CMMB POSITION PAPER

Strengthening Health Systems, One Community Health Worker at a Time

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The Global Context: Critical Shortages of Health Workers

Ending preventable maternal and child deaths, achieving an AIDS-free generation, controlling infectious diseases, and ending chronic malnutrition are critical goals for the well-being of the citizens of the world. Yet in many lower- and middle-income countries, building the robust, trained health workforce—one of the six building blocks of the WHO health systems framework—remains a work in slow progress; most countries are unable to meet the medical professional-to-population ratio as defined by the World Health Organization (WHO). Doctors, nurses, pharmacists, and pharmacist assistants are simply too few in number; sub-Saharan Africa, with 11% of the world's population and 24% of the global burden of disease, has only 3% of the world's health workers commanding less than 1% of world health expenditure. More than 4 million health workers are needed to fill the gap.[1] Too few are being trained; too few training institutions are turning out health professionals in the required numbers.[2] Imbalances in the overall skills mix and health care worker distribution exacerbate the situation: professionals are often reluctant to serve rural and remote communities, leaving their residents virtually without quality care. Workers who do remain carry heavy workloads that keep them on the edge of burnout. Poor pay and working conditions, as well as supplies and training insufficient for the job, are another challenge. The health workforce management skills needed to manage this complex situation are scarce.

For more than 50 years, those involved in primary health care have grappled with the question of how to meet populations' health needs, answered by the recruiting and training of locals as community health workers, a complementary and supplementary labor force to promote health-seeking behaviors. During the 1970s, for instance, part-time Barefoot Doctors served 800 million people in the People's Republic of China. Innovative case studies profiles in the WHO *Health by the People* (1975) were the foundation for the conference on primary health care that resulted in the Declaration of Alma-Ata, calling for "Health for All" by 2000. Increasingly, faced by the HIV pandemic, the global health community increasingly espoused task shifting, the delegation of health care tasks to progressively less specialized cadres of workers.[3] Since 2008, when the WHO promulgated global recommendations and guidelines

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[1] World Health Organization, *Taking Stock: Health Worker Shortage and the Response to AIDS* (Geneva: World Health Organization, 2007), http://www.who.int/healthsystems/task_shifting/TTR_response.pdf?ua=1.

[2] Ibid. For example, at the time of the consultation, the WHO African Region has only 354 institutions to increase the number of health care professionals by the needed 139%.

[3] Katharine Shelley, *Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide for Program Managers and Policy Makers* (Baltimore: Johns Hopkins Bloomberg School of Public Health, USAID/MCHIP, 2014), http://www.mchip.net/sites/default/files/mchipfiles/CHW%20Reference%20Guide%20Summaries.pdf.

after the First Global Conference on Task Shifting, nurses have taken over responsibilities that were once doctors' and so on.

Meeting the Challenge: Community-Managed Health Care

The process of task shifting eventually devolves work onto the patients themselves. But much of the work for communicating about healthy behaviors to these patients and to the community at large is absorbed by community health workers: *community health agents* in Peru, neither recognized nor salaried by the government; *agents de santé communautaires polyvalents* in Haiti, both trained and salaried by the national ministry of health. Brazil has achieved universal primary health coverage through its Serviço Especial de Saúde Pública, more than 220,000 *Vistadoras* providing home visits and services to 110 million Brazilians.[4] In those cases and many in between, CMMB has experienced and valued their ability to extend our reach into the community. We respect the knowledge seeking that drives many of them to participate in community health programs and their devotion to serving their communities in this important way. CMMB has empowered community health workers to coach their neighbors on safe motherhood, HIV and malaria prevention, correct infant and young child feeding, danger signs of sickness, and more. In Ethiopia, trained community health workers counsel people living with HIV, take blood samples, and forward the blood to technicians to perform rapid tests—freeing 20% of a nurse's time, which would previously have been spent on those activities.[5] CHW tasks are on the one hand service-oriented, toward the provision of *preventive* and *curative* care within the existing health system, and *transformative*, aiming to engage communities to take responsibility for their own health and to address the cultural determinants of good health, including inequity and poverty.

In this reorganization of community health systems, building capacity is critical. In almost all CMMB projects, community health workers have been involved. Like many other NGOs working in community health, CMMB has recruited, trained, mentored, and provided supportive supervision to build CHW skills. With such training and support, CMMB and our fellow NGOs have helped make health systems more efficient and effective and have improved the well-being of mothers and their children and families in the areas where we have worked.

However, to achieve global health goals, siloed work by individual NGOs is not enough. Mindful of the Global Consultation on Community Health Workers, held in Montreux in 2010,[6] which recognizes the usefulness of community health workers, it is critical that all community health workers be formally recognized and fully integrated into their national health systems.

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[4] Ibid.

[5] World Health Organization, *Taking Stock: Task Shifting to Tackle Health Worker Shortage* (Geneva: World Health Organization, 2007), http://www.who.int/healthsystems/task_shifting/TTR_tackle.pdf?ua=1.

[6] Global Health Workforce Alliance, *Integrating Community Health Workers in National Health Workforce Plans: Key Messages, Global Consultation on Community Health Workers, Montreux, Switzerland, 29–30 April 2010* (Geneva: World Health Organization, 2010), http://www.who.int/workforcealliance/knowledge/resources/CHW_KeyMessages_English.pdf?ua=1.

Also required are:

- Training following a national curriculum developed consonant with national priorities.
- Clear job descriptions, clear standards of excellence.
- Monitoring and management with care and respect.
- The tools they need to accomplish their missions, including simple diagnostic equipment, a simple uniform, a badge, and other items to mark their stature in the community.
- A balance of direct and indirect incentives: payment for their work, in the form of salaries or standardized per diems, on the one hand; and opportunities for personal and career advancement and learning on the other.

Integrating CHWs into health systems demands careful thought and planning, with involvement of stakeholders from communities to the national level. Coordination with existing structures and relationships with other cadres of health workers, must be considered, as well as: who and how the CHWs will be trained and how often, how they will be assigned, who will supervise them (and how gender issues complicating supervision will be managed), what monitoring and evaluation structures will be in place, and how they will be managed. Governance is an issue, as is the financial burden increased by the need to recruit and support yet another layer within the health system.

At their best, community health workers have the power to accomplish many of the functions and fill many of the roles filled over the years by faith-based organizations working on the ground: CHWs will be able to quickly and efficiently gather detailed information about community health needs and special situations in real time; they will have stature within the communities they serve, credibility, and respect, which will enable them to work efficiently, from a position of trust, that can translate to successful health promotion in communities.

Linking Micro to Macro: The Power of Faith-Based Organizations

In the shaping of these networks, faith-based organizations have an important role to play. They themselves have long experience recruiting community members in the capacity of both health promoters and community members, often involved for years in that community and earning them the respect of their constituents. FBO connections reach deep into and among communities. In addition, FBOs bring a broader world view, insofar as they are part of the larger network of institutions connected to their faith and to the global health community. On-the-ground ties potentiate FBOs to act as incubators for new ideas or to implement pilot projects to test new protocols. FBOs' wider networks also introduce the possibility for the infusion of support to national governments for community health workers' recruitment, training, and management. This dual experience makes their perspective invaluable as national governments move forward to design and implement a plan to formalize, professionalize, and integrate this essential cadre into their national health systems.

For more information on CMMB's activities in health systems strengthening, please see: "CMMB South Sudan Profile: Children and Mothers' Partnerships Initiative, Western Equatoria State" and "CMMB Concept Note: Strengthening Health Systems through Children and Mothers' Partnerships."