

Integrating Community Health Workers into Local Health Governance: A Strategic Lever for Gender-Responsive and Inclusive Health Systems

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Background

Community Health Workers (CHWs) constitute the backbone of primary health care delivery in Senegal, particularly for maternal, newborn, child and community-based services. As frontline actors embedded in communities, they are uniquely positioned to identify health needs, social barriers, and gender-specific vulnerabilities that formal health systems often overlook.

Global and national evidence shows that strong community health systems depend not only on service delivery but also on meaningful participation in governance, planning, and accountability mechanisms (WHO, 2007; Lehmann & Sanders, 2007). Senegal's National Development Strategy (2024–2029) and the Gender Institutionalization Plan (2025–2029) explicitly recognize decentralized governance, social equity, and gender equality as prerequisites for a high-performing health system.

However, recent evidence from the MSHP/CG (2025) study demonstrates that CHWs, particularly women, remain systematically excluded from decision-making spaces, poorly resourced, and weakly recognized within local health governance structures. This undermines both the effectiveness of health interventions and the equity of the health system.

Problem Statement

Despite their central role in service delivery and community engagement, community health workers are structurally marginalized from local health governance. Their limited participation in decision-making bodies, combined with weak institutional recognition, lack of financial support, and insufficient leadership training, has created a system where those closest to community realities have little influence over priorities, resource allocation, and accountability.

This exclusion is not gender-neutral: women CHWs are disproportionately affected, reinforcing gender hierarchies within the health system and weakening the responsiveness of policies to women's and children's needs. As a result, Senegal's health system risks reproducing inequalities at the very level where equity should be strongest - within communities.

Why CHWs Matter for Gender-Responsive Governance?

Community Health Workers, most of whom are women, are the health system's primary interface with households, caregivers, and vulnerable populations. Excluding them from governance means excluding women's voices, lived realities, and frontline evidence from health policy.

Integrating CHWs into decision-making is not an administrative reform, it is a gender equality and health equity imperative.

How was the assessment done?

The findings are drawn from a national gender analysis of Community Health Actors (MSHP/CG, 2025), combining quantitative surveys and qualitative interviews with CHWs and local authorities across eight regions, a review of global evidence from peer-reviewed research on community health governance and gender.

This mixed-methods approach ensured that both statistical trends and lived experiences informed the conclusions.

Key findings

- CHWs are largely excluded from decision-making, with over one-third not consulted at all, rising above 44% in some regions.
- Women CHWs are particularly marginalized, concentrated in service delivery but rarely in leadership or governance roles.
- More than half of CHWs receive no financial support to attend governance meetings, making participation economically unviable.
- Over 60% of women CHWs lack recent training, limiting their ability to influence planning, budgeting, and accountability processes.

What must be done

- Formally integrate CHWs into all local health governance bodies so community and gender perspectives shape priorities and budgets.
- Recognize and professionalize CHWs, with visible certification, status, and leadership pathways, especially for women.
- Invest in leadership and governance training to enable CHWs to participate as equal partners in decision-making.
- Finance participation, ensuring transport and meeting costs are covered so no CHW, particularly women is excluded due to poverty.

Objectives and Scope

This policy brief aims to:

- Inform high-level decision-making on the governance barriers faced by community health workers;
- Highlight gender-based inequalities in participation, recognition, and leadership within community health systems;
- Provide evidence-based recommendations to strengthen inclusive, accountable, and gender-responsive local health governance.

The scope focuses on community health workers operating at health post, district, and community levels, with particular attention to women CHWs, who constitute the majority of the workforce but remain under-represented in leadership and governance.

Methodology

The analysis is based on:

- The national study on gender inequalities experienced by Community Health Actors (MSHP/CG, May 2025);
- A review of peer-reviewed global evidence on community health governance, gender, and participation
- Comparative insights from West and Central Africa and similar low- and middle-income country contexts.

Findings were triangulated across quantitative survey data, qualitative testimonies from CHWs and authorities, and international evidence on governance and health systems strengthening.

The Gender and Health System Dividend of Integrating CHWs into local Health Governance

1. **Better health outcomes for women and children:** Women CHWs are the primary providers of maternal, newborn, child, and adolescent health services. When they participate in planning and governance, health services become more responsive to pregnancy and childbirth risks,, gender-based barriers to care, and cultural constraints that affect women's access to services.

This leads to higher service uptake, earlier care-seeking, and improved survival and wellbeing for women and children.

2. **Stronger, more accountable local health systems:** CHWs operate at the intersection of households, communities, and health facilities. Their inclusion in governance creates a real-time feedback loop between communities and decision-makers, improving targeting of resources, detection of service gaps, and responsiveness to community complaints and priorities.

This strengthens social accountability and trust in the health system.

3. Greater gender equality and women's economic empowerment: Formal recognition, remuneration, and leadership pathways transform CHW work from informal care into professionalized, income-generating and decision-influencing roles for women. This:

- Increases women's bargaining power at household and community level,
- Reduces economic vulnerability, and challenges harmful norms that confine women to unpaid care work.

4. Higher return on health investments: When CHWs help shape priorities and budgets, investments are better aligned with real needs, reducing:

- Wasteful spending on poorly targeted services, and
- Costly treatment of preventable conditions.

Integrating CHWs into governance therefore delivers more health impact per dollar spent, making it one of the most cost-effective reforms available to the health system.

Findings

Limited participation in decision-making bodies:

- CHWs are largely excluded from planning and governance structures. 31.3% reported not being consulted at all, rising to over 44% in Dakar and Kaffrine, despite their frontline role. They are treated as implementers rather than strategic partners, which weakens community accountability and relevance of interventions.

Systematic under-representation of women in governance:

- Women CHWs are particularly marginalized in leadership and strategic spaces, reinforcing gender hierarchies. They are over-concentrated in service delivery roles (especially maternal and child health) and under-represented in decision-making, limiting gender-responsive policy formulation.

Weak institutional recognition and insecure professional status:

- Although 97.6% of authorities acknowledge the importance of CHWs, most are not formally recognized within governance structures. Many, especially women, work without formal status, career pathways, or secure remuneration, leading to low morale and high attrition.

Insufficient financial support for participation:

- More than 54% of CHWs receive no financial incentives for their work or participation in governance meetings, rising to 97% in Ziguinchor. This makes regular attendance and meaningful engagement economically impossible, especially for women with unpaid care responsibilities.

Severe gaps in leadership and governance training:

- Around 60% of women CHWs and 65% of men have not received any training in the last two years. Women face additional barriers due to social norms that confine them to care roles rather than leadership, limiting their influence over health policies and budgets.

Recommendations

Key Recommendation	Issue	What Should Be Done	Why It Matters
Institutionalize CHW participation in health governance	CHWs, especially women, lack professional status and visibility.	Mandate their representation in health post committees, health development committees, and regional health boards through formal regulations.	This ensures that community realities and gender-specific needs directly inform planning, budgeting, and accountability.
Establish formal recognition and career pathways for CHWs	CHWs, especially women, lack professional status and visibility.	Introduce certification, public recognition mechanisms, and governance-linked career progression, with targeted visibility for women leaders.	Recognition strengthens legitimacy, retention, and the authority of women CHWs in decision-making spaces.
Implement a national leadership and governance training programme	Women lack access to leadership skills and governance roles	Develop a certified training programme (with ENDSS and partners) focused on planning, advocacy, budgeting, M&E, and negotiation, prioritizing women CHWs.	Leadership capacity is the gateway to power, influence, and gender-responsive policy outcomes.
Create a dedicated financing mechanism for CHW participation	Lack of allowances excludes CHWs from governance.	Establish a budget line within the National Community Health Programme to cover transport, per diem, and operational tools for CHW participation.	Without financial support, participation remains symbolic and structurally biased against women.