



Effectiveness of Community Health Workers

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Question

What is the evidence on the current use and role of community health workers in DRC and wider international systematic evidence on what works?

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1. Summary

Evidence supports Community Health Workers (CHWs) effectiveness in delivering a range of preventive, promotional and curative health services; reducing inequities in access to care; and supporting the empowerment of communities to demand social accountability from their governments and others to provide coverage of quality primary healthcare services. CHWs have the potential to contribute to the realisation of health-related goals, including universal health coverage. CHWs role should be clearly defined and they should be integrated into the health system and communities. CHWs are effective when supported in their education, career development, supervised, appropriately remunerated, and working under safe and decent conditions. Effective CHW initiatives and programmes should start with a situation analysis of population needs, health systems requirements and resource implications. WHO guideline recommendations to optimise CHW programmes should be adapted and contextualised to the reality of a specific health system.

CHWs are defined by the International Labour Organization as health workers who “provide health education, referral and follow-up, case management, basic preventive health care and home visiting services to specific communities”. CHWs are often relied on in fragile and conflict-affected settings where they are embedded within the community and trusted, and where there is often a shortage of professional health workers. CHWs are well placed to understand gender norms and act to counter them especially where there are opportunities to break down gender barriers and stereotypes during reorganisation of health system governance and delivery after conflict.

The WHO published its first evidence based global guidelines for Health Policy and System Support to Optimise CHW Programmes in October 2018. The vision of the guideline is that CHWs:

- will receive increased recognition
- adequate and harmonised training
- better integration into the health system and communities
- improved employment and working conditions to enhance programme sustainability
- alignment with broader national health and health workforce policies
- effective coverage of essential health interventions.

Guideline recommendations and key considerations for implementation were developed based on a systematic review of reviews; 15 systematic reviews (each one on a specific policy question); and a stakeholder perception survey of 96 respondents on the acceptability and feasibility of the interventions being considered. The quality of the systematic reviews was evaluated using the Assessing the Methodological Quality of Systematic Reviews (AMSTAR) tool and the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) methodology. The guideline recommendations cover three categories:

1. selection, education and certification
2. management and supervision
3. integration in and support by health system and communities

The list of recommendations should be considered as a menu of options, adapted and contextualised to the reality of a specific health system. These recommendations come with a cost which require long-term, dedicated financing, however, deployment of CHWs has been shown to

be cost-effective, and low-income countries have demonstrated that prioritising investments in large-scale CHW initiatives is possible. CHW programmes should be designed and implemented within a long-term perspective of the role of CHWs to ensure sustainability. Fragmented and short-term investments in CHWs is not a shortcut to progress.

There are three types of CHWs in the DRC: Site, Promotional and Disease-specific Relais. Site Relais receive formal training, which allows them to provide the minimum package of community activities and must have a higher level of education than Promotional Relais, including the ability to read and write. Selection criteria though can hinder recruitment of those willing to help but have difficulties in reading and writing. This may particularly relate to older people when younger people are seeking salaried employment. These CHWs play a critical role in bridging the health system with the community, serving their communities with minimal training and no remuneration and are constant in the absence of professional health workers. Being embedded within the community also means that they are in a unique position to understand and quickly refer larger health concerns at the community level. However, CHWs would benefit in the short term with provision of uniforms or badges to aid their recognition as health workers, bicycles or funding for transport, formal job descriptions and performance evaluation. Longer term support such as remuneration and coordination of CHW programmes could improve retention and sustainability of CHWs programmes.

Contextual factors influencing the performance of CHWs are often not captured in research on CHW programmes. A systematic review though provides an understanding that community, health system, political and socio-cultural factors can all interact with each other to impact on CHW effectiveness. Future health policy and systems research should better address the complexity of contextual influences on programmes and enablers to support policy makers and programme managers to improve the performance of CHW interventions.

2. Community Health Workers

Investment in human resources for health (HRH) will help accelerate and sustain progress in achieving the health targets of the Sustainable Development Goals (Cometto et al., 2018). Specifically, CHWs are receiving increasing attention as to their potential in contributing to achieving universal health coverage (UHC) (Cometto et al., 2018). This is owing to the evidence which demonstrates CHWs (i) effectiveness in delivering preventive, promotional and curative health services; (ii) contribution to reducing inequities in access to care; and (iii) supporting the empowerment of communities to demand social accountability from their governments and others to provide coverage of quality health services (Cometto et al., 2018). CHWs are most commonly employed in the context of primary health care services (WHO, 2018a). Evidence supports CHWs in being effective at delivering a range of healthcare services at this level for: maternal and newborn health, child health, communicable diseases, noncommunicable diseases, trauma and surgical care, public health and global health security, mental health and sexual and reproductive health (WHO, 2018b). CHWs can expand access to essential health services in underserved or excluded vulnerable populations and areas, including rural and remote areas; marginalised populations; pastoral and nomadic communities; and urban slums (WHO, 2018a). The individuals and communities living in these contexts often lack equitable access to primary health care and other services and consequently fall behind in terms of health service coverage and health and other development outcomes. CHWs extend services to the community and are often relied on in fragile and conflict-affected settings where there can be a shortage of professional health workers (R Steege et al., 2018). The WHO Global Strategy on Human Resources for Health: Workforce 2030

encourages countries to harness the potential of CHWs and integrate them into primary healthcare strategies and the health system (WHO, 2016).

However, CHW programmes often face challenges that can contribute to wasted human capital and financial resources, and missed opportunities to provide essential health services to communities (Cometto et al., 2018). Challenges to scaling-up and maintaining CHW programmes include poor planning; unclear roles, lack of education and career pathways; lack of certification hindering credibility and transferability; multiple competing actors with little coordination; fragmented, disease-specific training; donor-driven management and funding; tenuous linkage with the health system; poor coordination and supervision; and a lack of recognition of the contribution of CHWs (Tulenko et al., 2013). Many well intentioned and performing CHW initiatives fail to be properly integrated into health systems and remain pilot projects or small-scale initiatives that are excessively reliant on donor funding. The support for CHWs and their integration into the health system and in the community they serve, is uneven across and within countries. Good-practice examples are not necessarily replicated and policy options for which there is greater evidence of effectiveness are not uniformly adopted (WHO, 2018a).

3. Evidence supporting Community Health Workers

The first evidence based global guidelines for Health Policy and System Support to Optimise CHW Programmes was published by the WHO in October 2018 (WHO, 2018a). This coincided with the Global Conference on Primary Health Care, 40 years after the Declaration of the Alma Ata, which recognised CHWs as an essential part of primary healthcare (WHO, 1978). Selected highlights of the WHO guidelines have been published in a shorter document (WHO, 2018b) and an abridged version published in the *Lancet Global Health* (Cometto et al., 2018).

The WHO guideline (WHO, 2018a) primarily focusses on CHWs as defined by the International Labour Organization (ILO) in the International Standard Classification of Occupations (ISCO; occupational group 3253), but its relevance and applicability include other types of community-based health worker (Cometto et al., 2018). ILO defines CHWs as health workers who “provide health education, referral and follow-up, case management, basic preventive health care and home visiting services to specific communities. They provide support and assistance to individuals and families in navigating the health and social services system” (International Labour Organization, 2012).

Recommendations and key considerations for implementation in the guideline were developed based on one overview of overviews (Scott et al., 2018), 15 systematic reviews (each one on a specific policy question), and a stakeholder perception survey of 96 respondents on the acceptability and feasibility of the interventions being considered. The quality of the systematic reviews was evaluated using the Assessing the Methodological Quality of Systematic Reviews (AMSTAR) tool and the Grading of Recommendations, Assessment, Development and Evaluations (GRADE) methodology. (Cometto et al., 2018). The guideline provides evidence-based policy guidance to support governments, and domestic and international partners, with their strategies and investments to improve the design, implementation, performance and evaluation of community-based health workforce policy and planning at national and local levels (WHO, 2018a). Other beneficiaries of this guideline include development partners, funding agencies, CHWs themselves and the individuals and communities. The vision of the guideline is that CHWs (WHO, 2018a):

- will receive increased recognition
- adequate and harmonised training
- better integration into the health system and community
- improved employment and working conditions to enhance programme sustainability
- alignment with broader national health and health workforce policies
- effective coverage of essential health interventions.

The guideline recommendations were developed from 15 policy questions, summarised in Table 1 of the abridged version, spanning three categories: (i) CHW selection, education and certification; (ii) management and supervision and; (iii) integration in and support by health system and communities (Cometto et al., 2018). Subsequent guideline recommendations are summarised in Table 2 of the abridged version (Cometto et al., 2018). This list of recommendations should be considered as “a menu of interrelated policy options and recommendations, which need to be adapted and contextualised to the reality of a specific health system” (Cometto et al., 2018). Effective design of CHW programmes should start with a situation analysis of population needs and health system requirements (Cometto et al., 2018). CHWs should be integrated within primary health care teams and not simply seen as a way to save costs or as a substitute for healthcare professionals (Cometto et al., 2018). CHWs role should be clearly defined, performance measured and receive basic labour rights that include safe and decent working conditions (Cometto et al., 2018). Health policy and systems research e.g. implementation research, is needed to investigate the contextual factors and enablers (how, for whom, under what circumstances) (Cometto et al., 2018). The guideline encourages long-term perspective on the evolution of the role of CHWs over the next 40 years, including consideration of their education, certification and career progression, alongside the evolution of the primary health care system and changes in the epidemiological profile of the population (WHO, 2018b).

Evidence on CHW programme effectiveness adapted and contextualised helps to inform policy and practice (Scott et al., 2018). A systematic review of reviews on CHWs found a number of factors that enable effective CHW programmes including: community integration (whereby community members have a sense of ownership of the programme and positive relationships with the CHW), supportive supervision, continuous education, and adequate logistical support and supplies (Scott et al., 2018). Effective integration of CHW programmes into the health system can increase sustainability and credibility, clarify CHW roles, and nurture collaboration between CHWs and higher-level health systems actors (Scott et al., 2018). Gaps in the review evidence include the rights and needs of CHWs, effective approaches to training and supervision, CHWs as community change agents, and the influence of health system decentralisation, social accountability and governance (Scott et al., 2018). Funding research to expand contextualised evidence on how to design and implement CHW programmes will contribute to maximising effectiveness (Scott et al., 2018). Developing and strengthening CHW programmes will require consideration of existing evidence of CHW programme effectiveness, the country’s existing primary healthcare system and needs, inclusion of all stakeholders, and adapting programmes designed and implemented based on findings from implementation research (Scott et al., 2018).

A systematic review of 140 quantitative and qualitative studies identified factors related to the nature of tasks and time spent on delivery, human resource management, quality assurance, links with the community, links with the health system and resources and logistics having an influence on CHW performance (Kok, Dieleman, et al., 2015). The review found that good performance was associated with intervention designs involving a mix of incentives, frequent

supervision, continuous training, community involvement and strong co-ordination and communication between CHWs and health professionals, leading to increased credibility of CHWs (Kok, Dieleman, et al., 2015). The review also highlights that when designing CHW programmes policy makers should consider factors that increased CHW performance in comparable settings to maximise programme outcomes (Kok, Dieleman, et al., 2015).

A systematic review with a narrative analysis was conducted to identify contextual factors influencing performance of CHWs (Kok, Kane, et al., 2015). This synthesis of evidence showed that contextual factors related to community (most prominently), economy, environment, and health system policy and practice can influence CHW performance (Kok, Kane, et al., 2015). Socio-cultural factors (including gender norms and values and disease related stigma), safety and security, and education and knowledge level of the target group were community factors that influence CHW performance. Existence of CHW policy, human resource policy legislation related to CHWs, and political commitment were found to be influencing factors within the health systems policy context. All contextual factors can interact with each other to shape CHW performance and affect the performance of CHW interventions or programmes (Kok, Kane, et al., 2015). Research on CHW programmes often does not capture or explicitly discuss the context in which CHW interventions take place but this synthesis, given its wide scope, provides an understanding of the influence of context on CHWs and programme performance. Future health policy and systems research should better address the complexity of contextual influences on programmes to support policy makers and programme managers to improve the performance of CHW interventions (Kok, Kane, et al., 2015).

Policy recommendations in the WHO guideline are based on evidence. However, the guideline recognises very limited evidence in some areas and of sufficient detail to recommend specific interventions beyond broad strategies (WHO, 2018a). These areas cover certification or contracting and career ladders for CHWs, appropriate typology and population target size (WHO, 2018a). There is insufficient detail on which education approaches, which supervision strategies, or which bundles of financial or non-financial incentives are most effective or are more effective than others. Other evidence gaps include the absence of economic evaluations of the various interventions under consideration, and the lack of longitudinal studies tracking policy effectiveness over time (WHO, 2018b). These gaps offer priorities for future research agendas (WHO, 2018b).

The recommended policy options come with a cost which require long-term, dedicated financing, however, deployment of CHWs has been shown to be cost-effective for delivery of some essential healthcare services and where they are integrated within the health system (McPake et al., 2015), and low income countries have demonstrated that prioritising investments in large-scale CHW initiatives is possible (Cometto et al., 2018). Development partners and external funders should align their support of CHW programmes with public policy and national health systems (Cometto et al., 2018).

A systematic review found that CHW programmes promote equity of access and increased utilisation of healthcare services at the household level by reducing inequities relating to place of residence, gender, education and socio-economic position (McCollum, Gomez, Theobald, & Taegtmeier, 2016). There was no clear evidence for CHW provision of equitable quality of services (McCollum et al., 2016). Factors promoting greater equity of CHW services include recruitment of the poorest community members as CHWs, close proximity of services to households, pre-existing social relationship with CHW and provision of home-based services (McCollum et al., 2016). Care must be taken to ensure that barriers faced by clients at the health facility level are not replicated at the community level (McCollum et al., 2016).

4. Community Health Workers in the DRC

The Democratic Republic of Congo (DRC) is the second largest country in Africa and the fourth largest in terms of population (85 million based on United Nations estimates). The DRC borders nine different countries and is a major crossroad through Africa. Weakened by decades of social instability and violence; poor governance; weak infrastructure, with a lack of ground transportation contributing to provincial disparities; and humanitarian crises, leaves it one of the poorest countries in the world (Naughton, Abramson, Wang, & Kwan-Gett, 2017). Health indicators are poor, the health system is fragmented and under-resourced, user fees inhibit care-seeking and access, infectious disease outbreaks are recurring and detrimental, and disparities exist between urban and rural areas (Naughton et al., 2017). Additionally, a severe shortage of formal health care workers means that CHWs play a key role in supporting the health system, albeit studies are not obvious in the literature (Baba, Raven, Steege, & Theobald, 2018). The DRC does have some important strengths which, if invested in, could strengthen service delivery and programme implementation (Naughton et al., 2017). These strengths include: a growing mobile phone subscription rate; a high rate of prenatal care use; the significant involvement of many religious and private non-profit organizations in healthcare; and a well-structured and decentralised health zone system (Naughton et al., 2017).

There is no overall CHW programme in the DRC (R Steege et al., 2018). There are three types of CHWs, referred to in French as 'Relais communautaires'. Site Relais (SR) receive formal training, which allows them to provide the minimum package of community activities such as the distribution of Ivermectin and contraceptives, case management of malaria, diarrhoea, and acute respiratory infections. Promotional Relais (PR) who are trained to provide health information and education based on the specific needs of the community and can include malaria, nutrition and family planning. And Disease programme Relais who provide disease-specific services for the programme (Advancing Partners & Communities, 2013; R Steege et al., 2018). SR must have a higher level of education than PRs, including the ability to read and write, and have paid employment outside of the responsibilities of being an SR. Additionally, SRs are chosen by their community and therefore must be acceptable to them (Advancing Partners & Communities, 2013). All three types are unpaid. The government, in cooperation with NGOs and faith-based organisations, supports the supervision and implementation of CHW programmes (Advancing Partners & Communities, 2013).

A case study was carried out in Ituri Province, North-East DRC to rapidly appraise through document review and key informant interviews the current situation and evidence of CHWs in the DRC from a health systems and HRM perspective (Baba et al., 2018). The case study, conducted as part of the ReBUILD project, aimed to identify how CHWs can be better supported to be effective and sustainable in the broader health system in fragile and conflict affected settings (Baba et al. 2018). Key findings under the themes of types and roles of CHWs, selection, training, retention, performance, supervision, integration in the health system, programme sustainability and gender are summarised in Table 7 of Baba et al. 2018 (Baba et al., 2018). CHWs in the DRC play a critical role in bridging the health system with the community, serving their communities with minimal training and no remuneration and are constant in the absence of professional health workers (Baba et al., 2018). Being embedded within the community also means that they are in a unique position to understand and quickly refer larger health concerns at the community level (Baba et al., 2018). Short term support to CHWs such as provision of uniforms or badges for identification, bicycles or funding for transport, formal job descriptions and performance evaluation tools could improve CHW motivation and performance in this context (Baba et al., 2018). Longer term support such as

remuneration and coordination of CHW programmes could improve retention and sustainability of CHWs programmes (Baba et al., 2018). Additionally, a focus on gender transformative work at the community level may enable conditions for women to volunteer for CHW work and for men to stay in the CHW role (Baba et al., 2018).

CHWs need support to attract, retain and help their performance to ensure that they contribute effectively to health programmes. Raven et al. 2015 present a synthesis of findings from the five African country case studies of CHW programmes, one of which was in the DRC, to explore the current use of practices for attraction, retention and performance management of CHWs (Raven et al., 2015). In the DRC, as well as in Senegal, Uganda and Zimbabwe, CHWs were reported to more likely be female and aged over 30 years. Reasons given include that they are more interested in health issues, are already involved in health within families, are respected and listened to within communities and are viewed as being able to work easily with people. Older women are more likely to become CHWs as they have experience of looking after children and younger unmarried women are seeking salaried employment. The range of activities that CHWs do in the DRC span provision of healthcare services, health promotion/distribution of health goods and community organisation (Raven et al., 2015). CHWs across all five countries reported that their workload is very heavy. In the DRC CHWs were not given any provision of items such as uniforms, badges and t-shirts that aided their recognition as health workers (Raven et al., 2015).

A qualitative rapid appraisal study exploring the roles of community cadres in improving access to and retention in care for prevent mother-to-child transmission of HIV (PMTCT) services was conducted in 2015 in four African countries, one of which was the DRC (Besada et al., 2018). Community cadres in the DRC included the voluntary 'Relais communautaires'. Countries face challenges in following global recommendations to scale-up lifelong treatment for all individuals living with HIV which include ensuring good retention in care. Countries are at different stages of implementation of PMTCT Option B+ with Malawi and Uganda having more integrated and institutionalised approaches compared with the DRC and Cote d'Ivoire, which are at an earlier stage (Besada et al., 2018). Community cadres were found to provide an integral link between communities and health facilities, supporting overstretched health workers in HIV client support and follow-up. But again, their role in health systems is not standardised at country level or fully recognised, resourced or supported to realise their potential and sustainability (Besada et al., 2018). Understanding which services, strategies and approaches are most effective in improving outcomes along the continuum of HIV care is needed (Besada et al., 2018).

5. Challenges and opportunities facing CHWs in the DRC

Remuneration and incentives

In the DRC, CHWs are not paid. Where incentives for carrying out health campaigns were in place, they were too small and too late and therefore inadequate to achieve the desired performance (Raven et al., 2015). As mentioned previously, remuneration could help retention of CHWs and sustainability of CHW programmes (Baba et al., 2018).

Attraction, retention and performance management

HRM of CHWs, like any other health worker, relate to improving attraction, retention and performance (Raven et al., 2015). Management challenges of CHWs that are formal employees of a health organisation can be different to those of CHWs working on a voluntary basis or without

formal contract (Raven et al., 2015). Intrinsic motivation is likely to have greater importance for voluntary CHWs compared to a salary and benefits, together with incentives and disciplinary procedures, which are used to attract, retain and support the performance of formal employees (Raven et al., 2015). Voluntary CHWs can simply stop their contribution without resigning if they are dissatisfied and they cannot be formally dismissed by managers for non-performance (Raven et al., 2015). Programme managers need to understand which management practices are most effective in their context to attract and retain volunteer CHWs and to manage their performance.

Raven et al. 2015 used rapid country case studies to explore the current use of practices for attraction, retention and performance management of CHWs in five African countries – the DRC, Ghana, Senegal, Uganda and Zimbabwe (Raven et al., 2015). Expectations, HRM practices and human resource outcomes across all country outcomes are summarised in Table 4 of Raven et al. 2015 (Raven et al., 2015). The DRC case study provides a good example of how HRM practices helped to ensure CHW expectations were met (Raven et al., 2015). CHWs wanted to provide health support to their community especially for children and helping with access to healthcare services. They received feedback from their supervisors, management support and recognition from the community. Most felt therefore that their desire to serve their community was fulfilled (Raven et al., 2015). However, other expectations were not met. CHWs expectations of social status and prestige was not met as they were not provided with items such as uniforms, badges and t-shirts to aid their recognition as health workers (Raven et al., 2015). Matching management practices to CHW expectations of their role, understanding the different contexts and the challenges and opportunities CHW face in their work is essential for good CHW performance (Raven et al., 2015).

Selection and recruitment is complex involving many processes (Raven et al., 2015). Community members can volunteer to be a CHW and then go through a selection process or communities can nominate members to be a CHW and either the community leader selects or the community votes for the CHWs (Raven et al., 2015). Sometimes the health authorities ask community members to be CHWs. Several selection criteria across the five African countries were common including the ability to read and write, being from the community and the ability to communicate with the community about health. Criteria in the DRC also included having a source of income (Raven et al., 2015). However, these selection criteria may not apply to all those willing to become a CHW. For example, in the DRC someone may be willing to help but have difficulties in reading and writing. This may particularly relate to older people when younger people are seeking salaried employment (Raven et al., 2015).

Initial and refresher training, use of job description and supervision can influence performance of CHWs. Lack of necessary equipment, drugs and supplies to carry out their role; lack of transport or financial support for travel; insufficient training or supervision; and lack of support from the community can all negatively influence CHW performance (Raven et al., 2015).

Supervision and support

In the DRC, along with Senegal, little contact between programme managers and CHWs was found, although they do receive some support from the community through health centre committees, albeit minimal (Raven et al., 2015). Nurses and community health officers do supervisory visits with CHWs, but the frequency varies due to time and travel limitations. In the DRC, senior CHWs can take on these supervisory visits (Raven et al., 2015). A senior CHW heads a community outreach group of CHWs and holds regular meetings to discuss activities and solve problems. This group then reports to the health centre nurse. Some CHWs in the DRC felt though

that they were not supported and not provided with the necessary resources to do their work (Raven et al., 2015).

Evidence from a mixed-methods intervention study conducted over a period of one year in four African countries (Ethiopia, Kenya, Malawi and Mozambique) shows that supportive group supervision, with individual and/or peer supervision, can motivate CHWs and improve their performance (Kok et al., 2018). Supervision was perceived by the CHWs to be more supportive if it involved a problem-solving focus; joint responsibilities and team work; cross learning and skill sharing; the supervisor taking a facilitating and coaching role and, to a lesser extent, empowerment and participation of supervisees in decision making (Kok et al., 2018). Although qualitative and quantitative findings differed, which may be due to the different methods used, the authors of this study suggest that integration of supportive group supervision models in CHW programmes could improve CHW motivation and performance (Kok et al., 2018).

Effective scale-up of CHWs depends on supportive management and supervision. Existing tools do not measure the experience of CHWs from their perspective (i.e. perceived supervision) of the support provided by their supervisor. A simple new 6-item Perceived Supervision Scale (PSS) tool has been developed and validated across seven countries (Sierra Leone, Bangladesh, Ethiopia, Indonesia, Kenya, Malawi and Mozambique) to measure perceived supervision in low and middle-income countries (Vallieres et al., 2018). The PSS tool identified that over time, regular contact, two-way communication and joint problem-solving were perceived as critical from the perspective of the CHWs (Vallieres et al., 2018). The PSS tool also found that scores at baseline predicted performance-related outcomes at follow-up (Vallieres et al., 2018). The authors consider that this tool is applicable across multiple, culturally-distinct global health contexts with a wide range of CHW typologies; is simple and quick to administer and could assist programme managers in the management of community health programmes (Vallieres et al., 2018). The tool is available in nine languages with ongoing newly translated versions added to the tool's website www.perceivedsupervisionscale.com.

Flows of information and people

The relationships between the actors involved in managing CHWs are important in fully supporting CHWs. These actors are health service/programme managers, front-line supervisors and community organisations (Raven et al., 2015). Programme managers are responsible for overall programme delivery and developing practices to attract, retain and support performance of CHW. Front-line supervisors are responsible for implementation and especially performance management. Community organisations, e.g. the village health committee, may be involved in recruitment and selection of CHWs and may help with community and resource mobilisation (Raven et al., 2015). Programme managers and front-line supervisors may work in a bureaucratic environment partially responding to donor funding requirements whilst community organisations may work to different timelines with different organisational loyalties (Raven et al., 2015). To fully support CHWs and provide an effective HRM approach, there is a need for all three groups of management actors to be able to work together overcoming differences in their working environments (Raven et al., 2015). In the DRC, and Senegal, there appears to be very little contact between the CHWs and programme managers; however, some direction and support to CHWs from the community is provided through health centre committees, albeit minimal (Raven et al., 2015).

New partnerships and roles for CHWs and other community healthcare providers can offer innovative approaches to achieving UHC in fragile settings where there are acute human resource

shortages and acute health care needs (Orya et al., 2017). A qualitative study in Somaliland and Sierra Leone aimed to understand the perceptions of communities, stakeholders and Traditional Birth Attendants (TBAs) themselves to their newly trained role of support and referral rather than delivery of pregnant women (Orya et al., 2017). The study found that participants perceived that trained TBAs can “utilise their embedded and trusted community relationships to interact effectively with their communities, help overcome barriers to acceptability utilisation and contribute to effective demand for maternal and newborn services” (Orya et al., 2017). Changing TBAs practices, through appropriate training and support, was considered positive from multiple viewpoints in further integrating them into the health system and increasing utilisation of skilled birth attendants (Orya et al., 2017). TBAs appreciated strengthened relationships with health centres and being more integrated within the health system (Orya et al., 2017). Challenges were found to be the distance women need to travel to reach health centres, appropriate remuneration of trained TBAs and strategies to sustain their work (Orya et al., 2017).

Governance

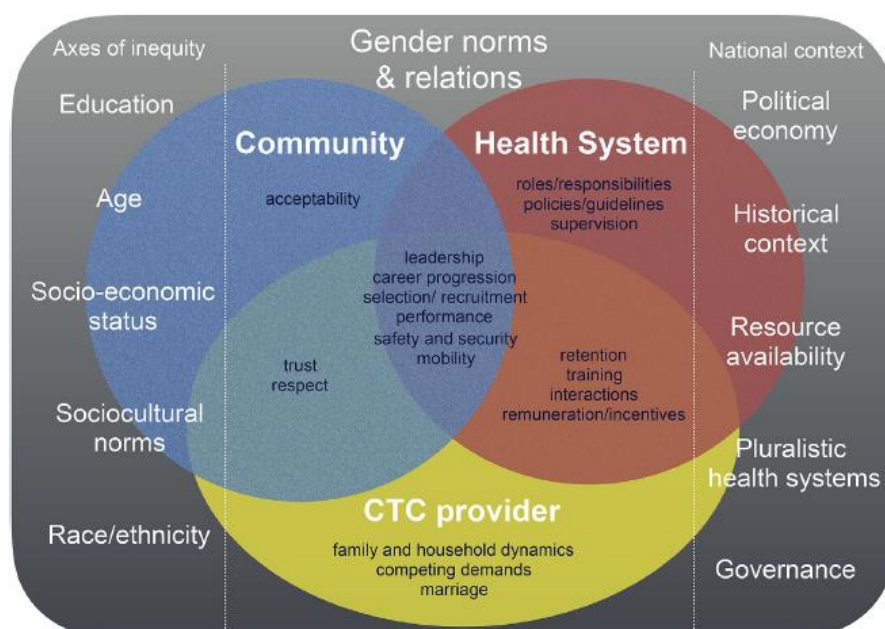
Targeted investments that leverage the DRC’s strengths for service delivery and programme implementation are worth considering (Naughton et al., 2017). Central government control is weak in many areas due to violence or lack of infrastructure. Decentralised interventions that can be implemented and autonomously operated at the local or provincial level could therefore have advantages over interventions that require involvement and coordination at the central government level (Naughton et al., 2017). For example the growing use of mobile phones could be used to provide training and decision support to CHWs and for disease surveillance where CHWs use mobile phones to report cases of diseases (Naughton et al., 2017).

6. Gender and Community Health Workers

Health systems can positively reshape and transform harmful gender norms owing to the sector being an employer of a significant proportion of the population and a sector that interacts with citizens throughout their lifetime (R Steege et al., 2018). CHWs work within the same gender norms and power relations that influence the households, communities and societies they serve. Because of these norms, and related power relations, CHW programmes can unintentionally deliver a service which reinforces rather than challenges gender inequity. This can even happen when gender neutral policies and programmes are in place which fail at the community level by not taking into account the fact that gender influences male and female CHWs’ ability to perform their role because of the influence of gender norms at programme, community and household level (R Steege et al., 2018). However, CHWs are well placed to understand gender norms and act to counter them (R Steege et al., 2018). This is especially so in fragile and conflict-affected contexts where there are opportunities to break down gender barriers and stereotypes and ‘build back better’ after conflict when reorganisation of health system governance and delivery often occurs (R Steege et al., 2018). However, a study examining health system reconstruction in post-conflict states (Mozambique, Timor Leste, Sierra Leone and Northern Uganda) found that the prioritisation of gender equity in human resource planning was not part of the recruitment or planning process of CHWs and gender barriers, such as a lack of education and restricted mobility, undermined female participation and advancement (Percival et al., 2018). Steege et al. 2018 provide recommendations and guidance for practitioners and policy makers who have responsibility for CHW programmes (R Steege et al., 2018). This brief suggests some ways that their workforce may be affected by gender norms and recommends what actions can be taken to address them.

In the DRC, selection criteria for CHWs promote equal opportunities for women and men (R Steege et al., 2018). For example, in Bunia district there are a total of 480 CHWs, of whom over a half (288) are female, and in Aru district there are 403 female CHWs out of a total of 840 (R Steege et al., 2018). In a DRC case study, CHWs were reported to more likely be female and over the age of 30 years (Raven et al., 2015). Reasons given were that they were more likely to be interested in health issues, are respected and listened to within the community, have experience of looking after children and younger unmarried women are seeking salaried employment (Raven et al., 2015).

Steege et al. 2018 present a conceptual framework to show how gender roles and relations shape CHW experience at the individual, community and health system level (R. Steege et al., 2018). At the individual level, the influence of family and intra-household dynamics are important; at the community level safety and mobility; and at the health system level career progression and remuneration – key priorities for policymakers to strengthen gender equity and efficiency of CHW programmes (R. Steege et al., 2018). Other axes of inequity and the political economy and health system context can also influence the CHW.



Source: Conceptual framework showing the areas affected by gender across the levels of individual, community and health system, the relationship between them and the complex interplay within the broader health and political environment. Taken from Figure 2 Steege et al. 2018 (R. Steege et al., 2018)

Gender transformative policies would support CHWs in applying principles of gender equity to their programmes in their context (R. Steege et al., 2018)

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