Community health systems: allowing community health workers to emerge from the shadows

We agree with the Editorial (May, 2017)[1] that stated "community health workers are desperately needed globally" but "often still stand…at the fringes of the health system, undefined and unsupported and therefore unable to completely fulfil their potential".[1] As the 40th anniversary of the Alma Ata Declaration approaches,[2] it is time to appropriately recognise the role and potential of community health systems. Further to the recent momentum highlighted,[1] we would add the lessons learned from the West Africa Ebola outbreak about the importance of community health systems[3] and the election of a WHO Director-General with direct experience in expanding Ethiopia's community level workforce.

USAID and UNICEF (in collaboration with WHO and the Bill and Melinda Gates Foundation) organised a conference in Johannesburg, South Africa, March 27–30, 2017, to support countries' ambitions to "institutionalise" community health. Attended by almost 400 people, the conference diagnosed the current state of community health systems. 23 country delegations defined roadmaps for community health systems that strengthen communities' capability, based on recognised and empowered community health workers being an essential element of primary health care.[4] The conference noted the continuum in the concept of community health between the community as a geographical place and level of health system service delivery compared with as a social construction of relations between individuals and groups.[5]

Three key required shifts emerged. First, a systems approach urgently needs to be taken for community health. Universal health coverage in all countries by 2030 is unattainable without strengthening community health systems—enabling community health workers to deliver preventive and curative services, and supporting the empowerment of communities to demand social accountability from their governments and other providers for coverage of quality health services. As the *Editorial* notes, community health workers require coordination, training, supervision and remuneration—but also reliable supplies, improved data systems, integration with referral health facilities, inclusion in community-level pooling and payment schemes, support by other health-related community cadres, and rectifying the inherent gender inequality whereby female community health workers are under-recognised, underpaid, overworked, and under-represented in decision-making.

Second, financing remains a key challenge—many countries remain reluctant to allocate health sector resources to the community level, and development partner funding faces a number of threats. For example, the ambitious plans to scale up community health programmes in Sierra Leone and Liberia post-Ebola are not yet fully funded. The investment case for community health shows that investing in community health workers can result in a 10:1 return. Community health workers and community health systems are neither inexpensive nor a panacea, but can be a sound investment leading to improved health outcomes—and also potentially greater productivity, insurance against crises, dignified employment, and improved gender equality.[6]

Third, our approach to policy-making and knowledge management needs to be transformed. All community health programmes require explicit, prospectively designed implementation research to fill evidence gaps, inform policy, and enable course correction in real time. But a shift in how lessons are learnt and policy reforms are driven is also required, built on South-South sharing of expertise and supported by participatory knowledge platforms. The opportunity exists to expand policy engagement with social movements to ensure that citizens' voices drive health policy reform to reduce disparities.

Country delegations in Johannesburg returned home clear on the change they wanted to achieve in their own countries (panel). As global partners, we need to fully support this impulse. Community health workers need to be institutionalised within community health systems, with empowered communities as their basis—not as an afterthought or luxury, but as a clear priority and contribution to realising people's right to health, achieving universal health

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***Panel:* Ten principles to institutionalise community health**

1. Engage with and empower communities to build viable and resilient community health systems with strong links to health and other relevant sectors
2. Empower communities and civil society to hold the health system accountable
3. Build integrated, resilient community health systems based on recognised frontline health workers
4. Implement national community health programmes at scale, guided by national policy and local systems context, to ensure effect
5. Ensure sufficient and sustainable financing for community health systems that is based on national and international resources, includes the private sector, and contributes to reducing financial barriers to health
6. Programme to reduce health inequities and gender inequalities
7. Ensure that communities facing humanitarian crisis receive essential health care, particularly at the community level
8. Invest in the development of inclusive partnerships to leverage and coordinate diverse civil society and private sector actors to support national acceleration plans and enable communities to shape and support the implementation of policies
9. Integrate community data into the health information system, including investment in innovative technologies
10. Employ practical and participatory learning and research to identify, sustain, and scale up effective community interventions while providing opportunities for country-to-country lesson sharing and informing a shared global learning agenda

coverage and, finally, delivering on Alma Ata's promise of health for all.

We declare no competing interests.

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