



Community Health Workers: The State of the Evidence, 2021

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Introduction

Community health workers play a critical role in maintaining and improving individual and collective health outcomes. Yet their contributions and potential remain under-recognized and CHW programs underfunded. By sharing learning and improving accessibility to the evidence, CHW Central promotes CHWs and supports CHWs, program managers, and policy makers to make the case for improved investment in and working conditions for the CHW workforce. Every year, CHW Central collects and makes available in our resource database as many resources related to CHWs—articles, gray literature, tools—as we can find. In 2021, we found 442 resources. That’s a lot of information—far too much for most program managers, CHWs, or researchers to go through. To make the scope of evidence more accessible, this brief state of the evidence report summarizes the nature and key findings of the CHW research, tools, and other resources published in 2021. Readers will find recommendations for further reading in each section of the report and a comprehensive list of citations in the Appendix. Links to all 442 resources can be accessed through the CHW Central Resources page.

Our Approach to Finding Evidence

With the support of the Network of the National Libraries of Medicine, CHW Central partnered with a librarian at the Tufts University Medical Library to develop a search strategy. The librarian and CHW Central interns searched Medline (PubMed), Google Scholar, MedNar, Cochrane Database of Systematic Reviews, World Wide Science, and WHO Global Index Medicus for peer-reviewed and gray literature in English relating to CHWs. After review, we included 442 resources in this report.

To organize the evidence and relate it to existing global guidelines for CHW programs, we grouped the evidence into four themes: competency development; CHW support structures; logistics of CHW work; intervention or services, and policy and systems structure. The first three themes are organized around the 15 recommendation areas outlined in the [WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes](#) (2018). The fourth reflects the research priorities advocated for in the same document, particularly related to CHW training and development, and additional topics covered in the 2021 literature.

What We Learned in 2021

The impact of the COVID-19 pandemic on CHW programs was a major focus of analysis and advocacy in 2021. The pandemic disrupted supply chains, strained CHWs by adding to their workload, and compromised data collection and use. However, the pandemic also highlighted the resiliency of CHWs and their importance which resulted in some countries in an infusion of funding for primary health care, CHWs and other community-based initiatives.

The pandemic also highlighted the lack of prioritization of CHW programming by national governments. Despite more resources being directed to public health, governments underestimated the potential for CHWs to assist and funding for CHW programs decreased as a proportion of overall health budgets.¹ Additionally, although several publications focused specifically on interventions to combat COVID-19, most included only a brief mention of the role of CHWs in implementing these interventions (mostly community-based outreach). For

instance, one resource described strategies for adapting CHW programs to the new context of the pandemic, including expanding CHWs' scope of work to relieve the burden on hospitals and clinics.²

Among the most comprehensive and useful publications in 2021 was a series of 11 papers edited by Zulu and Perry.³ These papers cover topics ranging from CHW program governance to CHW relationships with health systems and communities. If, as is likely, you don't have time to read through all 442 articles covering CHW issues published in 2021 and would like a summary of the evidence on CHW program management and systems considerations, we recommend reading the papers in the collection edited by Zulu and Perry. We draw heavily from their conclusions in the sections that follow.

Overview of the Evidence by Theme

Competency Development

Pre-service training/recruitment

There is no single set of **eligibility criteria** for community health workers. Eligibility such as age, education level, literacy, gender, and ethnicity vary across programs because CHWs are selected and trained to respond to the particular needs of their communities. Less professionalized CHWs, those that do not require a large or complicated skillset (such as community education) or certification, require different eligibility criteria than more professionalized CHWs offering services requiring greater skills such as blood pressure reading, medication dispensing, or injections. Communities need to be involved in the recruitment of CHWs and in decisions about eligibility criteria, such as minimum education required, work ethic, and the basic skill set needed.⁴ However, possible bias in selecting CHWs needs to be taken into account; some authors stress that CHWs should not be selected based on marital status and that minimum education and language requirements often restrict women from becoming CHWs.⁵

Accordingly, **pre-service training** needs also vary greatly according to CHW type and local needs.⁶ For example, vertical, disease-specific cadres, like TB volunteers, require a different skill set than CHWs that provide multiple services. There is no standard or "best" training duration for CHWs. Duration depends on the type of CHWs, their roles, and their required skill level and tasks.⁷ Training duration varies across programs from as little as four days (for TB volunteers in Myanmar) to as much as three years (for community health extension workers in Nigeria).⁸

However, some **common approaches** can be applied to pre-service training. For example, increased emphasis on CHWs engaging with one another throughout pre-service training builds early connections and enhances

learning.⁹ Strong pre-service training programs involve innovative and culturally appropriate approaches such as simulations, supervised practice, digital-based training (to bridge distance barriers), and storytelling.¹⁰

In-service training and development

To perform well and expand their scope of service, CHWs need **ongoing capacity development**. The WHO CHW Guidelines note CHW capacity-strengthening as a major area in which further evidence is needed. Capacity development may take the form of in-service training, continuing education, performance evaluations, and knowledge assessments. This includes advocating for continuing education and ongoing, iterative training for communities, supervisors, and other stakeholders.¹¹ In one example, after practicing CHWs were effectively trained by doctors and nurses on how to detect signs of epilepsy, 90 percent of suspected epilepsy cases reported at local health facilities were identified specifically by CHWs, 82.9 percent of which were later confirmed by neurologists to be true diagnoses.¹² This provides a powerful example of the clinically valuable competencies that can be acquired by already practicing CHWs when provided with specialized in-service training by qualified health care professionals.

CHW Support Structures

Roles and responsibilities

As the role of CHWs evolves, so does the evidence on certification, supervision, remuneration, and contracting agreements. One study concluded that the four most common overall barriers to successful and sustainable CHW programs are: “(1) inadequate financing, (2) interruptions in the supply chain for basic supplies, commodities, and medicines, (3) insufficient remuneration of CHWs, and (4) lack of or poor-quality supervision.”¹³ The support which organizations and systems provide must meet the needs of CHWs and the populations they work with. CHWs are as diverse as the communities they serve because, by their nature, CHW roles and tasks need to be driven by community need and acceptability.¹⁴ CHWs range from community-based educators offering health promotion to assistants delivering primary health services within health facilities and many roles in between.¹⁵ There is an ongoing shift away from specialized, disease-specific CHWs to more advanced CHWs with more responsibilities.¹⁶ In many contexts, CHWs of different types co-exist, often including paid CHWs working alongside unpaid CHWs, engaged by different agencies to perform different tasks, but nonetheless contributing to addressing community needs for health service delivery under very different conditions of engagement.¹⁷ The

FOR FURTHER READING

[Promising careers? A critical analysis of a randomized control trial in community health worker recruitment in Zambia](#) (Winthrop, 2022)

Excellent, specific account of the failure of CHW recruitment through a poster campaign, based on the promising results of a flawed randomized control trial.

[Perceptions of Lady Health Workers and their trainers about their curriculum for implementing the interventions identified for Essential Package of Health Services for Pakistan](#) (Sohail et al., 2021)

An insightful, in-depth analysis of gaps in CHW training curricula in Pakistan.

[Community Health Worker Training Curricula and Intervention Outcomes in African American and Latinx Communities: A Systematic Review](#) (Adams et al., 2021)

An assessment of CHW program outcome effectiveness by various modalities, including use of didactic sessions and specific learning theories.

[Recruitment, Training, and Roles of the Bilingual, Bicultural Navegantes: Developing a Specialized Workforce of Community Health Workers to Serve a Low-Income, Spanish-Speaking Population in Rhode Island](#) (McCarthy et al., 2021)

Highlights the role existing CHWs play in selecting, training, and preparing new cohorts to enter the workforce, including the mutual professional development benefits enjoyed by newly trained and existing CHWs involved in knowledge exchange.

[Evaluating a capacity building program on women’s health for displaced community health workers in fragile settings in Lebanon](#) (Naal et al., 2021)

Compelling case study of the far-reaching effects of capacity-strengthening programs in contexts where CHWs face marginalization and systemic constraints to serving their communities.

COVID-19 pandemic also resulted in the emergence of a new group of community health workers dedicated solely to that disease, which spurred calls for role integration with other, existing CHWs.¹⁸

Organizational support

CHW **certification** remains an important foundation for professionalizing CHWs, but one that is challenging to implement. Although standardized, certified CHW programs may be important, it can be difficult to establish and maintain certification schemes.¹⁹ Importantly, programs that succeed in establishing CHW certification enjoy greater sustainability in overall financing and CHW remuneration, as well as greater trust and support from communities. For example, in the United States, certification is increasingly enabling CHWs to secure funding through national health insurance schemes (i.e., Medicaid and Medicare).²⁰

Supervision supports and motivates CHWs to perform their jobs, but as with recruitment and training, supervision may take many forms, including external supervision, community supervision, group supervision, peer supervision, and dedicated supervision.²¹ Dedicated supervision is a term used by Westgate and her colleagues to describe supervision as a full-time job rather than as an activity carried out by individuals, such as clinicians or nurses, with larger scopes of work. To do their jobs well, supervisors also need support: “The largest current single collection of case studies on large-scale CHW programmes demonstrates that 15 out of 29 of the programmes evaluated had ‘weak supervision’ characterized primarily by lack of support (e.g., funds, tools, training, role clarity) for supervisors themselves.”²²

The World Health Organization recommends that CHWs be provided with **written contracts** specifying their role, responsibilities, working conditions, pay, and rights. In the case of Brazil’s highly developed and nationally institutionalized CHW program, the creation of formal contracts has allowed the government to effectively introduce legislation on safety and security arrangements for CHWs, which have been found to improve CHW working conditions and long-term incentives.²³ During the COVID-19 pandemic, for example, hazard exposure compensation was an important way of protecting and retaining the CHW workforce.²⁴ Although requirements for employers to offer certain safety and security benefits to hired CHWs can increase difficulties in hiring for certain contractors, the uncertainty and job insecurity that arises when CHWs lack formal contracts is disruptive to CHWs’ livelihoods and may present a barrier to qualified candidates taking on community health work.²⁵

FOR FURTHER READING

[Early Lessons from Launching an Innovative Community Health Household Model Across 3 Country Contexts \(Palazuelos et al., 2021\)](#)

Excellent source documenting the shift from vertical to more horizontal approaches across three completely different project sites.

[Evaluating the association of state regulation of community health workers on adoption of standard roles, skills, and qualities by employers in select states: a mixed methods study \(Jones et al., 2021\)](#)

Provides an excellent analysis of the effect of state regulation of certification on the adoption of key skill sets; the context may only be useful for high-income countries (especially the United States) but the method of analysis is generalizable.

[Developing a district level supportive supervision framework for community health workers through co-production in South Africa \(Assegaai et al., 2021\)](#)

Describes an original participatory methodology for constructing a framework for supportive supervision that could be scaled up elsewhere.

[Community-Based Interventions to Reduce Child Stunting in Rural Guatemala: A Quality Improvement Model \(Juarez et al., 2021\)](#)

Compelling evidence on how supportive supervision and feedback structures can go as far as improving multifactorial health/nutrition outcomes by enhancing CHW efficacy.

Incentivization

CHW **remuneration** remains an essential topic in discussions on CHW program sustainability, workforce equity, and empowerment. Methods of incentivization include financial (i.e., monetary, either direct or indirect), non-financial (e.g., uniforms, supplies, bicycles), health system-oriented (i.e., system reforms that are effective or supportive), and community-level (e.g., social acknowledgment/recognition).²⁶ Methods of remuneration vary greatly according to CHW type, from no compensation (e.g., Ghana's community health volunteers) to salary and benefits (e.g., Brazil's *agentes comunitários de saúde*).²⁷

There is a trend toward increased professionalization of CHWs, with accompanying expectations of high-quality training and fixed levels of remuneration. There also appears to be increasing use of performance-based financing for remuneration, though the WHO and others have recommended against relying too heavily on this approach.²⁸ Motivation does not come solely in the form of financial compensation or in-kind gifts; **professional development and personal growth** are also successful motivators for CHWs: "a CHW's relationship to local cultural contexts, labor markets, the state, and civil society can also greatly shape their motivation."²⁹ Mechanisms for assessing and adapting the effectiveness of incentives will be necessary as CHW roles and priorities change over time.³⁰

The chance for **career mobility** is a top motivator for CHWs in programs around the world but is not always available.³¹ CHWs in South Africa noted lack of opportunities for professional growth as a source of dissatisfaction.³² Where opportunities for growth are available or where there is hope for them, CHWs may stay on the job for long periods of time. India's accredited social health activists (ASHA)s, for example, are in large part motivated by the (albeit seldom realized) prospects of attaining formal government employment, because of the pay and status associated.³³

Logistics of CHW Work

Community engagement and resources

There is no single recommendation for a **target population size** a CHW should serve nor is there any evidence that one would be appropriate. The population size assigned to a CHW needs to be tailored to local geography, assigned responsibilities, and expected level of effort, among other factors. New responsibilities, such as responding to the COVID-19 pandemic, can rapidly and radically increase CHW workload and need to be

FOR FURTHER READING

[Community Health Worker Sustainability: Funding, Payment, and Reimbursement Laws in the United States](#) (Schmit et al., 2021)

Authoritative source on the state of official funding mechanisms for CHW programs across the United States whose methodology could be applied to other country contexts.

[Compensation models for community health workers: Comparison of legal frameworks across five countries](#) (Ballard et al., 2021)

An excellent, cross-country comparison of formal remuneration schemes, with detail beyond simple monthly monetary payment.

[How workers respond to social rewards: evidence from community health workers in Uganda](#) (Chowdhury et al., 2021)

Excellent example of the unintended, adverse consequences of implementing a non-financial incentive (a competitive, annual award) across a diversity of contexts with little contextual research beforehand.

[A community health worker \(CHW\) career web to support the us CHW workforce](#) (Nebeker et al., 2021)

Details a methodology for assessing the need for and construction of a tool dedicated solely to career mobility for CHWs.

[Promissory Capital: State Legitimacy among Women Community Health Workers in India](#) (Marwah, 2021)

An excellent, in-depth account of the consequences of failure by the state to provide opportunities for career mobility to CHWs.

managed to protect CHWs from exploitation and burnout.³⁴ Even without a worldwide pandemic or other catastrophe, when the CHW-to-population ratio is not carefully considered in a program's design, CHWs are at risk of being over- or under-worked and, as a result, not serving populations optimally.³⁵ In Brazil, CHWs are trained to meet the needs of populations from birth to end of life. Each CHW conducts monthly visits with the same 150–200 households, offering health promotion and clinical care over long periods of time.³⁶ While their household coverage is smaller than some other programs, this holistic approach with a concentrated population enables CHWs to meet a wide range of service needs for all members they serve throughout the life course.

The **community needs to clearly understand and be involved in CHW programs.**³⁷ One study of 29 large-scale programs where the community is engaged in CHW selection, program implementation, supervision, and performance evaluation concluded that engagement of community members in various aspects of CHW programming can have beneficial impacts in areas such as CHW retention, motivation, performance, and accountability.³⁸

Community members can play an important role in planning antenatal care interventions by informing CHWs of how their needs could best be served and the pressing access gaps that need to be bridged.³⁹ This can be considered an example of **mobilizing community knowledge** to support more systematic planning of intervention design, which could be essential to strengthen maternal and newborn health program policies and practices across Africa.⁴⁰

The **relationship between CHWs and local health staff** also strongly influences community perceptions of workers.⁴¹ In Thailand, strong partnerships between CHWs and local health staff helped ease hospital referrals and overall coordination of patient care, helping legitimize the perceived role of CHWs in health care provision. In contrast, a study in Uganda showed that having CHWs work under the direct supervision of higher-level health care professionals created the negative perception that they lack agency in their role and simply follow orders from a higher level (and in, some cases, untrusted) health care bureaucracy.⁴²

Availability of supplies

A lack of access to needed supplies remains one of the most commonly cited barriers to effective CHW functioning in programs around the world. It is essential that CHWs have the appropriate equipment to protect themselves and others, including against COVID-19.⁴³ The additional strain that COVID-19 placed on health systems resulted in logistical delays in the delivery and distribution of health and other supplies.

FOR FURTHER READING

[Does integrated community case management \(iCCM\) target health inequities and treatment delays? Evidence from an analysis of Demographic and Health Surveys data from 21 countries in the period 2010 to 2018 \(Winskill et al., 2021\)](#)

Interesting analysis of contextual factors involved in using integrated community case management to achieve broader, more equitable impact.

[“Eternally restarting” or “a branch line of continuity”? Exploring consequences of external shocks on community health systems in Haiti \(Sripad et al., 2021\)](#)

Unique analysis of adaptability of CHWs to a large variety of shocks and new disease burdens, with recommendations for strengthening resilience.

[Learnings From a Pilot Study to Strengthen Primary Health Care Services: The Community-Clinic-Centered Health Service Model in Barishal District, Bangladesh \(Uddin et al., 2021\)](#)

Good example of the positive effects of structured, deliberate community involvement in CHW programming, with a unique approach to implementation.

[Ethics of Neighborly Intimacy among Community Health Activists in Delhi \(Zabiliūtė, 2020\)](#)

Excellent, highly in-depth analysis of the relational characteristics that certain ASHAs employ to better connect with community members.

[Community-directed distributors—The “foot soldiers” in the fight to control and eliminate neglected tropical diseases \(Amazigo et al., 2021\)](#)

Provides extensive analysis of the community-driven factors that enable success of community-directed distributors in filling key service delivery gaps and motivating health leadership at the local level.

Data collection and use

While there is a need for high-quality community data systems, challenges remain with CHW data collection. CHW data collection and use are often incomplete or of poor quality because of user error, fragile data systems (digital or paper), or weak data collection expectations/processes.⁴⁴ These issues stem from the fact that many CHWs aren't trained or oriented to the importance and use of data and only see data collection and use as a box checking exercise. Other factors that contribute to weak community-level data include the lack of feedback provided to CHWs to help strengthen data collection practices, and the exclusion of CHWs in the use of data for decision-making.⁴⁵ Better orienting CHWs to the importance of data and involving them in the use of data for decision-making could improve the quality of data collected by CHWs.

Intervention or Services

A major focus of research on CHWs and CHW programs is the ability of CHWs to provide particular services. CHW service provision covers noncommunicable diseases, cancer (as a specific, but common, subset of noncommunicable diseases), maternal and child health, infectious diseases, nutrition/environmental health, mental health and COVID-19, among others. The growing array of interventions CHWs are described as being involved in suggests there may be an expansion of their roles as CHW skills and potential contributions become more evident.

Besides continuing to show effectiveness in interventions in which they are well known to be competent (e.g., health behavior change, health education and awareness campaigns, infectious disease tracking, chronic disease management including support with medication adherence, promotion of early screening), CHWs proved effective in some relatively new areas reported on in the 2021 literature. For example, as COVID-19 contributed to a rise in mental health issues, CHWs in the United States were deployed to implement increasingly advanced psychosocial counseling interventions. A CHW-delivered cognitive behavioral stress management program for low-income, Spanish-speaking Latinos yielded improvements in perceived stress and depressive symptoms, demonstrating a more advanced role for CHWs in applying therapeutically proven stress and mood management techniques beyond exclusively offering referrals to other social support.⁴⁶ CHWs in Tanzania were also effective in highly specialized therapeutic techniques in relation to the promotion of early child development through a home-based (yet relatively complex) health, nutrition, and responsive stimulation intervention.⁴⁷

FOR FURTHER READING

[Community Participatory Approach to Identify Common Evaluation Indicators for Community Health Worker Practice](#)
(Wiggins et al., 2021)

Unique description of a participatory methodology for identifying key evaluation indicators for CHWs (along with preliminary results).

[Digital Health-Enabled Community-Centered Care \(D-CCC\): A Scalable Model to Empower Future Community Health Workers utilizing Human-in-the-Loop AI](#)
(Rodrigues et al., 2021)

Describes an innovative digital health model to enhance CHW effectiveness.

FOR FURTHER READING

[Early Lessons from Launching an Innovative Community Health Household Model Across 3 Country Contexts](#)
(Palazuelos et al., 2021)

Unique example of a potentially transferable CHW intervention model tested in diverse settings that facilitates CHW contribution to upstream determinants of health and engagement with the broader health care system.

Policy and System Structure

Governance/policymaking

Lack of political will and weak governance lead to under-funded and fractured CHW programs that do not address the full scope of local health needs.⁴⁸ **National coordination** of planning, financing, monitoring, implementation, and other essential functions could help fix this: “Effective co-ordination of CHW programmes relies on principles such as (1) use of existing coordination mechanisms when possible; (2) inclusive representation of [human resources for health {HRH}] stakeholder constituencies; (3) coordinated leadership and stewardship; (4) defined roles for stakeholders; (5) coherent strategies linked with national health policies; (6) joint efforts and actions arising from increased investments in HRH; and (7) linkages with other coordination mechanisms.”⁴⁹ The COVID-19 pandemic demonstrated the need for strong governance of CHW programs that enables them to adapt and respond to changes and shocks.

CHW programs operate within broader sociopolitical systems, and are therefore influenced by policy environments.⁵⁰ While CHW programs run by NGOs and operating outside national health system, where these exist, have filled important gaps in service delivery worldwide, and while there is some support for the use of disease-specific CHWs and community-directed distributors in combating neglected tropical diseases, there is increasing recognition of the need to **integrate isolated programs into national health systems**.⁵¹

There are challenges to integrating CHW programs into national health systems, such as the level of respect for CHWs from higher-level health workers, facilitation of referrals, and functioning of supply chains.⁵² Where employment and governance systems are weak, CHW positions risk becoming politicized. In the Philippines, CHWs felt the need to align themselves politically with local leaders in charge of appointing and replacing CHWs and reportedly experienced pressure to adopt the same political affiliation to gain or keep employment.⁵³

Financing

The COVID-19 pandemic resulted in an explosion of funding for primary health care and subsequent calls for increased financing to CHWs and other community-based initiatives. Though such requests have not been universally met with the needed finances, the case of the United States is exemplary considering that, in March 2021, the CDC announced plans to provide \$332 million to 75 organizations for CHW services to support COVID-19 prevention and control, training, technical assistance, and evaluation, using funding from the CARES Act.⁵⁴ This had a tremendous impact on the infrastructure of service delivery by enabling an expansion of CHW roles and reach within the communities they serve.⁵⁵ Data from a subset of 10 African countries show the “median per capita cost of CHW programmes is US\$4.77 per year and US\$2,574 per CHW”; however, though cost

FOR FURTHER READING

[‘A seamless transition’: how to sustain a community health worker scheme within the health system of Gombe state, northeast Nigeria](#) (Wickremasinghe et al., 2021)

Powerful example of a successful transfer of responsibilities from NGO implementing partners to government actors, enabling sustainability and scale-up of an effective pilot CHW scheme.

[Framing the Integration of Community Health Workers into Health Care Systems Along Health Care and Community Spectrums](#) (McCarville et al., 2021)

Unique, original methodology for characterizing level of integration for CHWs into both health systems and communities, based on several criteria and including quantitative measures.

[Female Community Health Workers and Health System Navigation in a Conflict Zone: The Case of Afghanistan](#) (Parray et al., 2021)

In-depth analysis of different systems barriers that serve as hardships for female CHWs in Afghanistan; excellent depth of analysis that could—and should—be replicated in other contexts.

effective, CHW programs in these 10 African countries rely largely on donor funding rather than domestic resources.⁵⁶

Monitoring and evaluation of programs

New frameworks are being used to evaluate individual CHW performance and community-level outcomes separately.⁵⁷ One prominent framework, the Community Health Systems Reform Cycle, highlights the dynamic processes involved in CHW program scale-up, with stages including: “problem prioritization, coalition building, solution gathering, design, program readiness, launch, governance, and management and learning.”⁵⁸ Assessments should use data from a diverse combination of sources, including available, routine monitoring data (national and local) and primary studies and new assessments, to combat missing and inaccurate data.⁵⁹ Within the United States, statewide multistakeholder coalitions are increasing in number, with 20 states including CHWs in Medicaid Managed Care Organizations or Health Plans, which has had positive impacts on monitoring and evaluation systems.⁶⁰

Synthesis and Conclusions

Knowledge Added in 2021

The learning from the 442 articles, reports and other literature reviewed by CHW Central for 2021, reinforce much of what we already knew about the value and capabilities of the CHW workforce, but also shed new light on issues related to program financing, integration, supervision and sustainability. The importance of the CHW workforce was highlighted by the COVID-19 pandemic as were continuing gaps and challenges in the systems, program structures and workforce conditions that are designed to support them. Some key lessons learned include: 1) systems that spring up in parallel (or in isolation) from others should be combined with those in existence to maximize resources; 2) major events that cause systemic changes can be used as “windows of opportunity” to mobilize new funding for systems strengthening;⁶¹ and 3) CHW programs must have sufficient funding and adequate governance to be resilient to shocks such as a global pandemic.

Key Gaps and Steps Forward

Though much information regarding CHWs was published in 2021, many gaps and questions remain.

Reimagining CHWs as part of the health system

Even though CHWs operate within community health systems, there has been little research exploring their role in relation to the broader health care system in terms of their contributions to health system functioning and collaboration with other health care workers. More studies are needed on health systems strengthening to build sustainable CHW programs at scale, and the WHO building blocks framework should be expanded to include community-level services.⁶² CHWs can only sustainably expand and fill gaps to help achieve universal health care if the system in which they work can support them.

Advancing two increasingly different types of CHWs

More and more, authors describe a distinction between types of CHW programs, with some CHWs becoming increasingly professionalized and included in the formal economy, and others remaining unpaid and minimally trained. These two types of CHWs also have different roles in their communities and distinct scopes of work. Given the recognition of the need for CHWs to be paid and the greater likelihood that men have the education

and language mastery for more professionalized roles than women, this trend is neither equitable nor sustainable. Future research could explore how all programs can be collaboratively strengthened to help achieve universal health care without placing undue burden on the lesser compensated CHWs.

Working toward CHW program resilience

The COVID-19 pandemic strained an already stressed workforce and resulted in new, parallel management and data systems that divided resources. Several authors in 2021 called for strengthened resilience of CHW programs to future shocks. Going forward, researchers and practitioners could share evidence for successes and failures in building the responsiveness of CHW programs to unforeseeable health challenges. Financing, governance, and supply chains are particularly vulnerable; research could be done into whether or not—and how—certain program or system characteristics demonstrated resilience to sudden shocks and what new insights the COVID-19 pandemic brought at a systems level.

Top 10 Reads for 2021

If you're interested in learning more but don't have time to read 442 articles or reports, consider selecting from this list!

1. Agarwal, S., Abuya, T., Kintu, R., Mwanga, D., Obadha, M., Pandya, S., & Warren, C. E. (2021). Understanding community health worker incentive preferences in Uganda using a discrete choice experiment. *Journal of global health*, 11, 07005. <https://doi.org/10.7189/jogh.11.07005>
2. Allen, K. C., Whitfield, K., Rabinovich, R., & Sadruddin, S. (2021). The role of governance in implementing sustainable global health interventions: review of health system integration for integrated community case management (iCCM) of childhood illnesses. *BMJ global health*, 6(3), e003257. <https://doi.org/10.1136/bmjgh-2020-003257>
3. Khumalo, G. E., Lutge, E. E., Naidoo, P., & Mashamba-Thompson, T. P. (2021). Barriers and facilitators of rendering HIV services by community health workers in sub-Saharan Africa: a meta-synthesis. *Family medicine and community health*, 9(4), e000958. <https://doi.org/10.1136/fmch-2021-000958>
4. Majid, U., Zahid, M., Harold, K., Zain, S., & Sood, T. (2021). Challenges in the sociocultural milieu of South Asia: a systematic review of community health workers. *Rural And Remote Health*, 21, 6774. <https://doi.org/10.22605/rrh6774>
5. Moon, K. J., Montiel, G. I., Cantero, P. J., & Nawaz, S. (2021). Addressing Emotional Wellness During the COVID-19 Pandemic: the Role of Promotores in Delivering Integrated Mental Health Care and Social Services. *Preventing chronic disease*, 18, E53. <https://doi.org/10.5888/pcd18.200656>
6. Perry, H., & Hodgins, S. (2021). Health for the People: Past, Current, and Future Contributions of National Community Health Worker Programs to Achieving Global Health Goals. *Global Health: Science And Practice*, 9(1), 1-9. <https://doi.org/10.9745/ghsp-d-20-00459>
7. Rahman, M., Jahir, T., Yeasmin, F., Begum, F., Mobashara, M., & Hossain, K. et al. (2021). The Lived Experiences of Community Health Workers Serving in a Large-Scale Water, Sanitation, and Hygiene Intervention

Trial in Rural Bangladesh. International Journal Of Environmental Research And Public Health, 18(7), 3389.
<https://doi.org/10.3390/ijerph18073389>

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- Note: this is the introduction to a supplement comprised of 11 articles, all with important themes discussed in this report; The full contents of the supplement are available at <https://health-policy-systems.biomedcentral.com/articles/supplements/volume-19-supplement-3>

Link to the [State of the Evidence Report's Appendix](#): a complete list of the 442 references.

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