On the Front Line

Investing in community health workers to improve health and nutrition
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“Across the globe, community health workers serve as important sources of trusted knowledge in their communities, as providers of integrated primary health care and nutrition services, and as advocates for local priorities and needs. In many contexts, they are the only health-care providers for vulnerable populations.

In countries where these workers are fully integrated into the primary health-care system, they are at the vanguard of accelerating progress on universal health care and health system strengthening. If we could increase support to these workers, helping to extend their reach in vulnerable communities, the impact would be incredible.”

Catherine Russell, UNICEF Executive Director
Launch of the Community Health Delivery Partnership
October 2023
Key messages

Community-based care for health and nutrition is essential to strengthening a country’s health system and achieving equitable outcomes for children.

It is also crucial for achieving global health security through strengthening emergency preparedness and response. However, community-based health care is hugely underfunded and too reliant on external funding, preventing community health and nutrition programmes from realizing their full potential. At a 10:1 return on investment, community health systems and the workers who support them are some of the ‘best buys’ in global health care. The targeting of investment and the design and implementation of programmes are key to their effectiveness in improving health and nutrition outcomes.

Gender discriminatory policies and practices in many countries restrict the financing of community health workers, who are mostly women.

As a result, most front-line workers are poorly paid – if they are paid at all – and at risk of exploitation and abuse. Many are also overworked, which reduces the quality of care they can provide. Gender discrimination must be addressed so that community health workers’ pay, conditions and career opportunities can reflect their important role in improving health and nutrition outcomes in their country and supporting strong community health systems.

Funding for community-based health and nutrition programmes is often fragmented and poorly coordinated.

Resources may not be used in ways that achieve the best outcomes for children’s health and nutrition. In addition, donors’ priorities are often not aligned with countries’ national health and nutrition strategies, and often they will fund specific projects, rather than contribute to strengthening community-based health systems, reducing the impact of the funding.
Many community health programmes remain stand-alone initiatives.

If they are not sufficiently integrated into the primary health-care system, their overall impact is reduced because they cannot benefit from a multisectoral approach. Embedding community health programmes in the primary health-care system benefits both the programme and the health system.

Many programmes fail to involve the communities they serve in their design and implementation.

This is a missed opportunity to learn about the community’s needs and challenges, and to create a sense of ownership. Community health workers know their communities well and can provide a vital link between them and programme managers.

Strong political will across governments is key to the success of community health and nutrition programmes.

Other factors shown to positively influence their success are building successful partnerships; promoting strong governance systems; creating effective financial planning and management; attracting and managing donor support; outsourcing the delivery of services; and gathering data to inform the targeting of services and monitor the programme’s performance.
Community health workers are at the heart of primary health care

Brazil, 2023

Community Health Agent Lindalva de Freitas waves goodbye to Paulo Henrique, 6, after visiting him and his family at their home in Manaus on Puraquequara Lake.

© UNICEF/U.S. CDC/UN0822153/Enio Hiller
These front-line workers serve communities across the world, but their work is especially crucial and life-saving in countries with the highest burdens of child and maternal mortality and malnutrition in children.

Time is running out to meet the targets of the Sustainable Development Goals (SDGs) for the world’s children. Who can we turn to for help? Who can reach children in the most isolated and deprived communities? Who can reassure parents that immunization will save their child’s life? Who can help pregnant women and new mothers get the nutrition they need to raise healthy children? Who can help strengthen countries’ health systems, so that they will be better prepared to face the next pandemic or the aftermath of the next natural disaster?

The answer to all these questions is community health workers. They are front-line health-care workers – mostly women – who are trained to deliver vital health and nutrition services to women and children in their communities, such as vaccination and screening children for severe malnutrition (wasting). As members of the community, they are trusted, and they understand the community’s values and customs and the challenges it faces.

Community health workers are at the heart of community-based primary health care – the cornerstone of strong, sustainable and equitable health systems. They act as a bridge between vulnerable children and their families and the services they need. These front-line workers serve communities across the world, but their work is especially crucial and life-saving in countries with the highest burdens of child and maternal mortality and malnutrition in children. In these countries, they may be the only channel to deliver services to some of the most marginalized and hard-to-reach communities with children who have never received a vaccine (zero-dose children), counselling women on positive care practices and screening children for wasting.

Furthermore, community health workers are also the guardians of global health security, playing a critical role in detecting and reporting outbreaks of emerging diseases, in preparing for and responding to pandemics and in responding to natural disasters and crises. They are also the front-line workers who support communities through the ongoing health, nutrition and economic consequences of crises.
And yet, as women, community health workers are often unpaid, inadequately equipped, supported or protected, and largely unrecognized for their vital work. The health care they deliver is cost-effective, but it is hugely underfunded, partly because of a lack of political support. The existing funding is often poorly coordinated and over-reliant on external funding, which can be intermittent, short term and often focused on disease-specific programmes.

External funding does not usually contribute to strengthening the country’s primary health-care system, and the programmes it supports may overlap with primary health-care services. Furthermore, community health programmes are often not well integrated into the primary health-care system, and too often the communities they serve are not properly involved in their design and implementation.

The result of this failure to invest properly in well-designed, integrated, sustainable community-based health care is that children’s health, nutrition and development suffer, and they fail to achieve their potential.

The COVID-19 pandemic, followed by a global economic downturn and subsequent pressures on primary health care, have highlighted the results of this failure to invest. But these challenges also provide an outstanding opportunity to capitalize on the political focus and call on governments and partners to renew their commitment to investing in community health workers. The evidence for their effectiveness and the return on investment is compelling.

Our message remains clear – there is nothing for us, without us, and that it will take the strengthening of [the] CHW network to deliver primary health care, universal health, guarantee global health security and save lives.”

Margaret Odera
Community health worker, Mathare North, Nairobi, Kenya

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**BOX 1**

Why isn’t community health care integrated with primary health-care systems?

- Particularly in lower-income countries, the role of community health workers is not well defined and often not legally or administratively recognized as part of the health-care system.

- Social and cultural norms may mean that women are not recognized or valued for the work they do. It is often assumed that they can fulfill the role of a community health worker on top of their domestic work and caring responsibilities.

- The requirements for education and experience vary, and the level of training and support for community health workers is often limited.

While there is a strong case for professionalizing the role of community health workers, this needs to be balanced with avoiding over-institutionalizing them, so that they do not lose their autonomy and close links with the communities they serve.
The case for community health workers

Health worker Josephine (second from left) prepares to vaccinate a group of children in Dodoma against polio.

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2.1. The global context

The pandemic reminded us of the crucial role of front-line health workers. They were at the forefront of the emergency response – not only putting themselves at risk to save lives but also maintaining essential health services in very difficult circumstances throughout the pandemic. This highlighted how the cost of supporting and strengthening health-care systems is relatively small compared with the enormous cost of a global health crisis. The diversion of resources in responding to the pandemic also significantly contributed to a sharp decline in routine child immunization services and essential nutrition supplies. Between 2019 and 2021, the number of zero-dose children rose from 13 million to 18 million globally, an increase of more than one third. The number of under-vaccinated children also increased by 6 million, to 25 million. Furthermore, some countries have seen a 40 per cent or more increase in child wasting since 2016, particularly in areas affected by conflict, the climate crisis and the lingering economic effects of the COVID-19 pandemic.

As countries gradually emerged from the pandemic in 2022, they were hit by a global economic and food and nutrition security crisis. Again, it was community health systems that responded by delivering emergency supplies and treatment in the worst affected countries. And it is those health systems and the front-line workers who support them that will be increasingly critical as we face conflicts, food, and nutrition insecurity and climate change.

The impacts of climate change alone are expected to contribute to 250,000 additional deaths each year between 2030 and 2050 as a result of malnutrition, heat stress and the increased prevalence of diseases such as malaria and diarrhoea. The adverse effects of climate change on health are worse in countries with weak health infrastructures, highlighting the importance of strengthening health systems.
Without urgent action to scale up and support community health systems, UNICEF estimates that at least 30 million women and children will die by 2030, more than half of them in sub-Saharan Africa. Millions more will fail to achieve their full potential and realize their rights.

Supporting and strengthening community health systems that are resilient to climate shocks and economic pressures require a significant change in the ways we invest in health systems. The route to achieving universal health coverage – and the key to improving health outcomes – is through strong community-based primary health-care systems led by professional community health workers who are paid fairly and protected and supported in their work.

A health worker records the weight of a child during a health survey in Ndow Kota village, 50 kilometres from Bossangoa. © UNICEF/UNI453476/LeMoyne

Central African Republic, 2023
2.2. The case for investing in community health workers

The evidence for the effectiveness of community-based primary health care is extensive, and it has led to some remarkable improvements in health outcomes. For example:

- The Jamkhed comprehensive rural health project in Maharashtra, India, pioneered a model of primary health care with local women that combined a community-based approach to health care with socio-economic development. The project almost eliminated undernutrition in children, and improved child survival and maternal health. In some of the poorest communities in India almost all women received prenatal health care, reducing the maternal death rate to half that for the country as a whole.

- The community health worker programme in Liberia, launched in 2016 following the Ebola outbreak, initially focused on rural areas where people were underserved. A pilot programme, run by a partner in Maryland County with the aim of reaching more people and improving the quality of care, proved to be so successful that the government incorporated its approach into a 10-year community health worker strategic policy. The government has also committed US$1.8 million to the community health worker programme. Now over 5,300 community health workers, supervisors and nurses provide patients with accessible services and support the country’s health service.

Community health care is not only equitable, it is also ‘pro-equitable’, providing higher levels of coverage to disadvantaged communities than to better-off communities.

Community health workers are crucial in strengthening national primary health-care systems. They have a vital role to play in meeting the global shortage of health workers because of their effectiveness (as long as they are properly trained and supported), their speed of deployment (because they can be trained quickly) and their relatively low cost (less than one fifth of the cost of a nurse, for example). When supported by other health professionals, community health workers can help to accelerate improvements in the health of underserved populations by providing interventions that save children’s lives and improve their life chances.

“Ultimately, primary health care is an investment in a healthier, safer, fairer and more sustainable future.”

Tedros Adhanom Ghebreyesus
Director-General, World Health Organization

Bulletin of the World Health Organization, 2020

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Strong community health programmes have broader benefits too, such as surveillance for emerging disease outbreaks. When such outbreaks occur, community health workers are already on the ground to help the community respond. They are also well placed to undertake home-based screening for non-communicable diseases and disorders, such as hypertension and diabetes, as these become an increasing burden. Furthermore, when community health workers are paid properly, the income benefits their family, particularly their children’s education, and contributes to the local economy.

The return on investment of community health programming is estimated at 10:1 considering the number of deaths prevented, the high costs of health crises avoided and the economic impact of higher employment.

Despite this compelling evidence, sub-Saharan African countries’ spending priorities tend to be more focused on high-profile components of the health system, such as hospitals, than on community health services. For example, 60 per cent of the funding available for community health workers in sub-Saharan Africa comes from donors, and is mainly for disease-specific, vertical programmes rather than for strengthening the primary health-care system. These programmes can derail countries’ attempts to strengthen their health systems. Addressing this lack of sustainable funding for community health services will need high-level political commitment to change funding models.

And there is still so much unmet need. For example, the World Health Organization estimates that there were 14.3 million zero-dose children worldwide in 2022 and an additional 6.2 million children only partially vaccinated. At least 13.7 million children under the age of 5 suffer from severe wasting, which is responsible for 1 in 5 deaths among children under age 5. Reaching those children would not only reduce child mortality from preventable diseases but also benefit the health of their communities through improved nutrition and access to health care.

Furthermore, it is estimated that child mortality in priority countries could be reduced by one third if community-based child survival interventions could reach 90 per cent of those in need. This intervention alone would save millions of lives.
Based on an extensive review of community health programmes, the World Health Organization recommends that community health workers should be integrated into the health-care workforce across the world wherever health and nutrition needs remain unmet. Rather than considering these workers a second-rate solution to a temporary problem, it is time we recognize their potential as a way of accelerating progress towards achieving the health-related Sustainable Development Goals.

### 2.3. Learning from the successes of community-based health-care programmes

The evidence base for how community-based health-care programmes can improve population health is mounting. Afghanistan, Bangladesh, Brazil, Ethiopia, India, Liberia, Nepal, Pakistan, Rwanda and Zambia all have effective community-based primary health-care programmes. Strong political commitment was instrumental to their success.

For example, the Ethiopia health extension programme, introduced in the early 2000s and staffed by community health workers, was championed as a flagship programme by the Prime Minister and the Minister of Health, thus securing buy-in across the government. It was scaled up from a successful pilot project supervised by the Minister of Health, and was firmly embedded in the primary health-care system, increasing its effectiveness and strengthening the health system.
Many of the community health programmes in other countries also highlight that strong political backing and partnerships, and scaling up from successful pilot programmes are critical to achieving success. In the case of Ethiopia, it was the government’s firm belief in primary health care as the cornerstone of the health system that secured the success of the health extension programme. Other contributing factors include:

- **Strong donor management.** The programme in Liberia integrated a patchwork of restrictive funding to maximize its impact, identifying critical gaps and approaching donors for funding to fill them. This approach allowed the country to improve health outcomes despite its constrained resources. The Ethiopia programme also featured strong donor management and channelling of funding.

- **Financial planning.** The Government of Liberia drew up detailed budgets for its programme, focusing on costs, benefits and funding, which allowed it to monitor the cost-benefit of the various elements and identify future funding needs.

- **Strong collaborative governance.** The programmes in Bangladesh and Liberia have strong governance structures with representatives from government ministries, partners and the communities they serve.

- **Integration into the primary health-care system.** The programme in Rwanda is embedded in the health system, giving even the most remote communities access to primary care.

- **Data gathering.** All countries collect data through their community health programmes, which are used to inform and target programming to the areas of greatest need, and monitor the performance of the programme.

Despite their success, the programmes face challenges including funding; shifts in the political landscape; the poor working and living conditions of community health workers, which reduce their productivity; high levels of vacancies for and absenteeism among community health workers; a shortage of doctors and female community health workers; and differences in the capacity to manage programmes at the local level.
Volunteer health worker, Mahainue Marma, travels to remote rural communities in Thanchi, Bandarban District, to deliver routine childhood immunizations. The journey by boat is followed by two or three hours of hiking. In each community, health workers may expect to vaccinate up to 10 children.

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India’s example highlights the importance of learning from setbacks. Following the success of the Jamkhed comprehensive rural health project in Maharashtra, India’s national village health guide programme was hastily implemented in 1977 ahead of an impending national election. Despite the initial political impetus, the programme lacked coordination and failed to engage stakeholders. It also provided inadequate support and supervision for the community health workers, which were key elements of the Jamkhed project’s success. This resulted in the national programme losing sustainable funding and foundering.

However, the Government of India learned the lessons from this experience and went on to develop a network of about 1 million community health workers.

2.4. Overcoming gender inequities to build stronger community health systems

The World Health Organization and World Bank projections indicate that the world needs up to an additional 18 million health workers by 2030 to achieve the necessary coverage to meet the SDGs. Strengthening the global health workforce is one of the most cost-effective ways of improving health security, protecting socio-economic growth and accelerating progress towards achieving internationally agreed targets on reducing child mortality and malnutrition.

Approximately 70 per cent of the current global health workforce is female, many of them are not adequately paid or protected, and many are not paid at all. An analysis of community health workers in 24 countries in sub-Saharan Africa found that only 14 per cent were salaried. Often this is because gender-discriminatory policies and practices limit the funding allocated to community health workers, who are mainly women. This may be because these workers often have a low status in their communities, being from low-income families and lacking formal education. And, of course, community health programmes focus on serving women and children who are often a low priority in the wider political landscape compared with high-profile projects such as hospitals. This may account for the lack of political support for community health workers.
Community health programmes depend on women. However, if these programmes are to be resilient enough to respond to crises while also strengthening the country’s health system, they must address the gender inequities in many countries and prioritize equal opportunities for and the protection and support of female health workers. Steps to address these inequities include:

1. **Pay, conditions and career opportunities.** Too often it is assumed that being a community health worker is something that women can fit around other domestic work and caring responsibilities. Community health workers understand their communities and can be leaders and influencers in those communities. Their pay, conditions and career opportunities should reflect their important role.

2. **Safety and security.** All health workers can face discrimination and harassment in the course of their work, but women are particularly at risk because of their role in the community, working in remote areas and outside normal working hours, and sometimes having to confront harmful practices. Community health programme managers should ensure that women health workers are adequately protected and supported.

3. **Mobility.** Women health workers’ mobility can be more limited than men’s because of concerns about their safety, local cultural norms and practical issues. Programme managers should take account of this in planning so that it does not put women health workers at risk or limit their opportunities for career progression.

4. **Working conditions.** A shortage of community health workers can lead to high workloads, reducing the quality of care provided. Programme managers should aim for a ratio of community health workers to population that makes it possible for community health workers to see every child in their care once a month.

5. **Training.** This is essential to professionalize the role of community health workers, to integrate community health care into the primary health-care system and to allow community health workers to act as ‘gatekeepers’ of health services in remote and underserved areas. To achieve this, approximately half of community health workers will need basic training in primary health care. However, it is important that this training is provided in accessible locations and in local languages. Training should also focus on women’s health and safety in the workplace.
2.5. The role of partnerships

Partnerships are key to transforming community health systems, as evidenced by the case studies in section 2.3. All the successful programmes cited partnerships with other ministries, non-governmental organizations, donors and communities. Involving communities, civil society and religious organizations, and community leaders is key to forging trust within the community and building support for the community health workers. Despite political impetus at the outset, India’s village health guide programme failed partly because of poor coordination and failure to involve stakeholders.

Involving the community health workers themselves is particularly important, as they are trusted members of the community and understand the culture and social norms. They know what the barriers are, what will work in their local context and how to adapt services to suit the community.

Margareth, a Village Health Assistant working in the mountainous Morobe Province, raises awareness around maternal, newborn and child health.

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PART 3

Recommendations

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Part 3

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Adeline Ouédraogo, a community-based health worker in Ziniaré.

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Burkina Faso, 2022
We call on governments, key partners and communities worldwide to join us in concerted action to accelerate progress to achieving the Sustainable Development Goals for children by investing in community health workers and strengthening community-based primary health care and essential nutrition services.

**Recommendations:**

- **Build on the work of the Community Health Delivery Partnership.** Call on partners at the global, regional and country levels to commit to increasing their investment in community-based primary health care and essential nutrition services.

- **Organize high-level political missions.** Heads of government and ministers need to be convinced that prioritizing community-based primary health care and nutrition is the best way to strengthen their country’s health system. Programmes need long-term financing if they are to achieve their full potential.

- **Coordinate and streamline partner support under the One Plan approach and align domestic and partner funding under the One Budget approach.** This will support longer-term sustainable financing of community health systems, highlight funding gaps and allow the rapid mobilization of resources from different sources to fill them. Countries need to find alternative sustainable financing for community health and nutrition programmes to supplement funding from donors and domestic resources.

- **Integrate community health and nutrition programmes into the primary health-care system.** This is key to fulfilling the potential of the programme and strengthening the health system. The One Plan approach links communities with the primary health-care system.

- **Engage and strengthen community leadership.** This fosters ownership and is key to the success of community health and nutrition programmes. The One Plan approach involves community leaders and health workers in designing improved community health and nutrition programmes and encourages feedback from the community.

- **Professionalize the role of community health workers.** The One Plan approach recognizes the gender discrimination that front-line workers face and the importance of their role, and requires them to be adequately trained, paid, protected, supervised, equipped and supported.

We call on governments, key partners and communities worldwide to join us in concerted action to accelerate progress to achieving the Sustainable Development Goals for children by investing in community health workers and strengthening community-based primary health care and essential nutrition services.
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PART 3
RECOMMENDATIONS

• **Strengthen the accountability of community health and nutrition programmes.** The Community Health Delivery Partnership will collect and analyse data through a community health dashboard with the aim of monitoring and evaluating community health and nutrition programmes, developing key metrics for services provided by front-line health workers and recording investment in community health.

• **Ensure that community health and nutrition workers have supplies of the life-saving commodities they need under the One Plan, One Budget approach.** This includes developing training and quality assurance programmes and innovative products and material more suited for use in developing countries.

• **Promote and strengthen the sharing of best practices.** Insights and lessons learned from implementing community health and nutrition programmes across countries should be shared through the Community Health Delivery Partnership’s knowledge exchange platform to ensure that practices are continually evolving and improving.
For every child

Whoever she is.
Wherever he lives.
Every child deserves a childhood.
A future.
A fair chance.
That’s why UNICEF is there.
For each and every child.
Working day in and day out.
In more than 190 countries and territories.
Reaching the hardest to reach.
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It’s why we stay to the end.
And never give up.