

# Primary Health Care and Universal Health Coverage: the evidence on contributions and effectiveness of community health workers

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## BACKGROUND DOCUMENT

Event hosted by the Governments of Ethiopia and Ecuador  
at the 71<sup>st</sup> World Health Assembly



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*Refreshments will be served*

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## **Policy context: a growing global momentum**

2018 is the 70th anniversary of the establishment of the World Health Organization and the 40th anniversary of the Alma Ata Declaration on Primary Health Care. In this same year, the 71st World Health Assembly is considering the 13th General Program of Work of WHO, which is centered on the progressive realization of Universal Health Coverage as part of the Sustainable Development Goals. The 71st WHA is therefore an opportunity to highlight the achievements and challenges of the efforts made to fulfil the commitments of the Alma Ata Declaration over the past 40 years and how this can inform further efforts to strengthen primary health care. Behind the ambition of Universal Health Coverage is the premise of equity and health for all, ensuring that all segments of the population are able to access health services without financial hardship.

The WHO *Global Strategy on Human Resources for Health: Workforce 2030*, adopted by the World Health Assembly in 2016, underscored that addressing health workforce shortages, maldistribution and performance challenges is essential for progress towards all health related goals, including universal health coverage (UHC). Further, as evidenced by the recommendations of the *United Nations High Level Commission on Health Employment and Economic Growth*, there is also increasing recognition of both the multisectoral requirements for effective implementation of health workforce policies, and of the potential of the health sector to create qualified employment opportunities, in particular for women, contributing to the job creation and economic development agenda.

## **The universal truth: no primary health care without a workforce**

The foundation for a strong and effective health workforce, able to respond to the 21st century priorities, requires matching effectively the supply and skills of health workers to population needs, now and in the future. Addressing population needs for the SDGs and UHC and explicitly adopting an equity lens to leave no one behind requires making the best possible use of limited resources, and ensuring they are employed strategically through adoption and implementation of evidence-based health workforce policies tailored to the national health system context. The ongoing challenges of health workforce deficits and imbalances, combined with ageing populations and epidemiologic transformations, require a new, contemporary agenda with an unprecedented level of ambition. Better alignment to population needs, while improving cost-effectiveness, depends on recognition that integrated and people-centered health-care services can benefit from team-based care at the primary care level.

This approach entails harnessing the potential contribution of different typologies of health workers, operating in closer collaboration within the full scope of their profession while avoiding under-utilization of skills. Specifically, there is a need to prioritize the education, employment and equitable deployment of inter-professional primary care teams of health workers with broad-based skills, avoiding the pitfalls

and cost-escalation of overreliance on specialist and tertiary care. This requires adopting a diverse, sustainable skills mix, and harnessing the potential of community-based and mid-level health workers in inter-professional primary care teams.

### **Community health workers are effective in delivering essential services**

The Alma Ata Declaration stated that “primary health care relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers ... suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community”. Forty years of experience have resulted in compelling evidence that community health workers (CHWs) can be particularly effective in delivering basic and essential life-saving health services, particularly for poor and marginalized population groups: several systematic reviews and other studies demonstrate the effectiveness of various types of CHWs in delivering a range of preventive, promotive and curative services related to reproductive, maternal, newborn and child health,<sup>1,2,3,4,5</sup> infectious diseases,<sup>6</sup> non-communicable diseases,<sup>7,8</sup> and neglected tropical diseases.<sup>9</sup>

Other systematic reviews have identified the most effective policy approaches for a successful integration of health workers in health systems and the communities they serve. These include: providing CHWs with predictable financial and non-financial incentives, frequent supportive supervision, continuous training, embedment of CHWs in health systems and in the communities where they work, with clear roles and communication channels for CHWs.<sup>10,11,12,13,14</sup> There is also substantial evidence that delivering essential health services through CHWs may represent a cost-effective approach in a diversity of contexts.<sup>15,16,17</sup> Empowering CHWs offers also a critical opening for change towards achieving greater gender equity, empowerment and social accountability within communities.

Recognizing this positive potential, after decades of ebbing and flowing interest, there has been in recent years a renewed emphasis in the potential of CHWs in contributing to specific health priorities, such as integrated community case management of childhood illnesses. This growing attention was evidenced, for example, by the momentum of the 2 million CHWs initiative endorsed by the African Union Summit in 2017; the emphasis on the role of CHWs in the 90-90-90 campaign on HIV and AIDS targets; and events such as the *Institutionalizing Community Health Conference* hosted in March 2017 by UNICEF and USAID, which recognized the importance of CHWs integration in primary health care as a critical element of strengthening health systems at the community level.

However, there is also evidence that the support for CHWs and their integration in the health system and communities are uneven across and within countries; good practice examples are not necessarily replicated and policy options for which there is greater evidence of effectiveness are not uniformly adopted. Although they should be considered as an integral part of primary health care (PHC) strategies and of the health system, CHW programmes are often fraught with challenges, including: poor planning; unclear roles, education and career pathways; lack of certification hindering credibility and transferability; multiple competing actors with little coordination; fragmented, disease-specific training; donor-driven management and funding; tenuous linkage with the health system; poor coordination, supervision, quality control and support; and under-recognition of CHWs' contribution.<sup>18</sup> These challenges can contribute to wastage of both human capital and financial resources: many well-intentioned and performing CHW initiatives fail to be properly integrated into health systems, and

remain pilot projects or small-scale initiatives that are excessively reliant on donor funding, resulting in sub-standard capacities of CHWs, and uneven support for these health workers in many contexts.

### **Integration of CHWs in primary health care**

Successful delivery of services through CHWs requires evidence-based models for educating, deploying, remunerating and managing these health workers to optimize their performance and contribution to the health system across various health service areas.

To help inform policy dialogue and decisions in countries, the WHO Secretariat is facilitating the development of new guidelines on health policy and system support to optimize the role and performance of CHWs. This guideline, which is expected to be published in the summer of 2018, builds on the evidence on CHWs as enablers of effective primary health care, thus supporting the attainment of UHC. The forthcoming guideline is primarily focused on CHWs (as defined by the International Labour Organization through its International Standard Classification of Occupations), but its relevance and applicability include also other types of community-based health workers.

The ongoing guideline development process has identified supportive evidence for:

- Selecting CHWs for pre-service education considering minimum education levels appropriate to the tasks to be performed; membership of and acceptance by the local community; promotion of gender equity; personal attributes and capacity of the candidates.
- Determining duration of training in the local context based on competencies required according to role; pre-existing knowledge and skills; expected conditions of practice.
- Including in the contents of training promotive and preventive services; selected diagnostic and curative services where relevant to the expected role and applicable regulation; interpersonal and community mobilization skills.
- Balancing theoretical and focused training, and blending face-to-face and e-learning where feasible, with adequate attention to a positive training environment and due consideration to education infrastructure and faculty.
- Using competency-based formal certification for CHWs who have successfully completed pre-service training to improve CHW quality of care, motivation and employment prospects.
- Adopting a range of supportive supervision strategies.
- Providing practicing CHWs with a financial package commensurate to the job demands, complexity, number of hours, training and roles that they undertake.
- Offering a career ladder to well performing CHWs.
- Providing paid CHWs with a written agreement specifying role and responsibilities, working conditions, remuneration and workers' rights.
- Determining an appropriate target population size in relation to expected workloads, frequency, nature and time requirements of contacts required and expected time commitments of CHWs.
- Collecting, collating, and using health data by CHWs on routine activities, including through relevant mobile health solutions, while respecting data confidentiality and security.
- Adopting service delivery models comprising CHWs with general tasks as part of integrated primary health care teams; CHWs with more selective and specific tasks can play a

complementary role when required on the basis of population health needs, cultural context and workforce configuration.

- Adopting deliberate strategies that CHWs can implement to engage communities and to harness community resources.
- Ensuring adequate availability of commodities and consumable supplies, quality assurance, appropriate storage, stocking and waste management in the context of CHW programmes.

More detailed recommendations on all these aspects, including a critical analysis of the evidence, research gaps and policy implementation considerations, will be published in the forthcoming WHO guideline. <http://www.who.int/hrh/community/en>

### **Moving from policy to implementation: strengthening PHC in a holistic way**

The starting point for an effective design of CHWs initiatives and programmes is a sound situation analysis of population needs and health system requirements which enables rooting them in strong PHC systems. Planners and policy makers should adopt a whole-of-system approach, taking into consideration health system capacities, population needs and framing the role of CHWs through a holistic approach that considers other health workers, in order to integrate appropriately CHWs programmes into the general health system and in existing community structures.

CHWs initiatives and programmes should therefore be aligned to and part of broader national health and health workforce policies. As relevant, they should also be linked with national education, labour and community development sectoral or sub-sectoral policies and frameworks. Successful design, implementation and scale-up of community health worker programmes requires concerted efforts and multi-sectoral approach backed up by high level political commitment and leadership at national level.

Countries should use a combination of CHWs policies selected based on the objectives, context and architecture of each health system. The forthcoming WHO guideline does not represent a blueprint that can be uncritically adopted; it should rather be seen as a critical overview of evidence and a menu of inter-related policy options and recommendations, which need nevertheless to be adapted and contextualized to the reality of a specific health system.

The deployment of CHWs has been identified as a cost-effective approach. The policy options recommended in the forthcoming WHO guidelines have, in the aggregate, considerable cost implications, which require long-term dedicated financing. Countries at all levels of socio-economic development, including low-income ones, have demonstrated that it is possible to prioritize investments in large-scale CHW initiatives. In contexts where this is relevant, development partners should strive to harmonize their support to CHWs programmes, and align it with public policy and national health systems.

The upcoming conference on the 40<sup>th</sup> anniversary of the Alma Ata Declaration on Primary Health Care represents a unique opportunity to further bolster momentum and catalyze investments to support the scale-up of CHWs initiatives as an integral part of primary health care and health system strengthening.

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