Health policy and systems support for CHWs' programmes

Institutionalizing Community Health Conference

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CHW programmes: long history, wide diversity

Community health programs have a long history

- **Late 1800s**: “Feldsher” program in Russia established for providing primary health in rural areas
- **1960s**: Early CHW programs in Honduras, India, Indonesia, Tanzania and Venezuela
- **Late 1970s and 1980s**: More CHW programs across Nepal, Zimbabwe, Malawi, Mozambique
- **2000s onwards**: Evidence continues to grow; research by Johns Hopkins, MCSP, CORE, and others
- **1920s**: Barefoot Doctors in China help record births and deaths, provide health counselling
- **1978**: Alma Ata declaration and publication of “Health by the People” by WHO
- **Late 1990s onward**: CHW programs further developed across Asia, Latin America, and Africa

Today, different countries have very different approaches and are at different stages with community health

<table>
<thead>
<tr>
<th>Wide variety of roles</th>
<th>Unpaid Village Health Workers in Nigeria only do health promotion work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mix of public vs. private provision</td>
<td>Health Extension Workers (HEWs) in Ethiopia treat life threatening diseases</td>
</tr>
<tr>
<td>Varying integration with formal health system</td>
<td>Lady Health Workers in Pakistan are paid government employees</td>
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<td></td>
<td>Health Workers in Tanzania are volunteers</td>
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<td></td>
<td>Community Health Assistants in Brazil are managed by local nurses</td>
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<td>HEWs in Ethiopia are part of the formal healthcare system</td>
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</tbody>
</table>

Source: USAID, 2015
Evidence on CHWs

- Over 5000 articles in the last 10 years
- More than 90 literature reviews focused on CHWs

<table>
<thead>
<tr>
<th>Focal health issue</th>
<th>LMIC</th>
<th>HIC</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHC and system-level issues</td>
<td>17</td>
<td>9</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>Maternal and child health</td>
<td>33</td>
<td>2</td>
<td>2</td>
<td>37</td>
</tr>
<tr>
<td>Disease-specific: non-communicable</td>
<td>4</td>
<td>12</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Disease-specific: infectious</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64</strong></td>
<td><strong>24</strong></td>
<td><strong>3</strong></td>
<td><strong>91</strong></td>
</tr>
</tbody>
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Source: Scott K et al, forthcoming
Effectiveness and role of CHWs

- Reducing neonatal mortality through home-based preventive and curative care
- Linking women to obstetric care, breastfeeding promotion, promoting skin-to-skin newborn care
- Providing contraception
- Providing psychosocial, psychological interventions to treat or prevent mental, neurological or substance abuse disorders
- Working as cultural brokers and facilitating patient access to care for underserved groups
- Diagnosing and treating malaria, improving TB treatment outcomes, Counselling, treatment and care for HIV / AIDS
- Control of neglected tropical diseases
- Behavior change (diet change, self-management of hypertension, physical activity).
- Increased care utilization (cancer screening, making and keeping appointments); asthma care.


Most reviews are supportive of CHWs effectiveness and cost-effectiveness, but quality of evidence is low or very low.
Policy issues: classification

• What are community health workers?

• “lay health workers”, “frontline health workers”, “close-to-community providers”, "community based practitioners"?

• ILO ISCO: " Community health workers provide health education, referral and follow-up, case management, basic preventive health care and home visiting services to specific communities… Occupations included in this unit group normally require formal or informal training and supervision recognized by the health and social services authorities."

Source: ILO, 2008
Policy issues: (lack of) systems support

• "inconsistent support of community health workers (CHWs) and failure to integrate them into the health system have impeded full realization of their potential contribution in the context of primary health care."

• Scaling up and maintaining CHW programmes is fraught with a host of challenges:
  – poor planning;
  – multiple competing actors with little coordination;
  – fragmented, disease-specific training;
  – donor-driven management and funding;
  – tenuous linkage with the health system;
  – poor coordination, supervision and support, and
  – under-recognition of CHWs' contribution.

Source: Tulenko et al, WHO Bull, 2013
CHW integration: what does it mean?

- Include CHWs in HRH planning
- Have a budget line / resource allocation

- Ensure supplies/equipment
- Effective referral systems
- Regular monitoring & supervision

- Clear/ transparent selection system, involving and responding to needs of communities
- Curriculum to include scientific knowledge on basic preventive and curative care
- Adapt contents to health system needs

- Community preparedness
- Regular and sustainable remuneration package
- Opportunities for career and professional development

Sources: Bhutta et al, GHWA, 2010; Kok, Dieleman, et al. 2015; Campbell & Scott, 2011; Darmstadt, Lee, et al., 2009; Jaskiewicz & Tulenko, ’2012; Zulu et al, 2014; Pallas et al., 2013; McCollum, et al., 2016; Bosch-Capblanch 2011
CHWs in WHO Global Strategy on HRH

• “Addressing population needs for the SDGs and UHC requires ... a more sustainable and responsive skills mix through inter-professional primary care teams, harnessing opportunities from the education and deployment of community-based and mid-level health workers;”
• “In many settings, developing a national policy to integrate, where they exist, community-based health workers in the health system can enable these cadres to benefit from adequate system support and to operate more effectively within integrated primary care teams”
• **Invest in decent conditions of employment ...** provision of a living wage (including for community-based health workers) ... in line with the SDG Goal on Decent Work and Economic Growth.
• The International Labour Organization (ILO) to revise the International Standard Classification of Occupations for greater clarity on delineation of health workers and health professions.(72) This will entail a move towards definitions that reflect worker competency together with the tasks they perform. Of particular urgency is the need to streamline and rationalize the categorization and nomenclature of community health workers and other types of community-based practitioners.

Source: WHO 2016, Global Strategy on HRH: Workforce 2030
WHO CHW guidelines: policy questions

1. Are there desirable demographic or socio-economic profiles, or minimum pre-service training literacy requirements for CHWs selection?
2. What is the minimum duration of pre-service training for CHWs?
3. What are the essential competencies for pre-service education of CHWs?
4. What are the most appropriate delivery modalities of pre-service education of CHWs?
5. Can certification of CHWs improve their quality and results of CHW programmes?
WHO CHW guidelines: policy questions (cont.)

6. What are the characteristics of effective supervision strategies to optimize the results of CHW programmes?

7. What is the outcome of paying CHWs on their performance and population outcomes?

8. Should CHW be offered a career ladder opportunity/ framework within the health sector?

9. Should CHWs be formally engaged/ contracted?

10. What is the optimal population size covered by a CHW?
WHO CHW guidelines: policy questions (cont.)

11. Should CHWs collect and use data?
12. Should there be a **single type** of generalist practicing CHWs, or **more types** of practicing CHWs specialized in different areas of primary health care?
13. Do **community engagement** strategies improve performance and results of practicing CHWs?
14. Should practicing CHWs pro-actively **mobilize the communities** where they operate?
15. What strategies can be adopted to ensure adequate availability of commodities and consumable **supplies** in the context of practicing CHW programmes?
Evidence gaps and research priorities

1. Comparatively less research on NCDs.
2. More attention should be paid to cross-cutting enabling factors, for example, education, accreditation and regulation, management and supervision, effective linkage to professional cadres, motivation and remuneration, and provision of essential drugs and commodities.
3. How to ensure the sustainability of programmes through national planning, governance, legal and financing mechanisms.
4. Current evidence is a mix of varying degrees of quality, while the emphasis of future research must be on scientific rigour to strengthen the evidence base for policy and practice.
5. Avoid too narrow a disease- or intervention-specific focus. Investigate not only the effectiveness question (what works), but also the contextual factors and enablers (how, for whom, under what circumstances).
6. Translate this body of knowledge into evidence-based policy guidance.

Source: Maher and Cometto, WHO Bull 2016
For more information

http://who.int/hrh/community/en/
THANK YOU.

who.int/hrh
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