

Report of Side Event at 67th World Health Assembly

At the 67th World Health Assembly, the Global Health Workforce Alliance (GHWA) teamed up with the Government of the People's Republic of Bangladesh, the Government of Japan, the Japan International Cooperation Agency (JICA), International Federation of Red Cross and Red Crescent Societies, and the World Health Organization (WHO) for a side event titled 'Community Health Care: Bringing Health Care at Your Door'.

The event held on Friday, 23 May 2014 and provided an opportunity to deliberate on integrated community health care (CHC) and attaining the Millennium Development Goals (MDGs) and Universal Health Coverage (UHC). The session also explored effective policies and strategies that could be used to remove the obstacles to deliver quality health care and positioning community health workers (CHWs) as an integral part of local health teams.

The panel was chaired by Dr. Sigrun Møgedal, Special Adviser at the Norwegian Knowledge Center for the Health Services and adviser to the Norwegian Agency for Development Cooperation (Norad). In her introductory statement, Dr. Møgedal highlighted the importance of high-level politicians taking actions to deal with critical gaps in human resources for health (HRH). She noted that there is a growing interest in integrated community services as part of the health system in all countries, reflecting epidemiological and demographic changes with need for chronic care and support. She referred to the Lancet series on Bangladesh highlighting exceptional health improvements – in the survival of infants and children under 5 years of age, life expectancy, immunisation coverage, and tuberculosis control – despite low spending on health care, a weak health system, and widespread poverty. Many attribute these achievements to the community health care system in place, the plural system with both public and non state providers engaged in large-scale community-based approaches and investment in community health workers (CHWs) for doorstep service delivery. Møgedal also expressed that countries like Iran have maintained remarkable continuity in access to community based workers as the country have adapted to new challenges and new training needs. Referring to the ten action points¹, Dr. Møgedal made a call for national leadership to facilitate coordinated and harmonized approaches to integrated community health care with synergies across the different programs that support CHWs, volunteers and other FLHWs.

Subsequent to the demonstration of Bangladesh CHC through a video clip, a speech was delivered by His Excellency Mr Mohammed Nasim, MP, The Minister of Health and Family Welfare, Government of the People's Republic of Bangladesh. The Minister started his statement by emphasizing that community health care can be considered a crucial component of integrated, people-centered high quality health services anywhere in the world. He then went on to describe the experience in Bangladesh. During 1980s, the Government of Bangladesh set up a series of community clinics in every small rural catchment area, for an average of 6,000 population size. This was a vision of the Father of the Nation for addressing the health problems of the poor and unprivileged population groups. Today, approximately 13,000 community clinics are operational. These health facilities are built according to a unique model of public-private partnership in which the community donates the land while the government builds the infrastructures, recruits the personnel, and provides regular supply of medicines and logistics. To ensure sustainability, local committees participate in the management and oversight of the clinics. Other success factors include its simplicity and high level

political support, in addition to training and deployment of health workers from the local communities. A survey during 2010 revealed that Bangladesh has made substantial progress in maternal health; however, there remain considerable disparities. While concluding, the Minister highlighted that what had been achieved were only the first steps and that Bangladesh has a long way to go. In particular, he emphasized the need to continue to do and learn at the same time. The importance of global sharing to continue to develop thinking on how community based care can be the foundation upon which to develop effective high quality services was emphasized. Responding to the question on collaboration between government and NGOs in the community health system in Bangladesh, the Minister expressed that partnerships are critical for a resource-challenged country like Bangladesh. Multiple players contribute in our health system and we harness their potential for better health in Bangladesh through open policies, off course maintaining the leadership role of the government.

The value of CHWs has been recognized not only in low- and middle-income settings but also in high-income countries, as the case of Japan demonstrates. Mr Naoyuki Kobayashi, Deputy Director General of the Human Development Department at JICA, described the actions undertaken by his organization to scale up community-based health programmes toward the achievement of UHC in South Asian countries. Through the Safe Motherhood Promotion Project (SMPP), JICA is supporting Bangladesh to improve the health care services for women and children. The programme aims to establish the Community Support System, strengthen safe delivery services at hospitals, develop policies based on good practices, and increase collaboration with development partners. In addition to a number of other countries, JICA is also supporting Myanmar to introduce CHWs who can perform early diagnosis and proper treatment, preventive activities and supply chain management for malaria control. In the project area, over 60% of malaria patients are treated by CHWs, which indicates their significant contribution in local health services. Through those examples, Mr. Kobayashi pointed out that the bottleneck of further reducing mortality rates lies in the outreach to certain groups of people, especially the poor, minority people, and those living in hard-to-reach areas, and that CHWs can play a crucial role for those underserved people. Scaling up community based health workforce is one of key areas for JICAs assistance, an essential factor in achieving health MDGs and UHC.

Dr Mohsen Asadi-Lari – who is the Director General of International Relations at Ministry of Health and Medical Education Islamic Republic of Iran as well as a member of WHO’s Executive Board – discussed about the Primary Health Care (PHC) programme in his country. He informed that after the revolution in Iran, PHC programme started in 1985. This year, Iran will be celebrating the 30th anniversary of its PHC programme that has led to great achievements. The priorities of PHC in Iran are prevention, and increasing access to remote and under-privileged rural areas, vulnerable groups such as mothers and children, and decentralization. As Dr. Asadi-Lari explained that in rural areas, the main activities related to PHC rely on locally recruited and trained CHWs called Behvarz who work in a health house that provides nucleus of health services in a village. The CHWs maintain household folder containing significant health and demographic information about each family member. A vital horoscope, that counts every birth and death in the catchment area, is a key feature of this system. Through this paradigm, the achievements of Iranian PHC are brilliant as the life expectancy is now above 70 years and the inequities between provinces have steeply declined. The mortality rate of children under 5 has dropped to below 17 per 1000 live births. Iran has very successful rural PHC but still experience problems in the large cities and also in combating NCDs and

social determinants of health. Responding to a question on sustainability of CHWs in Iran, Dr Asadi-Lari informed that PHC programme is based upon population needs that are well responded through strategic interventions. The CHWs are recruited from the same area that they are supposed to work in. The local communities have an important role in such decision making. Their training lasts 2 years, is entirely task oriented, and conducted in the same district they are deployed. Complementing to this, continuing education with in-service training, quarterly journals, and monthly seminars, is ensured along with supportive supervision. Continuum of care and efficient referral system are other reasons of success. Most importantly, Iranian PHC programme is backed by law, with a national vision and robust policies with sustained financial support and well integrated health system. Despite of many successes, Iranian PHC face some challenges that require greater focus in coming years. These include strengthening urban PHC system, and incorporating emerging health issues such as Social Determinants of Health (SDH) and increasing burden of non-communicable diseases (NCDs).

The Secretary General of the Sierra Leone Red Cross Society , Mr Emmanuel Hindovei-Tommy, mentioned the key to achieving UHC is the expansion of the network of health providers and health institutions. Trained local volunteers, as part of the community health workforce, play an important role in extending access to health care to the most marginalized groups of society and remote communities where there is all too often an acute shortage of professional healthcare workers. Increasing health access at community level through skilled volunteers is at the core of Red Cross Red Crescent Societies's work all over the world. Sierra Leone Red Cross Society is part of a Network of 189 National Societies who support their public authorities before, during and after disasters, as independent auxiliaries to government in the humanitarian field. Today about 4,760 volunteers are working in Sierra Leone and delivering a variety of crucial and culturally sensitive health promotion messages, and increase local access to lifesaving curative measures, particularly related to immunization, malaria, Maternal and Child Health (MCH) and assistance in dealing with health emergencies.¹ In 2012, Sierra Leone had a cholera outbreak and the volunteers greatly helped in managing the epidemic. In addition, preliminary evidence suggests that the outbreak was less severe in communities where awareness around hygiene and hand-washing had been previously raised with the local residents. According to Mr Hindovei-Tommy, the contribution of Red Cross volunteers should be given more recognition by governments and their partners involved in front line health services, beyond only engaging them in epidemic outbreaks. Volunteerism requires investment, support and well planned approaches to engagement, management and retention. Sustainability of community health services depends of the recognition of the role of volunteers in providing critical health services. Governments may promote strategic measures to support National Red Cross and Red Crescent Societies to effectively manage community health volunteers as part of the health delivery system

Dr Shona Wynd, senior adviser at UNAIDS Geneva, indicated that while moving towards post 2015 era, we are all looking for more efficient, effective, accessible, patient centred, better designed health care that responds to the real needs of the people we are serving. Dr Wynd recognized the need to integrate interventions for key diseases (such as: HIV/AIDS, TB, Malaria) with situations affecting women's and children's health through reproductive, maternal, newborn, and child health (RMNCH) services. Such a process has the potential to create synergies in health care delivery and

¹ [Sierra Leone: Volunteers' contribution towards universal health coverage](#)

greatly expand coverage of essential services at local settings. According to Dr Wynd, CHWs working at the frontline can be instrumental in delivering integrated health services across the life spectrum. They can and do deliver. Therefore, we need to leverage community worker impacts which will help achieve MDGs and UHC. While discussing how we can best support community providers, she expressed that the national CHWs initiatives should be supported while the global community should encourage developing coordinated strategies that promote their integration within community and health systems and consider them an integral component of teams delivering health services in the local settings. Recognising the efforts of CHWs, adequate mechanisms are needed to be put in place for their continued development, remunerations, support and supervision. Featuring the role of partners and stakeholders, Dr Wynd referred to the Third Global Forum on HRH in Recife Brazil, where on November 12, 2013 a number of government leaders, donors, health workers, and civil society working in the area, announced their commitment to align with country objectives and harmonize their actions supporting CHWs and other frontline health workers (FLHWs). This “Joint Commitment to Harmonized Partner Action for CHWs and other FLHWs²” is underpinned by the “CHW and FLHW Framework for Harmonized Partner Action” that is built on a ‘three ones’ paradigm: one national strategy; one national authority; one monitoring and evaluation structure³. On behalf of the key partners group led and convened by the Global Health Workforce Alliance (the GHWA), she invited other partners and national stakeholders to align with this joint commitment and called to extend their efforts in national level implementation of the CHW Framework. She concluded that ‘we must do now’.

The Executive Director of the African Center for Global Health and Social Transformation (ACHEST), and Chair of African Platform on HRH (APHRH), Dr. Francis Omaswa, as the principal discussant, spoke about the importance in both the developing and developed world to empower countries and communities to build strong health systems, through trained and motivated health workforces. He said that we need to re-emphasise theoretical basis of CHWs. The primary responsibility for maintaining health is with each individual. CHWs play extremely important role as they help and support people to maintain health within their houses and community settings. UHC means that no individual, no community, and no country should be left behind to have access to essential health services, and the CHWs are going to do this working with the other team members. CHWs must be an integral part of any health system both in developing or developed countries. Let’s march forward empowering countries and encouraging country level ownership. The GHWA needs to continue working with the partners and stakeholders in the countries, regions and globally. He also emphasised that we all need to keep aligned with the joint commitment on CHWs that is a commitment to action.

Dr Edward Kelley, Director, Department of Service Delivery & Safety, HIS cluster, WHO HQ, provided some remarks given the role of the new WHO Department in supporting this side-event. He emphasized that integrated service delivery and health workforce are vital for each other and have a fundamental position in the local health system. He also highlighted that UHC is not just about access and managing catastrophic health care costs but about expanding access to high quality, people centred, integrated health services that will allow our populations to reach the promise of the highest possible health attainment. In this context he highlighted the work of WHO in developing a global strategy on People-Centered and Integrated Health Services (which will be linked to the upcoming GHWA strategy).

² http://www.who.int/workforcealliance/knowledge/resources/chw_outcomedocument/en/

³ http://www.who.int/workforcealliance/knowledge/resources/frame_partner_support/en/

The representative from UNFPA, Luc de Bernis, in his comments indicated that communities have important role in health systems integration. They are the clients and can influence the health services delivery. UNFPA is supporting a number of countries in scaling up CHWs and strengthening community based health care systems. Bangladesh is also one of the countries where through joint efforts by government and partners; maternal mortality has been markedly reduced. This is a success example to learn and follow. We all partners have common vision and insight regarding the role of CHW in health service delivery. Let us keep this momentum and continue synchronised efforts.

The representative from World Bank. Toomas Palu, talked about the community health services as a partnership between government health systems and communities where each side would need fulfil their roles. On the Government side, it would be about making sure that front line services have appropriate resources (human, financial, supplies) that often is a challenge, and on the community side to be an effective extension of the health system and at the same time be able and empowered to exercise voice and influence (through community governance mechanisms) on the responsiveness of health system to local needs.

The Director of Health Information Systems in the Assistant Director-General office at WHO, Dr Rüdiger Krech, in his closing remarks indicated the need of aligning future community health initiatives with rapidly shifting epidemiological and demographic contexts such as urbanization, ageing, increasing migration, poverty, and NCDs. To ensure sustainable health systems, the disease programmes need to resonate with the health services. That means joint planning and integration. We have to look at the barrier to scale up CHWs in support of CHC and focus on their employment conditions and training needs. He reiterated the message by the Minister of Health and Family Welfare, Bangladesh: 'Learn and Do'.

The session was attended by more than 100 participants from various HRH community including countries. Both panelists and members of the audience expressed their appreciation for the event.

ⁱ Ten action points:

- 1. Build community-based HRH systems in alignment with national health systems**
- 2. Utilize multisectoral engagement with robust coordination mechanisms to address capacity, management and working conditions of health workforce.**
- 3. Consider health labour market dynamics as it affects HRH production, deployment, retention, performance and motivation.**
- 4. Focus on CHC as part of harnessing innovations in many HRH areas though eliciting country commitments based upon evidence-informed HRH plans.**
- 5. Utilize the AAAQ framework for strategic interventions at multiple levels.**
- 6. Drive effective policy formulation, regulations, and expand fiscal space to match aspects related to health workforce supply, demand and sustainability in order to meet population needs.**
- 7. Ensure close linkages between CHC and embrace the drive towards UHC.**
- 8. Focus on production and management of community-based workers that are accustomed to the evolving local health needs in both urban and rural areas and whose functions are well embedded within the local health system, plans and processes.**
- 9. Seek country level experiences – such as that of Bangladesh – to inform CHC system development in Member States and to cross-fertilize ideas and approaches.**
- 10. Harmonize partners' action and promote multi-stakeholder collaboration to move the HRH agenda forward and achieve UHC.**