Research Article

Presicodesa's Opinions on the Legal Recognition of the Community Health Worker Profession within the Healthcare System of the Democratic Republic of the Congo: A Case Study of the Muanda Health Zone

Ngimbi Ngimbi Jean[1], Onoya Wedi Josué[2], Kafinga Luzolo Emery[3], Ntoto Nkunzi Bernard[4], Monizi Mawunu[5], Koto-Te-Nyiwa Ngbolua Jean Paul[6]

[1]Ecole Doctorale des Sciences de Santé, Institut Supérieur des Techniques Médicales de Kinshasa, Kinshasa, République Démocratique du Congo . dikarabajean@gmail.com. https://orcid.org/ 0009-0007-0795-931X
[2]Ecole Doctorale des Sciences de Santé, Institut Supérieur des Techniques Médicales de Kinshasa, Kinshasa, République Démocratique du Congo. wedijosue@gmail.com. https://orcid.org/0000-0002-7115-9452
[3]Ecole Doctorale des Sciences de Santé, Institut Supérieur des Techniques Médicales de Kinshasa, Kinshasa, République Démocratique du Congo. ekafingaluzolo@gmail.com. https://orcid.org/0009-0000-0653-2997
[4]Ecole Doctorale des Sciences de Santé, Institut Supérieur des Techniques Médicales de Kinshasa, Kinshasa, République Démocratique du Congo. ntotobernard@gmail.com. https://orcid.org/0009-0004-8194-9142
[5]Mention Science de la Vie, Faculté des Sciences et Technologie, Université de Kinshasa, Kinshasa, République Démocratique du Congo. Instituto Politécnico da Universidade Kimpa Vita, Uíge, Angola m.mawunu2000 @gmail.com. +244 942009168. https://orcid.org/0000-0001-6658-9223
[6]Ecole Doctorale des Sciences de Santé, Institut Supérieur des Techniques Médicales de Kinshasa, Kinshasa, République Démocratique du Congo . Centre de Recherche en Pharmacopée et Médecine Traditionnelle, Institut Supérieur des Techniques Médicales, Kinshasa, République Démocratique du Congo. Mention Science de la Vie, Faculté des Sciences et Technologie, Université de Kinshasa, Kinshasa, République Démocratique du Congo. jpngbolua@unikin.ac.cd, ngbolua@gmail.com. https://orcid.org/0000-0002-0066-8153

Abstract

The lack of legal recognition of the community health worker profession hampers the proper functioning of the healthcare system in the Democratic Republic of the Congo (DRC), particularly in the Muanda Health Zone. Accordingly, this study aims to explore the opinions of Presicodesa regarding the legal recognition of the community health worker profession within the healthcare system in this health zone.

This is a qualitative study employing a phenomenological approach. Data were collected between 3 and 30 July 2026 from 12 Presicodesa, selected according to the study's requirements using purposive non-probability sampling.

The findings reveal that the lack of legal recognition leads to professional abandonment, demotivation, poor performance, inadequate referral of patients to hospitals, limited participation in community activities and inefficiency. To achieve legal recognition, it is necessary to establish a ministerial order, ministerial decree or other official legal instrument defining and regulating the profession, its responsibilities, roles, tasks and duties. Further measures include establishing an official legal framework, providing formal academic training, creating a national identification and registration system, adopting a professional charter, officially appointing community health workers (RECOs), granting authorization to practise as RECOs and restructuring the community health worker profession.

Keywords: Opinion, Presicodesa, legal recognition, community health worker profession, healthcare system, phenomenological approach, Muanda.

1. Introduction

The availability of a competent, adequately trained and properly integrated health workforce is essential to achieving universal health coverage. Globally, the World Health Organization (WHO) estimates that the number of community health workers (CHWs) reaches approximately 4 million across 93 countries, including 1.9 million in the South-East Asia Region, 0.9 million in the Western Pacific Region, 0.3 million in the Americas, 0.9 million in the African Region, 90,000 in the Eastern Mediterranean Region and 10,000 in the European Region. Community health workers are employed in only 28 of the 54 countries (52%) in which they are present [1].

According to the World Health Organization (WHO), the training, supervision, remuneration, institutional integration and regulation of community health workers vary considerably from one country to another. The WHO recommends that community health worker programmes be based on a clearly defined role, appropriate supervision, selection based on well-established criteria, training tailored to the expected competencies, remuneration and integration into the health system. Within primary healthcare, community health workers serve as a link between households and health facilities, contributing to health promotion, disease prevention, patient referral, community surveillance and, depending on their level of competence, certain preventive and curative interventions. In developed countries, the increasing formalization of this community-based workforce is evident. In Europe, the WHO advocates the professionalization of the public health workforce, particularly through competency development, training, educational institutions, professional organizations and governance mechanisms. In the United States of America, the establishment of a voluntary certification system for community health workers (CHWs) aims to structure the workforce, support professional development and facilitate their integration into healthcare systems [1].

In Brazil, the institutional and legal recognition of community health workers is based on Federal Law No. 11,350 of 2006, which regulates their activities and defines the conditions for practicing their profession, including residence in the community, initial training and the required educational qualifications. The 2018 reform strengthened training requirements and provided for the possibility of specific technical training. The Saúde com Agente programme introduced a 1,200-hour technical training course for community health workers. Furthermore, Law No. 14,536 of 20 January 2023 recognizes community health workers and endemic disease control agents as healthcare professionals practicing regulated professions. The Ministry of Health also reports approximately 265,000 endemic disease control agents. Community-based work is therefore underpinned by close engagement with local communities within a regulated professional framework, the legal definition of duties, clearly established entry requirements, formal training, career development and legal recognition [2].

In Africa, several countries have established structured professional frameworks for community health workers, as has been the case in Brazil. In Ethiopia, Health Extension Workers (HEWs) are salaried personnel employed by the state and integrated into the national health programme. Their recruitment is based on educational qualifications, prior training, proficiency in the local language and membership of the community they serve. They receive formal initial training lasting one year, comprising both theoretical and practical instruction, followed by a competency examination that enables them to progress to a higher qualification level. This model emphasizes a structured career pathway, from community-based recruitment through certified professional training to public- or private-sector employment and continuing professional development [3].

In Zambia, Community Health Assistants (CHAs) constitute a formalized cadre of community health workers who undergo approximately one year of initial training combining theoretical instruction and practical experience. Their professional status is recognized by the Health Professions Council of Zambia (HPCZ), which provides for a specific Community Health Assistant qualification, successful completion of

a licensure examination and registration with the Council. The Council's regulatory documentation stipulates that no individual may practice as a regulated health professional without having received the required training and registered in accordance with the applicable professional legislation. This professionalization framework is based, in particular, on a curriculum leading to a Certificate in Community Health Assistants (CHA), which falls within the regulatory framework of the HPCZ. Holders of this certificate must pass the licensure examination to be registered as Community Health Assistants. The Council further emphasizes that individuals may not practice as health professionals without registration in accordance with the relevant legislation. This framework therefore combines recognized training, competency assessment, professional registration and authorization to practice, providing a structured model for regulating the community health workforce [4].

In South Africa, the professionalization of community health workers is relatively advanced. The national qualification in Community Health Work is incorporated into the national education and training system. The framework promotes the development of competencies required for health education, referral and support for community members navigating the healthcare system, as well as community assessment through a national registration system [5].

In Nigeria, some community health workers undergo well-structured post-secondary education through specialized training programmes. These include a three-year programme leading to a National Diploma in Community Health, which provides a pathway towards a community health career based on institutionalized training and a recognized qualification. The regulatory framework establishes requirements for professional training, registration and licensure, thereby formalizing the competencies and conditions required to practice as community health personnel [6].

In Rwanda, the legal framework supports the integration of community health workers into the healthcare system. Health legislation defines them as individuals trained to support the delivery of primary healthcare services within their communities and provides for a specific category of community-based health personnel within the organization of the health system. Since 1995, these workers have played an important role in health education, community mobilization and the improvement of community health [7].

Professionalization is based primarily on certified training, which constitutes a decisive step, together with public-sector employment status, a nationally recognized qualification, a licensure examination, registration with a regulatory body and explicit legal recognition of the profession. It is therefore important to distinguish between the training of community health workers (RECOs), their integration into the healthcare system, their professional recognition, their organization into professional associations and their legal recognition. The World Health Organization (WHO) specifically recommends a structured approach to the training and integration of community health workers. In 2025, it published a global guide to help countries design and implement CHW training programmes according to the competencies required and the national context [1].

Accordingly, professionalization follows a progressive pathway that can be represented as a sequence of

interconnected stages: candidate identification and selection → standardized initial training → competency assessment → award of a qualification → professional registration or certification → integration into the healthcare system → continuing professional development → professional organization → regulation and legal recognition → career development [1].

In the DRC, community-based healthcare has evolved towards frameworks for qualification, certification, registration, regulation and professional representation. However, the situation of community health workers (RECOs) remains characterized by training focused on specific interventions, a multiplicity of programmes and an insufficiently structured system of professional recognition. The absence of a clearly defined professional and legal status affects their motivation, training, community engagement, social protection and career development, while also hindering their sustainable integration into the healthcare system [8].

Furthermore, community health workers (RECOs) have played an important role for several years in bridging the gap between communities and the healthcare system. The different categories of RECOs include service-providing community health workers, health promotion community health workers and community volunteers assigned to specific programmes. This diversity highlights the need to define the importance of community-based healthcare and establish a structured national professional framework covering all community health personnel. In the Kabondo Health Zone, in Tshopo Province, 71.3% of the RECOs surveyed reported a lack of training and refresher courses provided by health authorities, while 63% reported the absence of certain benefits after carrying out their activities and difficulties in participating in community health activities. These findings underscore the need to implement appropriate training programmes, formally recognize the role of community health workers and improve resource allocation [9].
In the Muanda Health Zone, where this study was conducted, community health workers (RECOs) are not officially recognized within the healthcare system in legal terms. Consequently, exploring the opinions of Presicodesa can help clarify how the legal recognition of RECOs is perceived at community level, which forms of professionalization are considered necessary, and which strategies could facilitate their sustainable integration into the healthcare system.
Research question: This study seeks to answer the following research question: What are the opinions of Presicodesa regarding the legal recognition of the community health worker profession within the healthcare system of the DRC, specifically in the Muanda Health Zone?
Research objective: The general objective of this study is to explore the opinions of Presicodesa regarding the legal recognition of the community health worker profession within the healthcare system of the DRC, specifically in the Muanda Health Zone.
Specific objectives
To achieve our general objective, we established the following specific objectives:

- To describe the sociodemographic characteristics of the Presicodesa.
- To elucidate the opinions of the Presicodesa regarding the legal recognition of the community health worker profession within the healthcare system of the Democratic Republic of the Congo, specifically in the Muanda Health Zone.
- To propose strategies for the legal recognition of the community health worker profession within

the healthcare system of the DRC.

- To develop a university-level training programme for community health workers to facilitate the legal recognition and professionalization of their profession within the healthcare system of the DRC.

2. Material and Methods

2.1 Description of the Study Area

Our study was conducted in the Muanda Health Zone, located in Kongo Central Province, in the DRC.

2.2 Target Population

The target population comprised all Presicodesa in the Muanda Health Zone, located in Kongo Central Province, in the DRC, during the study period in 2026.

2.3 Methods

2.3.1 Study Design and Field of Study

This is a qualitative study employing a phenomenological approach. It falls within the field of environmental health.

2.3.2 Data Collection Methods, Techniques and Instruments

The survey method was used, with interviews conducted using an interview guide as the data collection instrument.

2.3.3 Study Procedure

Each interview lasted approximately 30 minutes and was conducted individually to collect data on participants' sociodemographic characteristics and their opinions regarding the legal recognition of the community health worker profession within the healthcare system of the Democratic Republic of the Congo, specifically in the Muanda Health Zone. Data were collected between 3 and 30 July 2026 from 12 Presicodesa, selected according to the study's requirements using purposive non-probability sampling.

2.3.4 Ethical Considerations

The study was approved by the Ethics Committee of the Doctoral School at the Higher Institute of Medical Techniques (ISTM), Kinshasa, as documented in letter No. 0030/CBE/ISTM/KIN/RDC/PMBBL/2025, dated 11 February 2026. Before data collection, authorization was obtained from the health authorities of the Muanda Health Zone, including the Presicodesa who participated in the study. The confidentiality and anonymity of all information collected were ensured.

2.3.5 Data Analysis

The interviews were audio-recorded using the voice-recording applications on Android mobile phones. The recordings were then transcribed and imported into NVivo 14 software for qualitative data analysis. The analysis involved describing the sociodemographic characteristics of the Presicodesa and examining the information gathered regarding the legal recognition of the community health worker profession

within the healthcare system of the Democratic Republic of the Congo. The interview transcripts were analyzed thematically, with central themes guiding the identification of recurring patterns and the development of categories from participants' verbatim accounts. These procedures were used to organize, interpret and analyze the collected data.

3. Results

Box 1. Sociodemographic Characteristics of the Presicodesa

Code	Age (Average = 51 years)	Sex	Marital status	Level of education	Occupation	Length of service
R1	42 years	Male	Married	Graduate	Teacher	9 years
R2	69 years	Male	Married	Graduate	Electrician	9 years
R3	44 years	Female	Married	Graduate	Civil servant	10 years
R4	44 years	Female	Married	Graduate	Housewife	5 years
R5	39 years	Male	Single	Graduate	Teacher	5 years
R6	42 years	Male	Married	Graduate	Civil servant	5 years
R7	70 years	Male	Married	State-recognised graduate	Civil servant	7 years
R8	47 years	Male	Single	Graduate	Unemployed	5 years
R9	50 years	Male	Married	Bachelor's degree holder	Civil servant	7 years
R10	50 years	Male	Married	Bachelor's degree holder	IT specialist	6 years
R11	48 years	Male	Married	Secondary school graduate	Seamstress	6 years
R12	63 years	Female	Married	Secondary school diploma	Teacher	5 years

Box 1 presents the characteristics of the study participants, comprising Presicodesa identified by codes R1 to R12.

Participants' ages ranged from 39 to 70 years, with a mean age of 51 years. Regarding sex, nine participants were men and three were women. In terms of marital status, 11 were married and two were single. Regarding educational attainment, five held a state diploma, four held a graduate-level qualification and two held a bachelor's degree. In terms of occupation, four were civil servants and three were teachers. The remaining participants comprised an electrician, a homemaker, an unemployed person, an IT specialist and a tailor.

Note: The figures reported for marital status and educational attainment do not add up to the total sample of 12 participants. These data should be checked against the original dataset before publication.

Box 2. Meaning of the Legal Recognition of the Community Health Worker Profession

Sub-theme	Verbatims	Significations
	R2. This involves the formal integration of the community liaison role into the healthcare system through a clearly defined legal framework, setting out the status of RECOS, their duties and limitations in practice, and their legal responsibilities R4, R6. The legal framework must specify their status, their duties and limitations in practice, their legal responsibilities, and the role of RECOS within primary healthcare. R5, R8, R9, R10, R11, R12. This is a process by which the role of community liaison worker is integrated into the national health system through a legal and regulatory framework that clearly defines their status, their duties and limitations in the performance of their role, and their legal responsibilities R7 (…), consists of conferring this legal status on the profession within the national health system, through clearly defined legal and regulatory texts aimed at clarifying the relationships between RECOs, health facilities, communities and health authorities.	Establish a clearly defined legal framework
	R1. The legal or regulatory recognition of the role of Community Liaison Officer involves determining what duties the role must perform in relation to other	Legal recognition

	healthcare professions. R6. (…); through legal texts and the regulatory framework, clearly define their duties and limitations in the practice of their profession, their legal responsibilities and their status R2. Clarify the role of the RECO in primary healthcare with a view to ensuring the quality of community interventions to safeguard and protect the population	

Regarding the meaning of the legal recognition of the community health worker profession, two main themes emerged: the establishment of a clearly defined legal framework and formal legal recognition.

Box 3. Current Process for Becoming a Community Health Worker (RECO) within the Healthcare System

Sub-theme	Verbatims	Significations
The current process for becoming a RECO within the healthcare system	R1. The RECOs are re-selected in accordance with selection criteria set by the head nurse.	Selected by the head nurses
	R11. The recruitment of RECOs is approved by the head nurse following selection by the community.	Chosen by the community
	R1, R2. They are selected by the community and their appointment is approved by the health area committee responsible for managing its activities.	Selection criteria

Regarding the current process of becoming a community health worker (RECO) within the healthcare system, three main themes emerged: selection by the Head Nurses, selection by the community, and selection criteria.

Box 4. Competencies of a Community Health Worker (RECO)

Sub-theme	Categories	Verbatims	Significations
Roles and responsibilities of a community liaison officer	Knowledge-knowledge	R1, R2, R4, R5. (…), they must be able to carry out home visits, provide primary healthcare and vaccinations, and understand the community's health and socio-cultural realities.	Understanding the realities of the community
		R10. They are a key figure who lives within the community and understands its experiences,	Providing guidance to

		problems and realities.	patients
	Expertise	R1, R2, R4, R5. He is able to communicate with the local population, carry out community-based assessments, make home visits, refer patients and collect data.	Communication and community-based diagnosis
		R10. Be able to carry out community-based assessments, collect data within the community and communicate.	Data collection
		R5, R6, R7, R8, R9, R10, R11, R12. Awareness-raising and social mobilisation activities.	Carrying out home visits
	Interpersonal skills	R1, R4, R5. Be able to engage with the local population, communicate effectively with the community, understand the realities of their community and communicate effectively.	Interpersonal skills, active listening, respect
		R9. They must possess interpersonal skills, be a good listener, show respect and be able to adapt to the realities of the community.	Team spirit and leadership
		R1. Demonstrate team spirit and leadership.	Good conduct.

The competencies to be developed by community health workers (RECOs) include knowledge of local community contexts, patient referral, communication, community diagnosis, data collection and the ability to conduct home visits. They should also demonstrate interpersonal skills, active listening, respect for community members, teamwork, leadership and appropriate professional conduct.

Box 5. Benefits and Challenges of the Community Health Worker Profession within the Healthcare System of the DRC

Sub-theme	Categories	Compiled verbatim transcripts	Significations
The benefits and challenges of working as a RECO	Benefits	R1, R2, R4, R5, R6, R7, R8, R9, R10, R11, R12: Do continuing professional development and supervision help to strengthen or develop the skills of RECOs? R3. Capacity-building through continuing professional development and supervision helps us to work effectively	Capacity building

		R1, R2, R4, R5, R6, R8, R9, R10, R11. In the event of illness affecting a RECO member or a member of their family, healthcare is provided with half the costs covered. R7. I am entitled to reduced-cost healthcare for myself and my family in the event of illness.	Medical care
		R8, R9, R10, R11, R12. Knowledge of the socio-cultural context or the health catchment area promotes acceptance of health interventions. R2. The community supports and accepts health interventions through community mobilization. R9, R12. RECOs form an important link between the community and health facilities. R7. Strengthening the link between the community and healthcare facilities. This builds the community's confidence in using the hospital. R10. Referral of the community following the identification of its health problems.	Consent to treatment
	Difficulties	R1, R2, R4, R5, R6, R7, R8, R9, R10, R11, R12: the irregularity or inadequacy of transport costs/financial justifications; quarterly rather than monthly payments. R3. Inadequate and irregular financial incentives and transport allowances, which are negligible compared to the volume of work.	Demotivation

		R1, R2, R4, R5, R6, R7, R8, R10, R11, R12 : lack or insufficiency of equipment, communication resources and logistical support. R9. The insufficiency of equipment, communication resources and logistical support constitutes a major obstacle.	Inadequate facilities
		R9, R10, R11, R12: lack of a legally defined professional status due to the lack of recognition of this profession. R11, R12: low social and institutional recognition of the profession. R5. The lack of a legally defined professional status disrupts the normal functioning of this profession, and the lack of supervision of IT staff is demotivating.	Lack of legal status
		R1, R2: RECOs ceasing their roles due to job insecurity R2, R4: RECOs' lack of motivation in their activities and the lack of patient referral to hospital R6, R10, R5: The inconsistent participation of RECOs in activities, leading to a reduction in the effectiveness and continuity of community-based interventions.	Consequences of RECO not being legally recognized

The benefits of the community health worker profession within the healthcare system of the DRC include capacity-building, access to medical care and community acceptance of healthcare services. Conversely, the main challenges are demotivation, inadequate equipment and the absence of legal status.

Box 6. Process for the Legal Recognition of Community Health Workers within the Healthcare System

Sub-theme	Grouped verbatim transcripts	Significations
Process for the legal recognition of RECOs	R1, R6, R7, R8, R9, R10, R11, R12: draw up a ministerial order, a ministerial decree or an official document defining and regulating the profession and the remit of RECOs. R3. Adopt an official legal framework regulating the profession of RECO and defining its remit and responsibilities.	Establishing a formal legal framework
	R1, R2, R4, R5, R6, R7, R8, R9, R10, R11. Introduce a recognized national certification scheme and a minimum duration for training. R12. Introduce a national certification scheme and a minimum duration for training R4. Organize academic training for RECOs to standardise the professional skills to be developed.	Academic education
	R1, R2, R4, R5, R6, R7, R8, R9, R10, R11, R12: assign a national identification number and establish a national register of RECOs. R2. Create a national system to officially identify and register RECOs.	Establishment of a national identification and registration system
	R2, R4, R5, R6, R7, R8, R10, R11, R12: to have a professional charter. R1. To draw up a professional charter to provide a framework for the practice of the profession R9. To establish learned societies for the RECO profession, involving the professional association, the RECO professional body and the trade union delegation, to campaign for their rights.	Code of Ethics

	R1, R2, R4, R5, R6, R7, R8, R9, R10, R11, R12: have an assignment approved by the health service. R5. Be assigned via the standard procedure by the health authorities.	Official posting
	R1, R4, R6, R7, R9, R10: Provide for the periodic renewal of authorization to practice in accordance with clearly defined criteria. R11. Establish a mechanism for the periodic renewal of authorization to practice R12. Authorization to practice as a community liaison officer is required.	Licence to practice
	R1, R2, R4. (…), review and amend the RECO operational policy to better organize their work. R6, R8, R9, R10. Develop a specific national policy for community liaison officers; harmonize recruitment and training criteria across the whole country; and strengthen their supervision. R7. Clearly define their areas of intervention, their role, tasks, scope of action and their responsibilities within health policy.	Restructuring the community liaison role

The sub-theme concerning the process of the legal recognition of community health workers within the healthcare system generated the following meanings: establishing an official legal framework; organizing formal academic training; creating a national identification and registration system; establishing a professional charter; officially appointing RECOs; granting authorization to practice as RECOs; and restructuring the community health worker profession.

4. Discussion

4.1. Meaning of the Legal Recognition of the Community Health Worker Profession

It refers to the official integration of the community health worker profession into the healthcare system through a clearly defined legal framework specifying the status of RECOs, their duties and limitations in the exercise of their profession, and their legal responsibilities. The legal framework should also define their role within primary healthcare services. The legal recognition of the community health worker profession is a process through which the profession is integrated into the national healthcare system by means of a legal and regulatory framework that clearly defines the status of RECOs, their duties and

limitations in the exercise of their profession, and their legal responsibilities.
It involves determining the tasks that community health workers are expected to perform and how they should interact with other healthcare professionals, through clearly defined legal and regulatory instruments. These instruments should specify their duties, professional limitations, legal responsibilities and status, thereby clarifying their role in primary healthcare and helping to ensure the quality of community-based interventions and the safety and protection of the population.
Respondent R7 stated that it "consists of granting legal recognition to this role within the national healthcare system through clearly defined legal and regulatory instruments, with a view to clarifying the relationships between RECOs, healthcare facilities, communities and health authorities". Community health worker programmes require clearly defined roles, adequate supervision, appropriate working tools and integration into the healthcare system [10].

4.2. Process and Criteria for Becoming a Community Health Worker (RECO) within the Healthcare System

The legal recognition of the community health worker profession is a process through which the profession is integrated into the national healthcare system by means of a legal and regulatory framework that clearly defines the status of RECOs, their duties and limitations in the exercise of their profession, and their legal responsibilities.
It involves determining the tasks that community health workers are expected to perform and how they should interact with other healthcare professionals, through clearly defined legal and regulatory instruments. These instruments should specify their duties, professional limitations, legal responsibilities and status, thereby clarifying their role in primary healthcare and helping to ensure the quality of community-based interventions and the safety and protection of the population.
Respondent R7 stated that it "consists of granting legal recognition to this role within the national healthcare system through clearly defined legal and regulatory instruments, with a view to clarifying the relationships between RECOs, healthcare facilities, communities and health authorities" [10].

4.3. Competencies of a Community Health Worker (RECO)

The competencies to be developed by RECOs include knowledge of local community contexts, patient referral, communication, community diagnosis, data collection and the ability to conduct home visits. They should also demonstrate interpersonal skills, active listening, respect for community members, teamwork, leadership and appropriate professional conduct.
In terms of knowledge and practical skills, RECOs should be able to conduct home visits, monitor vulnerable individuals, support primary healthcare and vaccination activities, and understand the health-related and sociocultural realities of their communities. As community members themselves, they are familiar with local living conditions, problems and circumstances. They also understand patient referral pathways and mechanisms for referring individuals to healthcare facilities. When illness occurs, they direct patients to hospitals for appropriate medical care.
In terms of practical skills, RECOs should be able to communicate effectively with the population, conduct community assessments, carry out home visits, refer patients to healthcare facilities and collect data. They should also be able to undertake community assessments, gather community-level data, raise awareness and promote social mobilization.

Furthermore, they should be able to collect, record and transmit data required for monitoring and evaluating community-based activities, demonstrating proficiency in the entire process of community data management.

RECOs should also possess interpersonal skills, including active listening, respect for community members and the ability to adapt to local circumstances. They should demonstrate teamwork and leadership, as well as the ability to engage and coordinate community members in health-related activities. Finally, they should exhibit integrity and adhere to ethical principles.

4.4. Benefits and Challenges of the Community Health Worker Profession within the Healthcare System of the DRC

Benefits

The benefits of the community health worker profession within the healthcare system of the DRC include capacity-building. Continuing training and supervision help strengthen and develop RECOs' competencies. Another benefit is access to medical care in the event of illness affecting a RECO or a member of their family, with half of the medical expenses being covered.

A further benefit is greater community acceptance of healthcare services, as community members are more willing to participate in and accept health interventions as a result of community mobilization.

Challenges

The main challenges include irregular or insufficient transport allowances and financial incentives, which are often paid quarterly rather than monthly. The amounts provided are inadequate and do not reflect the workload involved.

A further challenge is the shortage of equipment, communication materials and logistical resources, which constitutes a major obstacle to the effective performance of community health workers' duties.

In addition, the absence of a clearly defined legal and professional status, coupled with the lack of recognition afforded to the profession, undermines its proper functioning. The limited social and institutional recognition of RECOs, together with inadequate supervision by head nurses, further contributes to demotivation.

Consequences of the Lack of Legal Recognition of RECOs

The lack of legal recognition of RECOs leads to professional insecurity and may result in their abandonment of the role. It also contributes to demotivation and inadequate referral of patients to hospitals. Furthermore, the inconsistent participation of RECOs in community activities reduces the effectiveness and continuity of community-based interventions.

4.5. Process for the Legal Recognition of Community Health Workers within the Healthcare System

The legal recognition of community health workers within the healthcare system requires the establishment of an official legal framework, the provision of formal academic training, the creation of a national identification and registration system, the adoption of a professional charter, the official appointment of RECOs, the granting of authorization to practice as RECOs, and the restructuring of the community health worker profession. Establishing an official legal framework requires the adoption of a ministerial order, ministerial decree or other official legal instrument defining and regulating the

profession, including the duties and responsibilities of RECOs.

According to the WHO, the effective integration of community health workers requires coherent policies governing their selection, training, certification, management and supervision, as well as their integration into the healthcare system [11].

Formal academic training would enable the award of a nationally recognized qualification, based on a minimum training period, with the aim of standardizing the professional competencies to be developed. A national identification and registration system should also be established to assign each RECO a unique national identification number and maintain an official register of community health workers.

A professional charter is envisaged to regulate the practice of the profession. Professional bodies should also be established, including a professional association, an order of RECOs and a trade union representation structure, to defend their rights and interests.

Official appointments should be validated by the healthcare system and follow the established procedures through the competent health authorities. Finally, RECOs should be granted authorization to practice as community health workers on the basis of clearly defined criteria, with such authorization subject to periodic renewal.

The WHO specifically recommends that the roles of community health workers be clearly defined and integrated into the healthcare system, in coordination with other categories of health workers [11].

The WHO advocates competency-based certification following initial training that meets established standards. It considers certification a means of formally recognizing acquired competencies and facilitating professional development [1].

Furthermore, restructuring the community health worker profession requires reviewing and revising the policies governing RECOs to improve the organization of their work. This entails developing a specific national policy for community health workers, harmonizing recruitment and training criteria across the country, and strengthening supervision. It is also necessary to clearly define their areas of intervention, roles, duties, scope of practice and responsibilities within the national health policy.

The competencies of community health workers should be aligned with their roles, the needs of the healthcare system and the national context. The WHO recommends adapting training curricula to the actual functions performed by these workers. Each RECO should be attached to a healthcare facility, with clearly defined responsibilities, reporting lines and areas of intervention. WHO guidance also emphasizes the integration of community health workers into existing healthcare structures [1].

4. Conclusion and Future Perspectives

The lack of legal recognition of community health workers (RECOs) contributes to the poor performance of the healthcare system in the Democratic Republic of the Congo (DRC), particularly in the Muanda Health Zone. This study aimed to explore Presicodesa's opinions regarding the legal recognition of the community health worker profession within the healthcare system in the Muanda Health Zone.

This was a qualitative study adopting a phenomenological approach. It involved 12 Presicodesa selected according to the needs of the study using purposive, non-probability sampling. The survey method was employed, with interviews conducted using an interview guide as the data collection instrument.

The findings indicate that the legal recognition of the community health worker profession entails its official integration into the healthcare system through a clearly defined legal framework specifying the status of RECOs, their duties, limitations in the exercise of their profession, legal responsibilities and role

in primary healthcare. More broadly, legal recognition is a process through which the profession is integrated into the national healthcare system by means of a legal and regulatory framework that clearly establishes these elements.

The legal recognition process requires the establishment of an official legal framework, formal academic training, a national identification and registration system, a professional charter, the official appointment of RECOs, authorization to practice as community health workers and the restructuring of the profession. Establishing an official legal framework would require a ministerial order, ministerial decree or other official legal instrument defining and regulating the profession, including the duties and responsibilities of RECOs.

Formal academic training would enable the award of a nationally recognized qualification following a minimum period of training, thereby promoting the standardization of professional competencies. A national identification and registration system should also be established to assign each RECO a unique national identification number and maintain an official register.

A professional charter should be introduced to regulate professional practice. Professional organizations should also be established, including a professional association, an order of RECOs and trade union representation, to defend their rights and interests. Official appointments should be validated by the healthcare system and follow established procedures through the competent health authorities. Furthermore, RECOs should be granted authorization to practice according to clearly defined criteria, with periodic renewal.

Finally, restructuring the community health worker profession requires reviewing and revising existing policies to improve the organization of their work. This involves developing a dedicated national policy for RECOs, harmonizing recruitment and training criteria throughout the country, and strengthening supervision. Their areas of intervention, roles, duties, scope of practice and responsibilities within the national healthcare policy must also be clearly defined.

Acknowledgements

We would like to thank our steering team for their support and coordination, which made this study possible.

Conflict of Interest

The authors declare that they have no conflicts of interest related to this study.

Authors' Contributions

NNJ conceived and supervised the study.

O.W.J. participated in data collection, contributed to the study design and conducted the analysis using NVivo 14, including the discussion of the findings.

J.-P.N. conceived and supervised the study, drafted the main manuscript and approved the final version.

KLE, MM and NKB validated the data, provided guidance throughout the study, contributed to the discussion and approved the final version for submission.

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