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Q&A

Q&A with Madeleine Ballard

Dr. Madeleine Ballard is the CEO of Community Health Impact Coalition (CHIC), a global movement transforming healthcare by making professional community health workers the norm. Through research, advocacy, and organizing with community health workers, she has driven policy changes that ensure quality care for millions—including those who provide it. Dr. Ballard holds a PhD from the University of Oxford, where she was a Rhodes Scholar, and is a faculty member at the Icahn School of Medicine at Mount Sinai. Her work alongside CHIC has appeared in *The New York Times*, *Forbes*, *The Lancet*, and more. She is the recipient of the Skoll Award for Social Innovation, the Roux Prize, and the Schwab Social Innovator of the Year—honors that reflect both her significant contributions to population health and her leadership in building powerful coalitions that achieve breakthrough reforms at a large scale.

Could you share how your academic background of evaluation science has shaped your approach to your work with community health workers?

M.B.: Community health workers (CHWs) bring primary health services straight to their neighbors' doorsteps. I witnessed this firsthand while working together with CHWs to provide care for years in remote Liberia. My academic grounding in evaluation science provided a methodological foundation for addressing a historical tension in CHW programming: the gap between evidence of their efficacy to dramatically reduce morbidity and mortality in controlled trials yet repeated failure to do so in national-scale implementation. My research at Oxford focused on disentangling the key components driving intervention effectiveness and rigorous measurement of intervention fidelity—in other words, not just whether CHW programs work but which elements (e.g., salaries, skills, supervision, and supplies) drive success or failure. And that's what we at Community Health Impact Coalition (CHIC) focus on.

Leading CHIC, a multi-country coalition of CHWs, must require collaboration across diverse contexts. How do you ensure that the unique needs and challenges of different countries are addressed within the coalition's initiatives?

M.B.: Millions of CHWs are not paid, supported, or supplied. 70% are women. It's a dual-sided human rights issue. CHWs are exploited and less effective for patients. One billion people will never see a health worker. CHIC is making professional community health workers (proCHWs) the norm worldwide by changing guidelines, funding, and policy.

Madeleine Ballard
Community Health Impact Coalition, London, UK
Icahn School of Medicine at Mount Sinai, New York, NY, USA

CHIC prioritizes fidelity to evidence-based fundamentals—fair compensation, standardized training, reliable supplies, and supervision—which are universally required for CHW effectiveness. Adaptation applies only to operational aspects: training delivery (digital vs. in person), community engagement tactics, or task prioritization (e.g., malaria vs. maternal health). While context shapes implementation, decades of failed ''volunteer'' models prove that core supports cannot be adapted away. Rigorous studies, such as Rwanda's national CHW program, demonstrate that adherence to these non-negotiables drives success, while excessive localization undermines equity and impact.

CHIC's approach balances non-negotiable core principles with context-specific adaptations. CHW-led care delivery is a complex adaptive system, rather than a static intervention. However, rigorous evidence shows that certain elements—such as continuous training and supply chain reliability—are universally critical for CHW effectiveness, regardless of setting.

Adaptation applies to operationalization of these core components, e.g., digital vs. in-person training delivery, community engagement tactics, or logistical workflows, to better fit local infrastructure, culture, and health priorities. Ultimately, CHWs aren't clay to be endlessly reshaped—they're professionals requiring foundational supports that adaptation cannot ethically circumvent.

With a significant portion of the global population lacking access to essential health services, and given the critical role CHWs play in enhancing health outcomes and equity, what are some of the key challenges they face today, and how is CHIC working to address these issues?

M.B.: Despite their proven impact, CHWs face persistent challenges, many of which stem from systemic undervaluation of their work. Globally, a significant proportion of CHWs remain unpaid or underpaid, leading to high attrition and inequity,

particularly for women, who make up the majority of the workforce. Stockouts of essential medicines and supplies—which happen at higher rates in the community than in the facility—are another chronic issue, undermining both CHW morale and community trust. Additionally, CHWs often lack opportunities for career progression and are excluded from decision-making processes that affect their work.

CHIC considers the conditions that hold these problems in place and uses three interconnected tactics to solve their root causes. Firstly, we research to equip international norm setters with evidence, shaping the key policy documents that drive investment and national policy worldwide. CHIC can pool data and generate new multi-country proCHW insights that no single organization could.

Secondly, we advocate to influence global financing institutions. Current CHW funding is insufficient and inefficient. We engage donors to strategically invest in proCHWs. CHIC creates the surround sound necessary to change the practices of global financing institutions: the guidance they issue, how they measure success, and ultimately how they invest.

But health is not just technical. It's political. We need to make public-sector healthcare systems work, as governments are the primary providers in most places. Therefore, creating an enabling environment through proCHW guidelines and funding is not enough.

Thirdly, we activate in-country CHW networks to win national policy. CHIC is the unified voice of thousands of CHWs globally demanding the conditions for quality care. We seed national CHW associations to win policy, ensure effective implementation, and defend it.

We are unique in our policy-focused methods, top-down and bottom-up approach, and in our role as a systems orchestrator. The result? ProCHWs who are salaried, skilled, supervised, supplied, and integrated into health systems. This gets us closer to health for all, including those who provide it.

In your experience, what are the most effective methods for leveraging evidence-based data to influence policy and improve funding for CHWs on a global scale?

M.B.: Four principles guide our evidence-to-policy work at CHIC: first, the evidence itself must be relevant and robust. The case for proCHWs is compelling: it is a big idea that is cost effective and feasible enough to transform health systems worldwide. ProCHWs yield a 10:1 return on investment through reduced mortality and economic gains.

Second, evidence generation must be inclusive. We co-author studies with health ministers and CHWs themselves, ensuring that findings align with policymakers' operational realities and frontline workers' lived experiences.

Third, and equally critical, is how insights are shared. We know that policymakers are most persuaded by their peers, so we platform leaders from countries such as Malawi and Senegal—who have made evidence-based reforms—at forums such as the World Health Assembly and UN General Assembly to share their experiences and results with ministers who have not yet done so.

Finally, timing is critical. We map national policy cycles in over 100 countries and strategically engage ministers whose countries are approaching policy reviews in the next 24 months, ensuring that the right evidence reaches the right people at the most opportune moment to drive action.

Looking ahead, what critical steps do you believe health institutions and governments need to take to better integrate CHWs into national health systems and ensure that their contributions are properly recognized?

M.B.: With a global health workforce shortage of 18 million by 2030 and half the world's population still lacking adequate access to essential health services, now is the time for bold action that can reshape healthcare for generations. Millions of experienced and trusted CHWs are already providing door-to-door care, linking people to facilities, and offering essential social support, yet most operate outside formal systems, often unsupervised, unequipped, and undertrained—a situation that limits their impact and undermines their well-being.

In the midst of economic downturns, political instability, climate change, and pandemic risks, investing in proCHWs is a strategic choice. The evidence consistently shows that professionalized CHW programs deliver high-impact, cost-effective results, even in the most challenging environments.

Government leaders can act now by committing to a clear policy shift toward proCHWs. More than 40 ministers have already taken this path, and step-by-step guidance is available, including country case studies from Liberia and Ethiopia, providing practical insights on designing, optimizing, and scaling CHW programs.

With strong political leadership, proCHW models can be implemented nationally within years, not decades. Ministers have the opportunity—within a single term—to establish sustainable, proCHW programs that will strengthen health systems and advance universal health coverage for generations to come. The urgency and feasibility are clear; the time to act is now.

DECLARATION OF INTERESTS

M.B. declares no competing interests.

https://doi.org/10.1016/j.medj.2025.100745