and answers in this section:

1. An enabling policy environment
2. Coordination and harmonization with other donors in the space
3. A progressive costing and financing plan to ensure sustainability in the long term
4. An implementing partner or mechanism with the ability to provide payments (including a

determination that the payment of CHWs is within scope).

5. A detailed plan for *how* CHWs will be paid (see [detailed list](#) of what this should include below)
6. A plan and mechanism for tracking payment of CHWs
7. A learning agenda to set the guiding questions to be answered as PMI and partners move forward in-country under this new policy

It should be noted that many health offices have staff dedicated to health systems strengthening and implementing patterns who work on these systematic issues. We encourage PMI teams to work with other health offices to ensure these requirements are met.

PMI teams are not required to submit a formal report indicating that all of these requirements have been met, however, they should be prepared to address each of these requirements upon requesting to allocate funds for the payment of CHW salaries. PMI recognizes that, in many settings, it will take time to ensure that all of these pieces are in place, and that the work to lay the foundation is an essential piece of strengthening community health systems in support of PMI's objectives.

What does PMI consider an “enabling policy environment”?

An enabling policy environment in this context means that the government has an official policy that states that CHW are a part of the country's health workforce and may receive routine financial compensation for the work they do to support the health system. Community health policies vary widely by country and some may include details such as the salary amount to be paid; while others may not include a lot of detail, which might require more work to ensure a harmonized approach among partners financially supporting CHWs. Since the community health program generally sits outside of the NMCP, PMI teams are recommended to work alongside their USG and NMCP colleagues to engage with national community health structures such as Directorates of Community Health and other relevant ministries such as Finance or Workforce, along with elected decision makers, as well as multilateral development banks (e.g. World Bank/GFF, Africa Development Bank), that sometimes restrict the proportion of government expenses that can be devoted to salaries. This engagement is important for understanding how CHWs are situated within a country, and the different government structures and policies that determine the various components of community health system strengthening, such as the provision of routine financial compensation. Country teams are encouraged to work with these same government entities as well as with other local partners and donors in the country to develop or update these enabling policies and to generate the political will and develop national investment cases that prioritize the implementation of these enabling policies⁸.

⁸ For additional information, see examples of country-level work on creating an enabling policy environment that has been done by the [Financing Alliance for Health](#), examples of national investment priorities from the [Community Health Roadmap](#), and a [global investment case](#) for investing in CHWs.

What are the operational differences in applying this policy for countries with devolved government settings?

Countries in which policy and operational decisions are made at a state or county level pose both additional challenges and opportunities. The requirements listed above for paying CHWs in a centrally managed environment also apply to devolved settings, and it is recognized that the policy environment, plans, and mechanisms may differ and this may increase the management burden. However, there are also opportunities for innovation and sharing evidence and lessons learned from one decentralized local government to another that may help with advocacy efforts.

What do we do if we do not have sufficient PMI resources in the current or future fiscal years to pay CHWs? Could we pay a small portion of them? Could we pilot a model of paid CHWs?

It is not expected that PMI would be able to cover the costs of all of the CHWs in a country (or even the part of the country where PMI focuses). The intent of this policy shift is to be catalytic; that PMI coming to the table with funding to pay CHWs would bring other global (USG and non-USG) and local (public and private sectors) partners on board to share in the investment (and resulting return on investment) into CHW compensation and to approach it in a harmonized fashion across. Depending on the package of services for CHWs as defined by the country's policy, country teams in missions with multiple streams of funding are highly encouraged to use an integrated mechanism to combine funding streams as appropriate.

PMI country teams may consider paying only the CHWs in the "PMI focus" geographical areas where we work, but working with other donors and host governments to ensure that CHWs across the country are paid in a harmonized fashion is essential. While a pilot may be an important step in reaching full-scale, institutionalized compensation of CHWs, please note that a pilot would be subject to the same planning requirements as listed above for payment of CHWs with PMI funds more broadly, with the distinction that in the case of a pilot of a new policy, the "enabling policy environment" requirement would look like support from relevant ministries for a specific approach.

What can PMI do in countries where there is not a policy environment or Ministry of Health that is supportive of CHW payment?

In settings without a policy in support of payment of CHWs, we do not expect PMI to unilaterally change this. We do encourage PMI teams to think of their power as a convener, to speak with Mission and MOH colleagues and other partners (e.g. World Bank/GFF, Global Fund, PEPFAR, philanthropies, and other community health technical and implementing partners), gauge whether there is shared interest and possibility for fostering a more favorable policy environment, and advocate for that change.

PMI funds can be used to support the development of CHW policies⁹ and guidance that covers the full package of services provided by CHWs, as long as malaria case management is included. PMI funds can also be used to ensure the integration of vertical CHW programs into health sector-wide systems. This is in fact encouraged as it promotes sustainability and efficiency.

Depending on where a country is in terms of both remuneration and institutionalization, there are various entry points in which PMI teams can engage (directly or through partners). These entry points include the creation of political will for reform, capitalization on emerging political will and a mandate to inform, and the implementation and scale-up of best practices¹⁰.

Are there suggested amounts for CHW compensation?

PMI does not have any specific recommendations for the amount CHWs should be compensated, as the amount will vary by country and context. CHW compensation should be aligned with government policies on payment of health care workers and, according to WHO's recommendation, "commensurate with the job demands, complexity, number of hours, training, and roles that they undertake." In countries where there are policies that support CHW payments but no amount is given, country teams should work with MOH and other relevant ministries, as well as other stakeholders who may contribute to CHW payments, to determine an appropriate payment amount for CHWs and to incorporate this into formal policy. If the country has a policy regarding minimum wage, CHW payments should not fall below this amount.

Some countries may have policies regarding CHW compensation which provides an amount that falls below minimum wage. In these instances, we encourage PMI teams to think of their power as a convener, to speak with Mission and MOH colleagues and other partners to advocate for CHW compensation aligned with minimum wage standards. The International Labor Organization's global report on wages and minimum wages can be found [here](#). CHWs who work less than full time may receive a prorated wage that is commensurate with hours worked and national minimum wage. Aligning with other donors and/or ministries who may be financially supporting CHWs is an important piece of ensuring that paying CHWs contributes to institutionalization and professionalization of CHWs. As a point of reference, a [recent publication](#) documents the monthly salary of CHWs across 10 countries in sub-Saharan Africa and calculates a median of \$35/month.

What is the role of PMI vis-à-vis other donors who in some cases may be the main supporters of CHWs?

In countries where other donors are the main supporters of CHWs, PMI country teams can support the MOH and other relevant ministries to ensure that CHW remuneration policies are clear and consistent across the country, and that there is a plan for continuing payments to CHWs if/when the other donor

⁹ For concrete examples of the steps countries have taken, starting with generating political will and developing policies, see detailed write-ups on this process from [Liberia](#) and [Ethiopia](#).

¹⁰ Community Health Impact Coalition, 2021. Pay Community Health Workers presentation. <https://vimeo.com/630263325#t=52m30s>

activities are scheduled to end (as noted in the response to the question about requirements above). If CHW salaries are fully covered by others, it may not be appropriate or necessary for PMI to take on this role, and PMI can instead focus on other components of strengthening the community health system (see description of the 5 S's above). There may be a need to recruit additional CHWs (and ensure they are paid in line with existing CHWs, either through coordination, advocacy, or PMI funds) in order to reach the country's desired coverage targets, or to increase the skills, supervision, and/or supplies of current CHWs. Our hope is that countries with fully supported CHW programs will share lessons learned and best practices on how this was achieved, similar to the examples shared in the [Exemplars in Global Health](#) country narratives.

In many countries, multiple donors may be needed in the short-term to ensure that CHWs are paid, and PMI may have an important role to play in filling gaps. Community health programs have historically suffered from fragmentation within countries and as noted in the aforementioned Exemplars case studies, it is important to ensure coordinated and harmonized approaches between donors while working to ensure a sustainable financing pathway/plan/strategy is in place. PMI and USAID more broadly are also coordinating with other major donors at the global level (including the Global Fund, Unicef, BMGF, and the GFF), and HQ can provide support if needed with coordination efforts.

What are the expectations for ensuring the sustainability of PMI taking on the compensation of CHWs?

Paying CHWs in line with government policy and in alignment with government pay scales is an essential component of sustainability. As stated above, PMI encourages country teams to plan for a minimum of three years of support. Additionally, planning for the use of PMI funds must be done in conjunction with MOHs and other partners and include a clear plan for securing long-term financing in which PMI would not commit to cover more than ten years with expectations defined for all parties involved, with annual benchmarks and a list of policy/regulatory actions that need to be taken to ensure the successful transition of CHW payment. This should be a part of the Monitoring and Evaluation plan for this investment. It is recognized that reaching these agreements can take a significant amount of time. See the Evidence and Resources section for resources on the many steps necessary for achieving long-term sustainable financing.

What are the mechanisms we can use to pay CHWs?

In countries where Government to Government (G2G) mechanisms are in place, and where policy supports the payment of CHWs, local governments can use PMI funds to pay CHW salaries directly through their usual mechanisms.

In countries without G2G agreements, implementing partners can be used to pay CHWs via agreements with the government. In this situation, the government is the one guaranteeing that the CHWs will be paid (e.g. through a government contract), but the money comes from an implementing partner without

them being hired or contracted by the implementing partner. In these arrangements, implementing partners should consult with government partners on the appropriate salary, taking into account the sustainability concerns mentioned above. Also note that a mechanism should be designed in a way that allows for this, and consider project end dates vis-a-vis the length of PMI's commitment to pay CHWs. In future designs of central and bilateral funding mechanisms, the opportunity for both PMI and any other streams of funding to contribute to CHW salaries should be taken into consideration.

WHAT KIND OF PLAN NEEDS TO BE IN PLACE TO THE *HOW OF* PAYING CHWS BEFORE WE MOVE FORWARD?

Once again, there is no one size fits all with regards to payment. Country teams will need to think through the complex, detailed “how to” for CHW payments in their particular countries. Teams should consult with appropriate government partners including but not limited to MOHs, Ministries of Finance, and Directorates of Community Health. Particular attention should be paid to the potential impact of introducing CHW payment on other national programs and partners working in community settings.

Some points to consider:

- How payments will be made and monitored (e.g., cash, banks, digitally and how the system will be designed to ensure timely payments, which can include interaction between levels of government, whether or not payment is contingent upon a report)
- Frequency of payment
- Criteria for enrolling a CHW in the payment scheme
- Mechanisms (such as a CHW master list and/or registry, see question below) for tracking of CHWs
- Data sharing protocols/memorandums of understanding (what kind of data, how often etc) between a potential IP facilitating payments and the MoH

As has been stated, PMI should be acting within government policy, but many policy documents do not get into these details, and it can take time to lay the groundwork for this, and the work to set up systems for payment should not be understated, particularly if there is a shared investment with other health elements or other donors or host governments in order to undertake this systems-building work in a way that moves toward institutionalization of CHWs. However, it is important for PMI to engage in this groundwork with MOH and partners and not be put off by its sometimes daunting nature.

What are the expectations for tracking and reporting on compensation support with PMI funds?

Countries using PMI funds to pay community health workers will be expected to work with the MOH and partners to track the number of CHWs supported financially each year, the logistics around payment (ie., timeliness, completeness), nationally and disaggregated by district, and gender of the CHW. (Such tracking is also recommended for other forms of CHW support such as training and not limited to payment.) An especially encouraged way of doing this is through the establishment and/or maintenance of a national CHW master list (see next question) or through coordination with other ongoing monitoring and evaluation efforts within the community health platform in order to avoid fragmentation and duplication of efforts.

In addition, implementing partners must spend their resources and track their expenditures in a manner consistent with USG requirements according to the funding agreements in the case of USG audit. For reaching the unreached, it is also important to track the gaps in CHW coverage overall and in CHW payment in PMI-supported areas. As mentioned in the section on sustainability, it will be important also to track progress on the plan for host government ownership. Given the importance of CHW payment within the PMI strategy, countries should expect an initiative-wide data call on this (modality will be determined as the broader strategy implementation and reporting process evolves). M&E of CHW programs more broadly is an important consideration, and tracking of salaries should be linked to tracking performance and other systems components (retention, for example).

What is a Community Health Worker Master List (CHWML)?

A national georeferenced CHW master list is a “single source of truth” that contains essential data elements required to effectively describe, enumerate and locate all CHWs in a country. A CHWML, as opposed to a point in time effort to enumerate CHWs, is routinely updated and is ideally stored in a registry and integrated with national human resources for health (HRH) systems. A coalition of stakeholders have recently developed an [Implementation Support Guide](#) on the development of a national georeferenced CHWML hosted in a registry. PMI teams are encouraged to work with MOH and partners to ensure funding for the development and routine maintenance of the CHWML is secured.

How do we document and share what we learn along the way?

Given the many complexities that are outlined in this document, there are many questions that will need to be answered once country teams move forward. Teams are encouraged to develop a [learning agenda](#) that will help country teams and PMI more broadly to fill critical knowledge gaps and understand how the payment of CHWs does (or doesn't) contribute to the advancement of PMI's objectives. The sharing of lessons learned between countries will be essential moving forward as we all seek to learn together.

EVIDENCE AND RESOURCES

What is the evidence in support of payment of CHWs?

In the rationale for issuing their [recommendation](#) that CHWs should be remunerated for their work, WHO explained that the majority of reviewed studies were supportive of providing CHWs a financial package. Quantitative studies provided evidence that financial incentives may lead to improved CHW performance, and qualitative studies found that financial payments were well accepted, provided motivation and recognition, and may bring a sense of financial independence and self-confidence to CHWs. Additionally, this decision-making process included broader criteria such as labor rights and legislation, linking to the sustainable development goals (SDGs) promoting decent work and economic growth and achieving gender equality¹¹.

What are lessons learned from other intervention areas about paying workers?

It is important for teams to not underestimate the amount of effort required to set up and maintain these routine payment systems for CHWs. Detailed planning for how payments will reach workers is essential, and there are some lessons learned from campaign-style interventions (the settings in which PMI has historically conducted payments). One best practice is the signing of contracts (which include an anti-sexual harassment clause).

Another best practice is the use of digital payments. For example, Impact Malaria found that using digital payments for SMC in Mali resulted in >99% of workers being paid on time, that the use of microfinance institutions to pay costs up front in Niger was highly motivating, and that systems like Cameroon's that used cash payments encountered many difficulties in terms of on-time payments because of the extra verification that was required. Using a mobile payment was also found to be a best practice from ITN and IRS mass campaigns as well—it facilitates rapid payment but also reduces the risk of carrying large sums of cash in the field and has been found to be more gender equitable. (See this [success story](#) on the transition to mobile payment from VectorLink for more details). However, there are also lessons learned about the challenges of mobile payment along with ensuring careful planning and coordination with cell phone providers to ensure adequate coverage and local banks, and double checking rosters and cell phone numbers. *Given these lessons learned, digital payments (with careful planning) are highly encouraged where feasible.*

What are lessons learned from countries that have paid CHWs?

There are many lessons learned from across PMI partner countries and elsewhere, both in terms of successes and pitfalls to avoid when it comes to paying CHWs.

¹¹ <http://www.ilo.org/global/topics/decent-work/lang--en/index.htm>

- Ethiopia is often cited as the best example of an institutionalized CHW program. A detailed case study on how Ethiopia arrived at this success identified the following components: problem-driven approach to program design, political leadership, donor coordination, extended and structured piloting period, and commitment to evaluation and adaptation. Details on these insights can be found [here](#).
- Liberia has a very specific policy about donor investment in CHWs that specifies that all donors supporting CHW programs must do so in a harmonized way and at a fixed amount. The package of services CHWs provide is standardized, and so is the financial compensation commensurate for those services. A [detailed description](#) of the many steps in the process that Liberia underwent to get to this enabling policy environment can be found on the Exemplars website.
- In South Africa, labor unions and civil society advocates were very influential in pushing for a financing mechanism for CHWs, highlighting the importance of understanding the levers and individual people that influence policy.

Are there experts outside of PMI we can reach out to with additional questions?

Yes! [The Community Health Roadmap](#), the [Community Health Impact Coalition](#), and the [Financing Alliance for Health](#) are great resources. PMI (and USAID more broadly) are deeply engaged with these partners, so please reach out to the PMI community health team to facilitate a connection.

Are there other resources out there to help us think through this?

So many resources! So many, in fact, that they can be overwhelming, so we've attempted to create a guide to the resources here:

Global Reports

[*Strengthening Primary Health Care through Community Health Workers: Closing the \\$2 Billion Gap:*](#)

Report includes investment case for integrated community health system, quantification of funding gaps, and lesson learned on mobilizing financing

[*Strengthening Primary Health Care through Community Health Workers: Investment Case and Financing*](#)

[*Recommendations*](#): Report includes sections with investment case for CHWs and another on Developing a Pathway to Sustainably Finance Systems Costs

e-Learning

There is an incredibly comprehensive e-learning course on [Financing Community Health Worker Programs for Scale and Sustainability](#), which includes modules on political prioritization, costing, resources mapping and gap analysis making the case, sources of funding, investment planning and creative systems for sustainable financing, and public financial management.

Country-Level Information: Case Studies and Landscaping of CHW programs

The [Community Health Roadmap](#) platform includes individual roadmaps for community health programs investment priorities in featured countries (scroll down a ways to the map on the link provided to go to individual country pages).

[Exemplars in Global Health](#) (2019) undertook research on CHW programs broadly (including impact and challenges) and with deep dives into programs (including great details on the process for getting to the point where CHWs are paid) in [Ethiopia](#) and [Liberia](#), as well as case studies on [Bangladesh](#) and [Brazil](#) and a [cross-country synthesis](#).

[Health for the People National CHW Case Studies](#) (2020): 29 case studies of national CHW programs that provide good contextual and systems support information and summarize available information on CHW roles and performance.

[MCSP Landscape Analysis of National Community Health Worker Programs](#) (2019): Key features of programs in 22 MCHN priority countries that aims to provide a cross sectional reference point for the status of national CHW programs and highlight promising practices and gaps.

[Community Health Systems Catalog](#) (2017): Collated by the Family Planning-focused Advancing Partners and Communities project, this downloadable dataset includes information from policies and related documentation across 25 countries.

[Human Resources for Health Assessment](#) by Vital Wave, Intrahealth and Cooper Smith which looked at twenty countries to identify what is in place as well as the contextual factors that shape the health workforce information ecosystem environment. The assessment team mapped the administrative processes and data flows for three use cases to identify bottlenecks and promising “bright spots”: recruitment and deployment, salary payments, and performance management.

[PMI Digital Community Health Initiative Country Profiles](#): Developed beginning in 2020 to understand the current digital environment and define country-specific priorities for using digital technology in community health programs. While the focus is digital tools, the assessments and recommendations are rooted in the people, governance, and systems that underlie the implementation of digital tools, so these profiles are valuable resources for thinking around broader system strengthening efforts, such as paying CHWs.

Peer-Reviewed Research

[Compensation models for community health workers: Comparison of legal frameworks across five countries](#) (2021)

[Continuity of Community-Based Healthcare Provision During COVID-19](#) (2021): Demonstrates how *adequately supported* CHW programs were able to maintain the continuity of essential services during the pandemic.

[Community health workers at the dawn of a new era: Programme Financing](#) (2021): Synthesis of literature to make the case for investing in health programs, HRH, primary health care, and CHWs.

[Community health workers at the dawn of a new era: Incentives and remuneration](#) (2021): Provides examples of incentives that have been provided to CHWs and identify factors that motivate and demotivate CHWs.

[Understanding community health worker incentive preferences in Uganda using a discrete choice experiment](#) (2021)

Tools

[Community Health Planning and Costing Tool](#) (2020): designed to cost packages of community health services and produce results to help assess performance, plan future services, and prepare investment cases.

[Community Health Worker Assessment and Improvement Matrix \(CHW AIM\) Tool](#) (2011): Examines 15 programmatic performance components (including incentives) and includes action planning and resources guide.

[CHW AIM Updated Program Functionality Matrix for Optimizing Community Health Programs](#) (2018): Designed to identify design and implementation gaps in both small- and national-scale CHW programs, and close gaps in policy and practice.

[Toolkit for Improving Community Health Facility Management Committees: Program Functionality Assessment](#) (2017): Could be of use to countries considering using these platforms for CHW payment

[USAID Flagship CHW Resource Package](#): Collated by HRH2030, this resource package pulls together resources on CHW policy implementation enablers, and tools for building, managing, and optimizing CHW programs.