Chapter 8
Recruitment of Community Health Workers

Wanda Jaskiewicz and Rachel Deussom

Key Points

- Developing appropriate recruitment policies and processes is a critical feature of an effective large-scale community health worker (CHW) program.

- Community engagement in recruitment is highly desirable, but managing this in a way that is productive requires careful planning and adaptation.

- An effective recruitment program can help reduce attrition, which is a major challenge for many large-scale CHW programs.

INTRODUCTION

Recruiting and selecting the most appropriate individual to fill the role of a CHW is among the most essential elements that contribute to a well-functioning community health strategy. Recruitment is defined as "how and from where a CHW is identified, selected and assigned to a community, including selection criteria and processes."[1] As suggested in the CHW Assessment and Improvement (AIM) Toolkit's CHW Program Functionality Matrix, a best practice for recruitment is to recruit a CHW from within the community through community participation, meeting all selection criteria when possible. In special cases where a CHW may need to be recruited from outside the community, a second best practice is to ensure not only that the community participates in and agrees with the recruitment process, but is also consulted on the final selection of the CHWs.

Ensuring a "citizen voice" through the meaningful participation of civil society groups and communities has contributed to greater accountability for service delivery and improved program quality, as the program can be better tailored to local needs with community input.[2, 3] In addition, community participation in CHW recruitment and selection is more likely to use existing social structures and result in selection of CHWs that understand local issues and can deliver community health messages in a linguistically and culturally appropriate manner.[4, 5] Effective CHW recruitment and selection are key to increasing CHW retention.[6] Although there are many factors that contribute to CHW attrition, careful attention to CHW recruitment and ensuring the "right" person is selected for the job will go a long way to reducing turnover, protecting investments, and obtaining results in CHW programs.

This chapter will help readers to consider key questions, recommendations, and challenges for CHW recruitment planning and implementation, including selection, resource availability, and addressing CHW retention.

KEY QUESTIONS PROGRAM PLANNERS NEED TO CONSIDER WHEN RECRUITING CHWS

Following a systematic approach for CHW recruitment through development and implementation of a recruitment strategy with clear recruitment guidelines will help structure the process and ensure that program planners, managers, community members, and health worker teams are familiar with their respective roles in the recruitment process. To develop an effective and actionable recruitment strategy, stakeholders should consider the following questions and issues:

- What are the specific recruitment needs for the CHW program?

- What are the CHW selection criteria?

- What is the CHW recruitment process?

- How do available resources influence CHW recruitment?

- How can CHW retention be improved?

WHAT ARE THE SPECIFIC RECRUITMENT NEEDS FOR THE CHW PROGRAM?

The scope and intention of the health program as well as the needs of the community should always drive the recruitment process.[7] Before initiating the recruitment phase of any program, it is essential to understand the specific needs and context of the CHW program in which the CHWs will work. In particular, this process relates to having a clear description of the roles,

responsibilities, and tasks the CHW will undertake, the catchment area population in terms of the number of households to be served, as well as the geographic distance they will need to cover. (See Chapter 7 on roles and tasks for more details). This information will enable program designers to define the selection criteria, qualifications, and requirements that specifically correspond to the job that the CHWs will undertake. It also provides a clear scope of work for the CHW so that CHW candidates can determine if they are the right fit for the job.

CHWs that are from the communities that they serve are more likely to be invested in their catchment population's health outcomes and generally more likely to stay. Many CHWs also thrive in positions where there is opportunity for employment promotion. For example, a CHW may initially be recruited and trained, and after some good performance feedback, decide to train as an auxiliary nurse and be promoted. However, it is also important to recruit and select CHW candidates that understand what the job will entail, including the expected performance, conditions, management support, and remuneration (if any). The clear communication and agreement about CHW recruitment, including a defined scope of work, remuneration, and selection based on a transparent process, should drive CHW recruitment strategy and will help improve CHW retention in the long term.

Box 1. The Community's Role in Transparency

Ideally, CHWs are chosen by the community. Yet, the persons selected have an influence on the acceptability and sustainability of the CHW program within the local context. In some cases, CHWs are chosen by chiefs or appointed by government officials who award CHW positions to friends and relatives, or use the appointments as favors, for which they can go back and ask for something in return. The inappropriate selection of CHWs within communities was identified as a disincentive for CHWs. An evaluation survey of CHWs performed by UNICEF in 1989 reported that 45% of the CHWs surveyed were related by blood to their village chief or the sub-chief.[8] In Swaziland, an evaluation found that local chiefs preferred to select CHWs based on their own interests rather than the candidates' qualifications.[8]

Extensive experience and long-standing relationships with communities has helped many nongovernmental organizations (NGOs) and other international organizations to find ways to ensure that the selection process for CHWs is based on each candidate's interest and qualifications.

A more complete list of the factors that must be carefully considered before undertaking CHW recruitment is provided below. Many of these CHW program needs are covered in detail in other chapters of this manual.

- How many CHWs in total need to be recruited? Is recruiting managed at the national, regional, provincial, district or other lower level? Which level or organization will provide the resources for recruitment? What is the timeline for recruitment? (See Chapters 4, on governance, and 5, on financing.)

- What primary care services are included in the CHW strategy? What specific tasks are CHWs expected to carry out? What will be their workload? Are CHWs clear on their role, their responsibilities, and other job expectations? This may include meeting coverage or service delivery targets and reporting on the achievement of program objectives, tasks or activity outputs. (See Chapter 7 on roles and tasks.)

- How many days per month or hours per week are CHWs expected to dedicate to completing the tasks? Is their commitment full-time or part-time?

- What is the catchment population and geographic area for which CHWs are responsible? Will they receive transport support to reach their assigned catchment populations (e.g., bicycles, motorcycles, bus vouchers)?

- Are the CHWs compensated or are they working on a volunteer basis? Is compensation a salary, an hourly wage, or a stipend? What types of incentives, whether financial or non-financial, will be provided? If the CHW has been performing similar types of tasks previously, how were they remunerated, if at all? (See Chapter 11 on incentives.)

- What training will the CHWs receive to ensure their ability to complete assigned tasks (e.g., pre-service training or in-service training)? Are there criteria for certification or other qualification criteria related to CHW training that must be met for CHWs to work? (See Chapter 9 on training.)

- What supervisory and other management support, including resources (e.g., medicines, supplies, job aids, communication stipends) will they receive to enable them to perform well? (See Chapter 10 on supervision.)

WHAT ARE THE CRITERIA OF SELECTION OF CHWS?

Before recruiting CHWs for a community-based program, the criteria or qualifications that each individual CHW should meet to be considered for the program should be pre-defined. The selection criteria may include demographic elements, such as gender, age, marital status, and usual place of residence, as well as education level and ability to successfully complete training on standard competencies, which will be heavily dependent on the specific community-based health strategy that the CHWs will support, as well as the roles and responsibilities they will undertake. Residency is more often an important criterion in the selection of CHWs; recruiting CHWs from within the communities that they serve is considered a best practice[9] although this can cause challenges for large-scale programs that need to systematize the recruitment process. Nonetheless, even for large-scale programs, communities are often involved in the selection process and are consulted on the final selection of the CHW, as she or he needs to be welcomed to serve in their community.

Several persons with knowledge about and experience with large-scale CHW programs interviewed informally for this paper emphasized the importance of community trust and acceptance over other criteria, such as literacy and gender. More than the level of education, it is far more important that the person selected is engaged with his or her work, responsive, accountable, respected, and trusted by the community. These attributes are often associated with age and children. CHWs do not necessarily need high qualifications, but they must be able to and open to learn.

Table 1 presents the main criteria for CHWs in several countries with well-established community-based programs. Each program develops criteria taking into account the service content, cultural attitudes towards married or single women, and the requirements of basic literacy. For example, females should be required for family planning counseling, and, in countries, such as Afghanistan, where women cannot travel alone, females and males are selected to form pairs. Successful examples of programs using illiterate or low-literacy CHWs do exist, such as the Female Community Health Volunteers in Nepal, but in these cases, supervision, training, and appropriate forms using pictorial diagrams are adapted to the situation.

Table 1. Selection Criteria for CHWs in Selected Countries[10-15]

INDIA: ACCREDITED SOCIAL HEALTH ACTIVISTS (ASHAS)	BRAZIL: COMMUNITY HEALTH AGENTS (CHAS)	PAKISTAN: LADY HEALTH WORKERS (LHWS)	ETHIOPIA: HEALTH EXTENSION WORKERS (HEWS)
- Female ≥ 8th grade education 25-45 years of age - Married (or widowed or divorced)	- Adult - Work in community where they are from/ permanently reside there - Be literate	- Female ≥ 8th grade education 18-50 years of age - Reside in community/be recommended by their community - Married with children - Experience in community development preferred	- Female ≥ 10th grade education ≥ 18 years of age - Reside in community

Another important criterion for CHW selection is language skills.[16] Although it can be assumed that originating or residing in the community in which a CHW serves would ensure that s/he thus speaks the local language, the linguistic diversity of the catchment population could be such that multiple languages are spoken. Language differences may distinguish socioeconomic or ethnic groups, and efforts should be made whenever possible to recruit CHWs that can communicate with as many subgroups of the catchment population. Alternatively, recruiting several CHWs with complementary language skills to serve the same catchment population is a recommended option.

Selection criteria for CHWs may also be influenced by cultural, gender-based, and social norms that could determine CHWs' effectiveness. For example, if a community health program objective is to increase male involvement in reproductive health and maternal heath, then it may be important that the CHWs be recruited as married couples or at least that some of the CHWs in a specific catchment area be male. However, in India, Pakistan, and Ethiopia, where the community health programs focus on family planning, maternal and child health services and requires the CHW to enter the home or compound of a mother, it was determined that the CHW would be required to be female because it would not be culturally acceptable for a mother to allow an unknown man into the home.

If there were only male CHWs in these contexts, then the programs would be rendered much less effective. Likewise, if it is known that Pakistani LHWs are married with children, then the community members that they reach with family planning messages will be more trusting and receptive to their messages because the LHWs are exemplifying the family values that the communities also support. When a more advanced level of preventive and curative care is required, the selection criteria may include higher-level qualifications or a stricter age range. In India, for example, auxiliary nurse midwives (ANMs) must have finished 12 years of schooling and be between 17 and 35 years of age to be granted admission to the 18-month ANM training programs in nursing schools.[17]

Determining which stakeholders are the decision-makers for setting the criteria for CHW recruitment and selection is another important aspect to consider. In some community-based programs, ministries of health establish the criteria, whether from the central, provincial, or district level. In some countries' CHW programs, the selection criteria are standardized, and all CHWs are recruited against the same list of requirements, regardless of where they will serve. For example, in Mozambique, the *agente polivalente elementar*, or CHW, has been nationally recognized as a health worker cadre, for which training, qualifications, and selection criteria have been standardized nationally as well.[18] Further, it is recommended that any selection criteria concerning CHW competencies should be standardized if there is a common training.[19]

In other contexts, selection criteria may be localized to account for regional or other context-specific variations. Communities may independently determine the type and qualifications of the CHWs that they recruit through community health committees or other local entities. In Mali's decentralized health system, *associations de santé communautaire* determine the criteria, including remuneration, for CHWs that are to serve their catchment populations and subsequently fund and supervise their CHWs, often with municipal support.[20] In India, different states have defined their own criteria for the selection, training, and incentives, according to context. The way that community health needs and cultural context are reflected in a health program in Rajasthan state differ from West Bengal state, for example.[21]

Once CHW selection criteria are defined, the extent to which they are fully met is also variable. For example, in very rural communities where the general level of education is low, it may be difficult to meet defined education criteria. The functionality and governance mechanisms of decision-making entities that ensure that CHW selection criteria are met are also variable, as was noted in India and Ethiopia by Gopinathan et al.[22]

WHAT IS THE CHW RECRUITMENT PROCESS?

The ideal CHW recruitment process entails: establishing criteria, communicating CHW opportunities to identify candidates, interviewing and selecting CHWs from candidates, and hiring selected CHWs.[16] Although in the real world of program implementation many of these steps are full of challenges, we define these ideal steps so that countries can modify them where and when they require.

Developing CHW Recruitment Criteria

Policymakers and program planners at the central level often make decisions regarding the basic criteria for CHW selection. These decisions draw from an analysis in which many factors are considered, including the maturity of the program and its needs, the health and social needs of communities and clients, the size and health service scope of the program, and the organizational and financial capability of regional, district, and local management systems. Where it is feasible, various actors are involved in implementing the process: district health managers, the health facility team to which the CHW may report, other local authorities (including municipalities or traditional chiefs), and communities within the catchment population (whether through village health committees or other civil society representation). The pros and cons of various levels of stakeholder involvement and of the importance of community participation are further discussed later in this chapter.

Communicate CHW Position Opportunities and Selection Criteria

Once the selection criteria have been defined and a job description has been developed, the process of communicating the CHW job position(s) to communities and possible candidates can occur in a variety of ways depending on context and resources. Some methods that have been tried in the United States include:

- Announcing positions at community meetings, churches, and other social group gatherings;

- Conducting face-to-face or internal recruitment;

- Obtaining ideas from well-established and well-connected community-based organizations to help identify applicants;

- Receiving referrals from current CHWs;

- Posting fliers at shared community spaces, local recreational centers, municipalities, and health facilities;

- Placing newspaper advertisements; and

- Announcing positions on the radio.[7, 16]

During the CHW recruitment process, if there is not a clear understanding and acceptance of the proposed tasks for the CHW and how the work will be compensated, then community health workers may fail to perform. For example, in Dhaka, Bangladesh, CHW performance decreased because the expectations regarding workload and remuneration were not fully met.[23] In addition, the stakeholders involved in recruitment should encourage transparency when possible. For example, if the village health committee selects the chief's son due to social pressure from the chief, this could discourage other, more qualified candidates from applying. Even for the chief's son, his recruitment should be discussed openly in the community so that his credibility is not undermined. Transparency is not always readily achieved, but programs should be aware that not communicating clearly might present problems in the long run. Often, local leaders or mother groups are the most qualified to negotiate these types of issues.

Identify, Review, and Select CHWs Based On Agreed-Upon Criteria and Decision-Making Responsibility

How the recruitment process will continue toward selection of CHWs will in part depend on who is driving the recruitment: the community, the health facility, the village health committee, or some combination. In some countries in which the CHW program has reached a mature state, the selection process may include observations of the CHW in a simulated home visit or dealing with a common issue that would be encountered in the field. Also, in rare instances, CHWs may be selected on a trial basis to give the CHW, the community, and the program managers or supervising health facility staff the opportunity to determine if the CHW is right for the job. CHAs in Brazil are hired by their municipalities based on their "aptitude, posture, and attitudes, during simulated community problems" during the selection process.[24, 25]

As stated earlier, it is most ideal when the community can participate in the process of CHW selection and/or approval. Although this process may cause challenges in large-scale programs, it is nonetheless important to engage the community in the process to help ensure that their needs are taken into account. In Eastern and Southern Africa, community participation in health program planning improved program outcomes because facility-centered decision-making did not always favor underserved populations due to the differences in socioeconomic status between more elite, educated mid- and high-level health workers and the rural communities that they served.[26]

In a health center-driven recruitment process, CHWs may be selected with little or no input by community members. In Partners for Health CHW programs in Africa and Haiti, the clinical team interviews CHW candidates to determine if they meet the established selection criteria.[27] Clinical team members include doctors, nurses, social workers, or program managers to ensure that the CHW candidate has the capacity to acquire the clinical competencies expected for the CHW role. Depending on the complexity of tasks that the CHW is expected to perform, community members may not have the knowledge and skills to make this assessment.

Given the skill level for most CHWs in community health programs, recruitment should remain as local as possible. However, in many cases where CHWs require higher-level skills or skills that cannot be found within the community, then external recruitment may need to take place for this underserved area. In India, ANMs, who are very highly trained CHWs, are posted to sub-centers and primary health centers with no input from the communities in which they work.[28] In many cases, the ANM is not from the community. However, once in place, ANMs are expected to serve on the local village health committee so that they can better integrate with the community and participate in community decision-making.[29] Trained CHWs should have

already had exposure to the health issues faced by the community to which they are assigned or by similar communities.[30]

Another important consideration of CHW qualifications during recruitment are the expressed interest and motivation of the candidates. Are they "natural helpers"? Do they have a genuine investment in the health of their community? Do they treat all people with care and respect? Do they demonstrate problem-solving and leadership skills? Directly asking candidates why they are interested in working as a CHW is recommended.[16] A study among rural health workers in Papua New Guinea indicated that social factors and the community play an important role in health worker motivation.[31] Motivational factors will be further discussed in the section on CHW turnover.

Box 2. Examples of various processes for selecting CHWs

ASHAs in India are selected by and accountable to the local village level government through a participatory process that involves the whole village.[32] In Ethiopia, active health committees are involved in the selection of HEWs from the local community. The voluntary CHWs (Health Development Army) who work with the HEWs are nominated and elected by the community or the HEWs, but the community must approve.[33] In Nepal, women's groups and local village development committees (VDCs) are involved in the selection and oversight of female community health volunteers (FCHVs). In Mali, village health committees not only provide oversight for the recruitment process, but additionally compensate and supervise the volunteers working in the villages of that catchment area.

In Pakistan, a community member serves on each of the LHW selection committees, as well as on each of the lady health supervisor selection committees.[25] LHWs are recruited and selected using a clearly delineated process. LHW posts are advertised and applicants are then interviewed and selected based on specific criteria by a selection committee. The committee is comprised of a medical officer-in-charge, who is the chairman, a female medical officer, a lady health visitor/female medical technician, a male health technician/dispenser, and a community member. Selected LHW candidates are verified through documentation, and then formally appointed by the appropriate local health official (Office of the Executive District Officer of Health or the district health officer).[34] They also must be recommended by the councilor, who is a local elected official.[35]

In Table 2, the CHW Program Functionality Matrix from the CHW AIM Toolkit[36] can aid in determining how to assess and strengthen a recruitment process. The CHW AIM proposes 15 programmatic components that have been found to contribute to an effective CHW program; recruitment is considered to be a key component of the tool.

Table 2. Grading of Functionality of Recruitment Processes for CHWs[36]

0 = NON-FUNCTIONAL	1 = PARTIALLY FUNCTIONAL	2 = FUNCTIONAL	3 = HIGHLY FUNCTIONAL (BEST PRACTICE)
CHW not from community, and the community plays no role in recruitment.

No or only a few selection criteria exist and are not well known or commonly applied. | CHW is not recruited from the community, and the community is not involved in the recruitment process but approves of final selection.

Some selection criteria exist and are well known and applied, but are general and/or do not address specific issues such as gender and marital status. | CHW is recruited from the community, and the community is consulted on the final selection. If, because of special circumstances, the CHW must be recruited from outside the community, the community is consulted on the final selection. Some selection criteria exist and are specific about literacy levels, but do not address gender, marital status, or whether the CHW should come from the local community or not. | CHW is recruited from the community with community participation.

If, because of special circumstances, the CHW is recruited from outside the community, the community participates in and agrees with the recruitment process and is consulted on the final selection.

All selection criteria – literacy, gender, marital status, local residence – are met when possible. |

Hiring Preferred CHW Candidates

Once stakeholders agree on their preferred candidates, CHWs should be hired and integrated into the community health program. If a standard training is a requirement for deployment, the hired CHW should be enrolled in the appropriate orientation or training program (see Chapter 9 on CHW training).

The next section will discuss the availability of resources and how it can influence the CHW recruitment process and further the general availability of resources for retaining CHWs over time.

HOW DO AVAILABLE RESOURCES INFLUENCE CHW RECRUITMENT?

Resource availability for CHW recruitment can have an important effect on how the process is handled. Since the Alma Ata Declaration, many decision-makers not familiar with programming realities on the ground have historically and incorrectly considered community-based health programs to be a low-cost approach to primary health care delivery. As such, the sustainability of adequate financing for CHW programs is too often imperiled by competing priorities in health or other sectors.[37, 38] According to several key stakeholders interviewed for this manual, the number one cause of failure of CHW programs is that decision-makers do not factor in the high cost associated with the support functions required for CHW programs to function effectively. There is a mistaken idea that once CHWs are trained, it is a free program.

The resources allocated for the management and support of this cadre, whether volunteer or compensated, may be further limited or sporadic. Recruitment costs, although often considered only as an initial cost in setting up a program, can become considerable, especially when programs have high turnover of CHWs. This section will discuss resource-related considerations for CHW recruitment: who controls and who contributes toward resources and how additional or existing resources could be used.

It should be noted that how community-based health programs are financed will affect how recruitment takes place and who participates in the process. For example, *mutuelle* health committees, community- and employment-based groupings for resource mobilization, throughout West and Central Africa (Benin, Côte d'Ivoire, Ghana, Mali, Nigeria and Senegal) are tasked with mobilizing local funds for human resources within the health sector.[39] However, in Zimbabwe, the limited local control over available financial resources made it challenging for local health center committees to influence the way that community health programs were run.[3]

What are the resource requirements for successful CHW recruitment? They may include, but are not limited to:

• Time and effort to convene stakeholders to develop and standardize criteria (e.g., developing the recruitment process; CHW selection criteria, tasks, and responsibilities; and other aspects of the community health program as relates to human resources management);

• Costs related to communicating the availability of CHW positions (e.g., printing fliers, paying for newspaper or radio advertisements, and investigating CHW candidates within communities); and,

• Costs related to reviewing and selecting CHW candidates (e.g., obtaining a venue for conducting interviews, reimbursing of any transport or other expenses incurred by the CHW candidate, and announcement of selected CHWs via traditional communication channels).

Consideration of resources should be discussed by the stakeholders involved in CHW recruitment. For a given community health program and any CHW cohorts that are recruited during its implementation, resource investments should be generally standardized. One exception to this may be in a preliminary or pilot phase of program implementation, when modifications may be made prior to scale-up. Ideally, all stakeholders involved in CHW recruitment should make some resource contribution to the process, whether monetary or in-kind. For example, a village health committee could contribute the use of their meeting space. A district health office could provide in-kind transport to CHW candidates using their own vehicle. (See Chapters 4, on governance, and 5, on finance.)

Ensuring effective recruitment and retention of CHWs through the adequate mobilization of resources should be guided by the World Health Organization's (WHO) global policy recommendations for increasing access to rural health workers. These recommendations call for rural health workers (including CHWs) to be provided with an adequate combination of financial and/or non-financial incentives to remain motivated to stay there.[30] The quality of logistical support and supervision provided to CHWs, including promotion of their safety and well-being, will ensure greater CHW motivation and performance.[40]

The following section will further discuss key investments to ensure recruitment of high-quality CHW candidates and their retention.

HOW CAN CHW RETENTION BE FOSTERED?

After attention and care is spent to recruit and select CHWs that meet the job criteria, it is hoped that they will continue to serve their communities for as long as they are able. However, high CHW turnover is not only a common challenge for community health programs but also a red flag pointing to problems of design or execution. Carefully planning and executing a realistic and appropriate CHW recruitment strategy can help to reduce high turnover.[16]

Because many CHWs are recruited from their villages, the challenge of retaining them is not so much one of retaining them geographically at a post, although in some cases, CHWs may move out of their community. In fact, particularly when young, unmarried women are chosen to

become CHWs, moving away is actually a common contributor to attrition. However, in most cases, the challenge is rather to ensure that CHWs continue to perform their tasks actively and effectively. Particularly when a community health program has limited resources to supervise CHWs, and CHWs are working on a volunteer basis, strategies for motivating CHWs are essential. For this reason, issues of CHW turnover and retention should be considered as part of the CHW recruitment process within community health programs. This section will discuss issues and make suggestions for CHWs who move away or retire and those who become inactive due to decreased motivation.

There are important issues related to selection criteria and process that can influence attrition, and the consequences of the various choices should be considered. Usually, CHWs are recruited whenever there is a vacancy, and then trained when there is an opportunity. If there is already high CHW turnover, then a concern about the phased recruitment approach could be that CHW posts remain vacant for longer periods of time, until the next recruitment phase commences. If there is greater control over CHW recruitment at a decentralized level, then recruitment may be ongoing so as to be more directly responsive to community needs. Recruitment may also be contingent on available resources and the preferences of stakeholders. If decision-makers in CHW recruitment are not active or do not have the resources or motivation to recruit, select, and support a new CHW, then the role may not be filled.

Managers of community health programs should review past experiences with CHWs who are leaving their roles and should try to estimate future levels of turnover by answering the following questions:

- How many CHWs are needed?

- How many CHWs are leaving their roles within a given time period (i.e., what is the estimate annual rate of attrition)?

- Why are the CHWs leaving? Are they moving away from the geographic area? Are they aging out of the profession? Are they becoming inactive (i.e., are they losing interest)?

- What is the program's approach for evaluating the recruitment strategy?

If it is determined that there is high CHW turnover (e.g., more than 15% per year), then stakeholders should consider reviewing the community health program to address issues that may affect CHW performance and motivation. High turnover could be a concern because of the additional effort and resources that are required to recruit and train new CHWs and the potential for communities to be without a CHW during the repeated recruitment, selection, and training processes.

To address the retention of CHWs who may move out of their community, it would be important to understand why they are moving. Is it because they are seeking other opportunities for which there are greater incentives? Are they advancing their careers within the health care system or increasing their qualifications to become part of a higher-level health worker cadre? Are there any career path opportunities presented to CHWs to motivate them to advance within the system? If it seems that CHWs are leaving rural and remote areas and heading to more urban areas, it would be important to consider how a revised recruitment strategy might alleviate this problem. Again, the more experience the CHW has in a rural area, especially if they originate from that area, the more likely they will be to stay.[1, 30] A common pitfall is to set the bar fairly high on level of education and not to make married status a requirement. Thus the result is such that young, unmarried CHWs are recruited who are much more likely to move away – to get married, follow a spouse, or get a job in town.

It is recommended that community health program planners consider recruiting CHWs in an age range. Younger CHWs may have more energy to complete their tasks, but without further career and educational opportunities as a CHW, they may be more likely to leave their role to seek other opportunities. Older CHWs may be more likely to remain in their communities, but there is also the issue of older CHWs phasing out and retiring from their work. Also, older CHWs may not be able to cover their assigned geographical area as effectively as younger ones. In addition, they may require new training and skills acquisition. On the contrary, if the program values CHWs who are effective local opinion leaders, an older, more established person is likely to have more credibility than a 20-year old.

Depending on the governance mechanism for CHWs, then older CHWs could be assessed and phased out as needed. Although many of the FCHVs in Nepal are aging, they are not retiring. Older FCHVs in Nepal may be somewhat less "active" in the sense of going out and about and providing services. However, older FCHVs may be considerably more effective than younger ones in the sense that they are often well-respected and, therefore, can be very effective local champions for recommended health practices and service utilization. Women's groups are technically also able to remove FCHVs.[41]

Maintaining CHW effectiveness requires ensuring their motivation to remain active and, thus, productive at their tasks. Supportive supervision is recognized in the literature as a key approach for maintaining CHW motivation, although experience has taught that this is very difficult to achieve in large-scale public sector CHW programs. (See Chapter 10 on supervision.) Supportive supervision should include: regular monitoring of CHWs at their tasks, obtaining feedback from CHWs to consider potential program improvements, and ensuring the safety and wellbeing of CHWs at their work.[42-44] Unfortunately, it is common for few resources to be allocated for CHW supervision, even for paid, full-time CHWs. This shortfall may be because CHWs are widely dispersed from their respective referral primary health care facilities, thus transportation and communication challenges can be common. A top-down supervisory approach – where the CHW supervisor would be responsible for visiting each CHW and for initiating communication – may not be as feasible or effective as a participatory supervision model where CHWs and their communities are provided with the resources and autonomy to seek out the support that they need to perform well and stay motivated. In Thailand, participatory supervision (in which supervisors collaborated with facility-based health staff members and with communities) helped CHWs to be more effective, and the program was better tailored to meet the communities' needs.[45]

Reimbursing CHW transport, for example, to attend regular meetings among CHWs in a district or given geographic area at a referral health center can promote problem-solving and knowledge sharing, encourage peer-to-peer support, and increase CHW accountability and motivation.[40, 46] Or, paying for air time or mobile phone cards could encourage CHWs to communicate more frequently with referral health centers, which improves feedback mechanisms with other health professionals and can also improve the quality of care.[47] Still another example concerns promoting CHW occupational safety and health, a significant contributor to CHW motivation.[40] Indeed, "working conditions, part of the broader human resources management system, are important in terms of creating the conditions for effective and efficient work, boosting morale, and reducing turnover and attrition."[15, 48] Investments in CHW occupational safety and health have the potential to present "win-win" situations, where both the CHWs and their communities benefit.[40]

CONCLUSIONS

CHW recruitment is an important part of any community health program because the process of selecting and deploying appropriate and well-qualified CHWs will lay the foundation for the

program. Ensuring community participation in the planning and execution of the recruitment, selection, and supervision process is considered a best practice as it can improve program outcomes. Convening stakeholders, defining standards, and allocating sustainable resources for CHW recruitment has the potential to further improve the program. Once CHWs have been selected and are working, it is important to consider what kinds of incentives, whether financial or non-financial, will support CHWs to perform well and remain motivated on their jobs.

Key Resources

Karabi Bhattacharyya, Peter Winch, Karen LeBan, and Marie Tien. 2001. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability.* Basic Support for Institutionalizing Child Survival Project (BASICS II) for the United States Agency for International Development: Arlington, Virginia. Available online at: http://pdf.usaid.gov/pdf_docs/PNACQ722.pdf

Centers for Disease Control and Prevention (CDC). 2013. *Handbook for Enhancing Community Health Worker Programs: Guidance for the National Breast and Cervical Cancer Early Detection Program (Part 1).* Available online at: http://www.cdc.gov/cancer/nbccedp/training/community.htm.

Paraprofessional Healthcare Institute (PHI). 2008. *12 Steps for Creating a Culture of Retention: A Workbook for Home and Community-Based Long-Term Care Providers.* PHI National: Bronx, New York. Available online at: http://phinational.org/sites/phinational.org/files/clearinghouse/PHI12StepWorkbook.pdf

World Health Organization (WHO). 2010. *Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations.* WHO: Geneva, Switzerland. Available online at: http://apps.who.int/iris/bitstream/10665/44369/1/9789241564014_eng.pdf.

References

1. Crigler L, Hill K, Furth R, Bjerregaard D. Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving CHW Programs and Services Bethesda, MD: USAID Health Care Improvement Project University Research Co., LLC (URC), 2011.http://www.who.int/workforcealliance/knowledge/toolkit/50.pdf

2. Goetz AM, Gaventa J. Bringing citizen voice and client focus into service delivery. IDS Working Paper 138. Brighton, England: Institute of Development Studies 2001.http://www.sasanet.org/documents/Curriculum/ConceptualFramework/Bringing%20citizen%20voice%20into%20focus%20in%20service%20delivery.pdf

3. Loewenson R, Rusike I, Zulu M. Assessing the impact of Health Care Committees on health system performance and health resource allocation - final report, EQUINET discussion paper 18. Harare, Zimbabwe: EQUINET, 2004.http://www.equinetafrica.org/bibl/docs/DIS18%20res.pdf

4. Shakir FK. Community Health Worker Programs: A Review of Recent Literature. Washington, D.C.: University Research Co., LLC, 2010.http://www.hciproject.org/sites/default/files/CHW%20literature%20review_Jan2010_0.pdf

5. Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J, Task Force on Community Preventive S. Culturally competent healthcare systems. A systematic review. *American journal of preventive medicine* 2003; **24**(3 Suppl): 68-79.

6. Paraprofessional Healthcare Institute. 12 Steps for Creating a Culture of Retention: A Workbook for Home and Community-Based Long-Term Care Providers. Bronx, NY: Paraprofessional Healthcare Institute 2008.http://phinational.org/sites/phinational.org/files/clearinghouse/12-Step%20Workbook.pdf

7. Rural Assistance Center. Module 4: Program Implementation Rural Assistance Center, 2011.http://www.raconline.org/communityhealth/chw/module4/

8. Green E. Indigenous Healers and the African State: Policy Issues Concerning African Indigenous Healers in Mozambique and Southern Africa. New York: PACT Publications; 1996.

9. Lehmann U, Sanders D. Community health workers: what do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. Geneva, Switzerland: World Health Organization 2007.http://www.who.int/hrh/documents/community_health_workers.pdf

10. Bajpai N, Sachs JD, Dholakia RH. Improving access, service delivery and efficiency of the public health system in rural India. CSGD Working Paper No. 37. New York City, NY: The Earth Institute at Columbia University, 2009.http://globalcenters.columbia.edu/mumbai/files/globalcenters_mumbai/F.%20FINAL_NRHM_Report%202009.pdf

11. Aquino R, de Oliveira NF, Barreto ML. Impact of the family health program on infant mortality in Brazilian municipalities. *Am J Public Health* 2009; **99**(1): 87-93.

12. Prado TN, Wada N, Guidoni LM, Golub JE, Dietze R, Maciel EL. Cost-effectiveness of community health worker versus home-based guardians for directly observed treatment of tuberculosis in Vitoria, Espirito Santo State, Brazil. *Cad Saude Publica* 2011; **27**(5): 944-52.

13. Khan A. Lady Health Workers and Social Change in Pakistan. *Economic & Political Weekly* 2011; **XLVI**(30): 28-31.

14. Oxford Policy Management. External Evaluation of the National Programme for Family Planning and Primary Health Care: Lady Health Worker Programme. Management

Review.: Canadian International Development Agency 2009.http://www.opml.co.uk/sites/opml/files/LHW_%20Management%20Review_1.pdf

15. Teklehaimanot A, Kitaw Y, G/Yohannes A, et al. Study of the Working Conditions of Health Extension Workers in Ethiopia. *Ethiopian Journal of Health Development* 2007; **21**(3): 246-59.

16. National Training Center for the Prevention and Early Detection of Cancer. A Handbook for Enhancing Community Health Worker Programs: Guidance From the National Breast and Cervical Cancer Early Detection Program; Part 1. Rockville, MD: R.O.W. Sciences, Inc.; 1998. Available at: http://www.cdc.gov/cancer/nbccedp/pdf/trainpdfs/hb-introduction.pdf

17. Nursing Education in India. 2011. http://currentnursing.com/nursing_education/nursing_education_in_india.html.

18. GHI. The United States Global Health Initiative. Mozambique Strategy 2011. 2011. http://www.ghi.gov/documents/organization/175133.pdf

19. George A, Young M, Nefdt R, et al. Community health workers providing government community case management for child survival in sub-Saharan Africa: who are they and what are they expected to do? *Am J Trop Med Hyg* 2012; **87**(5 Suppl): 85-91.

20. Konate MK, Kante B, Djenepo F. Politique de santé communautaire et viabilité économique et sociale des centres de santé communautaires au Mali: Etude de cas en milieu urbain et rural (preliminary document). Geneva, Switzerland: UNRISD, 2003.http://www.unrisd.org/80256B3C005BCCF9/httpNetITFramePDF?ReadForm&parentu nid=F4478C9C2C2D0794C1256E200039D082&parentdoctype=paper&netitpath=80256B3C 005BCCF9/(httpAuxPages)/F4478C9C2C2D0794C1256E200039D082/$file/konate.pdf

21. National Health Systems Resource Centre. ASHA Which way forward...? Evaluation of ASHA Programme. New Delhi, India: National Rural Health Mission National Health Systems Resource Centre, 2011.http://nhsrcindia.org/download.php?downloadname=pdf_files/resources_thematic/Com munity_Participation/NHSRC_Contribution/ASHA_Which_way_forward_- _Evalaution_of_ASHA_Programme_Report_NHSRC_417.pdf

22. Gopinathan U, Lewin S, Glenton C. An analysis of large-scale programmes for scaling up human resources for health in low- and middle-income countries. Geneva, Switzerland World Health Organization 2012.

23. Alam K, Tasneem S, Oliveras E. Performance of female volunteer community health workers in Dhaka urban slums. *Soc Sci Med* 2012; **75**(3): 511-5.

24. Celletti F, Wright A, Palen J, et al. Can the deployment of community health workers for the delivery of HIV services represent an effective and sustainable response to health workforce shortages? Results of a multicountry study. *AIDS* 2010; **24 Suppl 1**: S45-57.

25. Bhutta ZA, Lassi ZS, Pariyo GW, Huicho L. Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems. In: WHO & global health workforce alliance, editor. Geneva; 2010

26. Baez C, Barron P. Community voice and role in district health systems in east and southern Africa: a literature review., 2006.www.equinetafrica.org/bibl/docs/DIS39GOVbaez.pdf

27. Partners in Health. Community Health Workers Recruitment 2010. http://model.pih.org/community_health_workers/chw_recruitment (accessed July 22, 2013 2013).

28. Mavalankar D, Vora K. The Changing Role of Auxiliary Nurse Midwife (ANM) in India: Implications for Maternal and Child Health (MCH) Ahmedabad: Indian Institute of Management Ahmedabad, 2008

29. Singh CM, Jain PK, Nair KS, Kumar P, Dhar N, Nandan D. Assessment of utilization of untied fund provided under the national rural health mission in Uttar Pradesh. *Indian journal of public health* 2009; **53**(3): 137-42.

30. World Health Organization. Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. Geneva, Switzerland: World Health Organization 2010.http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf

31. Razee H, Whittaker M, Jayasuriya R, Yap L, Brentnall L. Listening to the rural health workers in Papua New Guinea - the social factors that influence their motivation to work. *Soc Sci Med* 2012; **75**(5): 828-35.

32. MoHFW. Update on the ASHA Programme. 2011. http://nhsrcindia.org/pdf_files/resources_thematic/Community_Participation/NHSRC_Contri bution/Update%20on%20ASHA%20Programme%20_449.pdf (accessed Nov 15 2012).

33. Amare Y. Study of Implementation of Non-Financial Incentives for Voluntary Community Health Workers. JSI Research & Training Institute, Inc.; 2010

34. Oxford Policy Management. Lady Health Worker Programme: External Evaluation of the National Programme for Family Planning and Primary Health Care- Systems Review, 2009.http://www.opml.co.uk/projects/lady-health-worker-programme-third-party-evaluation-performance

35. CHW Technical Task Force. One Million Community Health Workers: Technical Task Force Report. New York: The Earth Institute, 2011

36. Crigler L, K. H, Furth R, Bjerregaard D. Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving CHW Programs and Services. Washington, DC: Health Care Improvement Project, University Research Corporation, and USAID, 2011.http://www.hciproject.org/sites/default/files/CHW%20AIM%20Toolkit_March2011.pdf

37. Berman PA, Gwatkin DR, Burger SE. Community-based health workers: head start or false start towards health for all? *Social science & medicine (1982)* 1987; **25**(5): 443-59.

38. Standing H, Chowdhury AM. Producing effective knowledge agents in a pluralistic environment: what future for community health workers? *Soc Sci Med* 2008; **66**(10): 2096-107.

39. Atim C. Contribution of Mutual Health Organizations to Financing, Delivery, and Access to Health Care. Synthesis of Research in Nine West and Central African Countries. Technical Report No. 18. Bethesda, Maryland: Partnerships for Health Reform Project, Abt Associates Inc., 1998.http://pdf.usaid.gov/pdf_docs/PNACH273.pdf

40. Jaskiewicz W, Tulenko K. Increasing community health worker productivity and effectiveness: a review of the influence of the work environment. *Human resources for health* 2012; **10**(1): 38.

41. Pradhan S. Personal communication. 2012

42. Haines A, Sanders D, Lehmann U, et al. Achieving child survival goals: potential contribution of community health workers. *Lancet* 2007; **369**(9579): 2121-31.

43. Lehmann U, Friedman I, Sanders D. Review of the Utilisation and Effectiveness of Community-based Health Workers in Africa. South Africa: University of Western Cape, South Africa SEED Trust, South Africa, 2004.http://hrh.uwc.ac.za/index.php?module=hrhlibrary&action=downloadfile&fileid=11193 0420852115

44. Ojofeitimi EO, Jinadu MK, Elegbe I. Increasing the productivity of community health workers in rural Nigeria through supervision *Socio-Economic Planning Sciences* 1988; **22**(1): 29-37.

45. Sennun P, Suwannapong N, Howteerakul N, Pacheun O. Participatory supervision model: building health promotion capacity among health officers and the community. *Rural and remote health* 2006; **6**(2): 440.

46. Deussom R, Jaskiewicz W, Dwyer S, Tulenko K. Holding Health Workers Accountable: Governance Approaches to Reducing Absenteeism. Washington, D.C.: IntraHealth International, Inc., 2012.http://www.intrahealth.org/files/media/holding-health-workers-accountable-governance-approaches-to-reducing-absenteeism/holding-health-workers-accountable-governance-approaches-reducing-absenteeism.pdf

47. Deussom R, Mitchell M, Ruben J. Using mobile technology to address the 'three delays' to reduce maternal mortality in Zanzibar.: International Journal of User-Driven Healthcare; 2013.http://cugh.conferencespot.org/CS35_Mitchell/12

48. Buchan J. What difference does ("good") HRM make? *Human resources for health* 2004; **2**(1): 6.