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PERSPECTIVE

Professionalisation of Community Health Workers: Time for a Formal Contract

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ABSTRACT

Community health workers (CHWs) are the backbone of strong primary healthcare systems. If properly supported, they can add significant value to access to healthcare service delivery. Yet, despite their proven effectiveness globally, systemwide support for CHWs remains sub-optimal. This study explores the concept of 'proCHW' programs - where CHWs are skilled, supplied, supervised and salaried. We suggest a fifth component is added to this framework—security (defined as formal contracts). Currently, many CHWs work voluntarily without any formal contract, rendering them vulnerable to sudden replacements. Therefore, institutionalising formal contracts will provide legal safeguards for CHWs, ensuring fair and safe employment conditions, including a minimum wage and opportunities for career advancement. To enable funding for establishing formal contracts for CHWs, strong political commitment, public-private partnerships, and tailored funding strategies based on local administrative systems are needed. By addressing these challenges, sustainable funding can be achieved, maximising the impact of CHW-led programs and improving primary health care globally.

1 | Introduction

Community health workers (CHWs) are a vital part of strengthening primary healthcare systems globally [1]. For example, in stunting prevention programs, CHW-led maternal education and counselling have been demonstrated to decrease the risk of stunting - a disease linked to lower productivity and a higher risk of subsequent ill health in later life [2, 3]. When the value of lives saved and productivity is considered, CHW-led programs can result in a major Return on Investment (up to 10:1) [4]. As a result, scaling up CHW-led programs has been included as one of the World Health Organisation's (WHO) priorities to improve primary health care [5].

However, despite this evidence, CHW-led programs remain underfunded [6]. CHWs often receive inadequate training and lack regular supervision [7, 8]. For example, in Indonesia, only 13% of CHWs receive pre-service training [9]. On a global scale, many CHWs also remain unpaid and work voluntarily [8]. Furthermore, CHWs often incur out-of-pocket expenses to fulfil their work-related duties. For example, a study in Rwanda found that CHWs faced up to $280 USD in annual out-of-pocket costs to meet their job requirements. This out-of-pocket spending places significant pressure on CHWs, especially those from low socioeconomic backgrounds [10].

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Summary

- Despite community health workers (CHWs)' vital role in global primary health care, too often they remain untrained, unsupervised, unsalaried, and working without formal contracts of employment.
- To optimise CHW-led programs in primary care, CHWs need to be skilled, supplied, supervised, salaried, and secure (i.e. have a formal contract of employment in place).
- Formal contracts for CHWs will enable job security.
- Strong political commitments, partnerships and tailored funding strategies are key to sustainable funding for establishing formal contracts for CHWs.

Considering these challenges, this article aims to highlight further ways to optimise CHW programs, including the need for formal contracts of employment to be initiated and potential challenges around funding which should be considered.

2 | Optimising CHW Programs With proCHWs

The 2018 WHO guidelines on optimising CHW programs recommend CHWs are adequately trained, supervised, salaried, certified, and supplied, with clear career pathways [11]. To summarise the key elements of this guideline, The Community Health Impact Coalition (CHIC), a field-catalyst formed of dozens of stakeholders involved in supporting professional CHWs (proCHWs) globally, coined the acronym 4S: skilled, supplied, supervised, and salaried [12].

Each of these components is interconnected. Ensuring a CHW is skilled to conduct its programme necessitates continuous training programs. Two studies conducted across five countries demonstrated that training for CHWs has a long-term impact, with only a small decline in measured knowledge up to 8 months post-training [13, 14]. Regular refresher training should also be conducted, as other studies have highlighted that acquired knowledge and skills may be lost without them [15]. Adequate programmatic supplies, such as measurement and counselling kits, are essential for CHWs to perform their work effectively and in line with their training. In procuring supplies for CHWs, specific considerations should also be given to their working conditions, as CHWs are often required to work in challenging conditions and hard-to-access areas [16]. Continuous improvement of CHWs' skills also requires supportive supervision, which entails an appropriate supervisor-supervisee ratio and data-based performance evaluation and feedback. To enable these approaches, CHW supervisors also need to receive adequate training and support [11]. Finally, ensuring CHWs receive a salary is crucial. Not only is a salary is considered to be an integral part of workers' rights [17] but it is in keeping with WHO best practices guidelines for CHW programming [11]. Furthermore, receiving a salary has been linked with increased CHW performance [18]. While we note that CHWs find value and satisfaction in doing community work, there is a unified and growing consensus that CHWs should be paid to ensure that their time and efforts are adequately compensated. In a worst case scenario, CHWs can actually be left out of pocket to deliver vital health care services when they do not receive a salary. This was demonstrated in a study from Rwanda where CHWs had to pay out-of-pocket to support the community health programme [10]. Similarly, in Ethiopia, many volunteer female CHWs often fared worse in both economical and psychological aspects compared to other women, the latter due to the perception that they are not working [19].

From an economic standpoint, a study from Indonesia demonstrated that providing CHWs with incentives and training resulted in a benefit-cost ratio of 2.08, meaning the benefits, when converted into monetary terms, outweighed the costs by more than twofold [20]. Furthermore, from a clinical perspective, positive net benefits were observed with reductions in malnutrition and diarrhoea and improved productive earnings of the targeted children in later years [20]. In addition, higher job satisfaction, related to the fulfilment of the 4S components of the proCHW model, is related to the retention of CHWs [21]. This, in turn, reduces the need to replace and retrain CHWs, which requires significant investment.

3 | Time for a fifth S? - Security

In addition to these recommendations, we propose a fifth element to the proCHW model: security, defined as CHWs receiving formal employment contracts (Figure 1), a policy recently enacted in Zanzibar [22]. This contract should incorporate rights to fair wages, reasonable working hours, and safe working conditions.

We suggest this fifth element for several reasons. First, formal contracts provide legal recognition of the employment relationship, which is crucial for ensuring CHWs are protected under international labour laws. This includes rights to fair wages, reasonable working hours, and safe working conditions. For example, in Brazil, CHWs are employed as state employees, enabling them to qualify for a minimum wage and be entitled to a health risk premium [23]. It also provides CHWs with an element of job security that could protect them from electoral cycle instability. Based on our experiences in Indonesia, CHWs are often replaced due to reasons unrelated to their performance, for example, political changes due to the appointment of a new village head [24]. This stability is crucial for maintaining consistent and quality healthcare services within communities.

Secondly, a formal contract should clearly outline the duties, rights, responsibilities, and expectations of both the employer and the employee. This clarity can help to avoid misunderstandings and ensure that CHWs know what is expected of them. With increased task shifting and sharing, creating clear roles and expectations of CHWs can help ensure their work (and the resulting care they provide) is streamlined and appropriately managed [11].

Contracts can also help to improve the financial stability and wellbeing of CHWs, which is important given the often challenging nature of their work. Furthermore, recognising CHWs are mostly women, the clarity on their rights and responsibilities will enable them to navigate gender-related constraints, such as

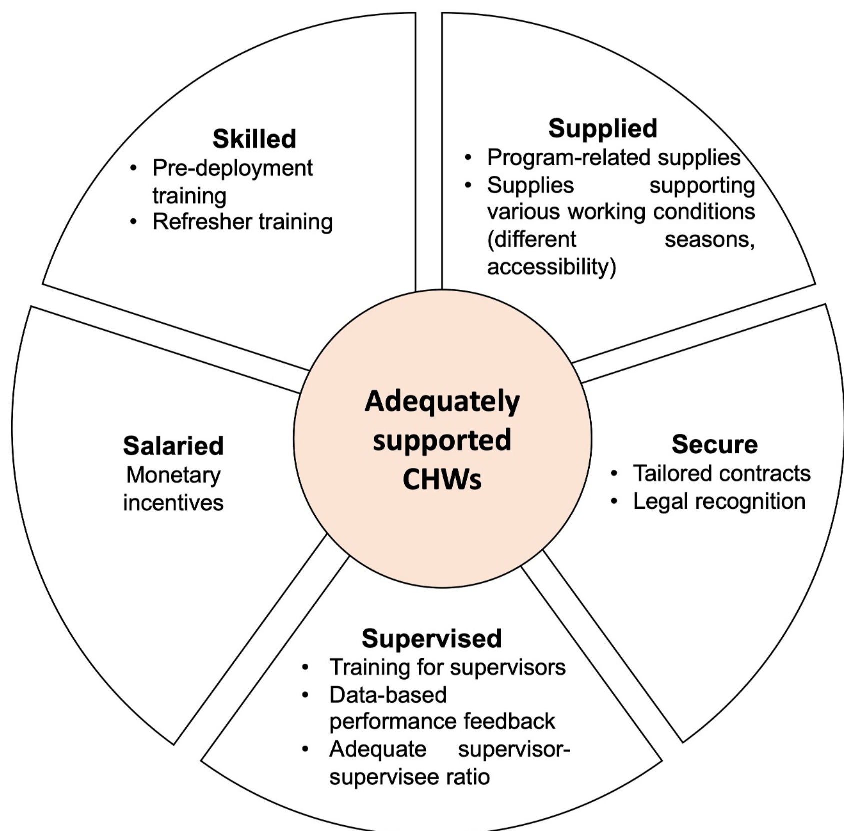

FIGURE 1 | Priority components to invest for community healthcare workers-led programs, 5S (skilled, supplied, supervised, salaried, secure).

movement limitations due to social norms and preventing gender-based violence [25].

Thirdly, formal contracts can facilitate the professionalisation of CHWs. Establishing formal contracts can help recognise the value of work performed by CHWs and can include provisions for training, professional development, and career advancement opportunities, which have often been lacking in the past and are suggested as the cornerstones of optimising CHW programs in the 2018 WHO guidelines [11].

Finally, consideration should be given to how contracts are drawn up and the participatory involvement of CHWs in this process. A study from Pakistan demonstrated that contracts tailored to the individual time preferences of CHWs yielded better performance than a uniform contract for all [26].

4 | Funding Considerations

Before formal contracts can be issued to CHWs, several challenges need to be considered to ensure sustainable funding of such programs.

Funding of comprehensive CHW programs is no small feat, and governments are often reluctant to make major investments into primary healthcare, given that tangible results may take many years to materialise. In addition, globally, the lowest amount of funding is allocated for preventive care, which is the primary focus of many CHW programs. A political commitment in the form of strong funding regulations will enable sustainable, long-term funding for primary health care and CHW programs [27]. Governments must take bold and decisive steps to fund long-term capacity building by ear-marking long-term and dedicated funding for proCHW programmes. Promising steps have been taken in this regard by the governments of Liberia and Kenya. For example, on the final day of the third International CHW Symposium in Liberia, Dr. Jallah (Liberian Minister of Health) announced the Monrovia Call to Action which clearly states professional CHWs should be the norm. This means CHWs should be 'formalised, paid a fair wage, skilled, supervised, and supplied to deliver the highest quality care, and offered opportunities for career progression' [28]. In Kenya, the first Community Health Policy 2020–2030 was launched in 2020. The policy outlined dedicated funding for community health services. Although CHWs in Kenya are still divided into formal workers and volunteers, the policy provides legal recognition for certifications and remuneration strategies for CHWs [29].

It is also important to note that in low- and lower-middle-income countries (LMICs), despite higher spending on preventive care compared to high-income countries, most preventive care programs are funded by external aid from the private sector [27] raising questions around funding sustainability. It is therefore important to continue investigating how proCHW programs can be sustainably funded and structured with government ownership [30]. Our experience in rural Indonesian villages shows that when presented with evidence of the benefits of CHW programs, public stakeholders are willing to allocate village budgets to fund

them. By improving their capacity to manage funding, even if external support is later reduced, CHW programs can still be optimised using the available government budget. Therefore, it is crucial to implement capacity-building programs focused on financial management skills tailored to relevant government stakeholders. At the same time, engaging the private sector remains an important strategy to fund CHW programs, as significant capital can be mobilised through effective public-private partnerships. In addition, from a purely financial proposition, investing in CHW programs is an attractive proposition for private sector funders. One recent study demonstrated that for every $1 (USD) invested in childhood stunting programs, the gains yielded for the private sector reached $2 to $81 annually [31]. Hence, striking a balance between public and private funding could be a pragmatic solution to ensure sustainability.

Lastly, it is also crucial to tailor the funding arrangement based on the local political system of a country. For example, in many countries, government-led health programs are paid by the Ministry of Finance, the Ministry of Health, as well as provincial and district governments. Should these public stakeholders collaborate by each providing funding for proCHW programs, comprehensive, sustainable funding for community health programs may be attained. However, these arrangements should ideally account for the varying funding capacities of local or regional governments; otherwise, community health inequalities may persist [32].

5 | Conclusion

To maximise the impacts of CHW programs, we suggest expanding the proCHW model from four to five essential components. CHWs should be both *skilled*, *supplied*, *supervised*, *salaried*, and *secure*. Ensuring the sustainability of CHW models through the implementation of formal contracts is essential as it offers CHWs legal rights and protections that have often been missing in the past. This includes contracts of employment which stipulate rights to fair wages, reasonable working hours and safe working conditions. Furthermore, formal contracts may help better clarify CHWs duties and support formal recognition and career advancement opportunities for CHWs. The first hurdle for proCHW programs however remains funding sustainability. This may be addressed through strong political commitments, public-private partnerships, and a robust monitoring and evaluation system.

Author contributions

AVM: conceptualization; data curation; writing–original draft; writing–review & editing. **RDP:** supervision; data curation; writing–review & editing. **TS:** conceptualization; supervision; writing–review & editing. **RA:** writing–review & editing. **RRN:** writing–review & editing. **MR:** writing–review & editing. **RA:** writing–review & editing. **ZP:** supervision; writing–review & editing; **JOD:** writing–review and editing.

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Ethics Statement

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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