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LOCAL HEALTH SYSTEM SUSTAINABILITY PROJECT

ESTABLISHING CAREER PATHWAYS FOR COMMUNITY HEALTH WORKERS – MODELS AND KEY CONSIDERATIONS

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LHSS TECHNICAL BRIEF

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1. Introduction

There is renewed momentum in strengthening primary health care as a cornerstone for resilient health systems and universal health coverage. Community health workers (CHWs) are integral to unlocking the full potential of primary health care, with over three million CHWs delivering essential services at the community level in low- and middle-income countries (LMICs).[1,2]

CHWs contribute to equitable primary health care by often serving as the frontline providers for underserved, marginalized, and hard-to-reach populations. They serve as a bridge between communities and health facilities, supporting referrals, improving continuity of care, and promoting health seeking behavior in a culturally appropriate manner.[3,4] CHWs are also an agile and responsive cadre that played critical roles in awareness raising, community mobilization, contact tracing, and data collection and reporting during the COVID-19 and Ebola outbreaks as part of national response plans.[5,6]

Yet despite CHWs' value in providing accessible, affordable, and people-centered primary health care, their roles are often loosely codified, inconsistently remunerated, and poorly integrated into formal health systems. Fifty percent of CHWs in LMICs serve as volunteers and receive little to no compensation.[7] CHWs also lack pathways for career progression, which contributes to low job satisfaction, demotivation, and attrition. These are key challenges for countries relying on primary health care and community health systems for expanded coverage of essential services and strengthened preparedness for future pandemics.

As part of the global effort to better recognize, support, and formalize CHWs as health care professionals, the World Health Organization (WHO) recommends focusing on career pathways for improved integration and optimization of CHW programs.[8] The 2023 Monrovia Call to Action that emerged from the 3rd International CHW Symposium in Liberia echoes this need for career progression opportunities as part of professionalizing CHWs—along with fair remuneration, adequate training and supervision, and access to supplies and equipment needed to deliver essential services.[9] Still, few programs exist that integrate CHWs into national health systems and have established career pathways. This in turn limits evidence and learning around

designing and operationalizing career progression for CHWs.

The USAID Local Health System Sustainably Project (LHSS) is implementing a multi-phased activity to address these knowledge gaps. The project has the following aims:

- **Phase 1:** Review, document, and spotlight evidence on the design and implementation of career progression models for CHWs, and their impact on motivation and retention
- **Phase 2:** Provide evidence-based and contextually tailored technical assistance to support CHW career-progression opportunities in three LMICs
- **Phase 3:** Contribute to the global knowledge base on CHW career pathways by disseminating findings and promoting the use of this evidence in policy and practice

LHSS's work in this area aligns to USAID's objectives for building high performing resilient health systems and supports the U.S. Government's Global Health Worker Initiative, which calls for increased and sustained investments to better professionalize CHWs in support of the Sustainable Development Agenda.[10] It will also contribute evidence and learning to USAID's Primary Impact Initiative for an integrated and harmonized approach to primary health care.[11]

This technical brief synthesizes findings from the first phase of LHSS's work. It distills results from a desk review, a convening of experts, and key-informant interviews that explored successes, challenges, and promising practices from countries currently designing or implementing career pathways for CHWs. As part of this inquiry, the brief identifies systems considerations for CHW career progression, including health workforce education and training, regulation and policy, management, and financing.

The brief is intended to 1) serve as an evidence-based resource for LHSS's technical assistance to partner countries in the second phase of the activity, and 2) inform decision makers within LMICs and the broader global health community working on design and implementation for CHW career progression, including policy makers, program managers, and funders. LHSS plans for a series of spotlight briefs on this topic in phase 3 of the activity that synthesizes learning from its phase 2 technical assistance and explores considerations for CHW career progression in more depth.

In drafting this brief, LHSS acknowledges the lack of a standardized definition for CHWs and the existence of different CHW typologies across countries depending on their role, education level, remuneration. Although LHSS is using WHO's CHW definition[12], this brief considers evidence that referenced career progression and professionalization irrespective of typology to capture the breadth of existing evidence around career progression in the context of CHW motivation and retention. Notably, the desk review surfaced articles related to CHWs and career progression that ranged across the spectrum from volunteer community health workers with some formal education to salaried CHWs who have completed a secondary education program and at least a year of formal training. Box 1 reflects LHSS's definition of key terms for the purposes of this brief.

Box 1: LHSS's Operational Definition of Key Terms

Community health workers: health care providers who live in the community they serve and receive lower levels of formal education and training than other health care workers such as nurses and doctors.

Professionalization*: Processes to formalize CHWs as a health cadre with distinct professional value and roles. This can include establishing pre-service requirements, job descriptions, supervision and mentoring structures, performance management, and professional and career development.

Career pathway*: Clearly defined and established sequence of positions that align with CHW skills and competencies to guide upskilling and upward career mobility.

Career progression*: Advancement or change to a different role with different scope based on set qualifications related to training and years of service. This can be either an upward or lateral move within the CHW track or other professional tracks.

*As part of developing this brief, LHSS established and used these definitions based on how the terms and concepts are used in the literature, and by country stakeholders. However, LHSS does not intend to offer standardized definitions of these terms.

2. Methods

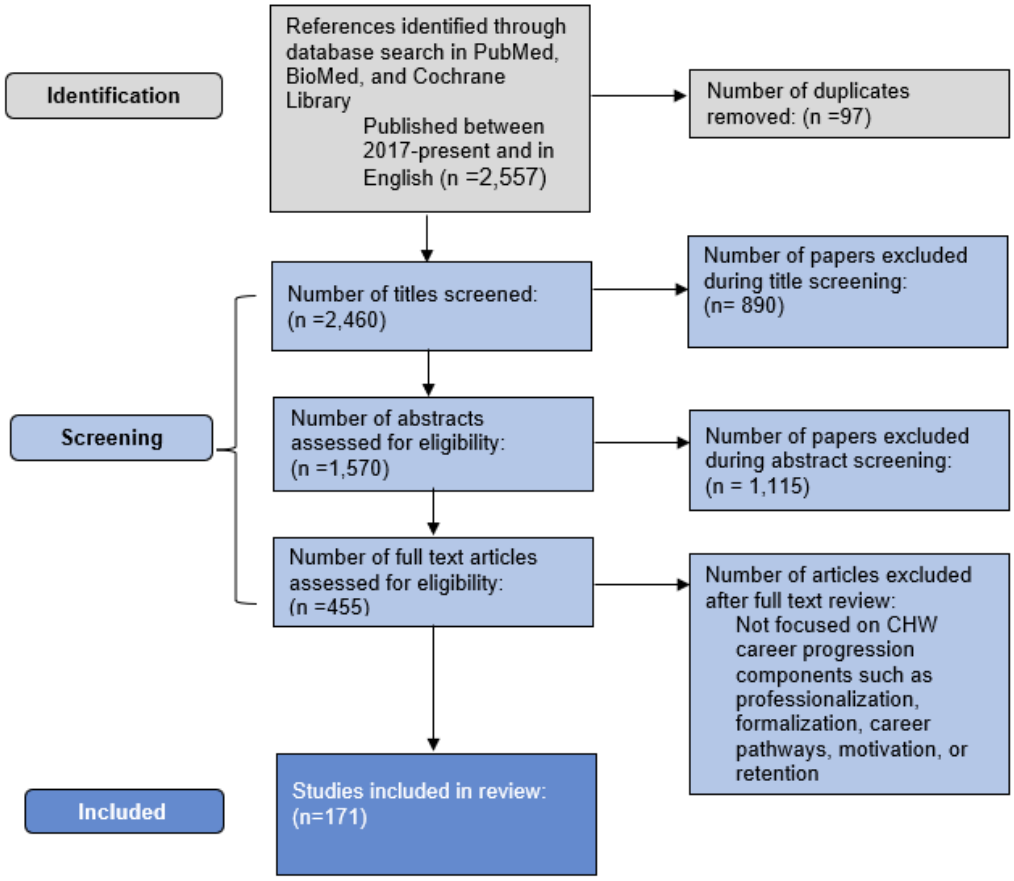
LHSS conducted a rapid desk review of evidence on CHW career progression and its links to motivation and retention. LHSS aimed to identify and assess new evidence published after the release of WHO's 2018 guidelines to optimize CHW programs.[13] LHSS also examined documented experiences from countries that have formalized CHW programs with career pathways. LHSS used Cochrane's guidance for rapid reviews[14] and searched PubMed, BioMed, and Cochrane Library databases. LHSS limited results to articles that were published in English from 2017 to 2022. The initial search resulted in 2,557 articles. Of these, 97 were duplicates and 890 were excluded after title screening. LHSS screened the abstracts of 1,570 articles and conducted full-text review of 455. Of these,171 were included in the final analysis. The final 171 articles were from countries at all levels of socioeconomic development status.

See Figure 1 for a flowchart showing the identification, screening, and inclusion of articles.

LHSS complemented the rapid desk review with a convening of experts working in the community health arena. Fifty participants representing 10 countries attended the virtual experts convening. Participants represented countries that have professionalized CHW programs, health workforce and CHW advocacy institutions, implementing partners, and donors. In panel and break-out sessions, attendees discussed LHSS's desk review findings and shared their perspectives on facilitators and barriers, promising practices, and other cross-cutting considerations such as financing and data for designing and implementing career pathways for CHWs.

In addition, LHSS reviewed selected gray literature and held one-on-one conversations with targeted country stakeholders as part of developing this brief.

FIGURE 1. RAPID DESK REVIEW FLOWCHART



3. Findings

What models have countries used to establish career progression for CHWs?

CHWs are diverse in terms of pre-service education levels, in-service training, designated roles, and remuneration. There is also a spectrum of professionalization and integration into health systems, from those operating outside of the system to those who are government employees and a formal part of the health system. Consequently, career progression opportunities differ across countries depending on the unique context for the CHW program and local priorities. In general, however, most countries with CHW career pathways require CHWs to meet formal education requirements and engage in ongoing trainings.

> *"Contextualization and customization [of CHW pathways] is important...need to address unique needs… and [countries] must have ability to manage the whole cycle including recruitment, training, and promotion."*
>
> –Experts Convening Participant

Countries are using different models to establish career progression for CHWs. These include:

- Career ladders that entail increased breadth or depth in scope of practice with each position. Ethiopia, Pakistan, and Nigeria have defined promotional pathways with set technical requirements for CHWs. For example, in Nigeria CHWs can progress from Junior CHW, to Community Health Extension Worker, to Community Health Officer.[15] In Ethiopia, CHWs (known locally as Health Extension Workers (HEW)) can progress from Level I through Level IV, with Level IV offering specialized training equivalent to a bachelor's degree.[16]
- Career ladders that entail leadership, management, and supervision roles. These are used in Brazil, South Africa, and the United States. For example, in the United States, some hospitals and health systems have education and training requirements for a CHW to advance to Lead CHW and take on managerial and administrative responsibilities.[17] In South Africa, embedding CHWs in formal management structures and expanding the scope of teams to include organizational relations, coordinating mechanisms, and communication structures that allow for interactions across all facility staff was found to build organizational support and create a feeling of respect for the work of CHWs.[18]

Country representatives from Ethiopia and Pakistan shared that their CHW programs have a hybrid model where CHWs who are promoted to higher positions are expected to have advanced technical skills and supervise, coach, and lead other CHWs. In Ethiopia, Level IV HEWs have advanced trainings and are required to oversee and mentor Level III HEWs. Similarly, in Pakistan, CHWs (known locally as Lady Health Workers (LHW)) receive additional technical trainings as one of the criteria to progress to a LHW supervisor position. This position comes with an expanded scope of supervision and mentorship.

Countries also have advanced practice and education opportunities that are not linked to formal career pathways. These opportunities offer in-service upskilling, advanced training, and scholarships to CHWs. Affording such opportunities serves to strengthen CHWs' technical capacity, increase professional value and status, and potentially support transition to another health worker role. These kinds of opportunities are available in Botswana, India, Liberia, Uganda, and United States.[19,20,21,22,23]

A CHW checks on a pregnant mother's health condition as a part of her daily door-to-door duty in Gazipur, Bangladesh.

In Botswana, CHWs have access to in-service training on specialized topics such as tuberculosis management.[23] In India, professional and training opportunities were found to be key factors influencing Accredited Social Health Advocates' job choice. This led to government reforms to provide scholarships for completing secondary school and preferred admission to nursing and midwifery schools, among other changes.[24,25]

Why is career progression important for CHW programs?

There is some documented evidence of high attrition among CHWs.[26,27] As countries seek to optimize and professionalize CHW programs as part of formal health systems, there is a need to couple these efforts with approaches that improve CHW motivation and retention. Context is important in determining what drives motivation and retention, though there are several documented cases of incentives related to professional development and career progression opportunities influencing CHW motivation. Accordingly, there are increasing calls to account for career progression in efforts to professionalize CHWs.[9]

> *"CHWs are requesting professional advancement, and this ties into their motivation."*
>
> –Experts Convening Participant

A multi-country study in 2021 found that opportunities for professional and personal development motivate CHWs the most whether paid or volunteer.[28] In Cameroon, training, supportive supervision, and provision of job-enabling resources like uniforms were linked with motivation and autonomy of CHWs.[29] CHWs in Lebanon who were trained and awarded training certificates through the Mobile University for Health program reported increased motivation, credibility, and community trust.[30] This highlights that professional development opportunities can have an impact not only on CHWs' individual performance, but also on how their professional identity is perceived and accepted by their communities.

During the LHSS virtual convening, country experts leading the design and implementation of career pathways noted achievements including reduced CHW turnover and increased community and national recognition of CHWs' contribution to improved community health outcomes, especially among low-income households. While the parameters of the LHSS desk review did not surface linkages between CHW programs with formalized, functional career pathways and health systems performance, such as cost effectiveness, efficiency or equitable delivery, this potential impact merits further exploration as countries move forward with integration of CHW programs into health systems.

Conversely, the literature and country stakeholders cite lack of career progression, as well as lack of meaningful support, coaching, and rewards for good performance, as contributors to CHW demotivation and attrition. In Kenya, community health volunteers in a 2021 study expressed feeling demotivated without a clear career path that would result in a paid position.[31] Similarly, quasi-volunteer Accredited Social Health Advocates in India indicated that their motivations to stay in their roles was often rooted in the hope of eventually developing a career and acquiring salaried government positions, although very few of these opportunities were available to them.[32]

Paid CHWs echoed these sentiments, with a 2023 study in Ethiopia finding that limited education and career progression opportunities were one of the factors for demotivation among CHWs.[33] In a different study, over half (51.5%) of CHWs surveyed in Ethiopia indicated feelings of frustration when thinking of their limited future career development opportunities. Young and/or newly recruited CHWs (hired within the previous two years) comprised a larger proportion of this group, with key implications for the retention of this cadre.[34] Career progression was also linked to motivation among paid CHWs in the United States, where CHWs shared a sense of legitimacy and motivation to stay in their role because of newly created career pathways.[35]

Other studies also found that lack of career progression is a particular challenge for recruiting and retaining young CHWs who are often interested in cultivating a long-term career and new socioeconomic opportunities. In Tanzania, CHWs shared that they were motivated to join the program because they were seeking a starting point for a career in health care, and that their desire to receive additional training to be a qualified medical practitioner was a

motivating factor to both join and stay in their CHW role.[36] Gender is another social factor that intersects with career progression opportunities. A study in Afghanistan found that female CHWs face significant barriers to promotion and were often sidelined for career progression opportunities due to harmful gender norms and limited access to education, impacting their motivation.[37]

Municipality Health Workers register vaccination data during a community campagn for COVID-19 screening and vaccination in Memo Village, Timor-Leste. (Photo: USAID LHSS Project-Timor-Leste)

What challenges do countries face in establishing career pathways as part of professionalizing CHWs?

While career pathways are documented as incentives for improved CHW motivation, implementation plays a key role in their effectiveness. Poor program implementation often leads to reduced CHW motivation.[42] It is likely that poor implementation of career pathways also has implication for CHW retention. However, the evidence is limited.

Countries that attempt to design and implement career pathways navigate several challenges related to policy, system, and practice, including:

- **Uncoordinated and siloed planning that limits standardized CHW training, accreditation, and ultimately career trajectories**. For example, in Afghanistan, health workers were typically trained by institutions under the Ministry of Higher Education. However, the Ministry of Higher Education was not involved in and did not accredit the CHW curriculum developed by the Ministry of Health. This meant that CHWs were not able to get into advanced educational programs administered and accredited by the Ministry of Higher Education with their CHW training and experience.[38] In South Africa and Cambodia, siloed implementation of CHW programs, including training, limited government ownership and integration into the health system, which could have implications for the CHWs absorption into the formal health workforce and their long-term career potential.[39,40] In Nigeria, CHW enrollment in pre-service training programs was hindered by several barriers, including challenges with program accreditation and insufficient publicity and information sharing on program openings and enrolment processes.[41] This impacted and often discouraged enrollment into training programs, and ultimately limited the efficacy of programs designed to offer CHWs pathways to professionalization.
- **Vague and inconsistent CHW recruitment, promotion, and incentive policies and practices**. A multi-country assessment of motivation and job satisfaction among salaried and unsalaried CHWs in Bangladesh, Kenya, India, Malawi, and Nigeria found that lack of clarity and consistency around hiring, training, and incentivizing CHWs lead to misaligned practices that could contribute to CHW dissatisfaction.[15] They also cause unclear expectations of advancement opportunities, leading to "broken promises" that impact motivation.[42] For example, in Zambia, CHW recruitment postings advertised career pathways, but the pathways remained unimplemented for over 1,400 new recruits.[43]
- **Time and material costs associated with attending formal trainings**. In Ethiopia, for example, country representatives noted that although CHWs can pursue government-funded higher education, the living costs for those wishing to take advantage of the opportunities—such as housing and transportation costs—were key hurdles. In Nigeria, tuition cost was reported as a barrier for CHWs hoping to attend formal training programs.[44]

- **Lack of CHW involvement in policy design, implementation, and evaluation**, which restricts CHW voice and severely limits discussions and advocacy on institutionalizing career pathways for CHWs.[45,46]

While these challenges are not unique to CHWs, there is an added layer of complexity for this cadre of workers who frequently benefit the least from the resources and structures of health systems. The same is true for crosscutting challenges countries face related to adequate and sustainable financing, availability and use of data, and gender and social inclusion factors when attempting to establish or expand career progression opportunities for CHWs. The paragraphs below expand on these three crosscutting factors based on findings from the desk review and experts convening.

Financing: Adequate financing and remuneration are key challenges to CHW programs. Governments are hesitant to legislate and commit to investing in CHW professionalization components such as career pathways because of minimal health budget allocations toward primary health care and community health.[47] And with less than 3 percent of development assistance for health being directed toward CHWs—mostly in vertical, siloed programming—financing remains a major barrier for CHW program design and implementation.[47] This limits career progression opportunities countries can sustainably fund for CHWs.

In addition to competing priorities for funding, LHSS heard from country stakeholders that the available fiscal space for CHWs and their career pathways is further narrowed by the impact of the COVID-19 pandemic on the global economy and emerging system stressors related to climate change. Thus, current models of national CHW programs with adequate and sustained domestic funding that have professionalization and career progression components are limited. Countries like Botswana, Brazil, Ethiopia, Ghana, Malawi, and Pakistan have budgeted for CHW career pathway components with a mix of domestic funding and foreign assistance. Such budgets covered integration of CHW compensation in government pay scales and benefits, development and delivery of training modules, and expansion of regulatory, supervision and management structures. However, country stakeholders LHSS spoke with underscored financing as one their core challenges for sustaining or accelerating progress for CHW career pathways and called for further exploration of financing models, including a graduation financing approach.

> *"Financing is a sticking point for most CHW programs and is something to examine in upcoming UHC agenda."*
>
> –Experts Convening Participant

Data: Data plays an important role in CHW program design, budgeting, and monitoring and evaluation. Comprehensive data can elevate the visibility of CHWs' contributions and support evidence-based advocacy for improved professionalization, including career progression opportunities.[47] Enumeration and inclusion of CHWs in national health budgets is also likely to facilitate their further integration into formal health systems. During the LHSS experts convening, country representatives shared experiences using data for targeted CHW recruitment and scope development. In Nigeria, data from the WHO Workload Indicators of Staffing Need (WISN) tool informed decision-making around increased CHW staffing and conversations around potential task sharing and task shifting. However, fragmented data collection and reporting platforms limit the availability and use of CHW data for policy and programmatic decision-making.[47,48,49,50] This lack of data on the number and type of CHWs and the services they provide can hamper planning and designing for effective career pathways. This is reflected in the limited evidence the desk review surfaced on the use of data for CHW career pathways.

> *"There is need to expand upon formalization and training approaches, and data can be used to understand where CHWs are currently engaged as well as where CHWs are needed to support achievement of UHC."*
>
> –Experts Convening Participant

Gender and social inclusion (GESI): GESI is an important factor to consider in designing and implementing CHW career pathways. Societal and cultural norms influence who has access to and can take advantage of progression opportunities, so it is important to recognize and account for power dynamics and imbalances in program design.

> *"Biases that women face, including sexual abuse, harassment at work, coercion to exchange sexual favors for promotion, etc. impact career progression, motivation, performance, health, and safety of female CHWs. These are very real problems that must be addressed when discussing the CHW workforce and career progression."*
>
> –Experts Convening Participant

With women predominantly serving as CHWs, country stakeholders who participated in the LHSS experts convening shared that CHW programs are often perceived as an avenue for empowering women. The role empowers women by providing them with opportunities to travel and socialize outside of the home; develop leadership, communication, and health literacy skills; and earn income. It also enables increased decision-making power; access to education opportunities and health care; and, in some cases, improved socioeconomic status.[51,52,53,54] These benefits lead to spillover effects as investments in developing, supporting, and paying women positively affects their families and communities. For example, in Bangladesh, a study found that female CHWs tend to apply their honorarium towards their children's education and income generating activities, producing a dividend for the investment that goes beyond the CHWs.[52]

However, there is a large body of literature on the negative impacts of gender and social norms on CHWs and their prospects for career progression. Normative recruitment and promotion practices perpetuate existing social biases and challenges, leading to preference for either younger or male CHWs for training and progression opportunities.[54,37,55] Access to education also presents a major systemic hurdle for CHWs seeking professional development. Women from lower socioeconomic levels or other underserved groups have less access to education. This leads to their exclusion from career progression opportunities that come with certain education requirements despite their years of experience as health leaders within their communities.[54,50] This exclusion is exacerbated by social expectations that CHWs balance domestic duties along with their CHW responsibilities, as well as their vulnerability to violence while working and traveling.[56,57,58] Further, the normalized concept of unpaid labor for CHW work disproportionally disempowers women, both professionally and economically. This is particularly true if, in addition to no or limited payment, CHWs are also not offered professional development opportunities. In a few studies, CHWs described pursuing or staying in their roles to secure improved socioeconomic status and living conditions, which often did not materialize.[59,38,60,61]

4. Country Spotlights

This section showcases CHW programs in two countries—Malawi and Pakistan—that offer promising practices for designing and integrating career pathways at a national scale. The information presented below reflects information shared by country representatives at the LHSS experts convening.

Malawi CHW Program – Health Surveillance Assistants

Context: The Malawi Ministry of Health hired the first cohort of health surveillance assistants (HSAs) to support immunization and cholera response programs in the 1990s. HSAs have since supported numerous vertical health programs and campaigns, making significant contributions to Malawi's achievement of Millennium Development Goals for child health.[62,63] In 2017, Malawi launched the National Community Health Strategy 2017-2022—the country's first such strategy—in response to high disease burden, funding and resource constraints, and service quality issues. Currently, over 11,000 full-time HSAs and senior HSAs operate in Malawi under this strategy. Approximately 60 percent are men and 40 percent are women in each cohort. HSAs and senior HSAs are supported by informal community health volunteers, village health committees, community health action groups, and health management committees. They provide promotive, preventive, and curative services. They also support surveillance and data management.

Pre-service requirements: HSAs must complete secondary school. HSAs undergo 12 weeks of pre-service training (eight weeks classroom and four weeks practicum), with approved plans for a one-year modular course to replace this training. The new one-year course offers HSAs an opportunity to take courses related to other health disciplines such as nursing, pharmacy, and environmental health. It will also be an accredited training under a regulatory body—the medical council of Malawi.

Career pathway: HSAs can transition to senior HSAs after passing a standardized oral examination by the civil service commission. Senior HSAs are responsible for leading service delivery and supervising HSAs in their catchment areas. Currently, there are approximately 9,500 HSAs and 1,500 senior HSAs. There is also a newly created pathway to promote senior HSAs to assistant disease control officers, following a one-year diploma training and certification.

Remuneration: HSAs are government salaried civil servants. A costing exercise was conducted to estimate salaries for established HSA posts. This was included in the Ministry of Health's overall health workforce remuneration package. HSAs receive approximately USD $180-300 per month, with senior HSAs earning at the higher end of the range. They also receive additional financial (i.e., irregular per diems) and non-financial incentives (e.g., protective wear, uniforms, bicycles, and recognition).

Funding: The HSA program is part of Malawi's national health workforce accounts and national health budgets. HSA salaries are covered by the government and represent the largest cost driver (30 percent) of the overall program costs. The government is working to ensure HSA positions are included in all district budgets. Other priorities include aligning the national costed community health framework with the national strategic health plan and disseminating the national community health framework to implementing partners for targeted support around key priorities (e.g., capacity building, performance recognition and career progression opportunities).

Success factors: Key factors in the success of Malawi's HSA program include strong political ownership (the government has committed to and successfully absorbed HSAs who were previously supported by development partners); inclusion of HSAs in all relevant policies and strategies; formal integration of HSAs into health workforce management tools and frameworks; consultative engagement with the Ministry of Finance as part of the process to align priorities; phased approach that started small and scaled up incrementally; and coordinated resource mobilization with government and partners.

Implementation challenges: Key challenges include limited financing to recruit additional HSAs while also increasing HSA wages and the length of time required to establish and institutionalize new CHW positions and trainings.

Accomplishments: During the experts convening, country representatives shared that the program's established career progression opportunities have resulted in increased demand to join the HSA career path; a decrease in HSA turnover; national recognition of HSAs as key frontline health workers; and positive spillover effects to other health workforce cadres (e.g., clarification of roles and responsibilities).

Pakistan CHW Program – Lady Health Workers

Context: The lady health workers program was developed in 1994 in response to human resource constraints and urban-rural health care divides. The LHW program is an all-female cadre of approximately 100,000 formalized health workers who provide a range of preventive and promotive health services to a catchment of roughly 1,000 patients per one LHW.[64] LHWs spend approximately 80 percent of their time in the field and the remaining 20 percent in community-based health facilities.

Pre-service requirements: LHWs must have a minimum of 10 years of formal education and LHW supervisors must have a minimum of 14 years of formal education. Pre-service training to become a LHW includes three months of classroom study and nine months of field-based learning. Continuous, on-the-job refresher trainings occur one day per month, for a total of approximately 15 days per year. LHWs are selected by the communities they serve and must reside within their designated catchment area.

Career pathway: LHWs who undergo additional training and achieve a specified tenure are eligible to advance. The additional trainings cover skill-based topics such as basic emergency obstetrical care, among other topics.[65] An individual must have one year of experience as a LHW to be promoted to a LHW supervisor, and two years of experience as a LHW supervisor to be eligible to become a field program officer.[64] LHWs and LHW supervisors are overseen by district and provincial coordinators. There are ongoing discussions to further expand and clarify career pathways for LHWs in Pakistan.[66]

Remuneration: LHWs receive salaries based on a government salary scale. LHWs earn approximately USD $50-125 per month, with LHW supervisors earning approximately USD $60-180 per month.[64,67,68] Both cadres are eligible to receive travel stipends. No other financial benefits are provided, but there is ongoing LHW-led advocacy for pensions and other benefits in most provinces.

Funding: LHW salaries are part of the government's health sector budget. The government also finances LHWs' one-year pre-service training, in-service trainings, and scholarships for advanced education.

Success factors: Key factors in the success of Pakistan's LHW program include strong political will and government ownership; effective coordination with development partners; standardized recruitment and training criteria; partnerships between the community, LHWs, and facility-based providers; and mobilization and advocacy by LHWs.

Implementation challenges: Key challenges include limited and inconsistent funds for trainings and supportive supervision and the high level of formal education required to become a LHW. Country stakeholders emphasized that the latter is a major barrier for LHW recruitment in the Pakistan context where women often have limited access to education.

Accomplishments: During the experts convening, country representatives shared that LHWs are accepted and nationally recognized by their communities and the government for their contributions to community health—particularly the health of low-income and impoverished households—across Pakistan. Other accomplishments include greater job security among LHWs following their regularization, and government-supported education, training, and employment for rural and urban Pakistani women.

5. Key Considerations for Countries Seeking to Establish or Enhance Career Pathways for CHWs

Context is important. CHW programs are spread across diverse contexts and roles and responsibilities will differ across countries based on capacity and need. Efforts to design CHW career pathways should start with in-depth analysis of the landscape to understand and align with health workforce priorities, available resources, profile(s) of existing CHW knowledge and skills, and any contextual challenges. This work should also include mapping out existing policies and practices related to health workforce regulation, education and training, and management such as certification, continuing professional development, performance management, planning and budgeting and other components of the overall local health workforce systems.

A comprehensive view of a country's CHW programs and its health workforce systems could inform contextually appropriate career pathways for CHWs and facilitate integration with the broader health system. For example, depending on their level of education and staffing needs at facilities, certain CHWs could move beyond the community to participate in facility-based services or join other health professions such as nursing, while other CHWs stay and grow as community-based providers. In other cases, context will inform differentiation of CHW roles and entry points to the cadre, including whether to maintain CHW volunteers as one form of entry point. Furthermore, such system-based design for career pathways could identify important leverage points for spillover effects on other health professionals as reported in the Malawi experience (see Section 4).

Political commitment is at the heart of success. Most large-scale national CHW programs with career pathways have the benefit of strong political will and support from key multisectoral stakeholders such as the ministries of finance and labor, and civil service commissions. Part of cultivating political commitment and support is capturing and elevating evidence on CHW impact while also demonstrating that their role can be optimized to address pressing health challenges and advance national health agendas. Strong political commitment can help drive the development of policy and regulatory frameworks to support career progression of CHWs, including the establishment of certification and quality assurance mechanisms. It also engenders clear ownership of CHW programs. This, in turn, can facilitate sustained domestic investments to support CHWs with formal career pathways as part of their integration into the broader health system. Examples of such institutionalization include integrating CHW compensation, management, and training into national or local health budgets and introducing laws to incorporate CHWs into civil service programs that have existing policies on promotions and education benefits for health workforce.

Rollout should be gradual, given the cost and time required for full integration. Countries with experience in CHW career progression have used iterative and incremental processes to align priorities, secure buy-ins, identify champions, mobilize and codify funding, upskill current CHWs, and introduce reforms to transition CHWs to salaried government employees. All these steps take a significant amount of time, and efforts to strengthen CHW career progression should plan for phased and gradual rollout given the documented risk of an "expectation gap" and demotivation if career progression is poorly and inconsistently implemented.[42]

Roles and responsibilities at each level should be clear and complement other cadres. CHWs operate within a broader ecosystem and the role and scope of CHWs throughout a career pathway should be considered in relation to other health workers to facilitate integration and acceptance. Clearly defined roles and responsibilities enable cohesive teamwork and collaboration with different health workforce cadres, and can help ensure expectations for CHWs are attainable, setting them up for success. Relatedly, it is also important to define roles and responsibilities at each level of CHW career pathway to ensure career progression opportunities are optimized for effective service delivery.

Program design should be flexible and responsive. There is a need for a flexible approach with CHW career pathways, specifically in underserved communities where members typically do not have advanced education or do not speak the official language for exams and interviews. Particularly in cases where career pathways are not part of the initial launch of CHW programs and are introduced at

a later point, it is important to design recruitment, training, and promotion programs that account for CHWs who already have been effectively serving in the role but may not meet the new criteria. This can include support to ensure sufficient and accessible training that is tailored to different numeracy and literacy levels, and consideration of CHWs who have limited formal education. Preliminary evidence on experience and training being more predictive of CHW competency than formal education further supports the need for flexible career pathway design that emphasizes experience and performance.[69]

GESI considerations should be intentionally and explicitly built into the process, from the initial phases of design to implementation and monitoring. Gender and other socioeconomic factors have been documented to affect CHW career progression opportunities. Women make up the majority of CHWs, but country experiences and the literature reflect that paid and managerial opportunities are dominated by men. Even when career progression opportunities are available, women are less likely to take advantage of them due to reasons such as being less likely to travel for additional trainings given domestic duties, inexperience with interviews, being overlooked for promotion due to patriarchal norms, and being exposed to harassment while seeking progression opportunities. Integrating GESI responsive policies and practices such as offering trainings closer to where CHWs live and serve and providing transport and childcare support into career progression will help ensure women can benefit from existing and new career progression opportunities. There is also a need to continuously learn from and adapt GESI considerations as power dynamics, social structures, and cultural norms evolve.

CHW-led mobilization and advocacy should be supported. CHWs' collective power and voice have influenced policies and priorities at the country and global levels. As CHWs continue to obtain recognition as professionals, they are enabled to play a central role in advocating for adequate payment, training, supplies, working conditions, and professional development. While CHWs should take the lead in advocating for stronger professionalization according to their needs, their efforts should be reinforced through support to professional associations and other umbrella organizations to ensure an enabling environment for their efforts. This can include governments and development partners sharing relevant data with CHWs and actively including them in program design and monitoring.

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Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the United States Agency for International Development (USAID) Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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