The sustainability of community health worker programmes depends on creating a package of incentives that is sufficiently attractive to prevent attrition. These packages will vary among settings, reflecting the different functions community health workers undertake in different communities. But all need to focus on priorities that include compensating community health workers for lost economic opportunities; providing adequate supervision and peer support; offering personal growth and development opportunities; and creating a strong support system within the community.

The incentives required to retain and motivate community health workers are not necessarily monetary. The disappointing results of evaluations of poor Alma-Ata large-scale training and deployment of community health workers underscore the fact that sound programme management and refresher training are more efficacious at sustaining workers’ effectiveness than initial training. Active community participation and support is a vital element of successful and sustainable community health worker programmes throughout the world. In the Philippines, for example, health workers at the barangay level, the smallest political unit in the country, have become a significant driving force behind improved child survival. This success has been encouraged by the Barangay Health Workers’ Benefits and Incentives Act of 1995, which includes such provisions as subsistence allowances, career enrichment and special training programmes, and preferential access to loans. Similarly, in Ceara, Brazil, a programme using a decentralized approach that allows community health workers to earn a substantial monthly income (twice the local average) has led to dramatic improvements in child health, including a 32 per cent reduction in child mortality.

Adequate programme supervision and support

Supervision and support systems for community partnerships in primary health care can diminish the community health workers’ sense of isolation and help sustain interest and motivation, reducing the risk of attrition. Skilled health workers based in, or closely linked to, health facilities generally undertake the supervisory functions, which can add to their already heavy workloads. Supervisors themselves require training to acquire the appropriate skills for oversight of community-based programmes. Resource constraints—human, financial or organizational—can limit the breadth and depth of supervision of the workers at the primary health care level. To combat undernutrition in young children, the government of India relies largely on the Integrated Child Development Scheme (ICDS). Begun in 1975, the scheme provides health, nutrition, and education services to children under six and pregnant and lactating mothers. It is the largest community nutrition programme in the world and is considered one of the world’s greatest successes. ICDS addresses undernutrition in India, Sri Lanka and the United Republic of Tanzania.

Attrition is related to multiple factors. Failing to discharge the responsibilities of a community health worker takes time and financial resources, and may involve significant opportunity costs. Community health workers, particularly those who are volunteers or paid in kind or part, may have obligations to meet and require income to support their families. If the demands on their time and resources prove overwhelming, there is a risk they will not function effectively as health workers or will drop out of community partnerships.

The sustainability of community health worker programmes depends on creating a package of incentives that is sufficiently attractive to prevent attrition. These packages will vary among settings, reflecting the different functions community health workers undertake in different communities. But all need to focus on priorities that include compensating community health workers for lost economic opportunities; providing adequate supervision and peer support; offering personal growth and development opportunities; and creating a strong support system within the community.

The incentives required to retain and motivate community health workers are not necessarily monetary. The disappointing results of evaluations of poor Alma-Ata large-scale training and deployment of community health workers underscore the fact that sound programme management and refresher training are more efficacious at sustaining workers’ effectiveness than initial training. Active community participation and support is a vital element of successful and sustainable community health worker programmes throughout the world. In the Philippines, for example, health workers at the barangay level, the smallest political unit in the country, have become a significant driving force behind improved child survival. This success has been encouraged by the Barangay Health Workers’ Benefits and Incentives Act of 1995, which includes such provisions as subsistence allowances, career enrichment and special training programmes, and preferential access to loans. Similarly, in Ceara, Brazil, a programme using a decentralized approach that allows community health workers to earn a substantial monthly income (twice the local average) has led to dramatic improvements in child health, including a 32 per cent reduction in child mortality.

Adequate programme supervision and support

Supervision and support systems for community partnerships in primary health care can diminish the community health workers’ sense of isolation and help sustain interest and motivation, reducing the risk of attrition. Skilled health workers based in, or closely linked to, health facilities generally undertake the supervisory functions, which can add to their already heavy workloads. Supervisors themselves require training to acquire the appropriate skills for oversight of community-based programmes. Resource constraints—human, financial or organizational—can limit the breadth and depth of supervision of the workers at the primary health care level. To combat undernutrition in young children, the government of India relies largely on the Integrated Child Development Scheme (ICDS). Begun in 1975, the scheme provides health, nutrition, and education services to children under six and pregnant and lactating mothers. It is the largest community nutrition programme in the world and is considered one of the world’s greatest successes. ICDS addresses undernutrition in India, Sri Lanka and the United Republic of Tanzania.