

Chapter 1

Introduction

Steve Hodgins, Lauren Crigler, and Henry Perry

Key Points

- The current enthusiasm for large-scale Community Health Workers (CHWs) needs to be tempered with a sobering reflection on the disappointments that followed a similar wave of enthusiasm in the 1970s and 1980s, noting challenges in scaling up and sustaining large-scale public sector CHW programs.
- Large-scale public sector CHW programs are complex entities that require adapting a systems perspective to the national and local contexts.
- CHWs are a diverse group of community-level workers. This guide distinguishes between two levels of CHWs: (1) full-time, paid, with formal pre-service training and (2) volunteer, part-time workers.
- The guide attempts to avoid categorical recommendations, but rather offers suggested issues and principles to consider and, when possible, brings in relevant program experience.

INTRODUCTION

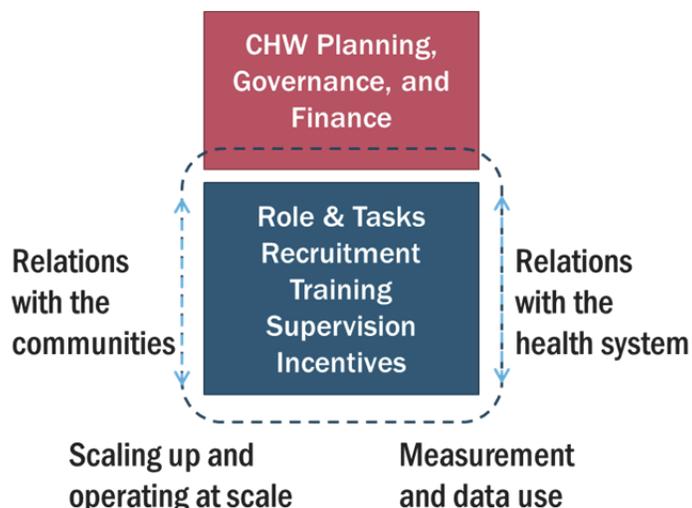
Recently, a renewed interest in CHWs has been seen globally. This renewal provides an opportune moment to take stock of issues and challenges such CHW programs face and what can be done to make them as effective as possible. With this in mind, this manual is intended to be used as a practical guide for policymakers and program managers wishing to develop or strengthen a CHW program, drawing lessons from other countries that have implemented CHW programs at scale.

Most of the evidence regarding the effectiveness of CHWs is derived from studies of small-scale CHW programs. Yet, the large-scale programs currently in existence or those being planned or scaled up are the programs that are going to make the biggest difference in the health of populations in the long run. Surprisingly, our organized knowledge of these programs and their effectiveness is surprisingly limited, although anecdotal information abounds regarding suboptimal functioning on the ground. Furthermore, the challenges they face in functioning effectively are daunting due to their scale and scope. This document focuses on large-scale, mostly public sector, CHW programs and how they might become as effective as possible. We provide many concrete examples of how large-scale programs have organized themselves, but more importantly we raise issues that need to be faced by any large-scale program. Our hope is that this discussion will provide policymakers and program implementers with food for thought that will strengthen the decisions they take on behalf of large-scale CHW programs in their country.

Throughout, we discuss major policy and programmatic issues that decision-makers and planners need to consider when designing, implementing, scaling up or strengthening a national-level CHW program. We offer an overview of specific challenges CHW programs face, country lessons, tools, and other resources that may be helpful, while incorporating relevant programmatic examples as much as possible.

Proceeding from broader, higher-level issues down to the more specific and operational ones, this manual sets the stage with a section addressing planning, governance and finance. The next major section considers a range of important issues related to human resources, notably: roles and tasks of the CHW, recruitment, training, supervision, and motivation. The third section concerns the context for community health work, looking at both the health system and the community. The fourth and final section addresses operational issues essential for achieving program impact, such as scaling up and operating at scale, as well as measurement and data use. All of these functions have critical inter-relations; therefore, design decisions in one area have consequences in many others, as Figure 1 depicts. Within the manual, this concept is reflected in frequent cross-referencing among chapters. Further, the manual includes, as appendixes, profiles of a number of large-scale CHW programs and insights arising from interviews with a number of key thought leaders in global CHW work.

Figure 1. Overview of CHW program sub-systems and their interactions



The contents herein draw particularly upon experiences from large-scale, public sector CHW programs. We have looked comprehensively across a range of factors determining the effectiveness of community health services—and taking a pragmatic view and promoting no single model since CHW programs serve different purposes depending on context. However, we believe that the experiences of other programs often provide useful lessons that can impact decisions to be made regarding CHW programs in additional settings. Specifically, we are interested in the factors that contribute to program effectiveness and performance in institutionalized programs operating in the public sector at scale.

Although decisions are frequently made to establish or close programs on the basis of “effectiveness,” in many instances, data available are insufficient to make a solid judgment on how effective these programs have actually been. As such, in trying to capture important lessons about what works under which circumstances, wherever possible, we make such inferences based on the best available evidence (which is often thinner than preferred) and on experience and expert judgment arising from those experiences.

THE COMMUNITY HEALTH CHALLENGE

For more than 50 years, as leaders in primary health care (PHC) have tried to elaborate strategies to better meet the health needs of populations, they have gravitated repeatedly to solutions that involve recruiting and training local people to play roles complementing and supplementing those of health professionals, encouraging healthier practices and care-seeking and, in some instances, providing services that otherwise would fall within the responsibility of health professionals through task-shifting. Such strategies have varied considerably by place and time, with different names for community-level workers being used. Some notable names include: Health Auxiliary Worker, Village Health Worker, Community Health Worker and, most recently, Front-Line Health Worker (albeit, this last designation is used also to cover PHC professionals and lesser-trained community-level workers).

Established in the 1960s–1980s, the initial wave of CHW programs were for a world that was very different from the one today. Many of the societies in which we work have become more prosperous since then: the standard of education and literacy has improved; economies have evolved in the direction of greater monetization and away from traditional subsistence economies; in many settings, the private sector now accounts for a large proportion of health services provided; road networks have expanded; and new technologies (e.g., mobile phones) are

in widespread use. Perhaps most importantly, the world today is much more urbanized and unequal.

Nevertheless, many of the issues that face policymakers, program managers, and external development partners, as they make decisions and design and manage community health programs, are essentially the same as those faced by their predecessors. Namely, how to sustainably finance such a program; how to design it so it will function effectively; how to select, train, motivate, retain, and supervise CHWs; how to ensure consistent supply of needed drugs and commodities; and how to monitor and ensure performance. Now more than ever, CHW programs need to be resilient and adaptable, adjusting to new evidence and policies with an improved capacity to implement newly approved recommendations.

Unfortunately, examples can be found today of decisions being made in the development or implementation of CHW programs that repeat mistakes made in the past, dooming programs to the same compromised effectiveness as before. Therefore, the goal of this guide is to enable policymakers and program implementers to reduce the frequency of such decisions, which often fail to take into account lessons from past experience.

SMALL-SCALE NONGOVERNMENTAL ORGANIZATION PROJECTS VERSUS LARGE-SCALE MINISTRY OF HEALTH PROGRAMS

Over the past 50 years, there have been a variety of highly influential, small-scale CHW program experiences, either linked to universities or nongovernmental organizations (NGOs). These experiences have served as the inspiration for important global initiatives in community health. For example, the 1978 Declaration of Alma-Ata was inspired in part by such experiences. Similarly today, recommendations are made to ministries of health and donors, calling for large-scale, public sector CHW programs, based on experiences with much smaller, more intensively supported programs. Though attractive, large-scale CHW programs are not a one-size-fits-all solution, and context-specific considerations must be made at scale. The value of these small-scale experiences is found in the sensitization of national- and global-level decision-makers to the power of CHW programs in achieving population-level health gains. However, these small pilot projects are often not replicable at scale, although they can provide the indispensable seed from which large-scale national programs can emerge.

An example of this discontinuity among successes observed in a small-scale, intensively supported program versus efforts in a large-scale program is the intensive postnatal, home-visit approach pioneered by Bang and colleagues in Maharashtra, India. Based on this approach and a few other small-scale, intensively supported community randomized controlled trials (RCTs) and demonstration projects, the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) jointly issued a call to ministries of health to introduce such programs at scale. These programs have since been widely introduced, though none have yet achieved high rates of effective coverage (and therefore population-level health impact). The translation from small-scale demonstration projects to large-scale programs is not straightforward and takes time and continued nurturing. It is crucial to understand the conditions necessary for successful implementation of a particular approach and what it would take to meet and sustain these conditions at scale. The need to develop robust organizational support systems in large-scale CHW programs for information systems, logistics of the supply system, management, supervision, and quality oversight are obvious, but lack of attention to these issues has been the downfall of many programs and leads to lost opportunities for program impact in many current programs.

ARE CHWS NECESSARILY THE ANSWER, OR PART OF THE ANSWER, TO YOUR SPECIFIC PROBLEM?

They may or may not be. The appropriateness or adequacy of the local health system can be judged by its results. What population coverage is currently achieved for key health services (e.g., immunizations, family planning [FP], tuberculosis detection, and treatment)? Depending on the setting, an approach involving some kind of outreach may be essential to reach high coverage. In some settings, however, such coverage may be achievable using services based entirely on health professionals. In fact, in some settings, CHWs are not the appropriate answer, and program decisions-makers need to consider feasibility before scaling up any given CHW program. This guide details all the necessary considerations that would feed into a judgment of appropriateness and feasibility of any particular plan for use of CHWs.

A SYSTEMS PERSPECTIVE

Although much of this guide focuses on CHWs, we are more fundamentally concerned about community health services, including efforts to influence health-related household practices and care-seeking. There are various strategies or approaches available to ensure adequate delivery of such services to a population. The use of a particular cadre of worker—whether volunteer or paid and whether a fully trained professional or a lesser-trained community-level worker—is one among a set of choices that, together, constitute the arrangements for community health services in a particular locality.

The CHW works within the context of a program, a community, and a health system. How effectively he or she contributes to improved health in the community depends on the effectiveness of a system. By nature, systems are interconnected, nonlinear, self-organizing, and dynamic. Although there may be some utility in categorizing components of the system as building blocks, to understand the functioning of the system requires that we acknowledge the dynamic interactions among the various system elements. Throughout this manual, we will look at CHWs within this larger systems context. With such a perspective, there is considerable cross-referencing among sections. Furthermore, we will focus not only on CHWs but also on community health **services** and the organization of care.

The organization of services—the system provisions to ensure effective delivery and linkages with the beneficiary population—consists of elements and relationships within a dynamic system. Overall performance of the system (i.e., how well it actually meets the needs of the population it is meant to serve) depends on the effective functioning of all of its parts, as they interact. As a result, design choices or the performance of particular elements can have very important consequences. Both at the design stage and during ongoing implementation, the needs and performance of the system **as a whole** need to be kept in view. This may seem to unnecessarily complicate things. However, if we are interested in effective programs, we do need to grapple with this complexity.

The important take-home message is that **any decision we make about a particular detail within a program potentially has ramifications or consequences for other parts of the system**. One should be wary, therefore, of categorical statements; for example, “to have CHWs who can safely do case management of sick children, an absolute criterion of selection needs to be high school graduation.” In a given setting, making such a decision may narrow the choice to men in their early 20s, who may, in turn, not be considered acceptable by the community for a role in caring for sick children, which, in turn, could result in quite low coverage. If that is the case, it may be appropriate to revisit the initial assumption. At the end of the day, we need programs that work—ones that effectively contribute to improving population health status.

Often, in a single location there are multiple programs making use of different types of CHWs. All of these may be officially under ministry of health (MOH) auspices. Yet, with different external partners supporting the programs, there may be little harmonization, with some more generously endowed programs providing more attractive training allowances or other incentives, with significant differences in how supervision is done, and without any provision for coordination across programs or across the different types of CHWs. Adding new CHW programs, or new functions to existing CHW cadres, needs to be understood as not happening within a vacuum, but within a local service delivery context that may, in some ways, be a bit of a mess.

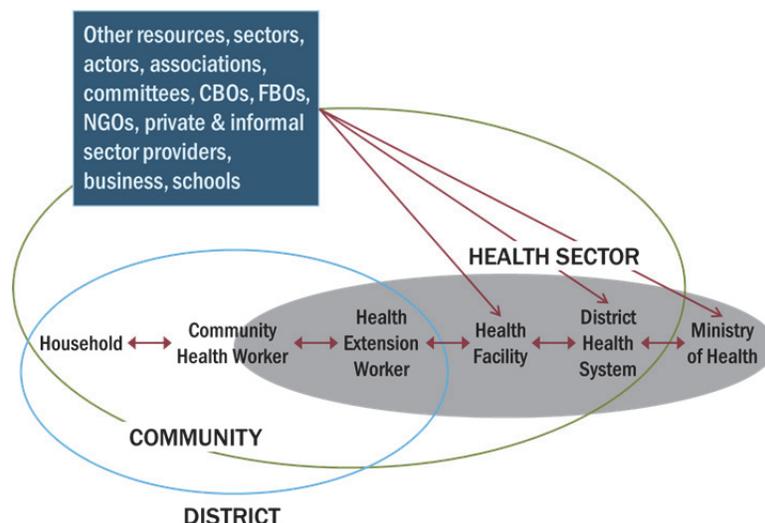
CONTEXT

Any particular CHW cadre works in a setting along with other health workers, CHWs, managers, and actors—each with their own roles and each, potentially, interacting with others. This set of relationships and interactions resembles an ecosystem. In that, these interactions, in turn, can affect the performance of particular actors, the emergence of competing interests, and the evolution of these dynamics over time (Figure 2).

Because different CHW programs are trying to do different things, and they operate in a wide range of settings, specific choices that work well or are essential in one particular setting are not necessarily helpful in another. Ray Pawson et al. have made helpful contributions to our thinking on the need to consider performance for particular types of programs looking closely at **how they are implemented** and the characteristics of the **specific settings** in which they are implanted, seeing how that plays out with regard to program performance.¹ From multiple such cases, one can then progressively build a “midlevel theory” that begins to draw fruitful, if contingent, lessons across settings.

Drawing on Pawson et al., we do not want to be overly prescriptive, but rather to try to raise a range of options and possibilities that need to be considered. Ideally, we would like to make specific suggestions in the form of, “under X conditions or type of context, if you are trying to do A, you should consider L, M, and N.” However, appreciating the complex interactions among the various systems dimensions underlying CHW programs, the diversity of what CHW programs are trying to do, and the conditions in which they are implemented, such advice would be very difficult to give. Nevertheless, in this guide, we will try to avoid making categorical recommendations, and instead offer **suggestions for consideration**, making explicit, when possible, the particular program experiences from which the lessons are drawn.

Figure 2. CHWs within the health sector



WHO ARE COMMUNITY HEALTH WORKERS?

The term Community Health Worker is currently used to cover a wide variety of cadres and programs. As such, it can be a source of confusion. For this reason, in this manual, we use the terminology shown in Table 1. Auxiliary Health Workers (AHWs) are, in some settings, considered to be CHWs. They are paid, generally full-time workers with pre-service training usually of at least 18–24 months, who may or may not be recruited from the localities where they serve. In most settings, however, such workers are not considered CHWs.* The next grade down is what we will call health extension workers (HEWs), who are also usually paid, full-time employees but normally have less than a year of initial training (in some cases, just a few weeks) and are generally recruited from the localities where they work. In some cases, compensation is mixed, with a fixed monthly amount plus incentives related to specific activities (e.g., the Accredited Social Health Activist Program in India).

On the spectrum from more to less formalized/professionalized CHWs, below the HEW, we have what will refer to in this guide as Community Health Volunteers-Regular (CHVs-R). These CHVs-R may have a role that can involve not only health promotion but also some limited elements of service delivery. They normally work at least several hours a week, generally not on a salaried basis, but may receive some material incentives. These CHVs-R, in turn, grade into various types of what we refer to as Community Health Volunteers-Intermittent (CHVs-I), whose duties normally involve only health promotion or community mobilization and who, in any given week, may not be involved in any such activity.

We recognize that this list is not fully exhaustive. There are other types that do not closely correspond to any of these categories, and there are cadres that stand in an intermediate position with respect to these types. For example, Ethiopia’s HEWs have more training than our category of HEWs, but less than our category of AHWs. However, we will use this vocabulary consistently and will use this typology to anchor our discussion. This clarity can avoid considerable confusion, when we might otherwise make generalizations about CHWs that, in fact, only validly apply to one of these categories.

Table 1. Categories of CHWs

	TERMS OF SERVICE, TRAINING, RECRUITMENT	FUNCTIONS (and further notes)
Auxiliary Health Workers (AHWs)	Salaried and full-time; pre-service training lasting one or more years (in a specialized training institution); not necessarily recruited from the area. May be hired through some unit of local government or through national civil service structure.	These workers often provide routine clinical preventive services (e.g., immunizations, FP), as well as case management, for a limited range of conditions (e.g., childhood illness). These functions may be provided from a very peripheral health unit (e.g., a health post) or, at least in part, from outreach sites.
Health Extension Workers (HEWs)	Salaried and expected to work more or less full-time; initial training generally at least several months (usually provided after recruitment); in some cases, this can be for up to a year. Usually recruited from the area, but may or may not originate in the community where they are serving.	This is the highest level of cadre that is commonly referred to as a CHW, though they may also be considered a type of AHW. Their functions may be very similar to those described above for AHWs.

* Note that in the 1960s and early 1970s, this term was used more broadly than how we are using it, and included health-facility-based support staff, as well as what we are describing as Health Extension Workers.

	TERMS OF SERVICE, TRAINING, RECRUITMENT	FUNCTIONS (and further notes)
Community Health Volunteers-Regular (CHVs-R)	Volunteer with certain regular duties (usually with at least some activity every week); possibly with regular episodes of short training (up to several days at a time) and may have some initial training lasting several weeks. They are from and live within their local communities.	May be involved in case management of childhood illness and in dispensing (e.g., birth control pills, condoms, and antenatal iron). In rare cases, may give injectable contraceptives, such as Depo-Provera or other injections. In some programs, duties and terms of service of CHVs-R start to approach those of HEWs (see above), with significant part-time involvement (e.g., 10–20 hours/week) and financial incentives representing an important source of revenue. These may be performance- or commission-based. In other programs, though these CHVs perform regular functions, they normally put in less time (e.g., 5 hours/week or less) and financial incentives may be minimal or not used at all.
Community Health Volunteers-Intermittent (CHVs-I)	Volunteer, relatively light, intermittent commitment; minimal orientation/training; may be numerous; local.	Typically have functions limited to health promotion, though they may also support periodic campaign activities (e.g., distribution of insecticide-treated bed nets, ivermectin, or vitamin A) and support for immunization campaigns.

VARIATION IN COMMUNITY HEALTH WORKER PROGRAMS

There is a multitude of differing CHW programs. At one end of the spectrum, we have national CHW programs or cadres, under MOHs. These are generally paid, full-time workers belonging to the first two categories above (i.e., AHWs or HEWs). There are, however, examples of programs with CHWs in the third category of CHV-R (e.g., Female Community Health Volunteers in Nepal) and the fourth category of CHV-I (e.g., CHWs in large community-directed intervention programs). National public sector programs may also make intermittent use of CHVs. All of these programs are typically tied closely to peripheral public sector health services (e.g., supported and supervised from health centers or health posts). But there are certainly many exceptions, such as national programs that make use of CHWs not having strong links with a particular health facility. The BRAC *Shasthya Shebika* CHW program is an example of such an exception.

At the other end of the spectrum, there are many NGOs and community-based organizations (CBOs) that have their own CHWs, who are not formally linked with public sector programs. There are also many examples of CHW cadres that are formally recognized by government but have strong links with NGOs (including donor-funded NGOs). Additionally, there are a few examples of large CHW programs operated by major NGOs, a prime example again being BRAC in Bangladesh.

Because our principal interest in this document is on efforts expected to contribute to population health impact at scale, our focus is primarily on large (generally national) programs and cadres operating under the MOH. In addition to varieties in institutional characteristics across CHW programs, programs differ markedly by technical content. On one hand, we have CHWs who are generalists that are responsible for a wide range of primary health care services (e.g., acute illness care, maternal and child health, immunizations, FP, and environmental health). But there are also many examples of cadres of CHWs working for specific technical programs (e.g., HIV/AIDS, malaria, or tuberculosis). In many countries, there are several

different types of CHWs working at the community level, with responsibilities falling under different programs.

CONCLUSIONS

The effective functioning of large-scale CHW programs offers one of the most important opportunities for improving the health of impoverished populations in low-income countries. This guide presents principles and programmatic suggestions that we hope will be useful as decision-makers and program implementers consider the initiation, expansion, or strengthening of CHW programs in their country.

References

1. Pawson R, Greenhalgh T, Harvey G, Walshe K. Realist review: a new method of systematic review designed for complex policy interventions. *J Health Serv Res Policy* 2005; **10 Suppl 1**: 21–34.