Framework for Action

Achieving Gender Equity in the Community Health Workforce

LAST MILE HEALTH

INTEGRATE HEALTH

September 2024

Pictured above: Gamina Létifa coming for a prenatal consultation at the Sanda-Afohou health center with community health worker supervisor Pali Pyalo and community health worker Asso Sirin.

In memory of Lola Adedokun

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Introduction

We are at a moment in history when existential threats are seemingly intractable. The United Nations Sustainable Development Goals (SDGs)—intended to address many of these threats by 2030—are increasingly out of reach. However, progress for universal health coverage (SDG 3) and gender equality (SDG 5) is possible when we focus on investment in the community health workforce.

Today, we have robust, compelling evidence demonstrating the valuable contributions of community health workers in delivering basic and essential life-saving health services globally. In addition, we know community health workers are primarily women, and they are more likely to go unpaid or underpaid for their labor and encounter systemic barriers to career advancement—career advancement that would improve their own lives and the lives of others in their communities.

Through this framework, we aim to share evidence-driven recommendations that can be implemented to advance gender equity in community health programming and examples of how organizations like ours are implementing these recommendations, underscoring the potential impact for women, for communities, for countries, and globally.

This framework is a call to action to community health implementers, policymakers, governments, and funders. We recognize that adopting the 16 recommendations in this framework will require sustained investment, political will, and deep collaboration, and we intend for this framework to be adapted for specific contexts and opportunities, spurring both short- and long-term change.

There is a long road ahead to achieving universal health coverage and gender equality. However, we invite you to use this framework as a tool for action and to join us in taking these important steps forward, moving us closer to a world in which women community health workers are prioritized at every stage of their professional lifecycle to the benefit of our global community.

Community health worker Yindjre Martine N'wintcha, from Naware, Dankpen district, Togo, carrying out a pediatric consultation.

Background

For millions of people, women community health workers[1] are the first and sometimes only point of contact with the formal health system. Globally, it is estimated that 70% of community health workers are female and those who are unpaid are most likely to be female.[2] COVID-19 highlighted not only the gendered nature of the health workforce and the higher proportion of women assuming caregiving roles, but also the heavy reliance on women community health workers in pandemic response.[3] Gender norms are "at the heart" of many of the challenges and inequities women community health workers encounter[4] because traditions and cultural norms restrict women to household responsibilities, including childcare and domestic chores, and prioritize these roles over those outside the domestic domain. As a result, when women enter the health workforce, they may face unintended consequences such as gender-based violence and restricted mobility and isolation, limiting their ability to succeed in their jobs. Restrictive gender norms also prevent women community health workers from developing their professional skills and from having the right supervision and supplies they need to succeed.

Community health worker Laura Mhango on her way to visit patients in Salima district, Malawi.

Many commitments have been made by leading global institutions and national governments to protect, empower, and enable women community health workers (e.g., 2018 *WHO guideline on health policy and system support to optimize community health worker programmes*), but the extent to which governments, non-governmental organizations, and international aid funders have delivered on these policy recommendations remains unclear.[5][6][7] Most recently, the Monrovia Call to Action from the 2023 Third International Symposium on Community Health Workers in Monrovia, Liberia, states: "The majority of [community health workers] globally who are women face barriers in accessing safe and decent work and leadership opportunities. Women [community health workers] are at risk of sexual

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[1] For the purposes of this Framework for Action, we define community health workers as those who provide health education, treatment, and referrals for a wide range of services; and provide support and assistance to communities, families, and individuals with preventive and curative health measures as well as access to appropriate curative health and social services. They create a bridge between providers of health, social, and community services and communities that may have difficulty in accessing these services. For a complete list of definitions, see the Glossary of Terms (Appendix A).

[2] Closser et al. (2023). Breaking the silence on gendered harassment and assault of community health workers: an analysis of ethnographic studies. BMJ Global Health. 8. doi:10.1136/ bmjgh-2023-011749. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10201268/

[3] Nanda et al. (2020). From the frontlines to centre stage: Resilience of frontline health workers in the context of COVID-19. Sexual and Reproductive Health Matters, 28(1). https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1837413

[4] Closser et al. (2023), p. 2

[5] B-Lajoie et al. (2014). Payday, ponchos, and promotions: A qualitative analysis of perspectives from non-governmental organization programme managers on community health worker motivation and incentives. Human Resources for Health. 12:66. doi: 10.1186/1478-4491-12-66. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4267436/

[6] Women in Global Health. (2023). Women community health workers: Leading change. Executive Summary. [Provided in advance of publication by LMH].

[7] World Health Organization. (2018). WHO guideline on health policy and system support to optimize community health worker programmes. https://iris.who.int/bitstream/handle/10665/275474/9789241550369-eng.pdf?sequence=1

exploitation, abuse, and harassment and have limited access to the same legal and other protections extended to formal health workers." It concludes that the transition to making professional community health workers the norm must be "undertaken with consideration for gender equity and social inclusion to protect jobs for women" and "policies should be designed to promote women's leadership and [community health worker] career progression."[8]

Community health workers have been acknowledged as a vital component of primary care since the Alma Ata Declaration in 1978. Today, we have robust, compelling evidence demonstrating their valuable contribution in delivering basic and essential life-saving health services, including improving access to care; reducing maternal, newborn, and child mortality; improving clinical outcomes for chronic diseases; and preventing disease outbreaks—achieving the health-related Sustainable Development Goals and universal health coverage.[9][10][11]

In Sub-Saharan Africa, close to 80% of the population representing 24 countries relies heavily on community health workers.[12] NGOs, social enterprises, and national governments are increasingly acknowledging and investing in the crucial work of community health workers.[13] Researchers estimate that the percent of community health workers in Africa receiving no salary could be as high as 85%.[14]

Yet formal integration of community health workers into the health workforce—as evidenced by structured salaries, training, and supervision—is inadequate and uneven across and within countries.[15] While it is encouraging to see a growing global awareness of the lack of pay for women community health workers, pay is only one of the factors required for a professional community health worker to succeed. Community health workers must be salaried, skilled, supervised, and supplied by a well-functioning community health system operating at national scale and integrated into broader public systems.[16]

Integrate Health and Last Mile Health's 2023 Clinton Global Initiative Commitment to Action

Integrate Health and Last Mile Health, two leading community health organizations with nearly 40 years of combined experience working in Africa, have committed to work in partnership to strengthen gender-responsive community health programs and launch a global campaign to center women in Africa's community health workforce.

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[8] CHW Symposium 2023. (2023). The Monrovia call to action. https://chwsymposiumliberia2023.org/the-monrovia-call-to-action/

[9] Bhutta. (2017). Community-based primary health care: A core strategy for achieving sustainable development goals for health. Journal of Global Health, 7(1). doi: 10.7189/jogh.07.010101. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5481898/

[10] Perry et al. (2021). Community health workers at the dawn of a new era: 11. CHWs leading the way to "Health for All." Health Research Policy and Systems, 19(111). https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-021-00755-5

[11] World Health Organization (2018).

[12] Idriss-Wheeler et al. (2024). Engaging community health workers in Africa: Lessons from the Canadian Red Cross supported programs. PLOS Global Public Health. 4(1): e0002799. doi: 10.1371/journal.pgph.0002799. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10796059/

[13] McKague & Harrison. (2019). Gender and health social enterprises in Africa: a research agenda. International Journal for Equity in Health. 18: 95-95. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6585088/

[14] Ballard et al. (2022). Payment of community health workers. Lancet, 10(9): E1242. https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(22)00311-4/fulltext

[15] World Health Organization. (2020). What do we know about community health workers? A systematic review of existing reviews. Human Resources for Health Observer Series No. 19. https://iris.who.int/bitstream/handle/10665/340717/9789241512022-eng.pdf?sequence=1

[16] Last Mile Health. (2024). The Six Ss. https://lastmilehealth.org/what-we-do/six-s/

Their 2023 Clinton Global Initiative Commitment to Action articulates plans to work with African ministries of health over two years to strengthen and sustain gender-responsive community health worker programs across four countries—Ethiopia, Guinea, Liberia, and Togo—as well as to develop and disseminate lessons learned to accelerate similar efforts across the continent.

Community health worker Mary Namboya (second from left) meets with community members called "secret mothers," who help her identify and connect with pregnant women in Chikwawa district, Malawi.

Purpose of the framework

In support of their commitment to develop and disseminate lessons learned, Last Mile Health and Integrate Health partnered with Sāmya Ventures to develop a framework for action to document how gender influences three stages of the career lifecycle of a professional community health worker:[17] 1) **recruiting** women community health workers into the workforce, 2) **enabling** women community health workers to succeed, and 3) **retaining** women community health workers and **advancing** their careers.

This is a first step in a series of actions that examines the literature and each organization's experiences **to provide actionable recommendations to community health program implementers, including in the four focus countries in Integrate Health and Last Mile Health's Commitment to Action**. This framework is informed by key global guidelines and tools (Appendix B), research evidence identified by a literature review (Appendix C), and consultations with expert implementers (Appendix D). It does not provide a comprehensive review of best practices.

Primary and secondary target audiences

While this framework for action is intended specifically for community health program implementers, progress requires alignment and coordinated action from all stakeholders involved in strengthening the community health system. Secondary audiences for this framework include a range of development partners: governments, funding agencies, philanthropic foundations, global health initiatives, global health advocates, and researchers.

[17] The three stages of the community health worker career lifecycle are derived from the HRH2030 Health Worker Life Cycle Approach. More information about how the Life Cycle Approach informed this framework is described in WHO Community Health Worker Guideline Recommendations Using HRH2030's Life Cycle Approach (Appendix B).

Recommendations overview

Types of recommendations

There are two main types of recommendations in this framework for action:

1. Actions community health program **implementers can directly advance**.

2. Actions that require community health program **implementers to partner** with policymakers, planners, and managers responsible for community health workforce policy and planning at national and local levels.[18]

While the popularity of community health programs has fluctuated over the past 50 years, over the past ten years "national governments increasingly are seeking to initiate, scale-up, or re-invigorate community health programs."[19] Ministries of health play a central role in driving national standards, and implementers should increasingly commit to supporting national programs and policies. Integrating community health programs can extend the benefit of community health workers to large populations and provide community health workers "wider and more sustainable financial, administrative, and regularity support."[20]

Issues to consider

a. While some evidence exists that shows a preference for female providers for community health service delivery,[21][22] there is limited and uneven evidence in the peer-reviewed literature on how gender influences community health workers' experiences through the three stages of the career lifecycle. Please see Appendix C for findings and observations on the state of the research and conclusions from our literature review.

b. Community health systems are highly context-specific. There is no "typical" woman community health worker, and different contexts may generate varying gender-based constraints that require distinct strategies, as gender norms vary between and within countries and continuously change.[23][24][25]

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[18] For the purposes of this draft, suggested actions for implementers to work with governments are described as advocacy actions and can be further refined by Last Mile Health and Integrate Health for specific country contexts.

[19] World Health Organization. (2020). What do we know about community health workers? A systematic review of existing reviews. Human Resources for Health Observer Series No. 19. https://iris.who.int/bitstream/handle/10665/340717/9789241512022-eng.pdf?sequence=1

[20] Ibid.

[21] McKague & Harrison. (2019). Gender and health social enterprises in Africa: a research agenda. International Journal for Equity in Health. 18: 95-95. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6585088/

[22] Olaniran A, Banke-Thomas A, Bar-Zeev S, Madaj B. (2022). Not knowing enough, not having enough, not feeling wanted: Challenges of community health workers providing maternal and newborn services in Africa and Asia. PLoS ONE 17(9): e0274110. https://doi.org/10.1371/journal.pone.0274110

[23] African Population and Health Research Center. (2020). Strategies to overcome gender-based constraints impacting community health worker performance. Policy Brief. https://aphrc.org/wp-content/uploads/2020/05/Gender-and-CHWs-policy-briefs.pdf_Uganda-audience.pdf

[24] Jackson et al. (2019). Gender exploitative and gender transformative aspects of employing health extension workers under Ethiopia's Health Extension Program. Tropical Medicine & International Health. 24(3):304-319. doi: 10.1111/tmi.13197. https://onlinelibrary.wiley.com/doi/10.1111/tmi.13197

[25] Women in Global Health. (2023). Women community health workers: Leading change. Executive Summary. [Provided in advance of publication by LMH].

According to the World Health Organization, "There are no standard blueprints that can be used to design and implement a [community health worker] programme. When developing programmes, decisions must be made based on national, subnational, district, and local realities. However, these can be informed by strategies used in other settings as well as by the successes, challenges, and pitfalls encountered there."[26]

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[26] World Health Organization. (2020).

Community health worker Azoumi Soule during a home consultation with a patient in Sanda Afohou, Bassar district, Togo.

BOX 1. Recommendations for action

CROSS-CUTTING recommendations

Recommendation 1: Women community health workers' voices are systematically incorporated into the decision-making process for planning and implementing health services.

Recommendation 2: Community health worker roles are officially recognized in national policies, with equal remuneration for women and men and comprehensive incentive packages for motivation and retention.

Recommendation 3: National digital systems maintain records of community health workers (e.g. a registry) and track this data, disaggregated by gender, to inform inclusive planning and programming.

RECRUITING women community health workers into the workforce

Recommendation 4: Local community leaders and members, including male partners, actively participate in efforts to change perceptions about community health workers and recruitment practices so women have equal opportunity for selection.

Recommendation 5: National community health policies include strong selection criteria and requirements that proactively enable the entry of women community health workers into the profession.

Recommendation 6: Governments commit to the preferential hiring of women community health workers until gender parity is achieved in the national workforce.

ENABLING women community health workers to succeed

Recommendation 7: Training modules are tailored to the specific needs and priorities of both women and men community health workers.

Recommendation 8: Community health worker training curriculum includes modules on gender sensitivity and safety to prevent and respond to gender-based violence.

Recommendation 9: Women community health workers can access context-appropriate transport modalities to enhance their safety and security on the job.

Recommendation 10: Digital tools are designed and deployed with a gender-responsive[27] lens.

Recommendation 11: Supervisors are selected through a process that increases opportunities for women to be appointed to these roles.

[27] Gender-responsive policies and programs have awareness and understanding of norms, roles, and power relationships associated with being female and male, based on an analysis of gender-based inequalities and constraints; insights translated into actions and systems that work to strengthen more equitable gender norms, roles, and power relationships (Gender Integration Continuum, 2020).

Recommendation 12: Personal protective equipment for women community health workers is designed and provided to meet their unique needs.

RETAINING women community health workers and ADVANCING their careers

Recommendation 13: Programs and policies prioritize community health worker safety and the prevention of gender-based violence.

Recommendation 14: Support structures and networks are established for the professional development of women community health workers.

Recommendation 15: National policies are implemented to ensure women community health workers maintain a fair workload and are not burdened with additional responsibilities beyond their roles.

Recommendation 16: National policies provide career pathways for women community health workers, promoting long-term professional development and growth.

Recommendations for action

A summary of evidence that **includes the rationale or the "why" for these recommendations** is provided in the four sub-sections outlined in the summary above. To illustrate how these recommendations might be translated into action—where available and appropriate—we provide the following types of information:

Implementation considerations

Detailed recommendations on how to implement recommendations from the research literature.

Implementation examples

Examples of Last Mile Health, Integrate Health, and peers working to implement recommendations.

Evidence highlights

Description of findings from specific studies in Sub-Saharan Africa that support recommendations.

Ideas for innovation

Interesting ways to move these recommendations forward supported by the research evidence and/or experience of community health program implementers.

Community health worker Tayagne Moissegma and her supervisor in Wadjadjo, Dankpen district, Togo.

Cross-cutting recommendations

Recommendations for action

Community health worker Constance Joe (right) from Garyeazohn, Liberia, reviews program materials with quality assurance officer Diana Dennis.

Several recommendations for action have implications for all three stages of the career lifecycle and are provided here as cross-cutting recommendations.

Recommendation 1: Women community health workers' voices are systematically incorporated into the decision-making process for planning and implementing health services.

Implementation considerations

Involve community health workers in program planning to leverage their valuable experience and perspectives, with a focus on ensuring women have equal leadership and participation in such planning.

Why? It is essential that ministries of health have policies in place that integrate and include the perspectives of women community health workers in health system planning.[28] The role of women community health workers at the bottom of the health system hierarchy gives them little power and almost no opportunity to "organize and take a seat at the policy table."[29] According to Jackson et al. (2019), they are "expected to remain subordinate, accepting what they are taught and implementing 'what we tell them.'" Women community health workers have limited opportunities to engage in planning or decision-making processes and are often denied agency by policymakers.[30][31] Informal status and lack of professional recognition prevents career mobility and means they are excluded from policy- and decision-making processes.[32] At the same time, women community health workers leverage their social capital to advocate for a woman's right to healthcare.

Recommendation 2: Community health worker roles are officially recognized in national policies, with equal remuneration for women and men and comprehensive incentive packages for motivation and retention.

Implementation considerations

- Compensation should reflect the demands of specific roles with respect to hours, workload, job complexity, and training.
- Once established, remuneration should be reassessed routinely (e.g., annually).
- Issue contracts that aim to formalize labor rights and provide social protections aligned to local law, such as maternity pay, sick pay, paid time off, and pensions.

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[28] Community Health Impact Coalition. (2018). Community health worker assessment and improvement matrix (CHW AIM): Updated program functionality matrix for optimizing community health programs. https://chwcentral.org/wp-content/uploads/2018/12/CHW-AIM-Updated-Program-Functionality-Matrix_Dec-2018-005.pdf

[29] Jackson et al. (2019).

[30] USAID. (2023). Establishing career pathways for community health workers: Models and key considerations. LHSS technical brief. https://www.lhssproject.org/resource/establishing-career-pathways-community-health-workers-models-and-key-considerations

[31] Women in Global Health. (2023). Women community health workers: Leading change. Executive Summary. [Provided in advance of publication by LMH].

[32] Ibid.

- Consider local and national contexts when recommending community health worker incentive packages, as community health workers can become overworked and undervalued due to constantly changing incentives and programmatic objectives.

Why? Community health workers deserve to be paid as professionals, with fair compensation provided regularly and on time. Globally, a significant number of women community health workers are either unpaid or grossly underpaid: 70% of the global community health workforce is women, but only 14% in Africa are paid adequately.[33] Women community health workers are often expected to volunteer without pay in contrast to their male counterparts, reflecting gender bias in community health worker programs.[34][35][36] Community perceptions of men and women community health workers differ, with male free labor seen as unusual and female labor expected to be unpaid.[37] Not paying or underpaying women community health workers impacts their motivation and the sustainability of community health systems.[38][39] Lack of regular payments can impact community health worker performance and damage their relationships in the community.[40] Unsalaried community health workers, particularly in dual-cadre programs, face exploitation.[41] Issues such as insufficient salaries, irregular payments, and the complexity of implementing fair compensation (including purchasing power parity) affect community health workers' performance and their ability to meet basic living costs.[42][43][44] Economic hardships, exacerbated by unpaid or poorly paid roles, compel community health workers to endure challenging and unsafe working conditions.[45][46]

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[33] Closser et al. (2023).

[34] Ahmed et al. (2022). Community health workers and health equity in low- and middle-income countries: Systematic review and recommendations for policy and practice. International Journal for Equity in Health. 21(1):49. doi: 10.1186/s12939-021-01615-y. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8996551/

[35] Closser et al. (2023).

[36] Women in Global Health. (2023).

[37] Steege et al. (2018). How do gender relations affect the working lives of close to community health service providers? Empirical research, a review and conceptual framework. Social Science & Medicine. 209: 1-13. https://doi.org/10.1016/j.socscimed.2018.05.002. https://www.sciencedirect.com/science/article/pii/S0277953618302375

[38] USAID. (2023).

[39] Women in Global Health. (2023).

[40] Steege et al. (2018).

[41] Ballard et al. (2023).

[42] Ibid.

[43] Jackson. (2018). "We prefer the friendly approach and not the facility": On the value of qualitative research in Ethiopia. Ethiopian Journal of Health Sciences. 28(5):555-562. doi: 10.4314/ejhs.v28i5.6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6308781/

[44] Steege et al. (2018).

[45] Closser et al. (2023).

[46] Women in Global Health. (2023).

Incentive packages should reflect job expectations, including financial compensation in the form of a salary and non-financial incentives.[47] Financial and non-financial incentives are critical motivators for community health workers.[48] Preferential access to credit, healthcare, inclusion in development programs, continued education, skills training, and career progression opportunities are critical non-monetary incentives for women community health workers.[49][50] Notably, a multi-country study in 2021 found that opportunities for professional and personal development motivate community health workers the most whether paid or volunteer.[51] Similarly, the literature and country stakeholders have cited lack of career progression as well as lack of support, coaching, and rewards for good performance as contributors to community health worker demotivation and attrition.[52] Sustaining financial incentives for community health workers poses challenges for government ministries and NGOs, requiring robust supervision and accountability systems.[53] Heavy workloads, inadequate pay, and lack of career advancement opportunities are significant issues for community health worker retention, particularly among women community health workers.[54][55][56]

> "If men became [community health workers][57] it would mean higher salaries. If [community health workers] were males, who are powerful—the salary would be double."
> — Community health worker in Ethiopia, where all community health workers are women[58]

Implementation examples

Integrate Health's paid leave policies in Togo

In Togo, over 90% of Integrate Health-supported community health workers are women, with a 90% retention rate over the past eight years. As salaried employees, Integrate Health-supported community health workers in Togo benefit from a fully paid maternity leave policy of 14 weeks. This policy ensures they have time to recuperate after childbirth and to focus on newborn and postpartum recovery. In the Kara region of Togo, Integrate Health supports community health workers to be hired as full-time salaried employees who are entitled by law to 30 days of

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[47] Community Health Impact Coalition. (2018).

[48] African Population and Health Research Center. (2020).

[49] Ajsegiri et al. (2022). It is not all about salary: a discrete-choice experiment to determine community health workers' motivation for work in Nigeria. BMJ Global Health. 7(10): e009718. doi: 10.1136/bmjgh-2022-009718. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9594556/

[50] B-Lajoie et al. (2014).

[51] USAID. (2023).

[52] Ibid.

[53] B-Lajoie et al. (2014).

[54] Jackson. (2018).

[55] Jackson et al. (2019).

[56] Raven et al. (2022). Supporting community health workers in fragile settings from a gender perspective: A qualitative study. BMJ Open. doi:10.1136/bmjopen-2021-052577. https://bmjopen.bmj.com/content/bmjopen/12/2/e052577.full.pdf

[57] For explanation of HEW, refer to Glossary of Terms, Appendix A.

[58] Jackson et al. (2019).

annual leave and 14 weeks of maternity leave. While this policy benefits community health workers, it does pose the challenge of maintaining continuity of care: taking a leave of absence can disrupt the vital services they provide. To address this challenge, Integrate Health hires community health worker replacements in each district where the organization works, with replacement community health workers receiving the same training and accreditation as their full-time counterparts. Every time a full-time community health worker plans a leave of absence, the replacement community health worker steps up to fill in. To ensure a smooth transition, they take sufficient time to familiarize themselves with every patient's situation, such as shadowing their full-time colleague, introducing themselves to patients, and meeting with the head of the local health center to discuss various priorities. While this replacement system requires additional resources, it offers quality of life and peace of mind to all involved. The system makes it easier for women to serve as community health workers, where they might otherwise not apply due to child rearing duties. Adhering to this model requires legal obligations and overcomes complexities far greater than if Integrate Health had chosen to employ volunteers. However, opting for the "easier route" would mean perpetuating patriarchal norms and exploiting women by leaving their work unpaid and unrecognized.[59] Though NGOs like Integrate Health may have more flexibility in deploying innovative human resources policies, this example provides guidelines for governments to consider and adapt.

Recommendation 3: National digital systems maintain records of community health workers and track this data, disaggregated by gender, to inform inclusive planning and programming.

Why? Establishing and maintaining digital records of community health workers that are disaggregated by gender can help identify gender inequities in the community health workforce—for example, in training, career advancement, and experiences of discrimination or violence—and support the design of programs and policies that are responsive to gender inequities. Comprehensive data, disaggregated by gender, would also elevate the visibility of women community health workers' contributions. Including community health workers' level of training and location would provide the data health systems need to include community health workers in supply chain planning, procurement, and delivery. This would enable governments to design career pathways with a comprehensive view of the health system, workforce priorities, and contextual challenges in consultation with key multisectoral stakeholders, including community health workers.[60][61] It is essential to capture and elevate evidence on women community health workers' impact to optimize their roles in addressing health challenges and advancing national health agendas.[62]

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[59] Integrate Health. (2024). Continuity of care and supported community health workers. Blog. https://integratehealth.org/continuity-of-care-and-supported-community-health-workers/

[60] Ajisegiri et al. (2022).

[61] USAID. (2023).

[62] Ibid.

Recruiting women community health workers into the workforce

Recommendations for action

Community health worker Agnes Panman from Zean Town, Liberia.

Recruitment and selection of community health workers depends on 1) how the community and health system define the community health worker role and 2) how a community health worker is identified and selected.[63] The 2018 WHO guidelines suggest applying "gender equity appropriate to the context" as criteria for selecting community health workers for pre-service training, as well as encouraging proactive policies to maximize women's participation in recruitment and selection given existing gender inequities in low-resource settings.[64] This is further emphasized in cultural contexts where women community health workers are needed to provide certain health services (e.g., reproductive, maternal, newborn, and child health).

Recommendation 4: Local community leaders and members, including male partners, actively participate in efforts to change perceptions about community health workers and recruitment practices so women have equal opportunity for selection.

Why? Power relations at the community level impede women's ability to become community health workers. There is an expectation that women's first obligation is to household duties (e.g., childcare, elder care, cooking, cleaning), while men focus on income-generating work.[65][66][67][68] The international literature suggests that lack of family support is a common challenge to women pursuing the role of community health worker[69][70] and the pursuit of community health activities depends on the family's ability to accept and compensate for the periods of absence of the person conducting these activities.[71]

Developing innovative approaches to address male partner resistance is also critical. Women's lack of autonomy in decision-making has emerged as a critical barrier to being nominated and selected as community health workers. In some countries (e.g., Liberia, Mozambique, Sierra Leone) it was reported that husbands did not want their wives to become employed or participate in community health work.[72][73] In the Democratic Republic of Congo, there are more women community health workers in communities where women's associations exist. They advocate for women and influence husbands' and relatives' attitudes towards granting women permission to join the community health worker program.[74]

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[63] Community Health Impact Coalition. (2018).
[64] WHO. (2018).
[65] African Population and Health Research Center. (2020).
[66] Hafez et al. (2023). Examining the gender imbalance in the National Community Health Assistant Programme in Liberia: A qualitative analysis of policy and Programme implementation. Health Policy & Planning. 37(2):181-191.doi: 10.1093/heapol/czac075. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9923372/
[67] Steege et al. (2018).
[68] UNICEF. (2021). Gender relations in community health systems in West and Central Africa. Research summary brief. https://www.unicef.org/wca/media/6731/file/UNICEF-Gender-relations-health-systems.pdf
[69] Closser et al. (2023).
[70] Steege et al. (2018).
[71] Steege et al. (2018).
[72] Raven et al. (2022).
[73] Steege et al. (2018).
[74] Raven et al. (2022).

> In many settings, community health workers are selected by committees composed of key community members, often including village and religious leaders.[75][76] Male community leaders are often the only or primary actors in the decision-making process, though some community health committees include strong representation of women.[77][78] Despite the fact that some national policies have gender recruitment criteria, community-level nomination and selection processes tend to continue to prioritize men over women due to gender norms or preferences.[79][80] The literature suggests that community health committees prioritized the nomination of men because of their perception that men are more entitled to or deserving of remunerated jobs; men have greater availability to work because they are not expected to do domestic labor while women are expected to stay home; or women are (or self-describe as) shy and not confident.[81][82][83] Engaging religious leaders can help foster gender-positive attitudes and reduce resistance in these contexts,[84] as religious leaders are important for communities' acceptance of women receiving care from health professionals.[85]

"Yes, in our culture especially where the program has been implemented in rural parts of Liberia, everybody in their own household have their own rules and responsibilities … They prefer their wives to stay home, wash clothes and look after the children … So, each man or woman has their role to play for every household. Also, there are roles for children where in the rural setting, they will prefer the boy child leaving from their community to go out and learn while the girl child stays there and learns from their mother how to take care of their home."

— Man engaged with community health programs in Liberia[86]

"Some husbands refuse to allow their wife to become a [community health worker], arguing that she will have a relationship with other men during training and that she will not have time to take care of the household and children."

— Woman from a community in Mozambique[87]

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[75] Jackson. (2018).

[76] Steege et al. (2018).

[77] Hafez et al. (2018).

[78] Raven et al. (2022).

[79] Hafez et al. (2018).

[80] Raven et al. (2022).

[81] Hafez et al. (2023).

[82] Raven et al. (2022).

[83] Steege et al. (2018).

[84] Idriss-Wheeler et al. (2024). Engaging community health workers in Africa: Lessons from the Canadian Red Cross supported programs. PLOS Global Public Health. 4(1): e0002799. doi: 10.1371/journal.pgph.0002799. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10796059/

[85] Bergen et al. (2020). Promoting equity in maternal, newborn and child health — how does gender factor in? Perceptions of public servants in the Ethiopian health sector. Global Health Action. 13(1). doi: 10.1080/16549716.2019.1704530. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7006674/

[86] Hafez et al. (2023).

[87] Steege et al. (2018).

Implementation example

Integrate Health's community-based strategies for recruitment in Togo

Integrate Health works with community leaders and members to recruit the best candidates to fill community health worker positions. First, they agree on an ideal candidate profile. Once the profile is defined, they work together to recruit community members who are interested in the role. Integrate Health places particular emphasis on prioritizing women's applications for the community health worker position. If the prioritization of women's applications is misunderstood by the populations approached during preparatory meetings for program implementation, the team carries out mass awareness-raising campaigns to explain the reason for the choice of women and to motivate and encourage women to apply for the job. The team dialogues with chiefs, community leaders, and husbands to ensure they understand the importance of women and women's roles in the field and for the position. The women are nominated by community members or themselves. Integrate Health and community leaders agree on the final list of candidates as a last step before training. This process not only identifies the best candidates for the role, but involves community leaders from the beginning so they can resolve any problems that arise.[88]

Integrate Health's recruitment strategy in Togo has resulted in over 90% of 200 Integrate Health-supported community health workers being women. Over time, this approach has empowered women to come forward as candidates, increased community trust (e.g., some women said they felt more comfortable discussing their health issues with a women community health workers), increased health center attendance, and improved health outcomes, particularly in maternal and child health. Community involvement has created a sense of ownership and responsibility, ensuring sustained commitment and support for the health program. Mass awareness campaigns and dialogues with community leaders and husbands have addressed gender issues, resulting in greater acceptance of women community health workers. Overall, this strategy has created a motivated and trusted team of community health workers capable of delivering effective health services. Furthermore, the government of Togo has now committed to increasing the percentage of women community health workers in the national cadre from its current level of 20% up to 40%. This recruitment strategy is not only increasing gender equity, but also contributing to significant health impacts. Peer-reviewed study results show a potential 30% decrease in under-five child mortality rates in communities where this approach has been implemented over a period of five years. This figure demonstrates a doubling of impact compared to the 14% national reduction estimated over the same period.

[88] Integrate Health. (2021). The power of community engagement. https://integratehealth.org/the-power-of-community-engagement/

Recommendation 5: National community health policies include strong selection criteria and requirements that proactively enable the entry of women community health workers into the profession.

Implementation considerations

- Governments should reconsider the use of strict education and literacy requirements and focus criteria on competency-based skills assessments and accreditation following community health worker pre-service training and caregiving experience.

Why? Many national policies (e.g., Liberia, Ethiopia, Democratic Republic of Congo) include a certain level of education or literacy as a requirement for community health worker selection,[89][90][91][92] which women often do not meet in many country contexts. For example, in Liberia, the requirement is a minimum equivalent of a sixth-grade education,[93] while in Ethiopia a tenth-grade education equivalent is required.[94] Women's lower educational status in these contexts means men are more able or likely to fill these roles,[95] highlighting how the prioritization of formal education as a requirement supports selection of men over women.[96] Based on findings from a review by the WHO and the Global Health Workforce Alliance, the WHO recommends a minimum primary school education level is appropriate to meet the needs of the community.[97][98] According to Rogers et al., "with this limited direction, selection criteria for community health workers varies widely" in different contexts.[99] However, the WHO emphasizes that there is very little evidence on the connection between selection criteria and predictors of community health worker performance,[100] so high levels of education may not be necessary as a key selection criterion. Instead, as recent research suggests, caregiving experience and training have been found to be more predictive of community health worker competency than formal education.[101]

[89] Hafez et al. (2023).
[90] Jackson. (2018).
[91] Jackson et al. (2019).
[92] Raven et al. (2022).
[93] Hafez et al. (2023).
[94] Jackson. (2018).
[95] UNICEF. (2021).
[96] Raven et al. (2022)
[97] WHO. (2018).
[98] WHO. (2020).
[99] Rogers et al. (2023).
[100] WHO. (2018).
[101] Rogers et al. (2023).

Evidence highlight

Training and experience outperform literacy and formal education as predictors of community health worker knowledge and performance, results from Rongo sub-county, Kenya[102]

A small quantitative study investigating predictors of community health worker knowledge and performance carried out by Lwala Community Alliance and the Kenyan Ministry of Health found that caregiving experience and training were more predictive of community health worker competency than formal education. Education, literacy, experience, training, and gender were explored as potential predictors of community health worker performance. Researchers concluded that policymakers and practitioners should reconsider the use of education and literacy requirements in the selection process of community health workers and instead encourage selection to focus on caregiving experience, as well as for programs to use competency-based assessments and accreditation following community health worker training.

Ideas for innovation

Incorporate literacy and numeracy components into community health worker training to increase women's literacy levels.

In Liberia and Sierra Leone, where literacy challenges place women at even greater disadvantage for community health worker selection, women joined an elders' educational program to increase their literacy levels. A small qualitative study explored how gender influences the ways community health workers are managed and supported and the effects on their work experiences. Through interviews with decision-makers and managers working in community health programs and managing community health workers, the study showed such programs provide some degree of help. According to one respondent, "some women who as a result of literacy support linked to the [community health worker] program have completed school and are in midwifery school."[103] Informants believe embedding literacy programs within community health worker training would support the participation of women and others with literacy challenges in the community health workforce.[104]

[102] Ibid.
[103] Raven et al. (2022).
[104] Ibid.

Recommendation 6: Governments commit to the preferential hiring of women community health workers until gender parity is achieved in the national workforce.

Implementation considerations

- This is particularly important for reproductive and maternal health roles, in which women community health workers are preferred by the community.[105]
- In some contexts, encourage governments to establish, integrate, and enforce gender quotas.

Why? A regional report of community health programs in 20 countries in West and Central Africa confirmed that most countries have a predominance of community health worker who are men.[106] Even when global recommendations and national policies in some countries support and prioritize the selection of women community health workers (e.g., Liberia, Sierra Leone), there often remain more men than women community health workers in these countries,[107] especially when the roles are paid. For example, Liberia's National Community Health Services Policy of 2016 included a stated preference for women to become community health workers and a goal to recruit primarily women, yet as of 2021, only 17% of community health workers in Liberia were women.[108][109] This is largely because policy ideals in recruitment and selection are mitigated by gender norms at the community level, and policies are not translated into action in the absence of explicit guidance and strategies on how to operationalize them at the community level.[110][111][112]

Implementation example

Last Mile Health Liberia gender assessment and takeaways

Launched in 2016 following the Ebola epidemic, the Government of Liberia's National Community Health Program deploys professional community health workers to provide primary health services in remote communities in every district across the country.

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[105] Olaniran A, Banke-Thomas A, Bar-Zeev S, Madaj B. (2022). Not knowing enough, not having enough, not feeling wanted: Challenges of community health workers providing maternal and newborn services in Africa and Asia. PLoS ONE 17(9): e0274110. https://doi.org/10.1371/journal.pone.0274110

[106] UNICEF. (2019).

[107] Raven et al. (2022).

[108] Exemplars in Global Health. (2024). Overview: Community health workers in Liberia. https://www.exemplars.health/topics/community-health-workers/liberia

[109] Hafez et al. (2023).

[110] African Population and Health Research Center. (2020).

[111] Hafez et al. (2023).

[112] Raven et al. (2022).

The program aims to give preference to women to become community health workers. However, after five years of implementing the program, only 17% of the community health workers the program employed were female. Last Mile Health partnered with the Government of Liberia, with support from Co-Impact, to conduct a gender assessment to examine the gender responsiveness of the program, identify and document gender inequities and their root causes, and assess how the program has impacted men and women differently.[113][114] In March 2023, the recommendations from the assessment were adopted into the revised national policy, which includes adjustments to the recruitment approach and curriculum to recruit and retain more women community health workers; these adjustments include lowering literacy and numeracy requirements for women and providing more support in training. In addition to their role in generating evidence and advocating for data-driven recommendations, Last Mile Health has also worked to operationalize the updated recruitment criteria in Grand Bassa County, Liberia, which was the final county in the country that needed to complete the initial recruitment of community health workers. In Grand Bassa, county health team officials and Last Mile Health engaged already-deployed women community health workers and supervisors in community mobilization to encourage women to participate in the process, as well as participating in the community selection process to offset recruitment bias that benefits men. This successfully increased the percentage of women serving as community health workers in the county from 20% to 33%, exceeding the Ministry of Health's interim goal of 30%.

Community health worker Yindjre Martine N'wintcha, from Naware, Dankpen district, Togo, proactively looking for patients in her area.

[113] Hafez et al. (2023).

[114] Last Mile Health. (2022). Towards a More Gender-Equal Community Health Worker Program: Key Takeaways from the Gender Assessment of Liberia's National Program. https://lastmilehealth.org/2022/03/07/liberia-chw-program-gender-assessment/

Enabling women community health workers to succeed

Recommendations for action

Community health worker Workinesh Getachew plays with children at her health post in Oromia region, Ethiopia, showing them images on the tablet she uses for her work.

Enabling women community health workers to succeed in their roles requires strong training, technology at the point of care, supportive and consistent supervision, and adequate and reliable supplies. Strong training involves both pre-service training that prepares community health workers for their roles and ensures they have the necessary skills to provide safe and quality care, as well as regular in-service training to reinforce initial training, teach new skills, and help ensure quality.[115] Technology supports decision-making at the point of care, facilitates accurate and efficient record-keeping, allows seamless transfer of data to district- and national-level health leaders, and underscores community health workers' professional status. Community health worker supervisors review community health workers' caseloads and offer guidance, help solve problems, and provide feedback including data auditing. In national programs, they also provide a critical link to the nearest health center and facilitate referrals for patients who need more advanced care. Adequate and reliable supplies—including medicine, diagnostic tools, and personal protective equipment—are necessary for community health workers to provide appropriate care and keep themselves safe while they do so.[116][117]

Recommendation 7: Training modules are tailored to the specific needs and priorities of both women and men community health workers.

Why? There is a noted lack of training opportunities for women community health workers, preventing them from performing well in their roles.[118] Most community health workers receive some training, but training content quality, length, responsibility, and approaches vary among programs, organizations, and countries. The acceptability of men and women community health workers to discuss certain health topics and provide certain services varies depending on context,[119] which suggests training content and competencies should be context-specific and address gender norms, roles, and relations among target and key populations and communities.[120] Women community health workers face additional gender-based constraints in accessing training, including lack of transport, restricted mobility, childcare responsibilities and other time constraints (e.g., inability to be away from family for extended periods of time or consecutive days), and inadequate housing conditions at training centers (e.g., group accommodations that might have low security; restroom facilities that are not equipped for women's needs).

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[115] Community Health Impact Coalition. (2018).

[116] Ibid

[117] Last Mile Health. (2024). The Six Ss. https://lastmilehealth.org/what-we-do/six-s/

[118] Women in Global Health. (2023).

[119] Ahmed et al. (2022).

[120] El-Kalaaway et al., 2021. Promoting gender responsive policies and programmes for community health workers: A gender analysis framework. https://chwcentral.org/wp-content/uploads/2021/03/CHW-GenderVF.Final-1.pdf

Implementation example

Last Mile Health blended learning in Ethiopia

One way to overcome gender-specific barriers to training access is to consider the use of blended learning formats. Until recently, in-service training for Ethiopia's entirely female community health workforce used only printed materials and in-person sessions at the district level, requiring significant travel for community health workers living far from training facilities. In-person training was costly and static, limiting participants' ability to access and practice key competencies taught in training modules. In partnership with the Ethiopia Ministry of Health, Last Mile Health adapted the training content using an innovative blended learning approach that incorporates both digital and face-to-face components, making it more flexible for participants to attend. The pilot module covered reproductive, maternal, neonatal, and child health, addressing areas of great need and potential impact. Rather than the standard ten in-person sessions, participants attended two in-person sessions, completed five digital sessions via self-learning using their tablets, and then returned for two more in-person sessions. The results of the pilot program showed that blended training reduced training costs from $605 to $372 per learner while delivering strong knowledge and skill assessment gains. In June 2023, the Ministry of Health formally adopted the blended learning approach for the country's Health Extension Program, which employs more than 40,000 community health workers. Last Mile Health has now also piloted training modules on immunization with GAVI, and for non-communicable diseases and major communicable diseases.

Last Mile Health's digital training content has consistently been powered by culturally appropriate multimedia in regional languages and includes animated videos and illustrations designed with a gender mainstreaming approach. 75% to 100% of lecture videos are narrated by women, and women scriptwriters and animators have been prioritized (and more have been hired over time, with 83% of scriptwriters identifying as women for the recent non-communicable disease modules). Similarly, during user testing, women from diverse regions were targeted to address ethnicity, culture, and language considerations. This participant testing is conducted by women serving as focal points, with a focus on comfort and usability for women community health workers.

Looking forward, Last Mile Health plans to adapt all training topics to the blended learning format and scale all modules to the full community health workforce, underscoring the power of designing training materials with and for women.[121][122][123][124][125]

Recommendation 8: Community health worker training curriculum includes modules on gender sensitivity and safety to prevent and respond to gender-based violence.

Why? Women community health workers are at high risk of sexual harassment, assault, and violence, which affects their ability to perform their duties safely and effectively.[126][127][128] Training should take an approach that addresses the causes, risks, and consequences of violence, discrimination, and exclusion in an integrated way to ensure the dignity, access, participation, and safety of all people, including marginalized groups and genders.[129] By training community health workers on skills for negotiating gender-based conflict and preventing violence in communities and households, community health workers may feel safer in their roles.[130] Gender sensitivity training has also been shown (e.g., in Ethiopia) to increase cooperation and collaboration among diverse community health workers, which is necessary for effective service provision when resources are limited.[131]

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[121] Last Mile Health. (2022). RMNCH IRT blended learning pilot abridged report. https://lastmilehealth.org/wp-content/uploads/2022/07/Blended-IRT_RMNCH_Pilot_Abridged_Report_v08.pdf

[122] Last Mile Health. (2022). A new chapter: Sharing the results of our blended learning training in Ethiopia. Blog. https://lastmilehealth.org/2022/07/25/sharing-the-results-of-our-blended-learning-training-in-ethiopia/

[123] Last Mile Health. (2022). Blended learning boosts health worker skills training in Ethiopia. Blog. https://lastmilehealth.org/2022/04/26/blended-learning-pilot-ethiopia/

[124] Last Mile Health. (2023). Ethiopia's Ministry of Health formally adopts blended learning approach for 40,000 community health workers, building on success of Last Mile Health pilot. Blog. https://lastmilehealth.org/2023/07/24/ethiopias-ministry-of-health-formally-adopts-blended-learning-approach/

[125] Last Mile Health. (2024). Community health worker training drives improvements in childhood immunization rates in Ethiopia. https://lastmilehealth.org/2024/01/23/from-0-to-96-community-health-worker-training-drives-improvements-in-childhood-immunization-rates-in-ethiopia/

[126] Closser et al. (2023).

[127] Jackson et al. (2019).

[128] Steege et al. (2018).

[129] Idriss-Wheeler et al. (2024).

[130] Closser et al. (2023).

[131] Dynes et al. (2014). Factors shaping interactions among community health workers in rural Ethiopia: Rethinking workplace trust and teamwork. Journal of Midwifery & Women's Health. 59(Suppl 1):S32-43. doi: 10.1111/jmwh.12135. https://onlinelibrary.wiley.com/doi/10.1111/jmwh.12135

Recommendation 9: Women community health workers can access context-appropriate transport modalities to enhance their safety and security on the job.

Why? Community health workers often require transport for home visits, especially if patients need to travel to a clinic or hospital.[132] Women community health workers face gender-specific mobility issues due to gender norms that restrict them from using public transport or private vehicles.[133][134][135] For example, in northern Nigeria, men community health workers were provided motorcycles, while women community health workers were prevented from using motorcycles until program developers held advocacy meetings with traditional leaders.[136] While it is beyond the scope of some implementers to ensure adequate access to transport by directly providing access to context-relevant modes of transportation or travel allowances, a first step is to provide training for how to use different transport modalities, such as learning how to operate motorcycles. For example, in Liberia, community health supervisors (who are primarily women) are trained to ride motorbikes as part of their onboarding, and being able to ride a motorbike is no longer a pre-requirement as it was in the past (which benefited men, as they were more likely to have this skill).

Recommendation 10: Digital tools are designed and deployed with a gender-responsive lens.

Why? Data systems that collect community-level data that can easily flow to the health system and back to the community are necessary for effective community health programs.[137] To achieve this, WHO suggests that community health workers document the services they provide and that they collect, collate, and use health data on routine activities through relevant mobile health solutions.[138] Digitization of tools for these activities has the potential to strengthen gender responsiveness of community health activities by enabling less literate users to perform the same duties as more educated workers because they can "enable women with limited literacy to log data, report, and manage their tasks better than paper-based work modalities."[139] In Liberia, women community health workers who participated in a pilot training for the electronic community-based information system (eCBIS) reported that they would need to learn more before using eCBIS compared to male community health workers. Male community health workers also had a significantly higher percentage of participants respond "very well" to being able to use eCBIS to schedule visits or to manage their digital device compared to female community health workers.

[132] African Population and Health Research Center. (2020).
[133] Hafez et al. (2023).
[134] McKague et al. (2021).
[135] Steege et al. (2018)
[136] Ibid.
[137] Community Health Impact Coalition. (2018)
[138] WHO. (2018).
[139] Hafez et al. (2023).

These results underscore the importance of deploying digital tools in a way that is tailored to meet the needs of women community health workers, who are less likely to access digital services globally compared to men.[140]

Idea for innovation

Develop apps with and for community health workers to use at the point of care to facilitate provision of key services.

Point-of-care apps can help community health workers manage consultations in real time, follow up with patients using consultation history, and manage medical files in the field. Evidence from Integrate Health demonstrates the value of these digital tools in producing reliable, accessible, and secure health data. In 2022, Integrate Health created the Tonoudayo app, a digital tool that allows for real-time management of consultations, efficient patient follow-ups, and optimal handling of digital medical records. Through Tonoudayo, community health workers collect secure, reliable, and high-quality primary care data to improve care delivery continuously. Key competitive advantages include feedback loops with community health workers to ensure usability, app customization, and key features such as appointment reminders.[141] Apps like these can help promote gender equality by allowing women community health workers to consult with female patients confidentially with regard to sensitive topics, such as family planning and reproductive health.[142] In contrast to paper records, this technology typically only allows individuals with permission (e.g., through password-protected platforms or encryption) to view patients' personal health information, ensuring data privacy and security if a tablet or phone is lost or stolen. In addition, multiple Integrate Health-supported women community health workers have expressed that they receive more respect during home visits when they are using their phone with the Tonoudayo app as opposed to paper registers. Furthermore, a small qualitative study in Mozambique investigating how gender influenced the experiences of community health workers using the MOVE (POM) mHealth app demonstrated that using the app increased empowerment and made both women and men community health workers feel like true healthcare professionals.[143] Women community health workers reported gaining more knowledge from using the app and highlighted realizing the importance of their roles when using the app with local women (a point men community health workers did not mention). Women community health workers also noted an increase in community respect and value, feeling more responsible and comfortable in their roles.

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[140] Gillwald & Partridge. (2022). Gendered nature of digital inequality: Evidence for policy considerations. Policy brief. https://www.unwomen.org/sites/default/files/2022-12/BP.1_Alison%20Gillwald.pdf

[141] Integrate Health. (2023). Advancing healthcare delivery in Togo: The digital transformation of Integrate Health. Blog. https://integratehealth.org/advancing-healthcare-delivery-in-togo-the-digital-transformation-of-integrate-health/

[142] Ahmed et al. (2022).

[143] Kinshella et al. (2022). How gender influenced the experience of using a mHealth intervention in rural Mozambique: Secondary qualitative analysis of community health worker survey data. Frontiers in Global Women's Health. 3: 661000. doi: 10.3389/fgwh.2022.661000. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8907823/

Men community health workers experienced improved interactions with nurses and pregnant women in their communities.[144]

Recommendation 11: Supervisors are selected through a process that increases opportunities for women to be appointed in these roles.

Implementation considerations

- Supportive supervision should include opportunities for sustained reflective practice to adapt to and respond to changing contexts effectively, as well as problem-solving on how gender norms influence community health workers' experiences and those of the communities they serve.[145]

Why? Men are more likely to occupy supervisory roles due to women's general lower position in health system hierarchies (e.g., Malawi).[146] In Sierra Leone, most peer supervisors (e.g., community health workers with additional training, allowances, and responsibilities) are men, and women rarely perform this role due to lower education levels and gender norms around leadership.[147] The 2018 WHO guidelines recommend that gender related factors should be considered in selecting supervisors and suggest that "having mostly male supervisors for mostly female [community health workers] may be inappropriate, reinforce gender barriers, and limit acceptability and effectiveness of supervision."[148]

In addition to having women supervisors who can coach women community health workers through their unique challenges, supervision must be an ongoing and regular activity in community health worker programs. This has been identified as one of the "weakest links" in community health programs as a result of poorly defined roles and difficulty providing supervision in remote areas.[149] Community health workers themselves have reported lack of supportive supervision as an issue,[150] and national-level key informants reported fears regarding inadequate reporting lines between community health workers and other providers in the health system.[151]

[144] Ibid.
[145] Raven et al. (2022).
[146] Steege et al. (2018).
[147] Raven et al. (2022).
[148] WHO. (2018).
[149] McKague & Harrison. (2019).
[150] Jackson et al. (2019).
[151] Kok et al. (2020). Enabling and hindering factors of health surveillance assistants' roles in provision of contraceptive services in Mangochi, Malawi. Reproductive Health. 17(1):57. doi: 10.1186/s12978-020-0906-3. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7171808/

Recommendation 12: Personal protective equipment for women community health workers is designed and provided to meet their unique needs.

Why? Women community health workers face additional burdens—such as limited mobility—in reliably accessing supplies due to gender constraints.[152] Furthermore, COVID-19 exposed that women community health workers, in particular, were expected to work without adequate personal protective equipment (or with personal protective equipment designed for the male body that did not guarantee them safety or dignity) while taking on high-risk duties and increased workloads.[153] Community health workers, particularly women, receive less personal protective equipment and fewer resources.[154][155] The lack of personal protective equipment makes community health workers appear as high-risk individuals in communities and impedes their work.[156] A peer-reviewed study in Togo found that women community health workers, equipped with appropriate protective equipment and medical supplies, maintained community trust in the health system during the COVID-19 pandemic.[157] Community health workers themselves highlight the necessity of personal protective equipment for confidence and safety in their roles, especially during emergency situations like the COVID-19 pandemic.[158] Lack of recognition puts women community health workers at the back of the line for essential equipment, diminishing their role and threatening community health programs.[159] A gender imbalance in the public health supply chain workforce could contribute to this issue, as well as a gender-neutral approach to logistics systems planning including last-mile delivery, digital tools, and supply chain capacity.[160]

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[152] McKague & Harrison. (2019).

[153] Women in Global Health. (2021). Fit for women? Safe and decent PPE for women health and care workers. Policy report. https://womeningh.org/our-advocacy-3/fitforwomenreport/

[154] De Menezes et al. (2022). Examining the intersection between gender, community health workers, and vector control policies: A text mining literature review. American Journal of Tropical Medicine and Hygiene. 106(3):768-774. doi: 10.4269/ajtmh.21-0619. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8922516/

[155] Women in Global Health (2021).

[156] Ibid.

[157] Haughton et al. (2024). A time series analysis of disruptions to maternal and child health care in northern Togo during the COVID-19 pandemic in the context of an integrated primary care program. Advances in Global Health. 3(1): 2123937. doi: https://online.ucpress.edu/agh/article/3/1/2123937/201157/A-time-series-analysis-of-disruptions-to-maternal

[158] Women in Global Health (2021).

[159] Ibid.

[160] VillageReach. (2024). Understanding gender imbalance in the public health supply chain workforce. Report. https://www.villagereach.org/wp-content/uploads/2024/06/VR_GenderPHSCworkforce_FullReport_FINAL-1.pdf

Retaining women community health workers and advancing their careers

Recommendations for action

A community health worker—part of Ethiopia's all-female cadre—conducts a home visit with a mother and child in Sidama region.

Retaining women community health workers in the workforce requires supporting work-life balance as well as promoting women community health workers' safety and protecting them from gender-based violence in the community and workforce. To advance, women community health workers need a clearly defined and established sequence of positions that align with community health worker skills and competencies to guide upskilling and upward career mobility. Community health program implementers can help advance women community health workers' careers by supporting an upward or lateral move within the community health worker track or a change to a different role with a different scope based on set qualifications related to training and years of service.[161]

Recommendation 13: Programs and policies prioritize community health worker safety and the prevention of gender-based violence.

Implementation considerations

- Introduce long-term community sensitization to address gender-based violence.[162]
- Establish safe work plans, such as events during daylight hours, partnering men and women community health workers, and encouraging support from male partners when women community health workers work at night.[163]
- Create safe spaces near health facilities for women community health workers who accompany patients to facilities to stay overnight.[164]
- Plan to mitigate increased risks of violence due to employment and address harassment through various measures, such as anonymous complaints systems.[165] Increase government support by means such as providing documentation (e.g., ID cards), providing counseling, and issuing public statements to affirm community health workers as government workers to reduce community harassment.[166] Hold governments, employers, bystanders, and perpetrators accountable and ensure timely reporting and response to sexual exploitation, abuse, and harassment appropriate to the country's legal structures and overall culture around gender-based violence.[167][168] Carry out regular monitoring and evaluation on safety mechanisms and safety reviews.[169]

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[161] USAID. (2023).
[162] Raven et al. (2022).
[163] Closser et al. (2023).
[164] Raven et al. (2022).
[165] Closser et al. (2023).
[166] Ibid.
[167] Women in Global Health. (2022). Her stories: Ending sexual exploitation, abuse, and harassment of women health workers. Policy report. https://womeningh.org/wp-content/uploads/2022/12/WGH-Her-Stories-SEAH-Report_Policy-Report-Dec-2022.pdf
[168] Women in Global Health. (2023). Women community health workers: Leading change. Executive Summary. [Provided in advance of publication by LMH].
[169] Closser et al. (2023).

Why? Women community health workers are at high risk of sexual harassment, assault, and violence, which affects their ability to perform their duties safely and effectively.[170][171][172] Personal safety is a major concern for women community health workers, particularly in settings where they are required to travel alone or at night and especially in conflict-affected areas or during health emergencies, where violence is often heightened.[173][174][175][176] Women community health workers face severe, intermittent violence in the course of their work in the community, including being yelled at, hit with household objects, and even threatened with murder.[177] In Kenya, women community health workers seeking to conduct HIV testing have reported threats of violence by husbands in the community; woman community health workers have also reported rape.[178] Some women community health workers risk the threat of violence by providing family planning services to women in secret.[179]

> "We are concerned about our safety because we are female."
>
> — Community health worker[180]

Lack of social authority increases the risk of harassment, abuse, and violence for women community health workers.[181] Reportedly, communities sometimes feel empowered to treat them badly because they know consequences for such behavior are unlikely.[182] There are significant barriers to reporting incidents of harassment and violence, including fears of not being taken seriously and potential social and economic consequences.[183][184] Women community health workers fear registering reports because they do not want to make enemies; often, if they do report, the complaint is registered as a personal matter.[185] Unpaid or "volunteer" women community health workers are most vulnerable to abuse and exploitation because they are the least able to access legal and other social protections.[186]

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[170] Ibid.
[171] Jackson et al. (2019).
[172] Steege et al. (2018).
[173] Closser et al. (2023).
[174] Hafez et al. (2023)
[175] Jackson et al. (2019).
[176] Raven et al. (2022).
[177] Closser et al. (2023).
[178] Steege et al. (2018).
[179] Ahmed et al. (2022).
[180] Jackson et al. (2019).
[181] Closser et al. (2023)
[182] Ibid.
[183] Ibid.
[184] Women in Global Health. (2023).
[185] Closser et al. (2023)
[186] Women in Global Health. (2023).

Women face additional harassment and safety risks when seeking advancement, further limiting their professional growth.[187] For example, in Malawi, it was reported that male supervisors could pressure and blackmail women into exchanging sexual favors for access to opportunities and career progression.[188] Still, many women community health workers stay in this role because few other income-generating jobs exist.

> "We are fearful of going out. One [community health worker] was abducted and raped (four years ago). There was no solution for this, no justice for the [community health worker], so that we are all fearful."
>
> — Community health worker[189]

Implementation example

Integrate Health's conflict management system for gender-based violence

In Togo, Integrate Health developed a conflict management system to address gender-based violence incidents reported by women community health workers. Recognizing that women's economic independence can disrupt traditional gender norms, Integrate Health engaged with husbands, community leaders, and the Ministry of Justice and Human Rights to address these issues.

When a case of gender-based violence is reported, Integrate Health starts a mediation process with the victim, the perpetrator, and the neighborhood chief. In cases where mediation does not provide a satisfactory outcome, the case is referred to community leaders. With Integrate Health's support, they manage the conflict and identify a durable solution. As a last resort, the victim is referred to the House of Justice, a structure composed of retired judges and lawyers who provide legal insights and help resolve disputes.

In parallel, Integrate Health organized meetings with women community health workers' husbands, aiming to shift men's perceptions of domestic violence, promote non-violent communication, and create a more supportive family and community environment. The training focused on domestic violence and also included a module on human rights, with a specific lens on women's rights as outlined in Togolese law. Togolese human rights lawyers led sessions to provide culturally relevant context.

Initial evaluations of this mechanism showed improvements including better respect from spouses, reduced abuse, and positive discussions about women community health workers' contributions, especially around earning a salary.

[187] USAID. (2023).
[188] Ibid.
[189] Jackson et al. (2019).

Recommendation 14: Support structures and networks are established for the professional development of women community health workers.

Implementation considerations

- Introduce mentorship programs and professional associations to represent and strengthen the work of community health workers.
- Provide opportunities for personal and professional development, including trainings on building self-confidence.

Why? Women community health workers often feel isolated due to limited opportunities to connect with peers and leaders, made worse by insufficient social support.[190][191] Prevailing social structures, including gender dynamics, may limit interactions between diverse health workers, reducing potential for collaboration and improved quality of care.[192] There is even limited opportunity to connect with other women community health workers working within the same health social enterprise.[193] Creating coalitions where women community health workers can share experiences and take collective action can increase the effectiveness of activism while ensuring more safety for individuals speaking out.

Implementation example

The Community Health Impact Coalition's Community Health Worker Advocate Program[194]

Integrate Health and Last Mile Health are part of the Community Health Impact Coalition (CHIC), a leading coalition of like-minded organizations advocating for salaried, skilled, supervised, and supplied community health workers to be the norm worldwide. One of CHIC's key activities is the Community Health Worker Advocate Program, a free digital training designed by and for community health workers to equip them with advocacy and storytelling skills. CHIC has found that community health workers with leadership training are two to four times more likely to engage in political, civic, and workplace advocacy. In addition, the initiative builds strong networks of community health workers globally. Utilizing WhatsApp channels, organizing national meetups, and hosting bi-monthly meetings, community health workers from different regions can exchange ideas, share experiences, and discuss ways to improve both the quality of their work and their working conditions. By connecting community health workers with one another, the initiative fosters a professional network that builds peer support and a community of belonging.

[190] African Population and Health Research Center. (2020).
[191] McKague et al. (2021).
[192] Dynes et al. (2014).
[193] McKague et al. (2021).
[194] Community Health Impact Coalition. (ND). What we do: Activate. Webpage. https://joinchic.org/what-we-do/activate/

Recommendation 15: National policies are implemented to ensure women community health workers maintain a fair workload and are not burdened with additional responsibilities beyond their roles.

Why? Women community health workers are often required to juggle multiple responsibilities (including domestic duties and other income-generating activities), which can impact their performance as community health workers and their retention in the workforce.[195][196] Married community health workers struggle to balance poorly remunerated community health work with the heavy burden of domestic responsibilities.[197] Women community health workers face an expectation to fulfill household chores and care for children and elderly family members in addition to their work.[198] In South Africa, women reported being pulled between domestic duties and their role as a provider in the community. In Rwanda, varying and unpredictable intensity of work was perceived as detracting from the time women community health workers needed with their families.[199] Furthermore, workload demands challenge the health of community health workers themselves.[200] In some cases, women community health workers are not able to live with their husbands or children.[201] In many settings, men have the final say in how women allocate their time to household work and community health work and, ultimately, whether or not they can stay in the role of community health worker.[202]

Recommendation 16: National policies provide career pathways for women community health workers, promoting long-term professional development and growth.

Implementation considerations

- Provide tailored leadership and skills training; ensure training is tailored to different numeracy and literacy levels and considers community health workers who have limited formal education.[203]

[195] Ibid.
[196] Raven et al. (2022).
[197] Ahmed et al. (2022).
[198] Steege et al. (2018).
[199] Ibid.
[200] Bergen et al. (2020).
[201] Jackson. (2018).
[202] Raven et al. (2022).
[203] USAID. (2023).

- Support women community health workers juggling multiple responsibilities so they can undertake further professional development[204] (e.g., offering trainings closer to where community health workers live, providing transport and childcare support, allowing time off for examinations).[205][206]
- Ensure management roles are based on performance as well as qualifications.[207]
- Start with in-depth analysis of the landscape to understand and align with health workforce priorities, resources, profiles of existing community health worker knowledge and skills, and any contextual challenges; include mapping out of existing policies and practices.[208]
- Rollout of a career pathway should be gradual, given the cost and time required for full integration in the health system.[209]
- Reserve a percentage of higher-level management positions for women to involve them in decision-making and leadership development.[210]
- Garner political commitment from the national government. Political commitment is "at the heart of success," as most large-scale national community health worker programs with career pathways benefit from political will and support from key multisectorial stakeholders, such as ministries of finance and labor and civil service commissions.[211]

Why? Men dominate higher-level positions, limiting advancement opportunities for women community health workers.[212] Despite the fact that some national policies state preferences for hiring women community health workers, systemic biases disadvantage women in career progression.[213] Despite their years of experiences as health leaders within their communities, which would allow them to progress to better positions, women community health workers face barriers to career progression due to lower levels of education and limited access to additional training.[214][215][216][217] Domestic responsibilities hinder women's ability to participate in additional training or career advancement opportunities.[218]

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[204] Raven et al. (2022).
[205] African Population and Health Research Center. (2020).
[206] USAID. (2023).
[207] Closser et al. (2023).
[208] USAID. (2023).
[209] Ibid.
[210] McKague & Harrison. (2019).
[211] USAID. (2023).
[212] Closser et al. (2023).
[213] Women in Global Health. (2023).
[214] Jackson. (2018).
[215] Jackson et al. (2019).
[216] McKague et al. (2021).
[217] Raven et al. (2022).
[218] USAID. (2023).

Additionally, time away from family and material costs associated with attending formal training is a barrier. For example, in Ethiopia, government policy states that community health workers will be provided opportunities to advance their educational status in the fields of midwifery, nursing, environmental health, public health, and family health—yet these opportunities are only available to women who have the financial means to study.[219] In Nigeria, tuition cost was reported as a barrier for community health workers hoping to attend formal training.[220] Some women community health workers who were offered training were reluctant to leave their family behind, as the training was for one year and took place in a different region.[221]

Career progression opportunities differ across countries depending on the context of the community health worker program and local priorities, yet are always linked to formal education requirements and engaging in ongoing training.[222] Context is important in determining what drives motivation and retention, related to professional development and career progression opportunities.[223] Diverse models for women community health workers to progress exist on paper but rarely in reality. For example, in Liberia, the plan to institutionalize the community health worker program into health training institutions is not yet implemented, and women lose out to men in initial recruitment. In societies where women do not have the same freedom of mobility as men, restrictions may be used as justification to exclude them from managerial roles.[224] The perceived absence of professional development opportunities and lack of transparent and clear career paths causes low job satisfaction, demotivation, occupational stress, and attrition among women community health workers,[225][226] and many are unhappy with the lack of opportunities to move into higher positions with better working conditions.[227] Ultimately, despite their critical role, women community health workers are typically excluded from formal leadership positions because they are not able to advance in their careers.

[219] Ibid.
[220] USAID. (2023).
[221] Jackson. (2018).
[222] USAID. (2023).
[223] Ibid.
[224] Closser et al. (2023)
[225] McKague & Harrison. (2019).
[226] USAID. (2023).
[227] Jackson. (2018).

Implementation example

Integrate Health Community Health Worker Ambassadors

The Integrate Health Community Health Worker Ambassadors program aims to empower community health workers by offering comprehensive training on how to effectively defend the health needs of their communities, represent Integrate Health to a range of stakeholders, and share their expertise to help improve public policy and community health programs. Community health workers are selected from different districts after a two-phase evaluation process (written tests and interviews). After selection, they participate in theoretical and practical training on advocacy, gender equality, climate change, public speaking, media relations, meeting management, and presentation skills. English language training is also provided, and community health workers prepare the necessary documents for regional and international travel. With Integrate Health's support, community health worker ambassadors participate in board meetings, staff meetings, resource mobilization with donors, and international conferences on community health and primary care. The program is designed to enable community health workers to play a leading role in global gatherings dealing with public health and universal health coverage.

In March 2024, 13 community health workers received training. These ambassadors have participated in key events including addressing the Togolese Minister of Universal Health Coverage during site visits and advocating for the professionalization of their role. In particular, ambassador Rebecca Tchotchokou has been invited by CHIC to speak at the UN General Assembly in September 2024. Additionally, two ambassadors have spoken at international conferences (Community Health Worker Symposium, Conference on Public Health in Africa), and ambassador Afi Kpaba won Women in Global Health's Heroines of Health Award in 2023.

Evidence highlight

Malawi community health worker program[228]

In 2017, Malawi launched the National Community Health Strategy 2017-2022—the country's first such strategy—which now employs over 11,000 full-time community health workers and senior community health workers. Community health workers can transition to senior community health workers after passing a standardized oral examination by the civil service commission, and senior community health workers are responsible for leading service delivery and supervising other community health workers in their catchment area. A newer pathway promotes senior community health workers to assistant disease control officers following a one-year diploma training and certification.

[228] USAID. (2023).

> Key factors in the program's success have included strong political ownership, inclusion of community health workers in all relevant policies and strategies, formal integration of community health workers into health workforce management tools and frameworks, consultative engagement with the Ministry of Finance to align priorities, a phased approach to scale-up, and coordinated resource mobilization. The program's established career pathway has resulted in increased demand to join the community health workforce, a decrease in community health worker turnover, national recognition of community health workers as key frontline health workers, and clarification of roles and responsibilities. This is an example of a national-level strategy that provides a clear career pathway for community health workers—and an initial step in facilitating career progression for all community health workers regardless of gender.

Community health worker Ambassador Djariyétou Aboubakare at the Koundoum health center.

Conclusion

There is robust, compelling evidence demonstrating community health workers' valuable contribution in delivering basic and essential life-saving health services, and that those services are delivered by a women-led workforce. Yet the key components community health workers need to succeed—including salary, supplies, supervision, skills, and integration into systems at scale—are rarely gender-responsive.

Integrate Health and Last Mile Health developed a framework for action to document how gender influences the three stages of the career lifecycle of professional community health workers, including 1) recruiting women community health workers into the workforce, 2) enabling women community health workers to succeed, and 3) retaining women community health workers and advancing their careers.

Based on the literature and their experience as implementers, the organizations developed 16 recommendations for community health program implementers to ensure community health programs are more gender-responsive. They also included key examples of where those recommendations have been implemented and the initial impact of this work.

While this framework for action is intended specifically for community health program implementers, progress requires alignment and coordinated action from all stakeholders involved in strengthening the community health system: governments, funding agencies, philanthropic foundations, global health initiatives, global health advocates, researchers, and community health workers themselves.

This global framework for action is a contribution to a movement dedicated to health and gender equity that originated long before Integrate Health and Last Mile Health were founded, and will continue for years to come. The organizations are particularly grateful for the expertise and leadership of women community health workers who go above and beyond to serve their neighbors, fight injustice, and inspire the next generation of health leaders.

We look forward to the collective work ahead to move closer to a world where health and gender equity are realized.

Appendices

Recommendations for action

Community health worker Mamie Wheajue from Rivercess County, Liberia.

Appendix A: Glossary of terms

- **Community health workers** provide health education and referrals for a wide range of services and provide support and assistance to communities, families, and individuals with preventive health measures and gaining access to appropriate curative health and social services. They create a bridge between providers of health, social, and community services and communities that may have difficulty in accessing these services.

  Note: We acknowledge the lack of a standardized definition for community health workers and the existence of different community health worker typologies across countries depending on their role, education level, and remuneration. The term "community health worker" is often used in a non-specific way, referring to a diverse typology of lay and educated, formal and informal, paid and unpaid health workers. We are using the definition of community health workers aligned with the *WHO guideline on health policy and system support to optimize community health worker programmes.* [229] The International Labour Organization (ILO) International Standard Classification of Occupations (ISCO) refers to community health workers as a distinct occupational group (ISCO 3253). In line with the WHO guideline, we considered evidence that referenced community health workers irrespective of typology to capture the breadth of existing evidence on stages of the community health worker career lifecycle. For the purposes of this paper, we use the term "community health worker" as a general term to represent other nationally and locally used terms (e.g., community health attendants [CHAs] and health extension workers [HEWs]). Throughout this paper, these terms are only included in quotations directly taken from the research literature.

- **Woman community health worker** is used rather than the term "female community health worker," because the framework examines how gender as a social construct (and not biological sex) interacts with the career lifecycle of a community health worker.
- **Gender** comprises the culturally defined roles, responsibilities, attributes, and entitlements associated with being (or being seen as) as woman or man in a given setting, along with the power relations between and among women and men. It includes the definition and expectations of what it means to be a woman/girl or man/boy, and sanctions for not adhering to those expectations vary across cultures and over time and often intersect with other factors such as race, class, age, and sexual orientation.[230]
- **Gender norms** are the often-unspoken social rules that govern the attributes and behaviors valued and considered acceptable for men, women, and gender minorities.[231]
- **Gender equality** is the concept that all human beings, irrespective of their sex or gender identity, are free to develop their personal abilities and make choices without the limitations set by stereotypes, rigid gender roles, or discrimination.[232]

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[229] WHO. (2018).

[230] Heise et al. (2019). Gender inequality and restrictive gender norms: Framing the challenges to health. Lancet, 393(10189): 2440-2454. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)30652-X/abstract

[231] Ibid.

[232] Heise et al. (2019).

- **Gender equity** is the process of being fair to women and men, boys and girls; to ensure fairness, measures must be taken to compensate for cumulative economic, social, and political disadvantages that prevent women and men and boys and girls from operating on a level playing field.[233]
- **Gender responsive** programs have awareness and understanding of norms, roles, and power relationships associated with being female and male, based on an analysis of gender-based inequalities and constraints; insights translated into actions and systems that work to strengthen more equitable gender norms, roles, and power relationships (Gender Integration Continuum, 2020).
- **Gender transformative** policies consider and address the differences in gender roles and norms, identifying the root causes while simultaneously looking for ways to change them based on the specific needs of each gender (WHO Gender Equity Unit, 2024).

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[233] Heise et al. (2019).

Community health worker Rolande Sansan showing danger signs to her patient during home consultation in Sarakawa, Koran district, Togo.

Appendix B: Description of key frameworks

The following three documents guided the development of this framework for action.

1. **World Health Organization guideline on health policy and system support to optimize community health worker programmes (2018)**

   The purpose of this technical tool is to facilitate the implementation of the WHO Global Strategy on Human Resources for Health: Workforce 2030 through the HRH2030 Health Worker Lifecycle Approach. It provides evidence to assist national governments and national and international partners to improve the design, implementation, performance, and evaluation of community health worker programs. The guideline was developed through a critical analysis of the available evidence based on a systematic review on what is required to facilitate the integration of community health workers in health systems and communities. It includes 15 recommendations on community health worker selection, pre-service training, competency-based certification, supportive supervision, remuneration, contracting agreements, career ladder, target population size, data collection and use, types of community health workers, community engagement, mobilization of community resources, and availability of supplies.

2. **Community health worker assessment and improvement matrix (CHW AIM tool): Updated program functionality matrix for optimizing community health programs (2018)**

   The USAID Health Care Improvement Project developed the CHW AIM Toolkit in 2011 to help national ministries of health, international organizations, and local NGOs assess community health program function and improve program performance. As a complement to the 2018 WHO guideline, the toolkit was updated in 2018 by USAID, UNICEF, the Community Health Impact Coalition, and Initiatives Inc. to support the operationalization of quality community health worker program design and implementation. The purpose of the tool is to identify design and implementation gaps in both small- and national-scale community health worker programs and close gaps in policy and practice. The CHW AIM 2018 revised programmatic components include role and recruitment, training, accreditation, equipment and supplies, supervision, incentives, community involvement, opportunity for advancement, data, and linkages to the national health system.

3. **WHO community health worker guideline recommendations using life cycle approach (2019)**

   The HRH2030 Health Worker Life Cycle Approach was created to ensure Chemonics-led USAID Human Resources for Health in 2030 country programs implement evidence- and policy-based strategies to build, manage, and optimize human resources for health. In 2019, HRH2030 created the WHO Community Health Worker Guideline Recommendations Using Lifecycle Approach, linking the 15 recommendations from the 2018 WHO guideline to the specific areas of the Health Worker Life Cycle Approach.

Appendix C: Literature review methods, findings, and observations

Methods: In May 2024, we carried out a targeted search of the peer-reviewed literature to elicit evidence on challenges and recommendations related to the intersection of gender and the community health worker career lifecycle. PubMed was searched for studies (available in free-full text in English) published between 1978 and 2024 with a global or Sub-Saharan Africa focus to answer the following research questions:

1. **What is the enabling environment required for women and gender-diverse community health workers to thrive through the lifecycle?**
2. **What are the key challenges and solutions?**
3. **What does excellence "look like" in terms of supporting women and gender-diverse community health workers throughout the lifecycle?**

Please note this is not a comprehensive or systematic review of the literature. This was carried out to support Integrate Health and Last Mile Health to inform the development of this framework, as well as other key documents related to their 2023 Clinton Global Initiative Commitment to Action.

Findings: Titles and abstracts of 387 peer-reviewed articles were reviewed, of which 45 were selected for full text review. After full text review, 29 articles were identified and included in the literature review. Ten articles focus on the community health worker career lifecycle from a global perspective, including five systematic reviews, two literature reviews, one mixed method study, one qualitative study, and one rapid evidence assessment. Nineteen studies were carried out in Africa, of which 18 used qualitative methods. All studies were published in the past 10 years. Selected gray literature included primarily research reports and policy briefs produced by global health institutions, such as the WHO, USAID, UNICEF, and Women in Global Health. They provide summaries of evidence from literature reviews, primary research often carried out in multi-country contexts, and insights from global experts and key stakeholders. Resources such as blogs, editorials, program manuals, and videos were excluded from the literature review, but are used in combination with other resources to support examples of Integrate Health and Last Mile Health's work illustrating recommendations.

Observations on the state of research: Given that our literature review was not systematic, the following observations are based on evidence provided by recent reviews, tools, and guidelines that relate to the intersection of gender and community health workers identified in our search.[234] [235] [236] [237] [238] [239] Overall, there is limited evidence on how gender influences community health workers' experiences throughout the career lifecycle or the ways in which gender roles, norms, and relations influence

[234] Ahmed et al. (2022).
[235] Closser et al. (2023).
[236] El-Kalaaway et al. (2021).
[237] McKague & Harrison. (2019).
[238] Steege et al. (2018)
[239] WHO. (2020).

community health workers' working lives.[240] According to the WHO (2020) systematic review, there is "little attention" present in the systematic review literature to "gender issues" that community health workers face.[241] This systematic review identified only two reviews[242][243] that discussed opportunities to empower and support community health workers.[244] According to Steege et al. (2018), there is limited country- and project-specific gender analysis on the ways that gender dynamics shape community health workers' experiences. There is relatively more and higher-quality evidence on the effectiveness of community health programs delivering specific health interventions (e.g., MNCH, HIV, TB) and acceptability of services provided, rather than strategies to integrate and support community health workers themselves.[245][246] Though some research is starting to report on the extent of equity of community health worker programs and identify intervention design factors which influence equity in health outcomes,[247] the rights, needs, and wellbeing of community health workers are rarely considered.[248] According to the WHO, "only modest attention in the systematic review literature" is given to views and opinions of community health workers themselves regarding training, supervision, remuneration, retention, work responsibilities, job satisfaction, and career opportunities.[249]

Specifically, little research has been done on experiences of gendered harassment, exploitation, and assault among women community health workers within the workforce.[250][251] "While most of the evidence in the literature is from South Asia, this is an issue with global reach; other articles have documented rape and fear of rape by community health workers in Kenya and the DRC" and documented in a range of contexts.[252] Closser et al. (2023) state that "it is not only programme managers but also researchers who have neglected this issue."[253] Based on their review, dynamics are not explored adequately and there are no quantitative measures that would give a precise sense of the extent of the issue.[254]

Conclusions: More research is needed on how gender influences the experiences of women community health workers throughout the career lifecycle. Research should include an intersectional approach to gender analysis and data disaggregated by gender, socioeconomic status, and age to understand the needs of distinct groups of community health workers. Attention should be paid, in particular, to the experiences of exploitation, harassment, and assault against community health workers in the force.

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[240] El-Kalaawy et al. (2021).

[241] WHO. (2020).

[242] Bhatia. (2014). Community health worker programs in India: A rights-based review. Perspectives in Public Health, 134(5): 276-282. https://pubmed.ncbi.nlm.nih.gov/25169614/

[243] Kane et al. (2016). Limits and opportunities to community health worker empowerment: A multi-country comparative study. Social Science & Medicine, 164: 27-34. https://www.sciencedirect.com/science/article/pii/S0277953616303732?via%3Dihub

[244] WHO. (2020).

[245] Ahmed et al. (2022).

[246] WHO. (2020).

[247] McCollum et al. (2016). How equitable are community health worker programmes and which programme features influence equity of community health worker services? A systematic review. BMC Public Health. 16:419. doi: 10.1186/s12889-016-3043-8. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4875684/

[248] Ahmed et al. (2022).

[249] WHO. (2020).

[250] Closser et al. (2023).

[251] WHO. (2020).

[252] Closser et al. (2023).

[253] Ibid.

[254] Ibid.

Appendix D: Consultations with expert implementers

The concept for the framework for action was initiated and refined in collaboration with Integrate Health and Last Mile Health, two leading organizations working in community health. Specific knowledge around the prioritization and feasibility of recommendations was informed by their knowledge as expert implementers working on community health in Sub-Saharan Africa.

Since its founding in Liberia's remote Konobo District in 2007, Last Mile Health has partnered with governments to build strong community health systems that equip professionalized community health workers to provide essential primary healthcare to the world's most remote communities. As of June 2024, Last Mile Health and government partners have deployed 16,500 community and frontline health workers to provide primary healthcare to 19.5 million people across Ethiopia, Liberia, Malawi, and Sierra Leone.

Integrate Health works alongside governments and local communities to implement and study an integrated approach to strengthening primary healthcare delivery in order to achieve universal health coverage. By integrating professional community health workers with improved care in health centers, this approach creates a patient-centered health system that is accountable to the community and dramatically reduces mortality in severely resource-limited settings. As of June 2024, Integrate Health serves over 200,000 people in Togo and 115,000 people in Guinea.

Community health worker Tamandja N'nimbiniyaou Victorine carrying out a pediatric consultation using the Tonoudayo app on her phone.

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