Building Capability beyond the Health Sector to Deliver Universal Health Coverage

TECHNICAL WORKING GROUP (TWG) #8

This paper serves as a background report to inform the Global Strategy for Human Resources for Health. The development of this paper has been coordinated through a thematic working group (TWG), comprising of 2 co-chairs and a group of experts drawn from various Global Health Workforce Alliance (GHWA) constituencies, operating under the oversight of the GHWA Board working group. The views expressed in the paper, do not necessarily reflect the official position of GHWA. All reasonable precautions have been taken by the co-chairs to verify the information presented in the papers.
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Abstract
With slow global progress building health workforce capacity, this paper asks whether health workforce strategies which focus only on health workers will be adequate to address changing health needs and the demands of achieving Universal Health Coverage. Although workforce strategies are increasingly recognising the role of Community Health Workers in extending service provision to poor and marginalised populations, the skills and competencies and multi-sector workforce needs to effectively empower communities and patients to improve health and well-being are not yet adequately addressed in workforce plans. There needs to be a paradigm shift on how services are configured to maximise healthy lives by focusing on people centredness and integration of services. To achieve UHC and other development goals, human resources beyond the health sector will need to be engaged and empowered to better manage and reduce health risks, share responsibility for the management and delivery of services, increase community and individual self-reliance which will consequently lead to more appropriate demand for services. Engaging the wider non-public health workforce can also result in behaviour change for healthier lives.

Introduction
The World Health Report 2006 highlighted the global crisis in training, maintaining and retaining a skilled health workforce and placed the workforce at the centre of international efforts to achieve the Millennium Development Goals (MDGs) (1). As we approach 2015 and a post MDG era, this paper asks whether health workforce strategies which focus only on health workers will be adequate to address changing health needs and the demands of achieving Universal Health Coverage. The Third Global Forum on Human Resources for Health (HRH), which resulted in the Recife Declaration (4), focused international attention on the health workforce capacity needed to achieve UHC; a proposed post MDG Goal. Subsequently, the World Health Organization (WHO) and the Global Health Workforce Alliance (GHWA) convened eight working groups to review strategies to tackle the health workforce crisis, gather evidence on what works and debate whether shifts in approach are needed. The working groups have been tasked to: 1) set out the labour market challenge (ref); 2) consider needs in fragile states (ref); 3) review efforts to improve productivity and performance (ref); 4) review data needs (ref); 5) analyse the stewardship challenges (ref); 6) debate the need for transformational approaches to education (ref); and 7) argue the ongoing need for better alignment and accountability of strategies to nationally defined needs (ref). The authors of this paper were asked to gather evidence and case studies to illustrate the potential role of communities, patients and their families and workers in sectors other than health in improving the public’s health and to consider whether and how these groups should be reflected in national Health Workforce plans. While the grounding of this paper is in the development of a community health workforce, this paper expressly does not review again the evidence and strategies for community health workers.

Background
Rich and poor nations alike are struggling to meet increasing demand for health services. Ageing populations, the changing burden of disease, increasing patient knowledge and expectations and developments in health technology are increasing pressure on an already over-stretched workforce and the adequacy of the current approaches to health worker production to meet these challenges has been questioned (30). The global shortage of health workers is estimated to be between 1.12 million in terms of formally trained health
workers (5), and 10 million in terms of the wider health and social care workforce (6). These shortages are compounded by problems of management, quality, location (distribution), motivation, retention and performance of health workers (7), slowing progress towards the MDGs and presenting a significant barrier to achieving UHC. These formidable challenges have been the primary focus of HRH strategies to date, but there is a growing recognition of the need for different and innovative approaches to capacity building which go beyond training and retraining the traditional health workforce, if services are to meet the needs of poor, marginalised or remote populations.

Strategies to address workforce shortages have moved beyond an exclusive focus on the formal/employed/trained health workforce. The effectiveness of shifting specific tasks from the professional health workforce to community and lay health workers has been systematically reviewed (8) and the importance of patient empowerment recognised (9). It has also been argued that the education, career development and professional growth of those who work outside the sector but support health and wellbeing needs to be professionalised to maximise the talent contributing to health wellbeing (10). It has been suggested that one of the potential benefits of looking beyond the formally trained health workforce as part of HRH strategic planning could be more appropriate demand for and therefore more efficient use of services (11). Moreover, the World Health Organization is launching, in conjunction with the new human resources strategy, the WHO People Centred Integrated Care Strategy. This strategy recommends a set of concrete strategies for “empowering people” as one of four key areas for action (ref).

This paper gathers evidence on the role of community provision of services, community, patient and carer/family engagement and empowerment and engaging non-public health professions in health and considers whether and how this contribution should be reflected in health workforce planning.

Methods
Mixed methods were used in finding, selecting, collating and synthesising the evidence on human capability beyond the health sector. For the purpose of this study HRH capacity beyond the health sector looked at individual and community empowerment as well as using the Royal Society of Public Health definition of the wider public health workforce (12) which defines this group as “any organisation or individual, who is not a qualified public health specialist, that has the ability or opportunity to positively impact on public health”. Information on community provision of services, community empowerment, patient and carer empowerment and engaging non-public health personnel in health improvement were collected and analysed. Literature including published reports, research papers and grey literature was non-systematically reviewed. Literature has also been included based on expert advice and country examples have been selected to illustrate approaches taken.

Evidence
Community provision of services
Community provision of services is currently one of the major connecting points in HRH strategies between the formal health system and the broader public health workforce. It has long been argued that delivery of primary healthcare can be extended beyond the formally trained health workforce through partnership between health professionals and the community. The aim is to extend the reach of health systems to a greater number of individuals and to poor, rural, marginalised, socially disadvantaged and underserved populations. A key goal is to expand equitable access to health services in an affordable way.
Using community members to deliver specific basic health services to the communities they come from is a concept that has been around for at least 50 years. For example, Thailand has successfully made use of Village Health Volunteers (Box 1). This is just one example of many ranging from small-scale community-based initiatives to large-scale national programmes where community health workers (CHWs) working alongside health professionals serve as a link between services and the community. In other infectious disease and outbreak programmes even recently in Africa such as the Ebola outbreak, the mobilization of the community has been key as they work with the formal health sector on organizing outreach, providing information and referral centres.

Box 1
Country example: Community engagement and empowerment in Thailand - Village Health Volunteers

In Thailand, community health volunteers, referred to as Village Health Volunteers (VHVs), have been in existence since 1970s. There are over 750,000 volunteers around the country and work alongside health-care providers at the village level. They play critical roles in Thai public health systems, with functions ranging from health promotion and education, to assisting in maternal and child health services, to conducting routine public health surveys to assisting in outbreak surveillance and notifications. The most recent and notable example of the VHVs role was their role in the community-based surveillance system for Avian Influenza, where they served as agents for educating villagers, reporting of any unusual incidents and assist health professionals in case detection and control (2). As the VHVs are present in every village, they were able to provide effective early warning to relevant government departments for appropriate actions.

VHVs in Thailand are empowered through training for capacity building and on-going support and engagement by health-care professionals as well as being part of a nationwide network. The factors that contribute to success and sustainability of the VHVs in Thailand include the prestige and public recognition and acknowledgement afforded to them by both the government and the community and political and financial commitment from the government to integrate VHVs as part of health care systems.

Whilst many CHW programmes have proved successful, others have failed because of unrealistic expectations, poor planning and underestimation of the effort and input required to make them work. Scaling-up and sustaining community interventions is complex, broad and often needs to be adapted to local context (13). Although some formal health workers consider that CHWs deliver second-class care for poor people and are not sustainable, others recognise their ability to engage with the community because they are familiar with and know the local culture and context (13). They can be in more regular contact with patients and can be quickly mobilised to deliver new interventions and respond to new health threats. Although there are evidence gaps on the cost-effectiveness of CHW programmes some evidence suggests that delivery of well-defined packages of care can be cost-effective (14). However, in order to achieve the MDGs and with the increasing focus on UHC, there is growing recognition of the contribution and potential of CHWs as an integral component of the health workforce which has led to a revitalization of CHW programmes (15). CHW programmes are increasingly seen as an integral part of national human resources for health strategies.
The definition and description of CHWs is broad and includes close-to-community health providers, lay health workers, village midwives, traditional birth attendants, formal and informal private practitioners and providers, community based drug distributors, lay counsellors and health trainers. Some are formally employed and remunerated whilst other provide services voluntarily without formal contractual arrangements. It is estimated that most (70% globally) CHWs are female (16). Many countries have several different types of CHWs, some of them being generalists providing a wide array of services while others work for specific technical programs. Roles carried out by CHWs cover education, health promotion, immunisation, management of disease outbreaks, community mobilisation, counselling, screening, point-of-care diagnostics, follow-up and referral to health services, data collection, community based drug distribution, basic treatment and care for some diseases. The scope of their work covers all health aspects including maternal and child health, sexual and reproductive health (SRH), HIV, malaria, tuberculosis and nutrition.

Whilst workforce strategies increasingly recognise and count CHWs, they rarely quantify the contribution of communities, individuals and patients, and never assess the human resource implications (in terms of time, skill and competency needs) of engaging the wider, non-health workforce. With the increasing use of informal care givers and a broader range of public health actors to improve population health, there is a need to estimate the resource implications of mobilising, enabling and maintaining community and patient engagement and building the skills and competencies of the wider public health workforce. In order to do this and understanding of the human resource needs community empowerment and patient engagement programmes and of building the broader public health workforce capacity is needed.

**Community Empowerment**

The concepts of community and individual empowerment are closely interlinked, as empowered individuals are key to an empowered community. Communities and families are essential components of care systems, and are often carers themselves in many situations. Henry Mosley states: “Households and communities are the primary producers of health. And households (especially mothers) are dependent on many resources, not just material, like medical services and technologies, but non-material resources, like time, values, knowledge, practices, gender relations, and social networks, to try to prevent and treat diseases and maintain health” (17). Local cultural values, norms, and family systems affect health practices, and affect both self-care and care-seeking (18). Efforts intended to improve individual and family health need to include an understanding of individual health behaviours, the health environment in which people live as well as access to health services.

Health workforce education often fails to adequately equip the health workforce with the skills and competencies to effectively engage with communities and health workforce strategies often fail to connect the health workforce to the skills and competencies of the social care and social development workforce who can bring these skills to the health sector.

Comprehensive community-based health programmes need to successfully address community-specific social, cultural, gendered, economic and health workforce barriers, which limit the ability of communities to address their health needs and access proven interventions. A review of literature by Laverack and colleagues explained the relationships between community empowerment and health outcomes through nine empowerment domains, including: participation; community-based organizations; local leadership; resource mobilization; asking ‘why’; assessment of problems; and links with other people and organizations and the role of outside agents and programme management (19).
Communication across sectors is needed to ensure access to basic needs such as clean water, sanitation and healthy food. Civil society action from the national to the grassroots levels, with partnerships, collaborative action and resource sharing between agencies, can create efficiencies of scale to reach common goals through public education/information dissemination, public dialogue, and advocacy from community to national levels (18). For example, research in Uganda demonstrated increased use and quality of services and a 33% reduction in child mortality after one year of community participation in governance and monitoring of health services (20).

Empowering and engaging the community can have positive results on health outcomes through improving skills and capacity, strengthening social networks and social support, promoting local leadership, facilitating resource distribution and increasing access for participation (21).

Social accountability interventions have been proven to be critical to enabling meaningful participation of citizens in health and education. The value of social accountability is that the government should be open to citizens and citizens have a right, and an enabling legal environment, to hold their government to account (see Box 2 for an example). Tools such as community scorecards, citizen voice and advocacy, and partnership defined quality, can catalyse the relationship between communities and government to improve services (22).

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**Box 2**

**Country example: Increasing provider accountability in Uganda**

Through two rounds of village meetings, localized nongovernmental organizations encouraged communities to be more involved with the state of health service provision and strengthened their capacity to hold their local health providers to account for performance in Uganda. A year after the intervention, treatment communities are more involved in monitoring the provider, and the health workers appear to exert higher effort to serve the community. We document large increases in utilization and improved health outcomes—reduced child mortality and increased child weight. (http://www.povertyactionlab.org/publication/power-people-evidence-randomized-field-experiment-community-based-monitoring-project-uga)

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Given the complexity of effectively engaging communities, the important role of the social care and social development workforce can be seen as critically important to the process of developing and improving health and well-being. Human Resource for Health strategies which fail to recognised and plan for social care inputs to complement health care delivery are likely to fail to maximise the potential of community engagement.

**Patient/Family engagement and empowerment**

Patients can be seen as assets to a health system, rather than passive recipients of care and in many disease cases, patients and their families provide a majority of what would be considered “care” for areas such as chronic care and sick child care. Strengthening the role of patients in their own care increases their self-reliance and empowers them with knowledge and skills and engages them in shared decisions and choice, ultimately improving patient health outcomes and reduce health care costs (9, 20). The definition of “patient engagement” ranges from “actions” to promote adherence to treatment prescription, to “behavioural activation” for healthy behaviours, to “a cognitive, behavioural, emotional and social construct”, which foster patient self-management”, to “a measurable marker of clinical results” (20).
Engaging patients has received increasing recognition as an effective process to empower individuals. Empowerment is an approach that facilitates individuals to build or recognize their capacity to realize self-worth, self-esteem, confidence, involvement in shared decision making and motivation for self-directed behaviour change - a central principle for health promotion and health education (8).

Patient empowerment is an increasingly important component of many advanced economies’ strategies to strengthen service delivery. For example, the Institute of Medicine in the US recommended that “Patients and families should be given the opportunity to be fully engaged participants at all levels, including individual care decisions, health system learning and improvement activities, and community-based interventions to promote health.” (ref). While some of the strategies employed to promote patient empowerment in countries are traditional ones that have been employed for many years, information technology is opening up new options such as the use of text messaging to produce timely information exchange, or even video gaming as a means to develop virtual community support networks (refs). There is also a major emphasis on widening the use of electronic health records and making individual records easily accessible to the patient, as a means to strengthen patient-provider communication. While this strategy is attracting considerable interest, there remain challenges both in terms of developing and implementing interoperable information management systems, and in assuring patient confidentiality (ref).

Other evidence has shown positive benefits of empowerment on individuals’ health and well-being through increased knowledge and awareness, improved self-efficacy, greater sense of control, positive behaviour changes and a greater sense of community and social support (17), for example through patient held records (Box 3). Empowered and engaged patients are more likely to be a knowledgeable partner in doctors’ in-depth counselling, making the consultation more efficient. They are also more likely to make informed decisions about care options; adhere to the prescribed treatment or medications, and seek support services appropriately. Empowerment facilitates effective and efficient management of chronic diseases or conditions (17, 18), promotes positive participation and independence among the aged population, which result in improved health and well-being as well as reduced the use of health-care resources (23). These not only improve health outcomes, but also reduce adverse events and reduce health care costs (18).

**Box 3**
**Country example: Patient held records, Denmark and Malawi**
Since 2003, all citizens in Denmark can access and partially edit their medical record through a national eHealth portal. Users can find information on their previous treatments and diagnoses, book appointments with GPs, renew prescriptions, survey local provider waiting times and quality ratings and connect to patients/carers like them through ‘chat’ facilities. In Malawi, citizens also access their health record but in the form of a physical health passport that travels with them to every health facility visit. The passport contains information on their health conditions, outpatient appointments, details of consultations and immunisation records. The health passports involve patients more in their care and means a provider can see their records wherever they seek care.

Patients can achieve health outcomes that formal services cannot through peers and collective action to help others. Patients respond to other patients that have lived through
the same experience. Self-management support programmes for chronic conditions are becoming more common across the world and patient rights are at the core of delivering care for themselves and others (Box 4).

Although there are examples of successful health outcomes from the power of patient groups, evidence on the effectiveness of each intervention including its specific content and context is required, even for well-known long established interventions. For example, exposure to women’s groups was associated with no reduction in maternal mortality unless at least a third of pregnant women were involved (24).

**Box 4**

**Country example: The AIDS Support Organisation (TASO), Uganda**

A network of 11 patient-run HIV/AIDS service centres around Uganda manage drug distribution, conduct home visits and educate other patients on better managing their condition and improving livelihoods of around 100,000 Ugandans with HIV per year. TASO began as a small support group developed by and for people living with HIV/AIDS. TASO focuses on the philosophy of positive living, i.e., understanding the implications of HIV infection and undertaking positive choices to prevent HIV infection and adopt strategies to improve one’s health condition as mechanisms to fight the HIV epidemic. TASO has developed regional centres and has strengthened its governance structure through a Board of Trustees and senior management team.

Patient-provider partnerships that involve family and peers in new models of care have been shown to correlate to better services and care, particularly with regard to managing long-term conditions and establishing preventative behaviors (23). Involving the family and community in that process brings added benefits in managing care and improving outcomes (25).

**Health workforce strategies need to consider where and how in the education and training process to build the skills and competencies for patient empowerment, and whether these are skills sets that need to be factored into health workers training, or brought in from other workforces with the potential to positively impact on the public’s health.**

**Community and individual engagement to increase self-reliance and make healthy lifestyle changes**

For an individual to improve their health in the medium to long term they must change their behaviour and sustain this change (21). This includes focusing on preventative behaviours that positively impact health, such as immunization, antenatal care attendance, hand washing, thermal warming of a newborn and on reducing behaviours that can damage people’s health such as alcohol misuse, poor eating patterns, lack of physical activity, unsafe sexual behaviour and smoking.

Although some single technique interventions may be effective for some people and/or with some behaviours, change in behaviour often happens because of a range of techniques working together. Innovative and low-cost behaviour change strategies can achieve major improvements in health (Box 5).
The National Institute for Health and Care Excellence (NICE) have recently issued guidance, including 17 recommendations to be implemented using a person-centred approach, for those involved in helping people to change their behaviour (26). Behaviour change programmes can be delivered by a range of people in different contexts from those working in the health service to people in the community to people in the workplace. The Making Every Contact Count (MECC) programme introduced by the National Health Service (UK), aims to provide staff, from hospital porters to receptionists, with the skills to offer brief health advice to colleagues and members of the public. Although uptake has been variable, the initiative is achieving success because of its simplicity, its low cost, its reach to a large number of people receiving health advice and the ease with which it can be incorporated into the work routines of staff (27). This approach has been taken up by other organisations including private health clubs and the fire and rescue services, and is a good example of the need to think and plan beyond the traditional health workforce when developing broader workforce capacity to improve the public’s health.

Whilst workforce strategies emphasise basic, pre-clinical and in-service training, Human Resource for Health strategies rarely consider the widely varied learning and development needs of either the wider health workforce (including cleaners and reception staff) or the multi-disciplinary workforce (in fire, police or social services) that could play a far more active role in promoting the public’s health. Budgets for continuing professional development are one of the first areas to be squeezed in cash constrained health systems, which potentially reduces opportunities to engage a large, willing and extended workforce in health promotion and disease prevention.

**Engaging the role of the non-public health professions in health improvement**

There are many factors beyond the health system that can impact on health outcome i.e. the wider determinants of health, which include access to housing, quality of food, local environment and level of education (2). Professions working within these sectors can be considered members of the wider public health workforce and can improve the public’s health. For example, architects improving the work place; town planners recognising the link between public health and the built environment; public health training for teachers to teach and act on health issues; greater training for police on mental health (12). Although these professions are not directly employed to influence public health they can have an impact on health outcomes. There is therefore a strong case to include a public health element into their initial and continuing professional development training (12).

The social service workforce encompasses a variety of workers, paid and unpaid, including governmental, civil society and community actors to ensure the welfare and protection of socially or economically disadvantaged individuals and families (Global Social Service Workforce Alliance). The role of this workforce is to promote stronger families and better futures for children. Initiatives are underway to strengthen the social service workforce and improve systems and services that keep families and children at the heart of the work and promote wellbeing, protection and healthy development (28). This workforce can work at

**Box 5**

**Care groups for maternal and child health in Mozambique**

A Care Group is a group of 10-15 volunteers, community-based health educators who regularly meet together with project or government staff for training and supervision. They are different from typical mother’s groups in that each volunteer is responsible for regularly visiting 10-15 of her neighbours, sharing what she has learned and facilitating behaviour change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behaviour change communication. They also provide the structure for a community health information system that reports on new pregnancies, births and deaths detected during home visits. Care Group peer-to-peer behaviour change communication improved child undernutrition at scale in rural Mozambique at low-cost (3).
many different levels from the micro-level in providing direct support and services to children and families to meso-level support of community groups such as child protection committees up to macro-level of those who affect policy change and link with other sectors. Community ownership and engagement is essential for integration and co-ordination at all levels. For example, households in Cote d’Ivoire that received community caregiver support received better care and had better clinical and social outcomes than those not being supported by a community caregiver (29).

The process of health workforce strategy development needs to be multi-disciplinary and multi-sectoral if it is to effectively develop an integrated approach to population, community, organisational and individual-level behaviour change that can target many levels simultaneously. Whilst the increasing recognition of CHWs as an integral part of the health workforce is to be welcomed, it is only the first step towards more comprehensive workforce planning. Multi-sector workforce plans, which bring together health and social development, which build skills and competencies for community and patient empowerment and which recognise the potential public health role of a wider range of different professional groups will be essential if we are to make most effective use of limited human resource capacity to improve the public’s health.

**Conclusions**

Drawing together the evidence and case studies on the potential benefits of looking beyond the health sector for solutions to the health workforce crisis, a number of key recommendations emerge to inform HRH strategic planning (Box 6).

The challenges of developing a health workforce that is capable of delivering UHC are growing. Population ageing, epidemiological transition, increasing expectations and demand and health technology advancement are increasing pressure on already over-stretched health workers. Embracing UHC as part of the post MDG agenda provides an opportunity to return to core public health values and approaches, and develop health systems and a health workforce which gives as great attention to health promotion and disease prevention as has been given in the recent past to service delivery, treatment and care.
There needs to be a paradigm shift on how services are configured to maximise healthy lives. To achieve UHC and other development goals, human resources beyond the health sector will need to be engaged and empowered to better manage and reduce health risks, share responsibility for the management and delivery of services, increase community and individual self-reliance which will consequently ensure more appropriate demand for services. Engaging the wider non-public health workforce can also result in behaviour change for healthier lives.

Health Workforce Strategies need to draw upon a growing evidence base for community and patient engagement to better define the skill mix required, facilitate interventions and mobilise communities to achieve UHC. There is a need to continue to strengthen the evidence base for CHWs including the use of more appropriate study designs and
methodologies for answering some of the complex programmatic and policy questions that remain. There is also a need to ensure that community programmes are driven, owned by and embedded in communities themselves. This will also help sustain and facilitate new programmes over long periods of time.

With the evidence base of human capability beyond the health sector growing, it is important that national and international HRH workforce strategies consider the community, patients and their families and non-public health professionals as an integral component of the health workforce needed to achieve health goals including UHC.

Acknowledgements

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