

Chapter 13

# **Community Participation in Large-Scale Community Health Worker Programs**

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## Key Points

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- Balancing the inherent tensions of a large-scale community health worker (CHW) program, where the CHW is the lowest-tier worker of a national health system while also acting on behalf of the always-changing local world of a community, will be an ongoing challenge requiring decentralized flexibility in program policy, design, and implementation.
- A successful CHW program requires the support and ownership of the community, as well as a supportive social and policy environment for community participation at national, district, and local levels.
- Cost and time of the implementer, district, and national-level personnel should be factored in when designing a community participation strategy.
- The development and support of community networks, linkages, partners, and coordination is necessary to enable a comprehensive community-participation approach for better health.
- Village health committees and other local governance structures can be effective mechanisms to ensure local leadership, legitimacy, participation, and governance, but these committees require continued training and investment.

## INTRODUCTION

The Alma-Ata Declaration of 1978 affirmed that health is a fundamental human right and encouraged the active participation of recipients of health services and communities in the planning, organization, operation, and management of health care systems.<sup>1</sup> The right to health can be viewed as a right to health care and a right to conditions that promote good health. Community participation provides an opportunity for citizens to have a voice in ensuring the state meets their needs and to contribute to life-affecting processes, while building or rebuilding trust between the public and the health system.<sup>2</sup> Health care is also experienced in a highly complex personal and community context where

- people are more likely to use and respond positively to health services if they have been involved in decisions about how these services are delivered;
- people have individual and collective resources (time, money, materials, and energy) to contribute toward their individual and collective health goals;
- people are more likely to change health behaviors when they are involved in deciding how that change might take place; and
- people gain information, skills, and experience in community involvement that helps them take control of their own lives and challenge social systems.<sup>3</sup>

CHW programs thrive in communities that have been mobilized as part of a larger political process for promoting better public health (i.e., in China and Brazil), but generally struggle where CHWs themselves are given the responsibility of galvanizing and mobilizing communities. Even when CHWs have support from community-based, faith-based, or nongovernmental organizations (NGOs), they can struggle when asked to take the lead in mobilizing communities, rather than working with the support of already active communities.

A CHW, by definition, is embedded in, drawn from, or at least related to the community in some way; and aims to make appropriate health promotion and service delivery strategies that reflect the political, environmental, social, and cultural dynamics and realities of the community. The CHW provides health care services in communities that are dynamic, evolving, and often unpredictable. The successful provision of such services requires that the CHW be known and trusted by the community. This important relationship with the community presents a challenge to national health programs. The challenge is to develop a national health program with standardized health system tools, clinical guidance, and performance targets based on medical evidence that are critical for scale-up, while at the same time empowering CHWs to respond appropriately to the specific needs and realities of local communities. The CHW stands at the intersection of these seemingly highly divergent needs.

In Part One, this chapter will review key questions related to community participation strategies, including:

- Why is community participation important to CHW programs and what does it look like?
- How can community participation be used to shape the design and management of CHW programs?
- How do you adapt community participation to local situations?
- What are key barriers and enablers to community participation?
- How can a community participation policy be designed to support a CHW program?
- What are various components of a functioning community participation strategy?

- How can governments maximize support of nongovernmental and faith-based actors in CHW programs?

Part Two will review community management structures in supporting CHW programs and answer the following key questions:

- What are common issues and good practices with community management structures?
- What are key questions to consider when designing a strategy for community management structures?

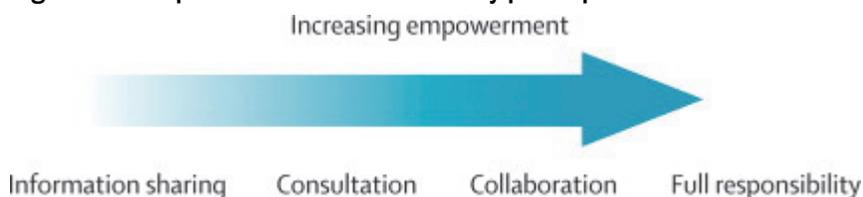
## **PART ONE: COMMUNITY PARTICIPATION AND COMMUNITY HEALTH WORKER PROGRAMS**

### **Why Is Community Participation Important to Community Health Worker Programs and What Does It Look Like?**

The ultimate responsibility of the CHW is to support equitable improvements in the health of the community he or she serves by both improving access to health services as well as building the capacity of individual, families, and communities to protect their own health. Therefore, efforts to strengthen CHW programs should seek community participation in planning, supporting, and monitoring service implementation to ensure that services are appropriate, the coverage of quality services is high, and that benefits accrue to those in greatest need.<sup>4</sup>

CHW programs often struggle to be successful when not part of a broader community engagement process. Such community engagement should be seen as an integral component of an effective CHW program. Community engagement refers to the process of getting community members involved in decisions that affect them, including the planning, development, management, and evaluation of health services, as well as activities, which aim to improve health or reduce health inequalities.<sup>5</sup> Its effectiveness is likely to depend on having explicit methods for involving individuals and communities, clearly defined roles and responsibilities, training for policymakers and clients, and adequate funding.

**Figure 1 From passive to active community participation**



Community engagement includes a variety of community participation approaches and runs along a continuum, from passive to transformative, and from informing, consulting, co-producing, and delegating power, through to more direct community control.<sup>6</sup> A 2011 review of CHWs<sup>7</sup> suggested that when managed effectively, a CHW program that is integrated with a well-functioning primary health care (PHC) system can provide a crucial link between community members and the PHC system itself, thereby providing a means for a continuum of care across multiple points of service. An earlier review<sup>8</sup> warned that CHWs often do not achieve their potential at scale due to social, cultural, and management factors, which are inextricably linked with the CHW's sometimes ambiguous position between the formal health sector and the community. Fostering the development of interpersonal, institutional, and community trust is therefore critical for effective CHW programs. Strategies to mitigate gender and cultural power barriers should be considered. A good CHW program can serve as a catalyst or platform for community participation.

Communities with high levels of community capacity—defined as the individual and aggregate strength of members to overcome barriers and cultivate opportunities to improve the overall well-being of a community and its individuals—are associated with improved health behaviors and ongoing collective action for health.<sup>9</sup> Community participation is important for communities and their health and enables CHW program success. Community ownership in the African Community-Directed Treatment Program, as defined by community leadership, selection of volunteers, and planning for the distribution of the drug ivermectin (to prevent river blindness), has been correlated with project sustainability.<sup>10</sup> CHWs can support community participation by sensitizing and educating the community on the benefits of health programs, supporting women’s groups and other community-based organizations (CBOs) to participate in health activities, and providing an opportunity for communities to engage more directly with the health system.

In order for CHWs to effectively carry out their duties, a level of trust between the CHW and the community is needed to enable relationships that will produce positive health outcomes. Trust is one of several critical factors, along with respect and partnership, that are easily overlooked when a CHW program is put into place.<sup>3</sup> CHWs can be from highly divided communities, within which they face a great deal of conflict. Class, caste, and other divisions can affect their own positions and loyalties. The organization responsible for the CHW, generally the state, an NGO or a faith-based organization (FBO) may influence the success of the CHW in working with the community. When employed by the government, CHWs may feel more responsible to their employer than to the community, limiting their success in motivating behavior change. Government-employed CHWs may also spend more time supporting health center services due to the shortage of other qualified personnel and have minimal time to administer services within their community.

### **Box 1. Country Examples of Community Engagement**

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In Brazil, the Family Health Care Team includes a CHW who is directly tasked with promoting the organization of the community and acting as a link among different sectors, enabling the community to address barriers to health by taking collective action. Uganda employs a Village Health Team strategy with nine different types of community workers, including the CHW, a community medicine distributor, hygiene extension workers, peer educators, and traditional birth attendants (TBAs) to mobilize the community. In Ethiopia, communities support the Health Extension Agents in communication activities using traditional and indigenous community associations, such as women’s groups, youth groups and religious institutions. In India, Village Health and Sanitation Committees, composed of village residents including the Accredited Social Health Activist (ASHA), provide support for the ASHA’s activities.

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An effective community engagement strategy will draw on community resources that can support CHWs to most effectively accomplish their health goals and tasks. We know that CHW programs change in both predictable and unpredictable ways as community and health systems evolve. Feedback from and the active involvement of all parties are needed to adapt effectively to these changes. CHW programs also need to learn how to meaningfully tap into the community’s reservoir of good will, volunteerism, self-interest, and desire to help others in the community. Table 1 illustrates some roles communities can play to support CHWs and the health system.

**Table 1. Illustrative roles communities can play to support CHWs and health systems, using the World Health Organization (WHO) health system building blocks framework**

HEALTH SYSTEM BUILDING BLOCKS	ILLUSTRATIVE COMMUNITY ROLES TO SUPPORT CHWS
Service delivery	<ul style="list-style-type: none"> <li>▪ Participate in multiple levels of CHW programming, including identification of objectives, formulation of action steps, support of health outreach activities, selection of CHWs, supportive supervision, and evaluation of CHW performance.</li> <li>▪ Increase demand for and use of CHW health services.</li> <li>▪ Determine fair and just distribution of CHW community activities and program benefits.</li> <li>▪ Provide support and incentives for CHW to perform interpersonal counseling, especially for home care, preventive and promotive practices and referral.</li> <li>▪ Develop and support collective systems for emergency transport and other referrals.</li> <li>▪ Participate in planning meetings with the CHW helping her to problem solve when issues, such as alcohol abuse, violence, and other health problems, surface.</li> <li>▪ Utilize new information technologies, such as mHealth (or mobile health), to support the CHW with health information sharing.</li> <li>▪ Take collective action based on CHW information whether it is advocacy, behavior change, or participation in service delivery.</li> <li>▪ Advocate for quality of care provided by CHWs and health centers.</li> </ul>
Health workforce	<ul style="list-style-type: none"> <li>▪ Utilize health innovations brought by the CHW and share them with peers.</li> <li>▪ Ensure that the CHW-recommended appropriate action is extended to the disadvantaged groups in their community.</li> <li>▪ Extend the reach of CHW health services by organizing peer groups for women, mothers, men, grandmothers, youth, or other people living with illness.</li> <li>▪ Provide feedback through CHWs to professional providers to ensure the quality of care.</li> </ul>
Health information system	<ul style="list-style-type: none"> <li>▪ Support CHWs to collect vital events information, and identify and prioritize health problems based on accessible local data.</li> <li>▪ Utilize local communication channels to diffuse health information brought by CHWs and make it public.</li> </ul>
Essential medical products, vaccines and technologies	<ul style="list-style-type: none"> <li>▪ Support CHWs by holding government accountable for the delivery of authorized health products, medications, and technologies at accessible locations.</li> </ul>
Health financing	<ul style="list-style-type: none"> <li>▪ Contribute labor, land, produce, cash, and other resources to support CHWs, locally appropriate health services, and disadvantaged populations.</li> <li>▪ Support CHWs to access and leverage government and other resources to address local health priorities.</li> <li>▪ Establish or contribute to community insurance schemes.</li> <li>▪ Participate in events and promote products recommended by CHWs and health centers.</li> </ul>
Leadership and governance	<ul style="list-style-type: none"> <li>▪ Organize representatives of local leadership and governance structures to support CHWs.</li> <li>▪ Ensure that health services provided by CHWs and local health facilities meet and are accountable to community needs.</li> <li>▪ Ensure that health services provided by CHWs and local health facilities provide quality care.</li> <li>▪ Work through CHW connections to focus political attention on government resource allocation decisions, prioritization of basic health services, and prevention of disruptions in the formal health system.</li> </ul>

As seen in Table 1, community members can support the work of CHWs in all six building blocks of the health system. Community members are involved with various stakeholders within the health system and with each other in various complicated relationships influenced by their social networks. These dynamic interactions and multiple perspectives overlay location-specific power dynamics. Complex adaptive systems analysis, using tools such as network analysis and causal loop diagrams, can help managers develop more effective ways to use these community systems to improve rather than impede CHW programs.<sup>11</sup> One can often find examples of conflict and distrust between community health providers—such as traditional healers, alternative healers, informal drug dispensers, and others—and the formal health workers.<sup>12</sup> Where these social, cultural, and likely political power struggles are found, quality of care and established care-seeking patterns will likely suffer. Therefore, when introducing CHWs into such a scene, it is wise to bring these groups together through mediation and community engagement in order to develop the most useful way that CHWs can be integrated into the existing care structure while building trust and a sense of their legitimacy within the community.<sup>13</sup>

### **How Can Community Engagement Be Used to Shape the Design and Management of Community Health Worker Programs?**

In order for CHWs to effectively carry out their duties, a level of trust between the CHW and the community is needed to enable relationships that will produce positive health outcomes. A CHW program can be designed in a way to maximize trust among CHWs, their clients, and the community at large, or at the least, to minimize the initial level of mistrust that might exist. In a 2012 interview, William Brieger, Professor of International Health at the Johns Hopkins Bloomberg School of Public Health, gave the following recommendation:

**Time and energy should be spent to ensure that communities have realistic expectations of the CHW program. When CHW responsibilities are not accurately portrayed to the community, false expectations may be set up resulting in CHW attrition or program stagnation.**

An enabling environment is critical to the establishment of a CHW program, requiring sound national policy and buy-in at district, facility, and community levels. Time must be factored in to sensitize all staff and community members that will have a role in supporting a CHW program. This may require advocacy, use of champions, and a series of community meetings. The importance of community participation in all aspects of CHW program design is discussed throughout the various chapters shown in Box 3. Specific roles of the community are summarized here, but covered in more depth in these other chapters. Contextual factors such as existing social structures, culture, and community needs influence all of these design elements.

## Box 2. Community Participation in Selection of CHW in Bangladesh NGO program<sup>14</sup>

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The NGO BRAC has a program of more than 100,000 CHWs called Shasthya Shebikas. With a focus on equity, the CHWs are recruited from village-based BRAC credit and development groups, called Village Organizations, formed by poor women in each village. The Village Organization nominates prospective female candidates to regional BRAC office members who finalize the selection. They deliberately select candidates who do not live near a health facility in order to increase health access for remote communities and to avoid competition with the health facility.

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## Box 3. CHW program design elements that can benefit from community participation

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Defining role and tasks.....	Chapter 7
Selection.....	Chapter 8
Training.....	Chapter 9
Supervision.....	Chapter 10
Incentives .....	Chapter 11
Monitoring and evaluation .....	Chapter 15

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### CHW Selection

CHW selection should be an open and transparent process within each community. Though requiring more time and additional effort, having the right CHW for the job in each community is critical to an effective program—and one of the most important components in community participation. In all communities, there are people and/or groups that dominate decisions about resource utilization. It is critical to recognize the influence of these people and to recognize that selection will most likely face issues of power and control. Communities are complex and vary in their dynamics, making community participation in the CHW selection process critical, whether the CHW is ultimately community selected or state selected.

## Box 4. Common CHW selection criteria<sup>15</sup>

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- Elected or endorsed by the community
  - Well-respected member of the community, with a good reputation
  - Honest, friendly, good communication skills
  - Willing to make household visits
  - Able to attend initial training and periodic refresher training courses
  - Willing to be supervised by the community and attend health center meetings
  - Live in the community
  - Share local language/culture
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The degree to which the program leaders engage community members and the degree to which community members understand what is to be expected of CHWs are important factors in determining whether the community makes a good selection. The ideal in both cases is to involve as many people from the community as possible (e.g., men, women, youth, elders, different castes, different tribes, wealthy, poor) in the selection itself or in witnessing the selection, so that the candidate is truly representative, not hand-picked by a leader, and not automatically of an elite caste. Dispelling notions of favoritism during the selection process is important to diminish any mistrust that could lead to jealousy or loss of willingness to cooperate.

To promote the program goal of equity, the selection criteria may favor underserved population representatives, such as women, those who are illiterate, and members of lower caste groups. Program designers should be careful of criteria that might exclude certain groups. For example, Benin set education level requirements high, feeling that it would help with data collection and reporting. However, the policy ended up excluding women who would have been a better fit for the community. In Ethiopia, when the proposed grade 10 educational level cannot be reached, program managers can change the educational and gender criteria. In the Uganda Community-Directed Intervention (CDI) Program for onchocerciasis, community members are organized around kinship groups, and these kinship groups select the ivermectin distributors from among themselves. Although the recommendation was to select one Community-Directed Health Worker (CDHW) per 250 people, Uganda decided to allow every self-identified kinship or neighborhood group to select as many CDHWs as practical. This provides a higher concentration of CHWs per population, each with the support of their kinship group.<sup>16</sup> Programs need to be flexible enough to adjust policies at the local level.

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#### **Box 5. Community participation in selection of CHW in Brazil<sup>14</sup>**

In Brazil, the CHWs are selected through a public process with community members. The Municipal Health Council, with support of the State Health Secretariat, conducts the process and guarantees transparency. Candidates are assessed for their aptitude, posture, and attitudes during a simulated community problem. The State Health Secretariat sets up interview schedules and conducts the interviews in public places, such as schools or community meeting halls. Communities encourage candidates to apply.

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#### **Box 6. Community participation in selection of CHW in different states of India<sup>17</sup>**

The CHW selection process laid down in India's guidelines specifies a sequence of events: starting from community mobilization, with facilitators helping in enabling weaker communities to articulate their choices based on a set of criteria, village meetings, and finally *Panchayat* (block level) endorsement of the final choice.

According to an evaluation in 2011, however, the entire sequence has almost never happened. In Assam, Andhra, West Bengal, and Kerala, a formal multistakeholder committee assigned by the government with this task made the decision. In Orissa, meetings of women's self-help groups facilitated by the Anganwadi Worker made the choice, while in Jharkhand it was the Village Health Committee. The evaluators found no clear evidence that the various selection processes made much difference to the overall health outcomes of the program, as long as the contribution of other selection factors, such as transparency and community participation, were followed.

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The formal introduction of CHWs back into their community after training can also be very helpful for the success of the program. This introduction could be in the form of a town hall meeting to make sure that the community is aware of and understands the CHW role. In Nepal, such a meeting made an important difference to the acceptability of CHWs in the community. It can also be important to have local leaders endorse the CHW.

### **Defining the CHW Role**

To be trusted, the CHW should be able to address the community's broader social development needs in addition to their health needs. It is important that the parameters around the roles and obligations of the CHW, the community, and the health center are clear. Two ways in which community members can participate are in the creation of the job description or by contributing to a code of conduct that will then be visibly displayed. Statements in a code of conduct often include behaviors, such as avoiding alcohol when serving as a community provider, not asking

for favors or monetary gifts from the community, being gentle and attentive, and so forth. In some countries, groups of CHWs create a common code of conduct that is then shared with the community. Common challenges include unrealistic expectations and undefined job descriptions.

Community members may also help to design the CHW's role to tailor it to their needs. While the national program may set up an essential health package, the community may prioritize certain aspects. If the community people do not see that a CHW has a role or something to offer them, then the program will not work. For example, while developmental and educational activities are considered important, curative services are demanded by communities who do not have access to these services.<sup>18</sup> While existing CHWs may deliver preventive interventions with minimal supervision, CHWs who deliver community case management (CCM) treatments for common childhood illnesses require more training and support from facility-based services.<sup>19</sup> Table 2 provides examples of the importance of community participation and the ways communities can participate in various health tasks.

**Table 2. Community Participation by different CHW roles**

CHW ROLE	IMPORTANCE OF COMMUNITY PARTICIPATION	WAYS COMMUNITY CAN PARTICIPATE
Health promoter, including communication, counseling, and support to improve health and prevent disease.	Behavior change requires repeated, intensive contacts over a period of time, and is influenced by peer support and community norms.	Participatory community or peer groups who witness visible change provide support and continuity for behavior change.
Health provider, including treatment of common illnesses, referral to health facilities, and care and support to the chronically ill.	Cultural perceptions of illness and treatment may undermine prevention, treatment, and care options unless addressed openly.  Social relations of care, if not understood and managed well, can worsen health status.	Participation in community planning approaches or formative research to uncover specific terminology and belief patterns that lead to behavior change.  Participation in quality improvement processes for provider interaction and use of facility-based services.  Election of specialized volunteer cadres who are patient advocates or who support referral to CHW.
Agent of change, including support for community mobilization, empowerment, and human rights.	Structural risks to good health (power dynamics, poverty, discrimination) will not change without community action.	Engagement in the problem-posing and problem-solving process at community meetings can lead to collective action to change circumstances.
Health manager, including vital event and other reporting.	Communities may not want to provide vital events information to government agents.	Election of volunteer cadre who support the CHW with household visits to neighbors (i.e., Care Group approach: see <a href="http://www.caregroupinfo.org">www.caregroupinfo.org</a> ).

## Box 7. Training: Country Examples<sup>20</sup>

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India prioritized the building of CHW skills in village health planning, while Brazil has taken on a human rights framework that focuses on problem-solving and conflict-resolution skills. An evaluation of the Brazilian program found that community health agents (CHAs) needed more knowledge about how political, financial, and environmental factors influence community health and how that applied knowledge influenced the effectiveness of the CHAs.

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While the community as a whole does not generally participate heavily in training, some training is conducted in the community and may involve community members. Besides learning technical health skills, the CHW needs to demonstrate respect and empathy for the patient by listening and expressing care and concern. Role playing of potential situations in the community is critical and is often followed by practice in the community. Training for community leaders in the CHW program, especially at the time of initiating a CHW program or during times of program change, can also be critical.

### Supervision

While a CHW needs a trained health supervisor, she also needs supportive supervision from community members. Many communities already have village health committees (VHCs) or other existing community management structures that were established as part of national health or democracy initiatives. These groups provide feedback to the CHW if any complaints are received regarding her performance; help her with problem-solving, especially if it relates to water and sanitation or other determinants; provide incentives, especially in the form of recognition; resolve conflicts that may arise; and have the ability to influence termination of work should there be discord between the CHW and the community.

Social support for CHWs from the community is a powerful motivator, but needs to be combined with incentives from the health system. Community involvement in CHW selection and supervision is key, as is public recognition. Community members need to have trust in the CHW. Support from community leaders provides her with legitimacy. Community management structures, whether formal or informal, can provide in-kind material support. Examples include exemption from duties in the community (e.g., community patrol and cleaning day responsibilities), donation of farm labor to help with the CHW's own farming, or donations (e.g., chickens or vegetables). In Jamkhed, India, farmers' clubs supported CHWs and helped them solve community problems.

## Box 8. Recognition and Motivation

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### CHW Recognition in Nepal

In 2003, the female CHW program established a National FCHV Day and the districts have been encouraged to hold events to celebrate this day.

### CHW Motivation in Rwanda<sup>21</sup>

A study in Rwanda found the three biggest motivators for CHWs to be the opportunity to develop social relationships through the work, trust and esteem from neighbors, and helping the community/saving lives.

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### Monitoring and Evaluation

If health facility workers, the CHW, and community members discuss and understand household data and vital events collected by CHWs and see the impact of what is happening in their community over time, the influence of CHWs in the community will become increasingly evident, resulting in increased CHW motivation.<sup>22</sup> Community-based health information

systems, birth registries and community scoreboards collected by CHWs, when fed back to the community, enable community members to understand the epidemiology of their setting and to prioritize solutions. Community management structures can also support the CHW in advocating to local government and health facilities for supplies and resources.

### Box 9. Community Accountability

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In Uganda, researchers used a randomized control trial to study the impact of an accountability methodology (Citizen Voice and Action facilitated by World Vision staff) that enabled poor people to scrutinize whether those in authority fulfilled their health responsibilities. After one year, absenteeism was reduced along with the average wait time for a clinical consultation. Under-five mortality declined while the number of women seeking prenatal care and using skilled birth attendants increased.<sup>23</sup>

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### How Do You Adapt Community Participation to Local Situations?

The level of community engagement needed will vary with the health outcome desired, the capacity of the community, and the degree to which the cultural context is supportive. No matter what approach is used along the community participation continuum, it will only be effective if it is responsive to community needs and implemented well. In underserved communities, especially among poorer populations, a community engagement strategy that is more robust and transformative will be needed. Finding the right balance between a CHW strategy that is highly tailored to local needs, on the one hand, and a rigid national program on the other hand that does not allow for local adaptation is key. A highly tailored strategy may take too long for national implementation, while a rigid program may prove ineffective because CHW messages and tasks may not be appropriate for particular communities. A CHW program should have community engagement principles that support a continuum of community participation, depending on circumstance that enables design and implementation flexibility at the local level. The challenge is to maintain the momentum of engagement over time, assessing the environment, and adjusting the program to respond appropriately to social and political realities.

### Box 10. *Atencion a la Ninez en la Comunidad* (AIN-C) *Monitora* Strategy in Honduras<sup>24</sup>

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AIN-C devoted considerable care to developing an operational strategy related to the community *monitoras'* job description, their selection, their task execution, training, supervision, and replacement. The goal was to overcome common problems with volunteer community worker schemes and to allow maximum flexibility for local ownership. The job of the *monitora* is manageable for a volunteer, as they work on average 15 hours per month.

The following are a few of the critical considerations:

**Flexibility and ownership:** Every community is made the owner of its program and of its success in achieving healthy growth in their children. Communities decide if they want to have the program in their community, how many and who will be *monitoras*, how they will reach every child younger than two years of age every month, how they will create a community environment that favors adequate child growth, and how they will interact with the government's health infrastructure.

**Teamwork with specialization:** A key practice implemented by AIN-C is the use of a team of volunteers at the community level rather than relying on just one person. Communities are told that they can choose anywhere from two to about five *monitoras* to be trained. Having a team means that each member contributes different strengths. One may be good at weighing and charting while another is good at counseling. In addition, a team minimizes the effect of turnover

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and enables all members to help each other learn and remember lessons from the training. The fact that over a five-year period, six to eight people might have worked in their community's AIN-C program (instead of just three) strengthens community commitment, knowledge, and ownership of the process and the program.

**Focus on tasks:** The job description of the *monitora* is the basis for determining all other program actions because their tasks support the community effort. The *monitora* manual is not a technical guide, but rather an operational guide to the actions that must be completed.

**Flexibility in operationalizing tasks:** AIN-C guidance does not give precise details on how *monitoras* are to perform their jobs. Instead, the program, in collaboration with the community, establishes goals for outcomes that must be reached. How the *monitoras* choose to reach the goals is up to them. For example, all children younger than two years should be seen by a *monitora* each month. Whether the *monitoras* accomplish this by, for example, house-to-house visits, neighborhood meetings, or community-wide meetings, is up to them.

**Rewards and incentives:** AIN-C provides regular incentives to its volunteers, and these incentives have both intrinsic and market value. Incentives are regularly provided and planned for—just like all other operational aspects of the program. Examples of the incentives are a letter from the Secretary of Health thanking the family of the *monitora* for their generosity, an identification card with a photo of the *monitoras*, and regular community parties in honor of the *monitoras*. Training and monthly meetings at the health center are also seen as incentives.

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## What Are Key Barriers and Enablers Community Participation?

Engaging in and supporting the empowerment of the community for community health decision-making and action is a critical element in health promotion and disease prevention. The impact of programs that target individual behavior change is often transient and diluted unless efforts are also undertaken to bring about systematic change at multiple levels of society.<sup>25</sup>

External and internal factors constrain the promotion of participatory development. External obstacles include the role played by development professionals and donors for immediate results, co-optation by government of community participation (e.g., using the political system as a form of social control), and the tendency among governments and development agencies to favor and apply certain selection criteria that favor the more vocal, wealthier, more articulate and educated groups. Further, governments and development groups may favor investment in product delivery and under-invest in the more intangible social processes and community participation that are critical to the product's use and long-term sustainability. Internal obstacles refer to conflicting local interest groups, gate-keeping by local elites, and local apathy.<sup>26</sup> A CHW can often do little to overcome these factors, which are inherent in the system.

Table 3 offers some of the factors that can either negatively or positively influence the success of community participation efforts with CHWs. Planners and organizers of these efforts may find it useful to keep these factors in mind as they plan for community engagement efforts in their setting. The categories and barriers were from a review of community engagement initiatives in the United Kingdom.<sup>5</sup> The more enablers who are present, the easier it will be for a CHW to engage the community in a meaningful way. The greater the number of barriers, the more a longer-term investment in developing meaningful partnerships with stakeholders will be required.

**Table 3. Barriers and enablers of community engagement with CHWs<sup>5</sup>**

CATEGORY	BARRIER	ENABLER
Power	Misuse of power by professionals, leaders, and developmental actors <ul style="list-style-type: none"> <li>Discursive – defining who can be engaged</li> <li>Positional – controlling the terms of engagement</li> <li>Financial – shaping level and type of support provided for communities</li> </ul>	<ul style="list-style-type: none"> <li>Broad community participation with an appropriate cross-section of community members</li> <li>Specific CHW selection criteria favoring disadvantaged groups</li> <li>Involvement of community governance group</li> </ul>
Skills and Knowledge	Lack of relevant skills and knowledge impeding communication	<ul style="list-style-type: none"> <li>Clear and realistic goals for CHW and community with appropriate skill-based training and continuing education</li> <li>Networking among peer CHWs and shared learning</li> </ul>
Practices of Engagement	Style of meetings, failure to accommodate cultural diversity, accessibility	<ul style="list-style-type: none"> <li>Environment of mutual respect, understanding, and trust</li> <li>Open and frequent interaction, information, and discussion</li> <li>Skilled convener</li> </ul>
Transaction Costs	Time lost and financial resources required, especially in rural areas	<ul style="list-style-type: none"> <li>Members see engagement to be in their self-interest and benefits of engagement as offsetting costs such as small visible activities</li> <li>CHW travel stipend and perceived valuable incentives</li> </ul>
Cultural	Stereotypical attitudes among officials toward gender roles and disabled; dominance of deficit images of communities as having high needs and few assets	<ul style="list-style-type: none"> <li>History of collaboration and cooperation in the community</li> <li>Partnership-Defined Quality (PDQ) and other quality improvement approaches*</li> </ul>
Active or Passive Resistance	Apathy and disinterest in communities that have been co-opted in the past	<ul style="list-style-type: none"> <li>Positive past experience</li> <li>Members feel ownership and share a stake in both process and outcome</li> </ul>
Appropriateness of Approaches (models of engagement)	Not being able to reach consensus; unrealistic expectations; confusion between representative governance (where the representative decides on behalf of the community) and participatory governance (where everyone votes)	<ul style="list-style-type: none"> <li>Basic governance training</li> <li>Clarity of roles and guidelines</li> <li>Shared vision</li> </ul>
National Policy Context	<ul style="list-style-type: none"> <li>Tensions between representative and participatory democracy</li> <li>Different forms of governance: participative versus managerial setting of targets versus central control with inspections and audits</li> <li>Tensions between the objectives of different policies – community partnerships versus organizational efficiencies</li> </ul>	<ul style="list-style-type: none"> <li>High-level commitment over time</li> <li>Favorable political and social climate</li> <li>Shared vision with guiding principles</li> <li>Governance training</li> </ul>

\*Partnership-Defined Quality (PDQ) is a process for engaging communities and health care providers to work together in defining, implementing, and monitoring activities intended to improve the quality of care.

CATEGORY	BARRIER	ENABLER
Other Factors	Lack of resources	<ul style="list-style-type: none"> <li>▪ Technical support from NGOs and voluntary sector</li> <li>▪ Diversity in the types of opportunities for various community groups</li> <li>▪ Sufficient resources</li> </ul>

## How Can a Community Participation Policy Be Designed to Support a CHW Program?

A policy or guidance document that outlines principles for community engagement should enable the government to:

- Set aside resources for investment in community engagement strategies, including CHW training and support, and in community management structures, training and support
- Make clear that the community needs to be involved in health care policy and delivery in government plans
- Enable multiple stakeholders in various parts of national and local government, the private sector, and the voluntary sector to better harmonize with and support community engagement strategies
- Enable civil society to hold both government and communities accountable

The policy should be created with representatives of government, NGOs, and civil society actors so that these strategies are not co-opted by governments to try and delay action or diffuse public criticism, legitimize an existing poor-quality service, or divest itself of responsibilities by passing them on to communities. The policy should also ensure that a small non-representative group of elites within the community cannot abuse these principles. The formation of a Community Health Desk, an office within the Ministry of Health (MOH) that oversees community health policies and practices, as implemented in Rwanda, may be helpful for coordination and iterative learning of lessons learned and new practices.

## What Are Various Components of a Functioning Community Participation Strategy?

While many countries have policies that support a functional CHW program and the development of community management structures as a main community participation strategy, a community engagement strategy is more complex, requiring multiple actions throughout the health system. Establishing political buy-in at national, district, and local levels of government is critical, as is establishing processes for maintaining appropriate expectations at the different levels. Community involvement in decisions about health systems has the potential to improve health care services. However, its effectiveness is likely to depend on having explicit methods for involving community people and clearly defining roles and responsibilities, for training of policymakers and clients, and for ensuring adequate funding.<sup>27</sup> A long-term investment and commitment is also needed for a cultural shift in viewing communities as impediments to public health to viewing them as agents of change.

An example of a robust community engagement strategy was developed by the National Institute for Health and Clinical Excellence in the United Kingdom.<sup>28</sup> It calls for coordinated implementation across ministry departments and organizations, long-term investment, organizational change processes to align values and attitudes to encourage community engagement, and training of staff and communities at national, regional, and local levels. Its

implementation, however, did not positively impact population health, though it did positively impact social capital and community empowerment.<sup>29</sup>

One of the main reasons why a program does not get implemented as planned is because program managers have strong and differing views of how a program ought to unfold. Different stakeholders have different explanations of how a CHW's work would lead to improved health status and what she should or should not do with respect to both the provision of curative care services and community empowerment and mobilization.

### **Box 11. India – Different Interpretations of the Role of the CHW**

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The government of India's policy is that the ASHA worker is a CHW that provides health promotion along with curative services. In the states of Kerala and West Bengal, the majority of stakeholders felt that the ASHA should only conduct health promotion activities and assist the facility with data collection and recording. Her role in responding to common but potentially life-threatening illness was down-played and not fully supported, undermining the huge investment in the ASHA program.

In the state of Assam, the state officials pushed for a health promotion role only for the ASHA worker, while district and field managers were advocating for a role that involved engagement of the ASHA worker in curative care. The lack of role clarity undermined the community's confidence in the ASHA. Of particular note was the fact that she was often out of supplies and her drug kit was not consistently refilled.

In the state of Andhra Pradesh, NGOs were involved in the selection and training of the ASHA worker at an early phase and brought an activist empowerment approach. In contrast, state officials and district medical officers supported only a health promotion role. Both groups ended up equally critical of the program, even becoming hostile to it. Even though national ASHA guidelines have been developed and approved, key mechanisms such as the process of selection, the emphasis on social mobilization, the refilling of the drug kit, and the development of a strong support system are modified on a state-by-state basis.

The Comprehensive Rural Health Project in Jamkhed, India, one of the world's pioneering CHW programs and India's first CHW program, is contracted by the government to provide training in the ASHA system to both government and NGO staff and to CHWs. Their program mandates that all people involved in the CHW program, from top-line supervisors to field managers, receive at least some training, including personal experience with community engagement, so they are fully aware and supportive of the CHW program.<sup>17</sup>

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### **How Can Governments Maximize their Work with Non-Governmental and Faith-Based Actors?**

NGOs and faith-based organizations (FBOs) were working with CHWs prior to the Alma-Ata conference in 1978. They have brought both human and financial resources to establish and support CHW programs as part of a broad technical and community mobilization effort, especially in underserved communities. They have brought new innovations in CHW program design and management, and they have tested MOH policies in the field for their effectiveness. They have established learning and training centers that have enabled others to adapt their approaches and scale them up, and they have built the capacity of local organizations and district programs of MOHs. Much of their focus is on equity and serving hard-to-reach and disadvantaged populations. Their expertise in community mobilization and community organization enhances the work of the CHW. Their efforts have enabled millions of people around the world to access basic medical care. FBOs, especially in many countries in Africa where they provide more than half of the countries' health services, have a major role in

providing health services for mothers and children. WHO estimates that 30%–70% of clinics and hospitals across Africa are owned or managed by FBOs.<sup>30</sup>

In some countries, NGOs manage very large CHW programs that are complementary to the work of CHWs employed by government, such as the CHW programs of the Catholic Pastorate of the Child in Brazil and BRAC in Bangladesh. NGO-administered CHW programs are better able to respond to changing circumstances since there is less of a formal bureaucracy involved. They also can reach populations with minimal access to formal facilities and assist in community mobilization efforts, including the use of multisectoral strategies, such as linking health programs with literacy or micro-credit programs.

On the other hand, multiple uncoordinated NGO efforts may undermine a national CHW strategy. NGOs may have a mosaic of different training systems with differing content and quality; competitive and duplicative working strategies limiting efficiency and the quality of care; diverse sets of competing incentive packages causing conflicts of interest; parallel services creating competition and friction with the MOH; and diversity in quality assurance, supervision and reporting systems, making it difficult for the MOH to have a coherent picture of CHW activities.<sup>31</sup> Thus, NGO programs can undermine large-scale CHW programs when not harmonized with government strategies.

NGOs should be encouraged to support a CHW system, following MOH guidance with input from civil society and other stakeholders, including CHWs. Policies should enable the NGO sector to support CHW services on behalf of the ministry, test CHW innovations in the field, set up complementary cadres of community volunteers especially in areas of high mortality, and build the capacity of community-based groups and organizations, including community governance structures. Encouraging multiple cadres of volunteers and groups who support a formal full-time, fully trained, and paid CHW may be part of a holistic CHW strategy, enabling the right numbers and mix of CHWs to support the specific needs of varying communities. Experience shows that CHW programs that have been sustainable have strong links with the government health system.<sup>18</sup>

### **Box 12. Kabeho Mwana (Life for a Child) Project in Rwanda<sup>32</sup>**

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Three international NGOs—Concern Worldwide, International Rescue Committee and World Relief—worked with the Community Health Desk in Rwanda to test a new CHW strategy in six districts of Rwanda that served approximately one-fifth of the country’s population. Rwanda is in the process of organizing all CHWs into cooperatives. In 2014, there were a total of 449 CHW cooperatives and of those about half are legally registered and recognized. Each cooperative has 100–250 members, through which CHWs meet quarterly at health centers. Each type of CHW is supposed to reach the entire village with messages limited to their CHW function. The project introduced a Peer Support Group (PSG) model to coordinate and cross-train CHWs in different behavior change communication interventions. PSGs averaged 20 CHWs from four to five neighboring villages who met at least once a month for training on health topics and for joint planning of home visits and other health promotion activities. Each CHW visited approximately 10 households per month to deliver messages on healthy family practices outlined at the PSG meetings. The repeated, familiar contact with fewer households resulted in increased CHW utilization and health behaviors, influencing the government to consider adoption of this strategy as national policy.

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## **PART TWO: COMMUNITY MANAGEMENT STRUCTURES**

In 1989, WHO recommended that an effective CHW program have the support of a group composed of members of the community who have active links with the health sector and improves governance at the local level. We refer to these groups as community management structures known by different names, such as village health committees, community health

committees, ward health committees, community advisory boards, and health management committees. In most countries, these management structures provide support to the CHW at the community level and a bridge to the health system, and may also be linked with the local political system. Well-functioning committees can describe their roles and responsibilities and how they relate to other groups, including the CHWs, the health facility, and the district health authorities.

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### Objectives of a Community Management Structure<sup>19</sup>

- Provide a support system for CHWs
  - Work with CHWs to mobilize the community for improved health
  - Assist with communication to and from the district health system and the local administration
  - Advocate for supplies and investments critical to good health.
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In other countries, health facility management committees (also known by different names such as health center committees) may exist, either as the predominant community management structure or in addition to other community governance structures. The health facility management committees provide oversight of the health facility, including CHWs who are associated with that health facility. These committees generally have administrative and financial responsibilities, such as ensuring the facility meets the community needs to increase usage, oversight of facility budgets and staffing, resource-generation activities, and management of insurance schemes to lower cost barriers for the poor. Because of their duties, these facility management structures have the potential to be more contentious and generally require more intensive support.

### What Are Common Issues with Community Management Structures?

While many countries have active community management structures, they are generally weak. Table 4, modified from the CHW Assessment and Improvement Matrix Tool,<sup>15</sup> highlights some best practices along with the most common issues and functionality problems of community management structures described in the literature.<sup>33</sup> An assessment of existing issues may help a ministry plan and budget for ongoing support. In many cases, clear and transparent guidance and exchange of good practices may be a solution. An EQUINET review of district health systems in East and Southern Africa found that community participation can have the most impact when supported by functional local management structures that promote participation in decision-making in addition to carrying out administrative tasks. However, when these structures are composed of elites, they are not accountable to any defined constituency and broad community participation is constrained.<sup>34</sup>

**Table 4. Community Management Structures: Guidance from the Assessment and Improvement Matrix<sup>15</sup>**

COMPONENT	GOOD PRACTICE	ISSUES THAT ARISE	RESULTS WHEN NOT DONE WELL
Recruitment/ Selection to Community Management Committees	Selection of enough members to represent the main social groups in the community while maintaining a small enough group to make decisions and take actions (6–12 members) Builds on well-functioning community structures where possible Selection by a broad segment of the community Election of esteemed community representatives rather than elites with sufficient gender, ethnic/tribal, and disadvantaged groups represented	Generally, committees are staffed by health workers, community members, and appointed key figures, but there is little guidance on optimal numbers and selection criteria and processes including size of committees, women, and quotas to ensure adequate representation of different segments of the community	There is a lack of consistent and regular functioning due to having a quorum Males may dominate Community members are selected by the community leader and may be the relatively affluent or prominent members seeking political gain
Committee role	The alignment, design and clarity of role from the community, CHW and health system perspective is known to all	Roles of the committee are not formalized Confusion exists regarding different roles such as governance, co-management, CHW support, resource generation, community outreach, advocacy, intelligence, social leveler	The committee generally wants to respond to community-expressed needs but may be seen by the health system as a utilitarian mechanism for supplying resources Views on if, when and how to involve communities and CHWs differ significantly between stakeholders on the committee They may have different implicit views of a CHW model focused on individual behavior change versus interventions that seek more broad community change
Initial training	Training is provided to the committee members on participatory, decision-making processes and problem-solving skills	Committee members may have inadequate training for their role Their health knowledge and management skills vary as does their confidence to lead	The committee is ineffective in solving issues between the community, health system and the CHW
Continuing training	Ongoing training is provided to committees to reinforce initial training, and build organizational development skills and health literacy to solve root causes of poor health	There is generally no budget or system to provide ongoing training that reflects committee's needs	Committees falter and may cease to function

COMPONENT	GOOD PRACTICE	ISSUES THAT ARISE	RESULTS WHEN NOT DONE WELL
Budget	Designated funding to enable community committees to take action to support CHW and health outreach activities	Under-resourced committee	Unable to perform actions
Supervision of the committee	Supportive supervision is carried out regularly to provide coaching and review of CHW activities and local data	Many committees have unclear reporting structure to local government or health system Inadequate support and poorly integrated into health system	Committee may be non-functional
Program performance evaluation	Evaluation to assess work and health changes over a period of time. Include key performance indicators related to community governance committees in job descriptions of relevant supervising health workers and managers and by conducting periodic structured audits of governance committees	No evaluation to know whether committee work is effective or not	Committee may falter over time or not be aligned with current health conditions
Community incentives to participate	An incentive package of non-financial incentives such as training, recognition, certification, etc. appropriate to job expectations	Community members are not publicly recognized There may be general community unawareness and no incentives for participation	Community members view participation in health as a tedious task of administrative supervision without pay and may cease to come to meetings
Incentives for supervising health workers to participate	An incentive package of non-financial incentives such as training, recognition, certification, etc. appropriate to job expectations	Duties may be seen as additional to work responsibilities with no added benefit	Lack of motivation to participate at committee meetings Seen as additional layer of administrative supervision by untrained people
Community involvement	The role that the community plays in supporting and joining the committee and supporting the CHW is well-understood	Social, political, and cultural factors all impact on the purpose, form, type and effectiveness of community involvement Health literacy, necessary knowledge of legal frameworks, and skills needed to participate effectively are wanting	When the community role is implemented poorly, it might create community resistance to participation
Referral system	A process to support the CHW with referral assistance when needed	Community has not created an emergency transport system for referrals to a health facility	Life-saving emergency transport systems and logistics help for referrals do not work

COMPONENT	GOOD PRACTICE	ISSUES THAT ARISE	RESULTS WHEN NOT DONE WELL
Communication and information management	Processes used by the governance structure include monitoring data flows to the health system and back to the community, publicly sharing information, and using data for service improvement Tools such as patients' rights charters, citizen report cards, suggestion boxes, health clubs, are used	Public health data do not exist Community does not take appropriate action to address disease epidemiology or address root causes of disease	Perceived lack of transparency may cause community resistance to change CHWs and health workers are not accountable to the community No or slow change in disease reduction
Linkages to health system	Community management structures are linked to the larger health system, with a supporting management culture that encourages transparency and openness between the health facility, CHWs and the community	Relationships among community committees, CHWs and the health system unclear Mistrust and imbalance in power and information	Health workers may control committees Community governance structures may be perceived as interfering with health worker duties, especially those related to use of funds and drugs Deterioration in communication from central ministry about the purpose and function of community governance structures may cause a decline in community governance
Country ownership	The MOH or other ministries have policies in place that integrate and include community governance structures in health system planning and budgeting and provides logistical support to sustain them	Unclear legal position Lack of support	Without a clear mandate, the community management structure has no direct influence over the core budget governing a CHW or health facility and little influence on clinic management There is a lack of clarity on the extent of the community's decision-making power to hire/fire the CHW

### Box 13. Village Health and Sanitation Committees (VHSCs) in India<sup>17</sup>

An evaluation of the ASHA program in India reported in 2011 found that where VHSCs are established and functional, they are supportive of many health activities and functions, though there is room for improvement, especially in the key task of village health planning. In Assam State, one ASHA facilitator was hired for 10 ASHA workers to provide support in holding VHSC meetings, counseling families, accompanying newborn visits, and supporting immunization and antenatal care services.

## Box 14. Revitalizing Community Health Committees in Liberia<sup>35</sup>

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Community Health Committees (CHCs) were a community management structure supported by the Ministry of Health in Liberia before the civil war. Medical Teams International (MTI) revitalized these traditional structures to support Household Health Promoters. Each CHC had on average eight members, including community leaders such as imams, pastors, women leaders, and trained community midwives. MTI developed a self-assessment tool around the following key tasks to enable the CHCs to appraise themselves at yearly intervals:

- Frequency and organization of meetings
  - Participation and leadership in meetings
  - Problem identification
  - Prioritization and action planning
  - Support to Household Health Promoters
  - Utilization of locally collected data
  - Establishment of emergency health funds and transportation system
  - Participation in conflict prevention and resolution
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## What Are Key Questions to Consider When Designing a Strategy for Community Management Structures?

There is no one-size-fits-all approach for designing or implementing a strategy on community management structures related to CHWs. However, a discussion around some key questions, as shown in Table 5, can help open the way for decisions on their potential roles and functions. A policy on community management structures would follow an assessment of their current content and context in relationship to a CHW program, followed by discussions on stakeholder perceptions and guidance around the mechanism.

**Table 5. Questions to consider in the design of a community management structure strategy<sup>36</sup>**

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### CONTENT Questions

- What is the purpose?
- What is the intended depth of community involvement?
- Who introduced the initiative and why?
- Does it build on existing community organizations and networks?
- Who is expected to represent whom and how?
- What technical knowledge is required?
- What training, supervision, and support are included for different actors?

### CONTEXT Questions

- Is community accountability prioritized nationally and internationally?
- How decentralized is the health system?
- How clear are lines of responsibility and accountability at different levels of the health system?
- Does the mechanism challenge or complement other health system interventions, existing community structures and socio-cultural norms?

### PROCESS Questions

#### *Stakeholder Perceptions and Relations*

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- What are the different parties' views on the relevance and relative costs and benefits of this mechanism?
  - What are relationships of power and trust and different levels within institutions, and among individuals? How will these be affected?

#### ***Mechanism Functioning***

- Who represents whom and how?
  - Who sits in groups and committees?
  - How are they selected and how do they link to the health system and the community?
  - How clear are their roles? What is their motivation?
  - How are decisions made?
  - How much of a decision-making role do they have in practice?
  - How was the intervention introduced? Which stakeholders were involved? How and at which stage? How did this work?
  - What training took place and what resources were allocated in practice?
  - What are the links to other institutions? How does information and communication flow among and within institutions?
- 

## **CONCLUSION**

This chapter highlights the critical importance of community participation to a CHW program. Because community participation can take many forms, and because each community is unique and always changing, large-scale CHW programs should be designed to enable local flexibility and tailoring in relation to community assets and needs. Maximizing community participation is not the sole responsibility of the CHW. Community participation is a process that requires leadership from the overall CHW program, as well as the support of the health system and local government at all levels, and partnerships with other organizations. The formation or strengthening of a community management structure, such as a village health committee, is often a strategy of choice for the community support of a CHW. However, these structures also require ongoing support and training if they are to work well.

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