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SYSTEMATIC REVIEW

Healthcare interventions involving community healthcare workers in the management of people with multiple long-term conditions: scoping review

[version 1; peer review: 2 approved with reservations]

Olona Mzimkulu[1,2], Lara Fairall[1,3], Max Bachmann[4], Tamara Kredo[5], Linda Velapi[6], Robyn Curran[1], Inge Petersen[7,8], Khosi Simelane[1], Daniella Georgeu-Pepper[1], Naomi Levitt[2]

[1]Knowledge Translation Unit, University of Cape Town Department of Medicine, Observatory, Western Cape, South Africa
[2]Chronic Disease Initiative for Africa, University of Cape Town Department of Medicine, Observatory, Western Cape, South Africa
[3]King's College London School of Life Course & Population Sciences, London, England, UK
[4]Department of Public Health, University of East Anglia Norwich Medical School, Norwich, England, UK
[5]Health Systems Research Unit, South Africa Medical Research Council, Tygerberg, Cape Town, South Africa
[6]Department of Nursing and Midwifery, Stellenbosch University, Stellenbosch, Western Cape, South Africa
[7]Centre for Research in Health systems, University of KwaZulu-Natal, Durban, KwaZulu-Natal, South Africa
[8]University College London Institute for Global Health, London, England, UK

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Abstract

Background

Community health workers (CHWs) play a vital role in healthcare delivery, serving as a link between their communities and primary healthcare facilities. Their role in managing individuals with multiple long-term conditions (MLTCs) is not clear.

Objective

To review published literature on the scope of practice and roles of CHWs as well as the tools they use in healthcare interventions that aim to improve outcomes for people living with MLTCs.

Methods

A scoping review was conducted in accordance with Arksey and O'Malley's guidance. We searched seven electronic databases (Medline via PubMed, Cochrane, CINAHL, Africa Wide info, Scopus, Web of Science, and APA PsycINFO) and reference lists of two relevant

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1. **Margaret Dunham**, Edinburgh Napier University, Edinburgh, UK
2. **Peter Bower**, University of Manchester, Manchester, UK

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systematic reviews. We included articles published from 2013–2025 in English that reported healthcare interventions in which CHWs managed people living with MLTCs. We extracted study details, including title and authors, year, setting, roles of CHWs, and types of interventions. Screening was conducted independently by two reviewers, and one reviewer conducted data extraction. We used a descriptive analytic method with narrative synthesis of findings.

Results

We identified 149 articles and, after removing duplicates, 108 articles were screened by title and abstract, and 14 relevant articles were included for full data extraction. Most studies (8/14) were conducted in high-income countries United States of America, England, and Australia. Roles of CHWs were classified into four categories: patient care management, education and empowerment, coaching and support, and coordination and follow-up. Interventions included collaborative care, health coaching, and digital literacy. Tools used by CHWs were digital or paper-based and included activity logs, a health literacy booklet and a health literacy video, and mobile applications.

Conclusions

CHWs have reported having a range of roles and tools to conduct their work in supporting patients with MLTCs. This can be applied in more settings to enhance integrated care in communities.

Plain Language summary

Community health workers are people who are trained to help people stay healthy, understand health information, and connect them with clinics or services. These people are often trusted by their communities because they understand the culture and needs of the community. The role that they play in helping people who are living with more than one long-term condition, which is known as multimorbidity, is not well known. We wanted to look at and understand what other people have already written about the role that is played by community health workers and the tools that they use in healthcare interventions that focused on improving the well-being of people with multiple long-term conditions. To accomplish this, we worked with the librarian to search for published papers in different records/databases. We looked at seven databases for papers that were written in English and were published between 2013 and 2025. These papers needed to report interventions that involved community health workers and the interventions that were intended to help people who are living with more than one long-term condition. We found 149 written papers; we removed the papers that were the same. We then looked at the topic of the paper and the summary of the paper to decide if the paper could be included in our study. We found 14 papers that were suitable for our study. Most of the research from the papers was done in developed countries such as England.

Community health workers help people by educating and supporting them. Interventions that involved community health workers were health coaching and working with other healthcare professionals. The tools that they use when they are doing their work include phones and booklets. This work showed that community health workers play several roles when they are helping people with multiple long-term conditions.

Keywords
community health workers, multiple long-term conditions, multimorbidity, interventions, primary care

Corresponding author: Olona Mzimkulu (MZMOLO001@myuct.ac.za)

Author roles: Mzimkulu O: Conceptualization, Data Curation, Formal Analysis, Investigation, Methodology, Project Administration, Writing – Original Draft Preparation, Writing – Review & Editing; **Fairall L**: Conceptualization, Data Curation, Formal Analysis, Funding Acquisition, Investigation, Methodology, Supervision, Visualization, Writing – Review & Editing; **Bachmann M**: Conceptualization, Data Curation, Formal Analysis, Funding Acquisition, Investigation, Methodology, Supervision, Visualization, Writing – Review & Editing; **Kredo T**: Conceptualization, Data Curation, Formal Analysis, Methodology, Writing – Review & Editing; **Velapi L**: Data Curation, Formal Analysis, Visualization, Writing – Review & Editing; **Curran R**: Data Curation, Formal Analysis, Methodology, Writing – Review & Editing; **Petersen I**: Conceptualization, Data Curation, Formal Analysis, Funding Acquisition, Writing – Review & Editing; **Simelane K**: Writing – Review & Editing; **Georgeu-Pepper D**: Writing – Review & Editing; **Levitt N**: Conceptualization, Data Curation, Formal Analysis, Funding Acquisition, Investigation, Methodology, Resources, Supervision, Visualization, Writing – Review & Editing

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Background

Multiple long-term conditions (MLTCs), also referred to as multimorbidity, are defined as the coexistence of two or more conditions in an individual. MLTCs are a challenge globally, with approximately one in three adults living with MLTCs.[1] In high-income countries (HICs), multimorbidity is mostly due to non-communicable diseases (NCDs), whereas in low and middle-income countries (LMICs), multimorbidity is often due to the combination of NCDs and chronic infectious diseases.[2]

MLTCs affect individuals, their caregivers, and health services.[3] People with MLTCs experience polypharmacy, defined as the use of multiple medicines,[4] reduced quality of life, and increased risk of disability. In addition, they are more likely to have chronic pain, impaired mental well-being, and reduced social networks.[5] They are also more likely to have frequent hospital and clinic visits and greater reliance on emergency care.[5,6] With the rising burden and complexity of managing the health of people living with MLTCs, the demand for healthcare workers with skills to manage these conditions is growing. Yet, the World Health Organisation (WHO) predicts a shortage of 10 million healthcare workers by 2030.[7] As a result of the shortage of healthcare workers, there has been a focus on task shifting and task sharing, in which responsibilities conducted by formally trained healthcare professionals are shifted to other healthcare cadres, such as CHWs, who are defined as frontline public health workers. CHWs are trusted members of, and/or usually have a close understanding of the community.[7,8] They have limited or no formal medical education, but receive training to enable them to provide support and services to the community.[9] CHWs have different job titles, including lay health worker, community health advocate, promotor, and titles that refer to special training or knowledge in a particular area, such as an HIV educator.[10]

Previous studies have established that CHWs can successfully provide care for maternal and child health and infectious diseases such as HIV, TB, and COVID-19.[10,11] Based on this, there is potential for CHWs to play a vital role in the context of MLTC care.[8,12–14] While CHWs see people with MLTCs, they are often not sufficiently equipped to provide care for multimorbidity simultaneously. In some countries, like South Africa, CHWs have been trained across the conditions; however, this is not the same as training to manage multimorbidity. Responsibilities are mostly focused on addressing single conditions with duties that include case finding and tracing, promoting treatment adherence, conducting health assessments, and linking communities with healthcare.[9,10,15–17] Even though CHWs have the potential to strengthen primary health care for people with MLTCs, most MLTC care is currently driven by doctors and nurses, and little is described about MLTC interventions involving CHWs.

CHWs use various tools to provide support and manage people in their communities. These include paper-based resources such as pamphlets, booklets, and digital clinical decision tools, which are apps designed to assist in the assessment, diagnosis, or treatment of clinical problems that are specific to a patient[18] and which might be useful for MLTC care. Whilst there is evidence that the use of mobile phones improves CHWs' productivity and assist them to enhance patient education, improve reporting, and provide healthcare services, challenges are encountered, such as the lack of proper training, inadequate technical support, and unreliable internet access.[19,20] Although this evidence shows that CHWs can use digital tools to provide support in managing single conditions, it does not clarify the role of tools for managing people living with MLTCs.

To date, the evidence shows what CHWs can do and what they cannot do, but there is limited involvement of CHWs in the management of people living with MLTCs. Thus, this scoping review was undertaken to address this gap in evidence: the scope of practice of CHWs in managing people with MLTCs around the globe. In addition, the evidence from this review was conducted to inform intervention development for ENHANCE, a randomised controlled trial being conducted in 32 clinics in the Western Cape and KwaZulu-Natal, South Africa. ENHANCE is evaluating a multi-faceted intervention that includes using an integrated MLTC clinical decision support tool for clinicians in primary health care facilities, a treatment literacy pamphlet, and a personal health diary to support CHWs managing people living with MLTCs during home visits.

Methods

This scoping review employed the five-stage methodological framework proposed by Arksey and O'Malley, and Levac.[21] We developed a protocol for the scoping review using the Joanna Briggs Institute (JBI) approach for clarifying the question.[22] Reporting was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Extension for Scoping Reviews (PRISMA-ScR).[23] The checklist can be viewed on the Zenodo repository (DOI 10.5281/zenodo.18908846). The figures, tables, and appendices referred to throughout this article can be found on the Zenodo repository using the following DOI 10.5281/zenodo.18908846

The patient and public involvement statement

This study did not use patients or the public. The findings of this scoping review will inform the development of interventions for patients living with multiple long-term conditions.

Step 1: Establishing the research questions

The following questions guided the review:

1. What has been the CHWs' scope of practice, and what tools have they used to manage people living with MLTCs?

2. What interventions have been used by CHWs in the management of people living with MLTCs?

Step 2: Identifying potentially relevant studies

We searched PubMed, Scopus, EBSCOhost, Cochrane, and CINAHL databases from January 2013 to January 2025, and we re-ran the search from November to December 2025. Our search strategy was developed with the assistance of a university librarian and included controlled vocabulary and free text terms, informed by previous literature. We used a variety of Medical Subject Headings (MeSH) and free text terms to refer to community health workers, such as aid workers, support workers, and advocate workers (*Appendix 1a PubMed Search Strategy*). We further manually searched and identified articles from the reference lists of two systematic reviews.[24,25] These reviews were not included in the analysis because articles that were identified from the reviews are already included. We used the Participant, Concept, Context (PCC) approach proposed by the Joanna Briggs Institute (JBI) to develop the inclusion criteria, as detailed in Table 1.[22] We targeted the population of CHWs; the concept was health interventions, defined as any treatments or strategies that improve outcomes and make a difference in the MLTCs.[26] Studies that use interventions that involve CHWs in the management of people who are living with MLTCs. The context included all studies that were conducted globally in communities or primary health care. The type of sources included all types of original studies. We limited our studies to those published in English, and we excluded study protocols, systematic reviews, conference abstracts, opinion pieces, and editorials. We reviewed reference lists of relevant systematic reviews.

Step 3: Selecting relevant studies

Before undertaking title and abstract screening, one reviewer (OM), piloted the screening criteria on 10 articles and refined them. Then the titles and abstracts of studies identified in Step 2 were independently screened by two reviewers (OM and LV) to identify those that[1]: involved CHWs (defined as individuals who did not have tertiary education, such as volunteers, support workers and lay workers),[2] included interventions that addressed MLTCs (two or more chronic conditions including mental health conditions). Differences between reviewers' assessments were discussed and resolved by consensus. For included studies, the full text was extracted by one reviewer (OM). The screening of titles, abstracts, and full texts was conducted and completed on Rayyan software for systematic reviews (https://new.rayyan.ai/).

Step 4: Data charting

An Excel data extraction form was developed and pilot tested by one reviewer (OM) on 10 articles and subsequently revised by two reviewers (OM and NL). The form can be viewed here https://zenodo.org/records/18908847 (DOI 10.5281/zenodo.18908846.) It included study title, author, published year, study design (quantitative, qualitative, mixed methods), article type (peer-reviewed, original article, guidelines, unpublished reports/grey literature), aims and

Table 1. Detailed inclusion and exclusion criteria.

Population	Community Health Workers
Concept	• Health systems interventions and models that used CHWs to manage individuals with MLTCs. • Interventions that include improving diagnosis, treatment literacy, and control of MLTCs. • Interventions covering training programmes for CHWs, prevention programmes. • We also included articles on the tools that are used by CHWs.
Context	• All groups of individuals of different ages, community centres, and primary health, including all settings and countries.
Type of Sources	• All types of original research studies • Articles with quantitative, qualitative, or mixed-method study design • Articles written in English.

objectives, location or setting (e.g. country where the study was conducted, communities, clinics), population (adults), research methods (e.g. sample size, methods of data collection), and description of interventions.

Step 5: Collating and summarizing of results

We completed a narrative synthesis that summarised the description of the responsibilities of the CHWs, their training, the tools they used, including whether they were digital or paper-based, and the support received.

Results

The PRISMA flowchart of the study is shown in Figure 1:*PRISMA flow Diagram.* We identified 149 articles based on the abstract and title, of which 41 duplicates were removed. The remaining 108 articles were screened by title and abstract, and of these, 86 articles were excluded with reasons. The remaining 22 articles that met the inclusion criteria were included for a full text review, after which 14 of the articles were excluded. We identified 10 other articles from the two systematic reviews that met our inclusion criteria, of which four were excluded after reviewing the full articles, and six articles were added to the other included articles. We excluded the systematic reviews from the analysis. Therefore, in total, we selected 14 relevant articles for analysis. The 18 articles that were excluded reported interventions that did not use CHWs (n = 6), studies with interventions that used CHWs, but the intervention focused on single conditions (n = 4), conference abstracts (n = 4), study protocols (n = 2), as well as the two systematic reviews.

Characteristics of included studies

*Table 2 (refer to extended data)*shows the characteristics of the included studies, including the countries, the settings where the studies were undertaken, study designs, and participants' mean age. Three qualitative studies, six randomised controlled trials (RCTs), three mixed-method studies, a cross-sectional study, and one quasi-experimental study. More than half (57%) of the studies were conducted in primary healthcare centres and communities; six studies were conducted in the United States of America (USA), one in England, and one in Australia. The remainder were conducted in India, China, and Nepal. The studies in high-income countries focused primarily on rural settings (37%) or urban areas where most people had low socioeconomic status. Most of the participants of the included studies were females (3721), but two studies did not report the gender. Their ages ranged from 15 to 78 years. The studies reported conditions that participants had; participants in three studies had diabetes, hypertension, depression in addition to heart-related conditions such as myocardial infarction, heart failure, coronary heart disease, and ischaemic heart disease. Three studies reported patients with hypertension and diabetes,

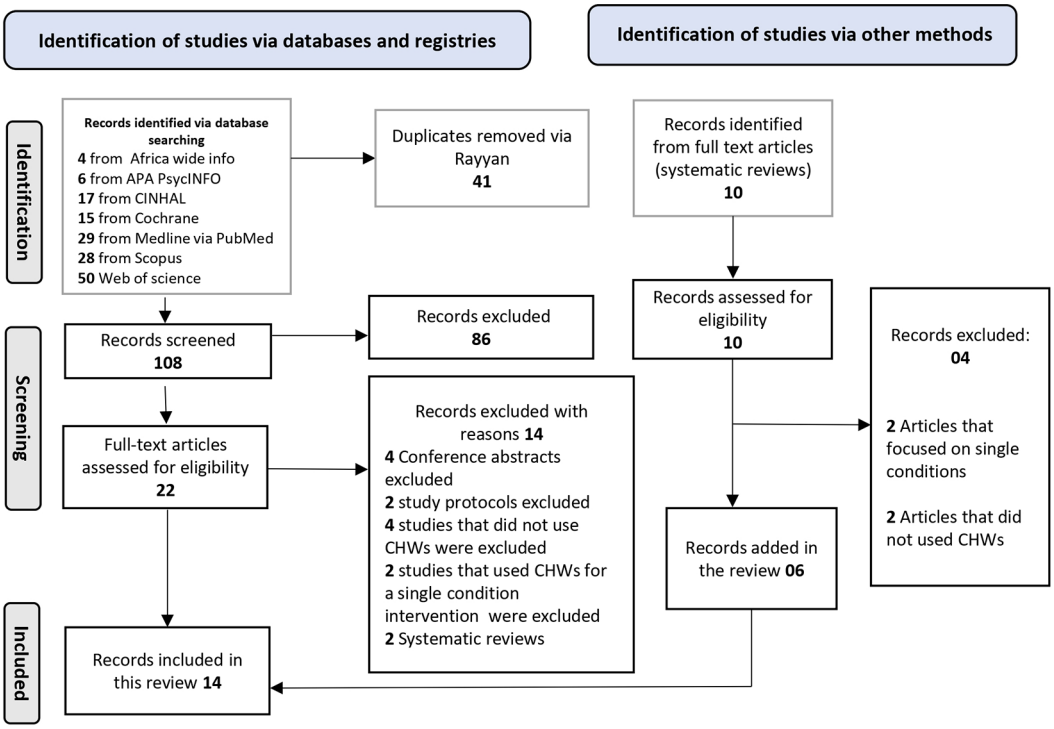


Figure 1. PRIMSA flowchart of study selection: RCT = 6, mixed methods = 3, qualitative =3; cross sectional =1; a quasi experimental design = 1.

plus other diseases such as obesity, stroke, arthritis, chronic pulmonary disease (COPD), and tobacco dependence. Three studies did not report the conditions, and the five remaining studies reported other MLTCs. Across all the included studies, approximately 5788 participants were enrolled, including professionals such as CHWs, doctors and nurses.

Roles of CHWs

As detailed in *Table 3 (refer to extended data),* CHWs had a range of roles in the selected studies in managing people living with MLTCs. The CHWs' roles were then categorised and subcategorized as follows:

Patient care management

Patient care management involves the coordination and oversight of patients' treatment plans to ensure they receive comprehensive and effective care. Six studies reported management of physical health, treatment compliance, and retention. Physical health management involves monitoring patients' physical well-being and coordinating care that addresses both their physical health and other health needs.[27] During these visits, CHWs provided patients with blood pressure machines and digital scales and developed a care plan with each patient.[28–31]

Education and empowerment

Five studies reported that CHWs promoted self-management behaviours, which involved empowering patients to take responsibility for their health, such as being able to set goals in a health diary and monitor weight and blood pressure.[24,28,32–34] In four studies, CHWs promoted treatment literacy and health literacy among patients and their families.[24,30,33,35] Treatment compliance involved supporting patients in adhering to treatment plans, and adopting dietary changes and healthier behaviours.[25,29,30,34,35] Health education focused on chronic condition risk factors and exercise advice, which included checking of joints. Additionally, CHWs delivered family-based education aimed at addressing social taboos and fostering a healthy family environment[30,36–38] . Four studies focused on reinforcing healthy lifestyles, such as providing support to quit tobacco use and to engage in physical activity and meditation.[27,30,37–39]

Coaching and support

Two studies reported that CHWs also served as health coaches, providing guidance and support to patients in managing their health. This role included helping patients to develop healthier habits and make informed choices about their wellbeing.[34,39] CHWs provided tailored health coaching, supported patients in areas related to social welfare, and offered counselling services.[27,39]

Coordination and follow-up

CHWs served as liaisons between health systems, patients, and families, provided appointment reminders to ensure patients stay engaged with their care, and assisted patients with health system navigation, and acted as patients' advocates.[24,36,39] The frequency of home visits conducted by CHWs in delivering the interventions varied. Three studies reported interactions at their homes, by telephone, and via video contacts.[28,31,33] The number of home visits varied from one to 12 in the studies; One study reported (n = 2) home visits[34] and two studies reported (n = 3) home visits[31,35] The studies did not specify whether the visits were conducted weekly or monthly. One study noted that CHWs provided up to four visits daily for six weeks.[32] Four studies reported more than 12 home visit sessions; some of these sessions were conducted bi-weekly.[29,33,36,38] Three studies did not report on CHWs' home visits.[37]

Interventions

Of the included studies, six reported collaborative or interprofessional interventions (*Table 3- refer to extended data*), which comprised healthcare providers from different disciplines, including CHWs. Four studies reported coaching programs, one reported a self-management intervention, one study reported a health literacy intervention, one intervention involved an exercise program, and one study reported a care coordination intervention.

Collaborative interventions included: (i) the Transition Clinic Network (TCN) that used former incarcerated CHWs to provide support to patients returning from imprisonment with health and social needs[27]; (ii) the Healthier Options through Empowerment (HOPE) intervention in which female CHWs partnered with nurses, doctors, and psychiatrists to diagnose and treat depression in patients with co-morbid diabetes and cardiovascular conditions[36]; (iii) The HOPE qualitative study highlighted the perception of CHWs who provided the intervention[29]; (iv) The Secondary Stroke Prevention by Uniting Community and Chronic Care Model Teams Early to End Disparities (SUCCEED) intervention used advanced practice clinicians (APC), nurse practitioners, or physician assistants together with the CHWs to address lifestyle factors,

health literacy, medication adherence and obstacles to behaviour changes in patients with stroke and history of hypertension[31]; (v) The Chinese Older Adults Collaborations in Health (COACH) tested the effect of the collaborative care approach, consisting of the COACH team: a village doctor, a CHW referred to as an aging worker, and a psychiatrist, to treat comorbid hypertension and depression[30];(vi) and an interprofessional model of Bridges Self-Management (SMS) intervention supported clinicians to integrate self-management.[32]

The coaching intervention was community-based, where CHWs promoted medication safety and mentored discharged adults in following self-care plans and improving disease self-management.[27,28,31,33–35,39] Only one intervention focused on exercise for people with arthritis and co-morbid COPD.[38] A health literacy intervention was delivered by CHWs to educate and support self-management of health.[33] Lastly, the care coordination and support intervention explored the impacts of training design to enhance the role of CHWs.[40]

CHW Training

Thirteen studies reported the training of CHWs, which ranged from 1 hour to under four weeks in duration, including some details of the training, excluding four that did not include details on training duration.[27,29,36,38] One study did not report training.[37] The training of CHWs was conducted in universities, colleges, and community centres. Training covered various topics, which included educating, coaching, conducting assessments, risk factor screening, and motivational interviewing.

Tools used by CHWs

Seven of the studies reported tools used by the CHWs; of these, three studies reported both digital tools and paper-based tools, three studies reported the use of paper-based tools only, and one study used a digital tool only. The paper-based tools included: (a) a health activity log, which was used to report the interaction with the patient, such as the mode of communication and the purpose of the interaction.[27]; (b) a health literacy booklet with a self-management tool that included health information, using pictures, colours, and symbols to engage with illiterate participants; nutrition and immunity building, chronic ailment management that included dosage/equipment management and follow-up visits, as well as hygiene, sanitation, and coronavirus prevention management[33]; (c) the 10 keys™ tool provided participants with ten keys to healthy aging and gave the participants the type of questions that they can ask their clinicians and ways to ask those questions[38]; and (d) a medication safety guide (MSG) tool containing medication safety principles, attitude reinforcement, consultation resources, and medication schedule reminder[35] .

Digital tools included: (a) Activities of daily living, Weight and nutrition, Awareness, Condition, Cognition, and social activities (AWACCS). This tool was used to identify any important changes in weight, eating, and drinking habits. It also captured changes in general conditions, including walking, strength, and endurance, as well as changes in memory and social activities.[40] (b) Health literacy videos were used as an addition to the health literacy booklet.

Discussion

This scoping review identified 14 relevant studies that describe the scope of practice, activities of CHWs, and the tools used when managing individuals with MLTCs. Our review also described interventions that tested strategies for CHW management of people living in MLTCs. Eight of the 14 studies were conducted in high-income countries in rural areas and community centres, and six in LMICs. The interventions included a collaborative or interprofessional model. Studies reported various roles of CHWs, which we categorised as patient care coordination, education and empowerment, coaching and support, as well as coordination and follow-up.[24,25,27–40] Our findings reported that CHWs used digital and paper-based tools to manage and support individuals with MLTCs. The duration of the CHWs' training ranged from an hour to five days.

This review concurs with other studies that have established that CHWs serve their communities by bridging the gap between the community and the health system, particularly in under-resourced areas.[14,41–43] CHWs found in LMICs have improved in reducing childhood undernutrition, maternal and child health, and contributing to the control of HIV and malaria, as well as health promotion. In HICs, they contributed to reducing disease burden by participating in the management of hypertension, in the reduction of cardiovascular risk factors, in diabetes, HIV, and cancer screening[44] . Understandably, more than half of the interventions in this review were from HICs in rural and community settings. This could be because MLTC research has been conducted in HICs for years[45] while in the LMICs, the focus has been mostly on single conditions.[3] This implies that the interventions that seek to address MLTCs in LMICs are fairly new, and the development and testing of these interventions are often complex and take time.

In LMICs, the health system is fragmented, with a high prevalence of chronic infectious diseases and NCDs[46,47] compared to the health systems in HICs, which are generally better resourced. This suggests that some of the collaborative interventions that use CHWs but require the support of doctors and other health care providers might not be as possible to implement in LMICs. This is particularly applicable to interventions involving medical specialists such as psychiatrists, who are often based in tertiary hospitals in urban areas.

Just under half of the interventions utilised collaborative and/or interprofessional models in which CHWs worked with different professionals from diverse disciplines, each contributing distinct expertise.[27,29–32,36] This has the potential to enhance care through the opportunity to refer patients for clinical intervention when needed.[48,49] It has been reported that CHWs make an impact in the field of mental health, HIV, and TB when they receive support from other health care providers with adequate training.[50,51–52] Even though the collaboration of CHWs with other clinicians can be effective, the limitation would be that when the support is minimal from other healthcare providers, CHWs may struggle to provide sufficient care to their communities.

The reported roles of CHWs for MLTCs identified in this review were similar to those reported for single conditions such as HIV and TB.[9,10] However, a notable difference was that CHWs played multiple roles when managing individuals with MLTCs. They provided education, conducted home visits, and performed different functions for different conditions. It is recognised that CHW programmes often lack effective training and supervision.[12,13,53,54] Effective training of CHWs improves their professionalism and, quality of their performance.[53] With the complexity in providing care for individuals with MLTCs, adequate training for CHWS is essential. While most of the included studies reported that CHWs received training, the duration of the training was short.

In the studies of this review, CHWs used a range of digital tools and/or paper-based tools to support their functioning. Digital tools have been used in different settings for different purposes, such as a health literacy intervention that was conducted in Pakistan and a mobile application management and reporting tool used in the USA.[31,33,39] Digital tools used by CHWs can improve the performance of CHWs in providing care, particularly in LMICs.[19,55] These tools play a crucial role in the management of individuals with different conditions by enhancing care coordination, enabling remote monitoring, and promoting patient engagement and surveillance data.[19,20,56] The use of digital tools received a lot of attention during the COVID-19 pandemic, which can be leveraged and tailored to manage individuals with MLTCs.[54] There were no specific tools that provided CHWs with guidelines for managing people with MLTCs. Both paper-based and digital tools were primarily tailored for each study and were not intended for a broader application beyond their specific research contexts. As a result, these tools are unlikely to be adapted for wider use in different populations and settings. Furthermore, none of the studies commented on the safety of the use of digital tools in the community, this may be a problem in countries with high rates of community violence as the CHWS can face theft of digital devices.

Strengths and limitations of the review

Our search was comprehensive, ensuring we captured a wide range of studies that reported interventions that evaluated CHWs' roles in the management of people with MLTCs. A limitation is that the review only included publications/studies in English; therefore, we may have missed publications in other languages. Notably, however, the review has highlighted the limited literature in which interventions have involved CHWs in the management of people with MLTCs. While several studies reported on the tools that CHWs used to manage people with MLTCs, most of these were paper-based and did not provide instructions or algorithms for CHWs to follow.

Conclusion

CHWs can play diverse roles in managing MLTCs, including educating and assisting patients with self-management. Given CHWs' unique relationship with communities, with adequate training and support from other healthcare providers, can enable them to lead certain tasks in the management of patients with MLTCs. Studies that were conducted in LMICs in this review were few compared to HICs. This highlights a critical gap in the literature but also suggests a significant potential for expanding CHW-led interventions in LMICs. With rigorous content-specific research, such interventions can be effectively adapted and scaled to manage and support people living with MLTCs.

Ethics

We used secondary data from the existing literature; therefore, we did not seek ethical approval.

Data availability statement

Zenodo**:** Healthcare interventions involving community healthcare workers in the management of people with multiple long-term conditions: scoping review https://zenodo.org/records/18908847 (DOI 10.5281/zenodo.20478586).[57]

This study contains the following data:

- Data extraction form
- Search strategies that were employed from PubMed, Cochrane, and EBSCOhost
- Extended data: Table 2 and Table 3
- PRISMA-ScR checklist

Data are available under the terms of the Creative Commons Zero v1.0 Universal.

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Peter Bower
University of Manchester, Manchester, UK

Thank you for the opportunity to comment on this timely scoping review, which usefully maps the current work on CHWs in the important context of MLTC.

The scope of CHWs needs a clearer definition. Table 1 is described as 'detailed...criteria' but they really not very detailed at all. The definition in the text seems to relate to education only.

I thought NIHR were moving away from the use of 'multimorbidity'. I think I would make that clear at the start and use MLTC consistently.

The statement 'CHWs have been trained across the conditions; however, this is not the same as training to manage multimorbidity' needs unpacking. How does the latter differ from the former?

The lack of PPIE is noted and could be flagged as a limitation.

The research questions talk about 'tools' and 'interventions' and I am not sure it is 100% clear in what way they differ.

There are several statements about how they managed systematic reviews, and I think it should be a single statement that existing reviews were used as sources of papers for this review. It sounds odd to say they are excluded when they are clearly the most relevant studies of all.

I think the distinctions they make between 'roles' need clarifying. Self-management seems VERY similar to coaching, and both could be a subset of 'patient care management'. It feels like there is an important distinction in relation to roles that are focussed on care and those that are about co-ordination – the other distinctions seem less clear to me.

This section also seems only loosely integrated with the section on interventions. Obviously, a scoping review is not designed to look at outcomes, but I think a little more could be said about what these trials are looking to achieve in terms of outcomes.

I note that this work is being done in support of another trial, so it would be useful to understand what has been learned in terms of that development. They note that 'multiple roles' are common, but what are the advantages and disadvantage here?

The authors highlight that CHWs are often used as part of models with other workers, and say that access to support from those workers is a rate limiter, but the introduction suggests CHWs are designed in part to overcome the shortage of health workers? How do they manage that tension? Did any of the studies involve independent practice?

'Studies that use interventions that involve CHWs in the management of people who are living with MLTCs' (page 5) does not seem to be a complete sentence?

The search data limit (2013) needs justification and flagging as a limitation.

Are the rationale for, and objectives of, the Systematic Review clearly stated?
Yes

Are sufficient details of the methods and analysis provided to allow replication by others?
Yes

Is the statistical analysis and its interpretation appropriate?
Not applicable

Are the conclusions drawn adequately supported by the results presented in the review?
Partly

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Applied health services research

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Reviewer Report 14 September 2026

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Margaret Dunham
Edinburgh Napier University, Edinburgh, UK

Thank you for asking me to review this submission.

- The purpose of this review is to explore the scope of practice of community health workers and appreciate what tools/guides they utilize in their support of people living with multiple long-term conditions in the community.
- The review methodology seems appropriate; however, it would be helpful to elaborate the identified five-stage methodological framework.
- It would be good to establish a definition of what Community Health Workers are, does this include registered professionals? Is there some particular definition of the role identified by the review team as part of the search?
- The findings section includes identified themes in respect of the role and responsibilities of community health workers. It would be informative to identify the associated papers as references within the sentence where first mentioned. For example, under the heading 'Patient Care Management' the six studies mentioned in the second sentence are not referenced. Please can this approach be applied consistently for all the thematic sections. Also, when relating the nature of the identified studies, it would be useful to have some appreciation of the identified data, how many people were accessed and a little more specificity about the populations. These points could also be picked up as considerations within the limitations for this review.
- Where the identified interventions are mentioned, this section begs further elaboration and some of the points are intriguing, such as the statement 'former incarcerated' about community health workers and needs context. Similarly, the section about the identified Tools used needs more development.
- The reporting of only qualitative findings is interesting, was there a rationale for this? Were there no data to compare/synthesize in relation to the care workers or the served populations?
- In respect of general presentation, the use of abbreviated forms for repeated non-complex language is rather off-putting and I recommend writing in full the terms MLTC, HIC, CHW etc. and also not starting a sentence/paragraph with an abbreviated form.

Overall, an interesting paper but more clarity and signposting are needed.

Are the rationale for, and objectives of, the Systematic Review clearly stated?

Yes

Are sufficient details of the methods and analysis provided to allow replication by others?

Partly

Is the statistical analysis and its interpretation appropriate?

Not applicable

Are the conclusions drawn adequately supported by the results presented in the review?

Partly

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: pain, older people and long term conditions. Qualitative researcher. Review and guideline development related to

I confirm that I have read this submission and believe that I have an appropriate level of

expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.