Chapter 16
Wrap-Up

Henry Perry, Lauren Crigler, and Steve Hodgins
Key Points

• The current enthusiasm for large-scale Community Health Worker (CHW) programs needs to be tempered with a sobering reflection on the disappointments that followed a similar wave of enthusiasm in the 1970s and 1980s and that challenges in scaling up and sustaining large-scale public sector CHW programs remain.

• Large-scale public sector CHW programs are complex entities that require adapting a systems perspective to the national and local contexts.

• This reference guide has attempted to avoid categorical recommendations and has suggested issues and principles to consider and, when possible, has cited relevant program experience.

• CHWs are not a stop-gap measure in a second-rate health program, but a permanent part of a highly functional and effective first-class health system.
Given the recent re-emergence of interest in large-scale CHW programs, we have taken the opportunity to take stock of issues and challenges that these programs face and what might be done to make them as effective as possible. This reference guide is intended to be a practical guide for policymakers and program managers who wish to develop or strengthen a CHW program, drawing lessons from other countries that have implemented CHW programs at scale. We have discussed major policy and programmatic issues that decision-makers and planners need to consider when designing, implementing, scaling up, or strengthening a national-level CHW program. We have offered an overview of specific challenges CHW programs face, country lessons, tools, and other resources that may be helpful for policymakers and program managers. As much as possible, we have brought in relevant programmatic examples.

We return to Figure 1 that was presented in the Introduction to highlight the inter-relationships between all the different parts of the “system” that makes up a CHW program. As should be even clearer than perhaps it was at the outset, because all of these functions have important inter-relations, design decisions in one area have consequences in many others.

Figure 1. Overview of Community Health Worker Program Sub-systems and Their Interactions

For more than 50 years, as leaders in primary health care have tried to elaborate strategies to better meet population health needs, they have gravitated repeatedly to solutions that have involved recruiting and training local people to play roles complementing and supplementing those of health professionals, encouraging healthier practices and care seeking and, in some instances, providing services that otherwise would fall within the responsibility of health professionals through task-shifting.

Strategies have varied considerably by place and time. Different names for community-level workers have been used. Some notable ones include: “health auxiliary,” “village health worker,” and “community health worker” and, most recently, “frontline health worker” (albeit, a designation used also to cover primary health care professionals, as well as lesser-trained community-level workers).

The initial wave of CHW programs established in the 1960s, 70s, and 80s was for a very different world from today. Many of the societies where we work have become more prosperous since then; the standard of education and literacy has improved; economies have evolved in the direction of greater monetization and away from traditional subsistence economies; in many settings, the private sector now accounts for a large proportion of health services provided; road networks have expanded; and new technologies (notably mobile phones) are now in widespread use. Perhaps most importantly, the world today is much more urbanized.
Nevertheless, many of the issues that face policymakers, program managers, and external development partners as they make decisions and as they design and manage community health programs are essentially the same as those faced by their predecessors: how to sustainably finance such a program; how to design it so that it will function effectively; how to select, train, motivate, retain, and supervise CHWs; how to ensure consistent supply of needed drugs and other commodities; and how to monitor and ensure performance. Also, now more than ever, programs need to be resilient and adaptable, adjusting to new evidence and policies to enable them to implement newly approved recommendations.

Unfortunately, examples can be found today of decisions being made in the development or implementation of CHW programs that repeat mistakes made in the past, dooming programs to the same compromised effectiveness as last time round. Our goal is for this reference guide to enable policymakers and program implementers to reduce the frequency of such decisions that fail to take into account lessons that can be drawn from past experience.

The accumulating evidence regarding the effectiveness of CHWs in low-, middle- and even in high-income countries provides strong indications that for the foreseeable future CHW programs are no longer just a stopgap solution. Investments in them are, in fact, investments in strengthening the health system. But, to reach their full potential they need adequate financing, just as all essential programs do. Whether emerging large-scale CHW programs can garner the financial resources they need to achieve their full potential is a question that is too early to answer at present.

Each of the chapters in this manual is authored separately, so they may differ in style and approach; however, in each case, authors were asked to present a series of key questions and provide alternative scenarios that might help decision-makers identify the best solution for their particular challenge.

Across chapters, there are key themes that emerge:

- Planning, managing, and financing CHW programs is complex because CHW programs generally fall somewhere between the formal health system and communities, and rely on the involvement of a wide range of stakeholders at local, national, and international levels. CHW programs frequently fall outside of the formal health structures and are poorly integrated with it.

- Careful planning that takes into account the full costs of the program is essential, and a plan for adequate financing that is fair and sustainable must follow. Establishing a strong a base of political support for long-term financing is critical if government funding is required. Early success can build long-term success – an ineffective program is hard to fund in the long term.

- Balancing the inherent tensions of a large-scale CHW program in which the CHW is the lowest tier worker of a national health system and also acts 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.

- Attention to human resources, from role definition and recruitment to training, supervision, and incentives must be considered in full at the outset (if possible) of the program. Each of these areas individually and cumulatively provides the means and mechanism for the delivery of quality services. The program is responsible for providing basic and realistic support for people expected to deliver any kind of service to a community.
• Early program quality can generate political support that will be valuable in providing the needed governmental financial support. Strong evidence of effectiveness can help to secure political support for funding and can be achieved by having a strong monitoring and evaluation program.

• Where community or local participation is well established, models of community-driven programs and local accountability may be appropriate and useful for CHW programs. Where local participation in governance is not well established (for example, because governance of the health and political systems are highly centralized) or is weak, stakeholders need to explore other mechanisms for accountability.

• It is challenging to include a very local participatory structure for governing a CHW program within a large-scale program, and there are few sustained examples of this. For large-scale programs, formal local governance structures, such as elected local government councils, may need to be relied on. Stakeholders need to consider how to organize CHW program governance in such contexts.

• Engaging localities in the governance of large-scale CHW programs is difficult to achieve without substantial resources, adequate planning, and sustained attention to maintaining these structures. Stakeholders need to consider what resources are needed and how these can be made available. However, the development and support of community networks, linkages, partners, and coordination is necessary to enable a comprehensive community participation approach for better health.

Although many themes and issues have been explored, we have not included a whole range of topics that are of great importance, but must be addressed elsewhere. These include the following:

• The effectiveness of specific interventions and specific strategies for delivering them in the community.

• Current advances in the application of mHealth for CHW programs and the potential of mHealth for CHW programs in the future.

• The adaptation of CHW programs to urban environments.

CONCLUSIONS

• Our goal in this reference guide has been to offer reflection and, hopefully, some guidance for policymakers and program implementers as they begin to plan new CHW programs, scale up existing programs, and/or strengthen existing programs. In 1987, Berman, Gwatkin, and Burger asked if CHWs were a “head start or false start towards Health for All.” The scientific evidence and programmatic experience that have accumulated over the past three decades (only a small portion of which has been cited in this guide) have provided a new and stronger foundation for being certain that CHWs definitely move the world toward Health for All, and not just as a stop-gap measure, but for the foreseeable future. We hope that this reference guide will help to enlighten the way—even if just a bit—toward Health for All. We firmly believe that the challenges of CHW programming can be met and that CHWs will not continue to be seen as stop-gap measures in second-rate health programs, but rather as a permanent part of a highly functional and effective first-class health system.
References
