
Policy brief

Community health workers: *What do we know about them?*

The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers

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Background

The use of community members to render certain basic health services to their communities is a concept that has existed for at least 50 years. There have been innumerable experiences throughout the world with programmes ranging from large-scale, national programmes to small-scale, community-based initiatives.

We now know that CHWs can play a crucial role in broadening access and coverage of health services in remote areas and can undertake actions that lead to improved health outcomes, especially, but not exclusively, in the field of child health. To be successful on a large scale, CHW programmes need careful planning, secure funding and active government leadership and community support. To carry out their tasks successfully, CHWs need regular training and supervision and reliable logistical support. CHWs represent an important health resource whose potential in providing and extending a basic health care to underserved populations must be fully tapped.

The *World health report 2006: working together for health* recognizes shortages of professional health workers as one of the key ingredients in the growing human resource crisis, particularly in low-income countries. One strategy to address this crisis is so-called “task-shifting” – a review and subsequent delegation of tasks to the “lowest” category who can perform them successfully. It is in this context that the concept of using community health workers has gained currency again.

Who are community health workers?

Community health workers are known by many different names in different countries. The umbrella term “community health worker” (CHW) embraces a variety of community health aides selected, trained and working in the communities from which they come. A widely accepted definition was proposed by WHO:

Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers.

CHWs are trained to carry out one or more functions related to health care. CHWs may receive training that is recognized by the health services and national certification authority, but this training does not form part of a tertiary education certificate. While early programmes emphasized the role of CHWs as not only (and possibly not even primarily) health care providers, but also as advocates for the community and agents of social change, today’s programmes emphasize their technical and community management function.

CHWs do not include formally trained nurse aides, medical assistants, physician assistants, paramedical workers in emergency and fire services and others who are auxiliaries, mid-level workers and self-defined health professionals or health paraprofessionals. Traditional, faith and complementary healers as well as traditional birth attendants also are not included in this definition, as these important groups warrant separate and detailed treatment in their own right.

The profile of community health workers internationally is very diverse. While there are some broad trends, they can be men or women, young or old, literate or illiterate. In almost all cases they come from the communities they serve. Most importantly, there is broad agreement that who and what CHWs are must respond to local societal and cultural norms and customs to ensure community acceptance and ownership.

What do community health workers do?

CHWs perform a wide range of tasks: home visits, environmental sanitation, provision of water supply, first aid and treatment of simple and common ailments, health education, nutrition and surveillance, maternal and child health and family planning activities, TB and HIV/AIDS care (i.e. counselling, peer and treatment support and palliative care), malaria control, treatment of acute respiratory infections,

communicable disease control, community development activities, referrals, recordkeeping and collection of data on vital events. These tasks are performed in many different combinations and with different degrees of breadth and depth.

A key issue of debate concerns the question of what functions individual CHWs can effectively perform, considering level of education, type and duration of training, health needs of the community and size and geographical spread of the population to be covered. There is little scientific evidence as to the optimal number and mix of CHW functions and tasks, but the consensus is that no one person can perform all the activities laid out in the Alma Ata Declaration.

What do we know about performance of CHW programmes?

Performance is made up of different but closely interlinked elements: use of services, impact effectiveness and financial performance or cost-effectiveness.

Use

Low use of CHW programmes is a common problem. Often, low use is seen to be linked to poor community introduction of the programme, which often then leads to political tensions between traditional hierarchies and the structures set up under a new regime or to a preference for formal, established health services. Use is clearly context-sensitive and linked to a number of factors internal and external to the programme. Experience shows that use can be influenced and improved through training, support and supervision of CHWs.

Retention/attrition

High attrition rates have been reported in many CHW programmes. Retention is affected by central concerns with governance and management, such as sources and sustainability of financing, community ownership and selection practices. It is clear that retention can and should be addressed as part of a broader package of management interventions.

Impact effectiveness

While impact effectiveness is clearly a crucial benchmark for programme planners and managers, it is important to note that it cannot be discussed in general, but needs specific definition: impact on what and impact over what period. The literature discusses effectiveness in relation to a range of impacts, of which mortality and morbidity rank prominently, not only due to their obvious importance, but also because they are more easily quantifiable than measures such as client satisfaction or community mobilization, and also may appear in the short to medium term, i.e. over one- to five-year periods. Within these parameters, many studies indicate some degree of impact effectiveness.

Cost-effectiveness of CHW programmes

Services provided by community health workers are expected to be more appropriate to the health needs of populations than those of clinic-based services, to be less expensive and to foster self-reliance and local participation. Furthermore, because CHWs are more accessible and acceptable to clients in their communities, they are expected to improve the overall coverage of services as well as equity, i.e. increased service use by poorer individuals and households. However, there is a dearth of data on the cost-effectiveness of CHW programmes to confirm these views. The limited studies available suggest that CHWs increase the coverage and equity of health service delivery, compared with alternative modes of service organization. However, cost-effectiveness analyses miss key elements of CHW programmes that do not lend themselves to economic analysis, such as altruism, volunteerism, community norms, reciprocity and duty, and these tend not to be reflected well in estimates of cost-effectiveness and hence are insensitive to a range of social benefits (including community mobilization), which often constitute the strength of CHW programmes.

What factors act as incentives and disincentives for CHWs?

A number of factors have been identified as incentives or disincentives for individual CHWs, the communities they serve or the health services. These influence the performance and use of CHW programmes.

CHW incentives and disincentives organized by means of a systems approach		
	Incentives	Disincentives
Monetary factors that motivate individual CHWs	Satisfactory remuneration/material incentives/financial incentives Possibility of future paid employment	Inconsistent remuneration Change in tangible incentives Inequitable distribution of incentives among different types of community workers
Non-monetary factors that motivate individual CHWs	Community recognition and respect of CHW work Acquisition of valued skills Personal growth and development Accomplishment Peer support CHW association Identification (badge, shirt) and job aids Status within community Preferential treatment Flexible and minimal hours Clear role	Person not from community Inadequate refresher training Inadequate supervision Excessive demands/time constraints Lack of respect from health facility staff
Community-level factors that motivate individual CHWs	Community involvement in CHW selection Community organizations that support CHW work Community involvement in CHW training Community information systems	Inappropriate selection of CHWs Lack of community involvement in CHW selection, training and support
Factors that motivate communities to support and sustain CHWs	Witnessing visible changes Contribution to community empowerment CHW associations Successful referrals to health facilities	Unclear role and expectations (preventive vs. curative care) Inappropriate CHW behaviour Needs of the community not taken into account
Factors that motivate MOH staff to support and sustain CHWs	Policies/legislation that support CHWs Witnessing visible changes Funding for supervisory activities from government and/or community	Inadequate staff and supplies

Source: Bhattacharyya K, Winch P, LeBan K, Tien M (2001). Community health worker incentives and disincentives: how they affect motivation, retention and sustainability. Arlington, Virginia: BASICS/USAID.

Many successful programmes use multiple incentives over time to keep CHWs motivated. A systematic effort that plans for multiple incentives over time can build up a continuing sense of satisfaction and fulfilment for CHWs.

What makes for successful CHW programmes?

Community participation

There is overwhelming consensus that community participation is a vital constituent of successful and sustainable CHW programmes throughout the world. It is also widely acknowledged, though, that a considerable gulf exists between the ideal of programmes driven and owned by communities and programme realities.

In most of the cases that show successful community participation, substantial and time-consuming investments were made in: (a) securing participation of communities; and (b) involving them in all aspects of the programme, including the identification of priorities and project planning. In other words, community mobilization precedes and accompanies the establishment of CHW programmes as an iterative learning process.

Political stewardship and adequate resourcing

Successful and sustained large-scale CHW programmes usually have and certainly require significant support from government. They require advocacy, stewardship and direction from political leaders and ministerial officials to be considered an integral part of health sector activities. Attention to reliable and adequate resourcing is crucial. Where government does not create and sustain an enabling environment, CHW programmes run the risk of withering on the geographical, organizational and political periphery.

Good programme management

Management is one of the most crucial, yet often sorely neglected, factors of CHW programmes. Their geographical and organizational location on the periphery, often with ill-defined ownership and accountability, means that they need particularly careful, attentive and sustained management. It must be stressed that, while the different aspects of management will be discussed separately, as a rule the success or failure of the management of a programme is made up of a combination of these factors.

Selection

Virtually every document discussing community health workers emphasizes: (a) that CHWs should be chosen from the communities they will serve; and (b) that communities should have a say in the selection of their CHWs, although it is accepted that, to date, active participation of communities remains the exception and needs to be vigorously nurtured.

Whether and how communities are in practice involved in selection processes will depend largely on issues of governance, the role of formal health services and particularly the extent, form and structure of broader community participation, which will be discussed below. The most common approach employed by organizations to initiate CHW selection has been the setting up of village health committees (VHCs), which are then charged with the selection of CHW candidates.

Training/continuing education

Length, depth, organization of, responsibility for and approaches to training vary dramatically across programmes. There is agreement today that training should be competence- and practice-based and located close to CHWs' working context. Training materials and activities should be specifically developed for CHWs rather than using training packages developed for facility-based workers.

But while the literature reflects a great diversity of approaches, location, organization and length of training, there is agreement on one matter: that continuing or refresher training is as important as initial training. A number of studies have found that if regular refresher training is not available, acquired skills and knowledge are quickly lost; and that, on the other hand, good continuing training may be more important than who is selected initially.

Supervision and Infrastructure support

It is widely acknowledged and emphasized that the success of CHW programmes hinges on regular and reliable support and supervision. It is equally acknowledged, however, that supervision is often among the weakest links in CHW programmes.

Small-scale projects are often successful because they manage to establish effective support and supervisory mechanisms for CHWs, often including a significant amount of supervision and oversight by the community itself. National programmes are rarely able to achieve this consistently, because supervision is not sufficiently costed or planned for and the greatest need for supervision exists in the most remote areas, where health services are most overstretched and ill-equipped.

Clear strategies and procedures for supervision therefore need to be defined at the outset of programmes and requisite skills need to be taught so that health personnel, CHWs and community health committee members know what is expected of them as supervisors. The guidelines for supervision should include a list of supervisory activities. The most important element of supervision is ensuring the two-way flow of information. It is also vital that supervisors act as positive role models.

Hand in hand with supportive supervision go other forms of support, in particular logistics and infrastructure support. Issues such as the reliable provision of transport, drug supplies and equipment have been identified as crucial to CHW effectiveness.

Conclusions

- CHWs can make a valuable contribution to community development and, more specifically, can improve access to and coverage of communities with basic health services. There is robust evidence that CHWs can undertake actions that lead to improved health outcomes, especially, but not exclusively, in the field of child health. However, although they can implement effective interventions, they do not consistently provide services likely to have substantial health impact and the quality of services they provide is sometimes poor.
- For CHWs to be able to make an effective contribution, they need to be carefully selected, appropriately trained and – very important – adequately and continuously supported. Large-scale CHW systems require substantial increases, compared to what they have generally enjoyed, in support for training, management, supervision, and logistics.
- CHW programmes are neither the panacea for weak health systems nor a cheap option to provide access to health care for underserved populations. Numerous programmes have failed in the past because of unrealistic expectations, poor planning and an underestimation of the effort and input required to make them work. This has unnecessarily undermined and damaged the credibility of the CHW concept.
- By their very nature, CHW programmes are vulnerable unless they are driven, owned by and firmly embedded in communities themselves. Where this is not the case, they exist on the geographical and organizational periphery of the formal health system, exposed to the vagaries of policy swings without the wherewithal to lobby for and advocate their cause, and thus are often fragile and unsustainable. Evidence suggests that CHW programmes thrive in mobilized communities but struggle where they are given the responsibility of galvanizing and mobilizing communities. Examples of successful programmes can thus be found in the wake of community mobilization efforts, either as part of large-scale political transformation, such as in Brazil or China; or through local mobilization, often facilitated by nongovernmental, community-based or faith-based organizations. In many cases programmes last through the lifespan of the mobilization effort and wither or collapse entirely as the momentum of mobilization is lost. A key challenge lies in institutionalizing and mainstreaming community participation. To date the largest and most successful programme in this regard is the Brazilian Family Health Programme, which has integrated CHWs into its health services and institutionalized community health committees as part of municipal health services to sustain social

participation. This means that community participation does not become an alternative but an integral part of the state's responsibility for health care delivery.

- The question as to whether CHWs should be volunteers or paid in some form remains controversial. There exists virtually no evidence that volunteerism can be sustained for long periods: as a rule, community health workers are poor and expect and require an income. Although in many programmes they are expected to spend only a small amount of time on their health-related duties, leaving time for other breadwinning activities, community demand often requires full-time performance. The reality is that CHWs as a rule and by their very nature provide services in environments where formal health services are inaccessible and people are poor. This also complicates the issue of community financing, which is rarely successful unless institutionalized, as in China in the 1970s and 1980s. Most of the evidence reflects failures of community financing schemes, leading to high drop-out rates and the ultimate collapse of programmes.

Given present pressures on health systems and their proven inability to respond adequately, the existing evidence strongly suggests that, particularly in poor countries, CHW programmes are not an easy investment, but nonetheless a good one, since the alternative in reality is no care at all for the poor living in geographically peripheral areas.

While there is a lot to learn, there is a lot we do know about making programmes work better: appropriate selection, continuing education, involvement and reorientation of health service staff and curricula and improvement of supervision and support are non-negotiable requirements. These need political leadership and substantial and consistent resourcing.

We need to learn from examples of large-scale successful programmes in this regard, particularly providing longitudinal evidence of what works and what does not work. This presently constitutes the biggest knowledge gap.