



Cesar Lopez / CARE

COMMUNITY HEALTH WORKER PROGRAMS: GAPS AND SOLUTIONS | *A Multi-Country Study*

This report presents the findings from an analysis conducted by CARE USA to assess the challenges facing community health workers (CHWs) in Bangladesh, Ethiopia, Guatemala, Nigeria, and the United States. It makes recommendations for CHW programming with a focus on policy solutions and programs implemented by governments.



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ACRONYMS

BRAC	Bangladesh Rural Advancement Committee
C3	Community Health Worker Core Consensus Project
CDC	Centres for Disease Control and Prevention
CHCP	Community Health Care Provider
CHEW	Community Health Extension Worker
CHIC	Community Health Impact Coalition
CHIPS	Community Health Influencer, Promoter, Services
CHMIS	Community Health Management System
CHO	Community Health Officer
CHW	Community Health Worker
CHW AIM	Community Health Worker Assessment and Improvement Matrix
COVID-19	Coronavirus Disease 2019
CSC	Community Score Card
eCHIS	Electronic Community Health Information System
EHR	Electronic Health Records
EPI	Expanded Program on Immunization
FLHW	Frontline Health Worker
FWA	Family Welfare Assistants
GDP	Gross Domestic Product
HA	Health Assistant
HEW	Health Extension Worker
JCHEW	Junior Community Health Extension Worker
LMIC	Low- and Middle-Income Country
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare
NGO	Non-Governmental Organization
PPE	Personal Protective Equipment
RENAP	National Registry of Persons
RHB	Regional Health Bureau
SDG	Sustainable Development Goal
SHE	Skilled Health Entrepreneur
SIAS	Sistema Integral de Atención en Salud
UH&FPO	Health and Family Planning Officer
UHC	Universal Health Coverage
UNICEF	United National Children’s Fund
USAID	United States Agency for International Development
WHO	World Health Organization



Carolina Rivas/ CARE

1.0 EXECUTIVE SUMMARY

To achieve universal health coverage (UHC) and be fully prepared for future pandemics, the world needs to get serious about investing in health systems and the health workforce. Health workforce demand will continue to grow and evolve as health systems are impacted by climate change, health and humanitarian emergencies, and demographic shifts.

Even before the coronavirus disease (COVID-19) pandemic, there was an estimated gap of 18 million health workers.ⁱ Although evidence shows that investment in the health work force, and particularly in frontline health workers (FLHWs) gives as much as a 10:1 return on investment,ⁱⁱ the world risks having a shortage of 10 million employed health workers by 2030.

FLHWs and community health workers (CHWs) have a critical role to play in filling this gap and contributing to resilient health systems that are better prepared for emergencies and leave no one behind. However, the majority of CHWs—70% of whom are women—are unpaid or underpaid, face limited career growth opportunities, are underrepresented in health leadership positions, and are not sufficiently integrated into formal health systems.

A CARE multi-country study analyzing government-supported CHW programs in Bangladesh, Ethiopia, Guatemala, Nigeria and the United States using the [CHW Assessment and Improvement Matrix \(AIM\)](#) found that insufficient funding of these programs affects remuneration and other incentives for CHWs but also leads to inadequate resources for training, data collection, and equipment and supplies. This negatively impacts CHWs' motivation, retention, and recognition and, in general, poses major barriers to achieving UHC and the Sustainable Development Goals (SDGs). It also puts the world at huge risk for the next pandemic.

The study also confirmed that even when there are strong CHW policies and strategies in place at the national level, these are often not effectively implemented at the local level. Many governments are off-track to meet global commitments on CHWs included in United Nations Political Declarations on Health, in particular the UHC and the Pandemic Preparedness, Prevention, and Response Declarations. Inclusion of CHWs in decision-making processes around programming, advocacy, and access to global and national mechanisms and tools to hold governments accountable is critical for patient and national health outcomes.

Most importantly, the study shows that health crisis preparedness and resilience of CHW programs is facilitated by ensuring an enabling environment in which CHWs feel recognized as a critical part of a country's health workforce and respected by the community, with equitable access to career advancement and leadership opportunities. This can be achieved through integration into the formal health system and recruiting and supporting CHWs from the

communities in which they will work. Integration into the health system can provide CHWs with more sustainable, administrative, and regulatory support, which greatly enhances the quality of CHW programs. This, alongside CHW recruitment from local communities, creates a built-in retention strategy and increases community trust necessary for improving access to services, including during health emergencies.

KEY FINDINGS:

Adequate funding for CHW programs, and particularly remuneration, is critical to all components of CHW programs.

Having inclusive community accountability mechanisms and tools in place, such as CARE's Community Score Card (CSC) is key to holding governments accountable for implementation of national policies and global commitments.

For the success, quality, and resilience of CHW programs, CHWs must be fully integrated in national health systems and infrastructure and supported holistically to unleash their full potential and meet the health challenges in front of us.



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2.0 INTRODUCTION

HEALTH WORKERS GAP

The World Health Organization (WHO) projects a gap of 10 million health workers by 2030, mainly in low- and middle-income countries (LMICs).ⁱⁱⁱ However, countries at all levels of socioeconomic development face varying degrees of difficulty in the employment, deployment, retention, training, and performance of their workforce. This poses a major barrier to achieving UHC and preventing and responding to future pandemics.

FLHWS AND CHWS CONTRIBUTION

CARE supports health workers working at the frontline throughout the world. FLHWs are essential to a strong health system and filling the gap but are a diverse group with differing roles and challenges. Many of them are CHWs, but they also include nurses, doctors, and pharmacists who provide services in community-based health facilities. They are the first point of contact for people needing basic curative and preventive care and health services, often in remote and rural areas. They are a bridge between providers at the health facility level and communities that may have difficulty in accessing them, including historically marginalized communities. Along with providing services, they also carry the responsibility of imparting health education, coordinating care between service providers, providing health products, improving patient self-efficacy, and reinforcing the right to health.

CHW definition:

WHO **defines** CHWs as “healthcare providers who live in the community they serve and receive lower levels of formal education and training than professional health care workers such as nurses and doctors.”

CHWs’ employment status, institutional affiliation, training, duties, and remuneration vary across countries and programs. They may be formally or informally employed by government health systems, non-governmental organizations (NGOs), or civil society organizations or comprise volunteers drawn from the served community.

GENDER DYNAMICS

Globally, 70% of health workers are women, including women “at the last mile” who are connected to the formal health system (such as midwives and CHWs) and those outside the formal health system (such as community volunteers, educators, and advocates). Women health workers face specific gender-related challenges:

- More than half of female FLHWs (at least 6 million women) are unpaid or underpaid. Those who are paid make 28% less than men on average.
- Female FLHWs often carry a double burden of responsibility in the workplace and unpaid domestic work at home.
- Female FLHWs often lack access to support for caregiving responsibilities, including affordable child-care or senior-care.
- Female FLHWs are particularly vulnerable to physical or sexual violence in the workplace and to discrimination.

INADEQUATE INVESTMENT

Investing in FLHWs, including CHWs, is a cost-effective solution to help fill the global gap in health workers and ensure sustainable and resilient health systems that leaves no one behind. Evidence shows that investment in the health workforce, and particularly in FLHWs, gives as much as a 10:1 return on investment.^{iv} Despite the strong case for investment, funding for this sector is fragmented and limited. The funding gap for at-scale CHW programs in sub-Saharan Africa alone has increased from an estimated US\$3.1 billion to US\$5.4 billion between 2017 and 2021.^v

A recent survey conducted by the Africa Centres for Disease Control and Prevention (CDC) on the community health workforce, programs, and systems in Africa shows that:


- Only 21% of the 42 African countries that participated in the survey had a CHW investment case, and only 26% have a budget line for payment of CHWs.
- 71% of countries are still using paper-based data collection systems, and 32% do not integrate CHW data in human resources for health information systems.
- Only 55% of countries have a costed strategic plan for CHWs.

FOCUS OF THIS REPORT

CARE USA carried out a country analysis of the role, challenges, and impact of government-supported^{vi} CHWs within the cadre of FLHWs in five selected countries:^{vii} Bangladesh, Ethiopia, Guatemala,^{viii} Nigeria, and the United States. These countries were selected to reflect a variety of CHW programs in a range of national contexts with differing economic resources. To orient this analysis, the CHW AIM framework^{ix} was used.


3.0 CHW STATUS IN THE SELECTED COUNTRIES

BANGLADESH




Bangladesh has a pluralistic health system with both public and private providers. In 1998, Bangladesh instituted an ambitious new public health intervention: a community clinic for every 6,000 people. More than 13,200 community clinics have been established throughout the country, providing critical health services in rural areas.^x Currently, the country has about 148,000 CHWs of whom 60,000 are paid by the government.^{xi} There are three types or cadres of CHWs in Bangladesh: i) Community Health Care Providers (CHCPs); ii) Family Welfare Assistants (FWAs) and iii) Health Assistants (HAs). There are also other cadres of FLHWs including those affiliated with the Bangladesh Rural Advancement Committee (BRAC) and those funded by non-governmental organizations (NGOs), such as the community skilled health service providers/health entrepreneurs (SHE model) supported by CARE and Gono Sathya. The Government's National Strategy for CHWs (2019-2030) focuses on supporting, engaging, and integrating CHWs into the national health system.^{xii}

ETHIOPIA



Ethiopia launched its Health Extension Workers (HEW) program in 2003. Currently, there are approximately 40,000 HEWs in Ethiopia supporting their communities. The program is primarily funded by international development partners and funding agencies. Roughly 85% of HEWs are deployed in rural health posts, which represent the service delivery point closest to the community in rural settings. On average, one health post serves 3,000 to 5,000 people. The country is currently implementing the second Health Sector Transformation plan which runs from 2020–2025. Efforts are underway to enhance training and supportive supervision for HEWS to improve quality and promote retention.

GUATEMALA



In 1996, Guatemala launched the Comprehensive Health Care System, or the Sistema Integral de Atención en Salud (SIAS). By 2003, this program trained and deployed over 27,000 CHWs, making a positive impact on the delivery of health services.^{xiii} However, the program was terminated by the government in 2013/2014 and has not been replaced by a similar mechanism to support the training and integration of CHWs within the health system. Traditional midwives, called comadronas, however, have continued supporting women, especially among indigenous groups, and assist with 70% of births in rural areas.^{xiv}

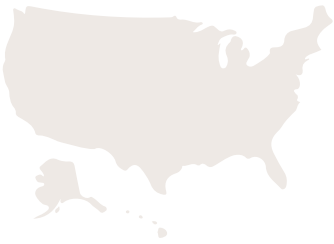
NIGERIA

The current system in Nigeria has three cadres of CHWs: i) Community Health Extension Workers (CHEWs); ii) Junior Community Health Extension Workers (JCHEWs); and iii) Community Health Influencer, Promoter, Services (CHIPS). In 2018, the CHIPS program was launched, and they have taken over more of the community-level duties with CHEWs and JCHEWs being placed in clinics. As of 2018, Nigeria has 116,454^{vi} total CHWs and the government is targeting 200,000^{vi} CHIPS workers to be trained under the program (10 to 20 CHIPS workers per ward). Traditionally, there has been weak financial support for CHW programs in Nigeria and as of 2021, individuals in Nigeria directed slightly over 76% of their out-of-pocket spending towards health care.^{xv} The new government, however, sees the CHW program as key to strengthen primary and community health care in the recently launched Nigeria's Health Sector Renewal. There are plans to retrain, recruit, regularize, standardize, upskill, and certify larger numbers of CHWs in the next three years.



UNITED STATES

The health system in the United States is a mix of private and public providers. In 2010, the U.S. Department of Labor created a standard occupational classification for CHWs and since then, key policies, including the Patient Protection and Affordable Care Act have brought a focus to the role of CHWs. CHWs implement programs and advocate for people who may have limited access to health and social services. Funding for CHW roles and services is a mix of sources including private funding, government grants, and Medicaid, which is an important avenue for more sustainable funding for CHW services. Approximately 50% of states allow for Medicaid reimbursement of CHWs and the trend is growing.^{xvi}



4.0 APPLICATION OF THE CHW AIM FRAMEWORK TO THE FIVE SELECTED COUNTRIES

The **CHW AIM framework** measures CHW program performance on ten components (see Table 2, below). For each component, countries/programs can receive a scoring level of Non-Functional, Partially Functional, Functional, and Highly Functional. There are specific criteria that a program must meet to reach each scoring level. **A perfect score using this framework is 40 and the maximum in any one of the components is four.** Moving from one scoring level to another is based on the specific criteria detailed in the framework. For example, under supervision, to move from a 3 to a 4, a supervisor must visit with CHWs monthly rather than quarterly, conduct home visits with CHWs to observe and deliver feedback, and supervise and assess the patient experience without CHWs present.

TABLE 2 | SUMMARY OF COUNTRY SCORES USING THE CHW AIM FRAMEWORK

Component	United States	Nigeria	Guatemala	Ethiopia	Bangladesh
Role and Recruitment	2	2	3	2	2
Training	3	3	3	2	2
Accreditation	3	3	3	2	2
Equipment and Supplies	4	2	1	2	2
Supervision	3	3	3	3	2
Incentives	3	3	1	3	2
Community Involvement	4	2	4	1	3
Opportunity for Advancement	3	2	3	3	1
Data	3	3	1	2	3
Linkages to the National Health System	3	3	2	3	3
Total	31	26	24	23	22

In this analysis, the United States had the highest total score of 31, almost 10 points greater than Bangladesh with a score of 22. Nigeria has the second highest total score, which is surprising considering the weak support for CHW programming in this country and the huge percentage of out-of-pocket spending on health care. CHW programs in Bangladesh, in contrast, are relatively well funded with sustainable government resources, but Bangladesh has the lowest total score. CHWs in Nigeria tend to receive consistent, regular payment from the government above the minimum wage (except for CHIPS) whereas in Bangladesh the salary made by CHWs is not sufficient for a minimum standard of living is a clear indication that adequate payment of CHWs is an important contributor to a higher overall score.

The following sections review the various CHW AIM framework components in each of the five countries.

4.1 CHW ROLES AND RECRUITMENT

How the community, CHW, and health system design and achieve clarity on the CHW role and from where the CHW is identified and selected.

Across the board, countries have challenges with CHW roles and recruitment. The only country to score above 2 under this component is Guatemala where recruitment is driven by the community and informed by the experience of generations of midwives. For the other countries included in this analysis, the scores are influenced by the multiple active cadres of CHWs, which leads to confusion among CHWs about their role, affects their credibility in communities, and is likely to impact other elements of programming; Bangladesh is a clear example of this phenomenon. Additional reasons for low scores include unrealistic recruitment requirements (USA) or access to training barriers (Nigeria).

In the **United States**, health programming is the responsibility of individual states, leading to differing definitions of CHWs and their roles across the country, although attempts are being made to define the role of CHWs nationally.^{xvii} The hiring of CHWs is fragmented across the country and dependent on the recruiting entity. CHWs can be hired through state and local governments, clinics and hospitals, care centers, insurance companies, and nursing care facilities.^{xviii} With this wide range of employers, there are not universally applicable recruitment policies. In addition, there are challenges related to recruitment from underserved and marginalized communities due to recruitment strategies that may overemphasize educational background, technological literacy, or previous health care experience.

In **Nigeria**, the role of CHWs is outlined in National Standing Orders, which are guidelines for CHW training and delivery of services to the community. In general, CHWs provide preventative, curative and referral care to communities with CHEWs and JCHEWS expected to spend 40% and 60% of their time in the communities, respectively. However, due to staffing shortages in public health facilities and limited funding available to support community outreach services, CHEWs and JCHEWS are increasingly supporting doctors, nurses, or midwives in health facilities. The CHIPS cadre of CHWS was initiated to fill the gap at the community level but has not taken off successfully.

In **Guatemala**, among indigenous populations, the role of comadronas is culturally defined by the Mayan worldview, and they are born into the role rather than recruited. From a young age, they begin their training with experienced comadronas. The National Policy on Comadronas of the Four Peoples of Guatemala (2015-2025) outlines the role of midwives supporting women during pregnancy at the community level and promoting and disseminating knowledge.^{xix}

In **Ethiopia**, national criteria for recruiting HEWs include age, educational level, and residence, and there is a preference for women in the role. In rural areas, HEWs are all women. HEWs in Ethiopia have defined roles and responsibilities and are recruited from their communities. Their roles include health promotion, disease prevention, and treatment of malaria, pneumonia, diarrhea, and malnutrition as well as the provision of immunizations and family planning. According to CARE Ethiopia, however, there is a low level of trust in HEWs and the services they provide among communities. This is the result of a range of factors, including perceived poor skills and poor quality of training.

In **Bangladesh**, the three cadres of CHWs are hired by the government from their communities but the community itself does not have a role in their selection.^{xx} CHCPs are required to have 12 years of schooling and be able to operate a computer, and they are comprised of half men and half women. They provide primary health care services at community clinics and do not do household visits. FWAs are required to be female and have at least 10 years of schooling. They provide family planning information and services, both at community clinics and when visiting households. HAs can be either male or female and require 10 years of schooling; in practice most HAs are male.^{xxi} They mostly provide services delivered through the Expanded Program on Immunization (EPI)^{xxii} both at community clinics and at EPI centers in the communities. Coordination among these cadres and ensuring synergies across their roles has been challenging as have the different supervisory channels for these three cadres.

4.2 TRAINING

How pre-service training is provided to CHWs to prepare for their role and ensure they have the necessary skills to provide safe and quality care; and how ongoing training is provided to reinforce initial training, teach CHWs new skills, and help ensure quality.

Training programs for CHWs vary by country and context. There may also be variations in opportunities for training or advancement depending on the funding and management of various CHW programs. More standardized training and certification processes may improve the overall quality of CHWs programs and provide CHWs with greater employment opportunities due to the transferability of their basic skill set across different settings.

In the **United States**, there is no standardized core training or curriculum for CHWs. At the state level, there have been curricula or training programs developed and approved by state health departments, officials, or entities within the public health domain. In general, CHW core competency training has minimum hour requirements, ranging from 60 to 120 hours (although Texas requires a minimum of 160 hours of training). Some states also include a requirement for CHWs to be an instructor or co-instructor for a minimum number of hours to test their knowledge.^{xxiii} The latest report by the CDC in 2016 shows 10 out of 25 states that were reviewed have policies supporting a standardized core curriculum.^{xxiv} While employer-dependent, many core trainings are free, either paid through grant funding or employers.

In **Nigeria**, different cadres of CHWs have different training experiences. Training centers use an accredited curriculum for JCHEWs and CHEWs which includes one year of on-the-job training with mentorship and two to three years of formal training. For CHIPS, there are two weeks of in-class training, one week in the field, and one week of review required. They then have mentoring support from CHEWs for three months. There is an established training infrastructure for CHEWs and JCHEWs that is guided by an accredited curriculum. A community health registration board and national board should, in principle, oversee the training schools, but implementation is uneven. For CHIPS, the training is provided by the government and includes a

mentorship program with CHEWs, but the requirements are significantly less than for the other cadres. Development partners have been critical for the investment in training of CHIPS, but sometimes funding restrictions have prevented the completion of the full two-week training cycle.

In **Guatemala**, new comadronas are trained by existing ones with knowledge exchanged via hands-on experience. The Ministry of Health (MoH) provides ongoing annual, formal, and mandatory training, but it can be overly technical for the comadronas and inaccessible, with trainers who do not speak local languages. This makes it challenging to grade with, on the one hand, ongoing training in the community with strong mentorship, and, on the other hand, training from government which is seen as more “formal” but criticized for its approach.

In **Ethiopia**, the training for HEWs defined in the government policy is robust. Those with a grade ten education are enrolled in twelve months of training that includes practical placements in health facilities. For those with a nursing diploma, training is limited to three months. Despite this, communities often believe that HEWs have low levels of skills and competency due to inadequate training that does not sufficiently meet the needs of HEWs in terms of their roles and responsibilities.

In **Bangladesh**, all CHWs participate in training, with CHCPs receiving twelve weeks of training, including six weeks of theoretical training and six weeks of practical work. The FWAs and HAs receive three weeks of training and additional in-service training, although this is not standard. In both cases, CHWs also receive on-the-job training after the theoretical work. While refresher training is mentioned in policy, feedback from the CARE Bangladesh country office reveals that refresher training does not happen regularly, usually only three to five years after the initial training. As with the CHW selection process in Bangladesh, the community does not have a role in training.

4.3 ACCREDITATION

How health knowledge and competencies are assessed and certified prior to practicing and recertified at regular intervals while practicing.

Similar to training programs, accreditation of CHWs varies by country and context, and more standardized certification processes may enhance quality of programs and career opportunities for CHWs.

In the **United States**, as of 2020, 19 of 50 States have implemented voluntary CHW certification programs. There has been a push for certification to build greater consistency in the profession and define a common set of responsibilities, skills, knowledge, and training. However, there is some pushback from CHWs who feel mandatory certification presents additional barriers to maintaining the diversity and localization of CHWs, including from existing CHWs who may need certification.



Kate Adelung / CARE

In **Guatemala**, comadronas are recognized and certified by the MoH, allowing them to register with the National Registry of Persons (RENAP) so that they can issue birth certificates for assisted deliveries. Paradoxically, they are not recognized as health workers who have the right to receive remuneration from the government for their services.

 In Guatemala, CHWs can issue birth certificates for assisted deliveries

In **Ethiopia**, the government certifies HEWs once they complete their training. There is testing post-training, but no regular testing after the initial certification. As described by CARE Ethiopia, the credibility challenges of HEWs among communities suggest that the certification does not carry much weight with local communities.

In **Bangladesh**, the national CHW policy document (2019-2030) clearly states that CHWs are certified after training completion. Certification can be issued by training institutes or by anyone designated by the Ministry of Health and Family Welfare (MoHFW). Based on feedback from the CARE Bangladesh team, there is very little testing of CHWs in Bangladesh to manage and monitor their skills and there is a gap between the policy and actual availability of certification for CHWs.

 **19 of 50 States** have implemented voluntary CHW certification programs.

In **Nigeria**, CHWs are recognized by the government and receive certificates for their training. Once training is complete, CHWs can become government employees. There is an annual renewal process for JCHEWs and CHEWs that requires completion of a course or short seminar, but no details on enforcement are available. While CHIPS receive a certificate after four weeks of training, they are not recognized by the government and can not be employed by the government.



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4.4 EQUIPMENT AND SUPPLIES

How the requisite equipment and supplies are made available to CHWs when needed to deliver expected services.

In the four LMICs included in this study, stockouts, supply chains, and general availability of equipment and supply availability—both to CHWs but also to community clinics more broadly—pose challenges. Running supply chains to underserved, marginalized, or rural communities is complex and expensive. The score for the USA is higher, which, in part, reflects the fact that CHWs in the USA do not generally deliver medications.

In the **United States**, there is little evidence to suggest that equipment and supplies pose a challenge for CHWs. Supplies and equipment are available through employers. Even during the COVID-19 pandemic, there were few reports of CHWs lacking personal protective equipment (PPE), especially as the pandemic escalated. The role of CHWs is also very different in the U.S. than it is in other countries, with a stronger focus on education, knowledge sharing, coaching, and social support to communities rather than on providing medical services.

In **Nigeria**, the government provides supplies to all CHWs through health facilities, although there have been challenges in maintaining supplies in both health centers and for the CHIPS, which continue to impact effective delivery of services. As the CHW programs are implemented at a state level, specific supply chain and funding challenges vary across states. CHIPS are expected to receive a standard set of supplies upon completion of

training but may not receive these supplies consistently as they begin their work in the communities.

In **Guatemala**, the MoH provides basic supplies to comadronas once or twice a year, but the amount of supplies often does not meet the needs of comadronas. In many cases, comadronas are forced to acquire the supplies they need for themselves, relying on their own income to make these purchases.

In **Ethiopia**, HEWs can obtain supplies from health posts and health centers. The health centers are also able to provide emergency backup supplies when necessary. HEWs should have access to supplies like condoms, oral rehydration salts, and contraceptives. However, according to feedback from CARE Ethiopia, HEWs usually do not have adequate commodities to do their work effectively, which impacts their credibility in the communities they serve.

In **Bangladesh**, the equipment and supplies that CHWs require are available through the local community clinics. Each CHW can track their supply and usage, which is then compiled into a wider registry. Restocking occurs at a national level with community clinics submitting requests. However, reviews of community clinics in Bangladesh noted that the level of service can be uneven and stock-outs are common.^{xxv}



Josh Estey / CARE

4.5 SUPERVISION

How supportive supervision is carried out such that regular skill development, problem solving, performance review, and data auditing are provided.

Scores for supervision were quite consistent in the five countries included in this study as supervisors seem to have basic tools for evaluating CHWs, there is regular engagement with CHWs, and government policies outline structures for supervision, although the supervision does not always meet the expectations of CHWs.

In the **United States**, a CDC review^{xxvi} found that CHWs practice under supervision and the supervision delivers better health outcomes—including disease self-management, chronic disease-related health outcomes, and social outcomes—in community settings. A 2016 CDC report on state-level CHW laws noted that eight of twenty-five states included in the review have some legal provision authorizing health care professionals to supervise some or all health delivery services provided by CHWs.^{xxvii}

In **Nigeria**, the system for supervision is often complicated by the dynamic between state and national level governments. Even though the work of CHEWs and JCEWs work is overseen by the state and they are supervised by higher-level health care professionals such as medical officers and nurses in the clinics with which they are affiliated, the national government funds the CHW program and national government advisors visit states to review the work of JCEWS and CHEWS and conduct capacity-building activities. This gives the national government the most oversight and leads to minimal ability to hold states accountable for quality supervision. States have been pushing for more ownership at the state level, but this has not been very successful. The day-to-day supervision of CHIPS is done by JCEWs or CHEWS, but this supervision is very limited, due to CHIPS working outside of the health facilities and the program being tied to the national government.

In **Guatemala**, comadronas are regulated through the MoH but there is no official supervisory system in place. Despite not being officially supervised, most of the comadronas abide by the regulations imposed on them by the MoH, such as attending annual training.

Within communities, comadronas are trained and mentored by existing comadronas who are also de facto supervisors and who build upon intergenerational knowledge and experience that is not acknowledged in the formal sector.

In **Ethiopia**, the MoH has a supervisory framework that includes federal, regional, and district health offices. HEWs are supervised by Health Centers, which can oversee up to five Health Posts. The Regional Health Bureau (RHB) is responsible for supervising the Health Centers and makes biannual supervisory visits, while Health Centers make quarterly supervisory visits.^{xxviii} The RHB uses different tools and methods for supervisory visits, including peer review and performance assessment tools.^{xxix}

The **Bangladesh** CHW policy document (2019-2030) notes the need for supportive supervision of CHWs, which includes group supervision, peer supervision, and community supervision. The document does not detail a hierarchy or clear reporting pathway for CHWs or how supervision is managed. FWAs are supervised by Family Planning Inspectors (male) who are responsible for three to six FWAs.^{xxx} The HAs are supervised by Assistant Health Inspectors who oversee three HAs, and CHCPs are supervised by a subdistrict-level Health and Family Planning Officer.

4.6 INCENTIVES

How a balanced incentive package reflecting job expectations, including financial compensation in the form of a salary and non-financial incentives, is provided.

Limited funding for CHW programs and the fact that CHWs are often not recognized as full-time health workers results in CHWs often being unpaid, underpaid, not paid regularly, or given amounts that are not commensurate with their workload. Financial resources for non-financial incentives, equipment and supplies, training, and data collection are often also lacking.

In the **United States**, the median annual wage for CHWs was estimated in 2022 at USD 46,190 with an hourly wage of USD 22.1^{xxxvi}, compared to the average annual wage of USD 53,132 for all other occupations in 2022.^{xxxvii} The National Association of CHWs conducted a national survey in 2021 and found that over three quarters of CHWs strongly believed that incremental salary increases should be incorporated into a CHW career path.^{xxxviii} High turnover in the sector is largely attributed to low pay, with evidence showing that even moderately higher wages would have a significant impact on satisfaction and retention.^{xxxix}

In **Nigeria**, there is range of CHW income levels. HEWs and JCHEWs receive a salary ranging from N25,000–N130,000 (USD 16– 83.28) per month, depending on the level of education, seniority and experience.^{xxxv} The minimum wage for federal workers was N30,000 (USD 19.23) in 2023. The salary is paid for by the government and, in most cases, is a consistent, regular payment. According to CARE Nigeria, CHIPS CHWs get paid N6,500 (USD 4.16) per month but there have been campaigns to increase their pay to N10,000 (USD 6.41) or even N30,000 to align with the minimum wage. CHIPs are not formally recognized as “workers” and their pay is categorized by the government as a stipend, which does not require alignment with minimum wage laws. The government is working on an economic empowerment model to support CHIPS with additional training and funding to start their own businesses.

In **Guatemala**, following years of advocacy by the National Alliance of Indigenous Women’s Organizations for Reproductive Health, Nutrition, and Education, the Guatemalan Congress approved a law in March 2022 that

stipulates an annual payment of Q3,000 (USD 380) to each of the comadronas registered with the MoH in the country.^{xxxvi} This sum of Q3,000 is well below the income needed to stay above the poverty line and meet the minimum wage in Guatemala, which is Q3384.59 in 2024. Also, while the comadronas did receive this annual payment in 2022, they did not receive it in 2023 and it is still unclear if they will receive it in 2024. As comadronas are not recognized as health workers or government employees, the minimum wage laws can be circumvented. This means that most comadronas are paid by community members for the services they provide, but the amounts they are paid are very low and they give their services for free if the patient does not have sufficient economic means.

In **Ethiopia**, HEWs are remunerated depending on their level of training and location, but most pay falls within a set range. According to CARE Ethiopia, the starting pay for HEWs is typically ETB 4,000 (USD 72 USD) and HEWs with Level IV training can earn around ETB 9,000 (USD 163) per month, which is above the minimum wage of 420 ETB (USD 7.40) per month in 2024. HEWs also receive annual leave as part of their pay. The government oversees payment of HEWs and does so consistently. While the workload and expectations are high for HEWs, the starting pay is above minimum wage expectations and significantly above the poverty line.

In **Bangladesh**, the three categories of CHWs are paid salaries for their work, with FWAs earning BDT 14,490–34,909 (USD 132–318) per month, HAs earning BDT 14,820–35,897 (USD 135–327) per month, and CHCPs earning BDT 16,466–39,740 (USD 150–362) per month.^{xxxvii} These salaries do not include any additional benefits. The bottom of the pay range for CHWs in Bangladesh is above the Bangladesh minimum monthly wage of BDT 12,500 (USD 113), although according to feedback from CARE Bangladesh, the salary made by most CHWs is not sufficient for a minimum standard of living and the level of pay has an impact on the motivation and retention of CHWs in the country.

4.7 COMMUNITY INVOLVEMENT

How a community supports the creation and maintenance of the CHW program.

Community participation is essential for well-performing CHW programs. Evidence from CARE health projects implemented during the COVID-19 pandemic^{xxxviii} suggests that CHW recruitment from and by communities and deep roots in pre-existing community structures greatly facilitate community support and trust-building. As every country and community context is different, there is no one-size-fits-all approach for community involvement. However, in all cases, trust and respect between CHWs and communities help bridge the gap between communities and a health system that can be difficult to access or navigate.

In the **United States**, CHWs are seen as trusted and essential health workers in marginalized and underserved communities. The deep community ties of CHWs both stem from and help to mitigate the effects of traditional exclusion of these groups, especially communities of color, from formal health care systems. CHWs are seen as advocates for the communities they serve and for social justice more broadly.

In **Nigeria**, the lower score in this category is driven by the fact that the traditional cadres of CHWs spend most of their time in clinics while CHIPS workers—who spend more time in communities—are not considered formal workers by the government and thus fall short in how they are supported, affecting community respect. Lower community involvement in CHW programs is also the result of the CHIPS program not being implemented countrywide. Even where the CHIPS program is active, there does not seem to be a high level of community support for CHWs or engagement with them beyond receiving services.

In **Guatemala**, comadronas come from the, primarily rural, communities that they serve and are embedded in the fabric of these communities. They are well respected and are considered leaders and people of authority. They support indigenous communities who are often discriminated against in the formal health system; this has fostered deep levels of trust between those communities and the comadronas.

In **Ethiopia**, communities often express a lack of trust and respect in HEWs. This is due in part to the quality of services HEWs provide and also to the difficulty HEWs have in covering large numbers of households spread across diffuse geographic areas. In an effort to increase trust in HEWs, the Ethiopian government has included CARE's CSC in their policy documents. CARE created this pioneering accountability tool for communities to assess, plan, monitor, and evaluate health services and it can increase community ownership of CHW programs.^{xxxix}

In **Bangladesh**, the three cadres of CHWs are recruited from communities and, while often based in community clinics, they are known, supported, and valued by the local communities. A review of three maternal health programs in Bangladesh, for example, noted that community groups formed to support the CHWs in ensuring safe pregnancy and delivery care for women in their community. Government policy also emphasizes the need for community involvement to ensure greater local governance and community empowerment in the health sector. minimum monthly wage of BDT 12,500 (USD 113), although according to feedback from CARE Bangladesh, the salary made by most CHWs is not sufficient for a minimum standard of living and the level of pay has an impact on the motivation and retention of CHWs in the country.



Carolina Rivas / CARE

4.8 OPPORTUNITIES FOR ADVANCEMENT

How CHWs are provided career pathways.

While poor pay is a significant contributor to high turnover with CHWs, the lack of opportunities for advancement is also a key issue. Many CHWs are from the same marginalized or low-income communities they serve and are often looking for opportunities to be more financially and socially secure. Offering professional advancement opportunities, including the possibility of becoming a dedicated CHW supervisor, is critical.

In the **United States**, career pathways for CHWs are not clearly defined. The high turnover in the sector has led employers to consider how to better retain their workers. This includes looking at systems to better support and promote workers. For example, tiered CHW systems or pathways to become supervisors can give CHWs a sense of opportunity for the future.

In **Nigeria**, there are opportunities for JCHEWs to move up to become CHEWs based on their experience and performance. CHEWs can obtain the position of Community Health Officer (CHO) but there is no clear path to becoming a nurse, midwife, or doctor. There is also no formal route for CHIPS to becoming JCHEWs due to the marked differences in training curriculums. Additionally, there are gender structures in the country that impact roles for women and opportunities for advancement. The government policy for CHIPS, for example, stipulates that male supervisors are preferred.

In **Guatemala**, there is no formal career hierarchy for comadronas. Older comadronas in communities are more respected and listened to, which, in principle, acts locally as an incentive for younger comadronas to continue learning and to later succeed their elders and continue serving their communities.

In **Ethiopia**, there are levels of training for HEWs that offer opportunities to upgrade their skills. Approximately 25% of HEWs have undertaken these opportunities for upskilling. The opportunities are very dependent on the performance of individual HEWs and from where they are recruited. Many HEWs are recruited with little experience and limited educational backgrounds, which impacts their ability to advance in their careers.



In Ethiopia, approximately 25% of HEWs have undertaken opportunities for upskilling.

In **Bangladesh**, there are no clear policies for career advancement for CHWs. As in Nigeria, gender plays a role in blocking the ability for FWAs (who are all women) to advance their careers, as their supervisors are all male. The constraints on women's ability to become supervisors and a lack of ongoing training for CHWs make it a challenging context for career advancement of CHWs.



4.9 DATA

How community-level data flow to the health system and back to the community and how they are used for quality improvement.

It is critical to invest in comprehensive digital data systems as well as in training on data literacy to equip CHWs to document their visits consistently in a standardized format and to report data to public sector monitoring and evaluation (M&E). Because of CHWs' strong connections with communities, community data collection has the potential to be more accurate and extensive than data collected by non-CHWs.

In the **United States**, there is no consistent policy on how CHWs collect and share data about their patients. Because the health care system is very fragmented, different organizations have different policies. The COVID-19 pandemic highlighted some of the challenges with existing systems for documenting and sharing data, which became more essential than ever during a pandemic. In these situations, emergency public health directives are used to require health care providers to submit data, but the lack of coordination and technical infrastructure and the expense of this process results in suboptimal results and an inability to properly respond to crises. While Electronic Health Records (EHR) are not perfect, they present an opportunity to aggregate data for better analysis. However, there is no consistent policy on how CHWs collect and share data from EHRs.^{xiv} EHRs can be time consuming to complete and access and require a level of CHW technical literacy regarding computer equipment and software. The public has access to their EHRs, but underserved and marginalized communities may not have the technology or literacy to access their records. They may also distrust or question the security of accessing their EHRs.

In **Nigeria**, JCHEWs and CHEWs collect data from patients and households including health maps, patient history, and clinic referrals. This data is summarized at health clinics and then shared with local governments. Templates are used to collect data, but most of the collection is analog. A community health platform was developed for CHIPS to guide their collection of data at the community level. The collected data is shared with other levels of government, but state compliance is needed to ensure

quality national data. A digital tool for data collection as part of the Community Health Management System (CHMIS) is currently being tested in seven states. There are also several digital data collection tools currently being used by CHWs, but these tools are typically designed as part of individual projects or by private sector partners with minimal or no linkages to the national system. This means that these data are usually not part of state and national governments' analysis to inform decision-making.

In **Guatemala**, while comadronas do need to register births in the National Registry of the People and must sign the certificate for it to be valid, they do not collect data on their patients or fill out any forms to report births to the government. However, the MoH usually keeps track of pregnant women in the communities, and they monitor the evolution of pregnancies.

In **Ethiopia**, there is a reporting structure in place from Health Posts to Health Centers that runs through a National Health Management Information System. However, there is no mechanism for data flow from the Health Posts/HEWs to the community. Currently, most data are collected on paper, but a digital tool called the Electronic Community Health Information System (eCHIS) is being tested through a U.S. Agency for International Development (USAID) funded program.^{xiv}

In **Bangladesh**, the government policy introduces e-record keeping, e-reporting, and digitization. However, to date, most health data is still in paper registers. All three cadres of CHWs collect and submit data to community clinics who then file reports to government health committees at the sub-district level. There is a commitment to gather data within a central collection point, namely community clinics, and to collate that data for higher levels of government. Although the government has been considering digitization for some time, plans for digitization have fallen behind since, as noted by the CARE Bangladesh team, digitization activities have yet to be implemented in a comprehensive way.

4.10 LINKAGES TO THE NATIONAL HEALTH SYSTEM

The extent to which the MoH has policies in place that integrate and include CHWs in health system planning and budgeting and provides logistical support to sustain CHW programs at district, regional and national levels.

In many countries, governments are not the only ones supporting CHW activities. In all five study countries, NGOs (both local and international) run programs that recruit, train, and support CHWs and can differ from the government-run programs in terms of role definition, compensation, and other elements. Multiple, non-integrated CHW programs can contribute to a fragmented health system that is confusing for CHWs, communities, and government and NGO actors alike. This has led to the recognition that, across the board, there is a need for much stronger governmental policy alignment, without jeopardizing the relationship between CHWs and communities that is essential for trust and buy-in of CHW programs.

In the **United States**, four models for integrating CHWs into the health system have been identified:^{xlv}

- 1. Community-clinical linkages:** These involve partnerships between community-based organizations and health centers. CHWs may get referrals from health centers for patients who require support for social needs, health coaching, or advocacy, or they may conduct outreach to communities to connect them to health services and support.
- 2. Employment within health care:** In these situations, CHWs are employed by health care institutions, hospitals, or other institutions within the health system. The CHWs can act as a liaison between the formal system and communities.
- 3. Integration with payers:** After passage of the Affordable Care Act, there are opportunities to integrate CHWs into health teams through Medicaid. This includes employing CHWs directly or providing funding for others to directly hire and include CHWs in primary care and hospital-based teams.

4. Coordination by a public health department: Health departments themselves provide CHW services to patients from multiple care providers, both private and public. This model has been used for a long time, especially to respond to public health crises.

Two challenges have emerged from integration: First, as CHWs bridge different organizations and communities, the integration can get complicated where they are paid by one entity, employed by another, and working with yet another. This reflects the fragmentation of the U.S. health care system and reveals the ways in which CHWs must find ways to fit and be resourced within this system. This also can impact long-term goals since funding may be short term and comes from different sources. Second, being integrated into formal systems can impact CHWs' credibility or ability to be advocates for the communities they serve.^{xlvii}

In **Nigeria**, national and state-level governments have earmarked financial support for CHWs within their health budgets, but implementation of programming is uneven. Since states hold the responsibility for health, they can decide whether or not to implement programs from the national government. To that end, not all states have implemented the CHIPS program. Various levels of government need to align to ensure CHW programs are integrated consistently.



Josh Estey / CARE

In **Guatemala**, the efforts by the government to engage comadronas by asking them to register and receive training and certifications seem to be more about control than actual integration of the comadronas into the health system. Comadronas are discriminated against and face language barriers, which dissuade them from engaging with the formal health sector. Most of their work is done within communities themselves, from recruitment to supervision, and there are no formal referral or data collection processes for comadronas.

In **Bangladesh**, there is a clear government support and policy for integrating CHWs into the health system including recognition of the role they play within the wider health system. CHWs are integrated into community clinics with clear referral pathways. The government's health budget also takes CHWs into consideration, but funding is insufficient despite additional donor funding. This hinders

implementation of the policy and impacts adequate compensation and training for CHWs and the availability of equipment and supplies.

In **Ethiopia**, there is a clear policy in place to integrate HEWs into the health system. HEWs are supposed to be a bridge between their local communities and the formal health services and are required to dedicate at least 75% of their time to community outreach activities.^{xlvii} However, recent reports indicate that HEWs spend most of their time at health facilities and not in the community.^{xlix}



In Ethiopia, HEWs are required to dedicate at least **75% of their time to community outreach.**



Cesar Lopez / CARE

5.0 CONCLUSIONS

When health systems are weak with health worker gaps and insufficient funding, CHW programs are often created as “add-ons” and not adequately integrated into the broader health system.^l The lack of management and coordination of CHW programs leads to confusion about the roles of CHWs, diminished trust in their contributions, and hampers a broader enabling environment for CHWs that is critical to resilience, sustainability, and success of CHW programs. Inadequate remuneration of CHWs causes dropout, which, in turn, leads to even bigger health worker gaps and inadequate health service coverage.

FINANCING CHALLENGES

Financing remains the **largest systemic barrier** to scaling and sustaining quality community health services.

For example, sub-Saharan Africa faces a \$5.4 billion annual financing gap for CHWs.^{li} These countries continue to rely on a mix of government budgets, donor funding, and, in some cases, funding from communities themselves to pay for their CHW programs. In sub-Saharan Africa about 60% of funding comes from donors while 40% is from governments.^{lii} Where communities themselves pay CHWs (for example, in Guatemala), this is likely to negatively impact people as many of these communities have little surplus income to contribute for health services.^{liii} In Nigeria, people directed more than 74% of out-of-pocket spending towards health care in 2023.^{liiv}

To facilitate sustainability and better integration of CHW programs into national health systems, there is an urgent need for governments to increase domestic budgets for health through, for example, tax reform, insurance schemes, and partnerships with the private sector. According to the WHO World Health Report 2010, governments must spend the equivalent of at least 5% of their gross domestic product (GDP) on health to achieve UHC.^{liv} According to the WHO's three-year average health expenditure data (2019-2021), 132 governments had not reached this target.^{lvii} Of the five countries included in this study, only the USA (17.7%) and Guatemala (5.82%) spend more than 5% of GDP on health, while Bangladesh (2.6%), Ethiopia (3.4%), and Nigeria (3.2%) fall well below this target.^{lvii}

At the same time, a recent study estimated that only 2.5% of total health-related development assistance was accounted to CHW programs between 2007 and 2017, and most of this funding was for vertical disease-control programs.^{lviii} Donor funding must also be more fully aligned with national and costed CHW plans and strategies to help fill gaps, avoid parallel systems, and increase sustainability of CHW programming. Finally, gender-responsive health budgeting, which addresses the unique needs of women and the gender gap in the distribution of resources, is critical. This is especially true for CHWs since the vast majority are women and most of them are underpaid or unpaid.

IMPLEMENTATION CHALLENGES

Any national policy, budget priority, or global commitment on CHWs, no matter how strong, will only lead to change if it is effectively implemented. CHW programs in the five study countries face challenges related to implementation issues even when policies and funding commitments are in place. For effective implementation to occur, government officials, CHWs, and community members need to come to the table to identify gaps in implementation and service delivery.

A variety of CARE programs demonstrate that investing in locally led accountability, community networks, and women's leadership skills and empowerment is critical to amplify community voices to hold governments accountable.

The CSC is a social accountability approach developed by CARE to improve government accountability to communities regarding the M&E of service delivery and policy implementation. The Government of Ethiopia has adopted the CSC tool into its social accountability program and CSC-related improvements in service provider (mainly government) effectiveness, accountability, and responsiveness.^{lix} Other community accountability mechanisms include initiatives such as the “Ombudsperson” model in Uganda, launched during the COVID-19 pandemic, which enabled women to band together and feel empowered to make changes to the health system as part of local Community Councils.^{lix}

INTEGRATION CHALLENGES

Based on the findings of this study and other sources^{lxi}, it is clear that CHW program integration into the national health system and standardized and sustainable support, regulation, and financing through the MoH are key enablers of improved program performance and acceptability and credibility of CHW programs in communities.

Integrating CHWs by systematically selecting, training, and supporting community members to provide elements of primary health care to their own communities not only extends health benefits and service delivery to a larger number of people, including those marginalized or living in remote areas, but **also creates local economic opportunities if adequately remunerated, especially for women.**

One of the reasons for these potential effects is that the health sector employs women who live in areas where they might not have many other employment opportunities.

As CHWs work at the interface between communities and the public health system, they are accountable both to the communities they serve and to government, particularly if they are more integrated into the national health system. ^{lxii} This means that CHWs often experience challenging dynamics in terms of managing differing expectations from government and communities in terms of professionalization of skills, training, and recruitment requirements on the one hand and staying deeply embedded in the community on the other hand. In fact, professionalization may lead to overly rigid requirements, which can pose barriers for certain cadres of CHWs to apply, get certified, or access training. Involving communities with the recruitment, training, and performance processes led by government has proven to make these processes more CHW-friendly and increases acceptability of CHWs by the community.^{lxiii}



6.0 RECOMMENDATIONS TO GOVERNMENTS

More funding for health systems in general and for CHW programs in particular, especially for compensation, is necessary but insufficient. Governments must ensure a broader enabling environment for CHWs to unleash their full potential and meet current health challenges. This includes:

Investing in CHWs' empowerment and skills beyond simple health service delivery. In addition to technical skill building and training, female CHWs should be supported holistically to develop leadership and advocacy skills, strong support networks, and broader areas of expertise such as financial literacy and entrepreneurship. This not only results in stronger, more resilient, and sustainable CHW programs but will also empower these individuals beyond their roles as CHWs to improve their own lives and those of their families and communities.

Facilitating strong community participation not just as recipients of care, but also as designers, implementers, and financiers of CHW programs. Community involvement in CHW recruitment processes, role definition, training

curriculum development, and implementation leads to increased understanding of and trust in CHWs' activities among communities, increases access to services, and makes CHW programs more responsive to the specific needs of the community.

Supporting the development and use of community-led accountability mechanisms and tools to enable communities to monitor effective implementation of national health policies at the local level. Mechanisms such as the CSC and Community Councils help strengthen health systems accountability, ensure more effective policy implementation, allow for addressing key barriers to health services, and elevate community-driven solutions.



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