



## Opinion paper

## Employing practitioner expertise in optimizing community healthcare systems

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## ABSTRACT

To harness the potential of community health workers (CHWs) to extend health services to poor and marginalized populations and avoid the pitfalls of the post-Alma-Ata period, there is an urgent need to better understand how CHW programs can be optimized. Understanding that several operational questions are unresolved by current academic evidence, this viewpoint considers the role of practitioner expertise in optimizing community health systems and highlights findings from a recently published report that captures implementation experience from 15 countries. The viewpoint considers applications of the report's suggested community health design principles and implications for implementers, philanthropists, policymakers, and academic researchers.

Community health workers (CHWs) are increasingly a core component of healthcare systems throughout the United States and globally. CHW utilization has grown in many American value-based healthcare programs,<sup>1</sup> and in the past two years alone, twenty-three countries have adopted principles for institutionalizing community health,<sup>2</sup> the African Union has called for the employment of 2 million more CHWs by 2020,<sup>3</sup> and CHW-led health delivery was highlighted as a critical strategy by the World Health Organization.<sup>4</sup>

CHWs—lay health workers to whom healthcare responsibilities can be ‘task shifted’ from other medical providers (e.g. nurses, doctors)—were widely promoted as a way to provide healthcare services as early as the 1978 Alma-Ata Declaration.<sup>5</sup> In the 1980s and 1990s, however, reviews found large-scale CHW programs often failed to replicate the success of small-scale pilots [e.g.,<sup>6,7</sup>]. Rigorous evidence has since accumulated on the efficacy of CHWs to complete a diverse range of health-related tasks,<sup>8–14</sup> including reductions in child morbidity and mortality, and neonatal mortality, when compared to usual care.<sup>10</sup>

Despite international enthusiasm for a more pronounced investment in CHW programs as a strategy to accelerate health progress, our knowledge of the optimization of CHW program implementation remains limited.<sup>15,16</sup> Given this, and the reality that some important questions are unresolved by the research literature, a coalition of CHW practitioner organizations

compared their experiences to gain further insight on practices that facilitate successful CHW programmatic implementation. In a new published report – *Practitioner Expertise to Optimize Community Health Systems* – we and our colleagues discuss the existing evidence and share operational insights derived from experience implementing CHW programs across fifteen countries, providing direct care to over one million patients annually.<sup>17</sup>

Our work together led to clear alignment on a series of design principles that, in our experience, drive programmatic quality yet remain controversial or not fully adopted by other CHW programs throughout the world.<sup>1</sup> These suggest that effective CHWs are:

1. **Accredited:** The health knowledge and competencies of CHWs are assessed prior to practicing; CHWs must meet a minimum standard before carrying out their work.
2. **Accessible:** To improve accessibility, timeliness, and equity of care, point-of-care user fees should be avoided when possible.
3. **Proactive:** For active disease surveillance, CHWs go door-to-door looking for sick patients and providing training to families on how to identify danger signs and quickly contact a CHW.
4. **Continuously Trained:** CHWs are trained using modular delivery or other types of in-service learning. Continuing medical education is not only available to but required of CHWs.

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<sup>1</sup> While the roles and responsibilities of CHWs vary greatly depending on context and location, the implementing organizations behind this report work exclusively with professionalized CHWs who perform promotional, preventive, and curative tasks. As such, any guidance and insight shared in this paper should be read as pertaining to cadres with similar characteristics.

5. **Supported by a Dedicated Supervisor:** On a frequent and regular basis, CHWs benefit from a dedicated supervisor who assesses patient experience and provides 1-on-1 coaching.
6. **Paid:** CHWs are compensated financially at a competitive rate relative to the respective market.
7. **Part of a Strong Health System:** CHW deployment is accompanied by investments to increase the capacity, accessibility, and quality of the primary care facilities and providers to which CHWs link, including pharmacy management.
8. **Part of Data Feedback Loops:** CHWs report all data to public-sector monitoring and evaluation systems and data get used by those who collected it to improve programs and CHW performance.

As a part of our research, we describe examples of each of these design principles in action, offering sample tools and guidance on how such principles can improve CHW performance. Some of these examples include competency-based CHW accreditation in Uganda, structured CHW supervision in Mali, pharmacy management support in Togo, and strengthening of and integration with public-sector monitoring and evaluation systems in Nepal.<sup>17</sup> The report also discusses each theme more broadly, weighing in on key debates in the field regarding, for example, CHW selection and performance-based incentives.

When applied together these design principles provide an opportunity to significantly enhance CHW program implementation globally. It is worth noting that these design principles are not proposed as supplemental embellishments, but core practices necessary for efficient and high-quality community health delivery. Investments to strengthen primary care via community health delivery can result in an economic return of up to 10:1 due to increased productivity, reduced risk of epidemics, and the economic impact of greater employment, however to realize such returns, certain design and implementation of community health systems is necessary.<sup>18</sup> Yet as noted above, many countries currently see little impact from their community health investment, and our collective experience suggests that closer attention to health system design and implementation can help to close this gap, in particular when design principles as aforementioned form the foundation of community healthcare systems.

Practitioner expertise, while never conclusive, remains an essential component of evidence-based practice. When paired with findings from the research literature, it is a key element in ensuring local, national, and global policies are operationally specific enough to be meaningful for those designing, financing, and implementing CHW programs.

As we look ahead, cultivating uptake of these principles requires a broad coalition of stakeholders. We invite implementers to pool their experience and expertise to create widely employed design principles and to promote their adoption in policy and practice. Foundations and development institutions will also be critical drivers of this effort by incorporating such standards into the structuring and financing of CHW programs. Finally, policymakers can lead the way by guaranteeing incorporation of these principles into their own local and national programs.

In parallel, we invite the global health community broadly to join with us to launch an effort to identify and track key performance indicators that constitute best practice delivery for community health across contexts. Researchers will play a key role in this endeavor by refining existing theories of CHW performance [e.g.,<sup>19</sup>] via operational research and component selection experiments testing elements of CHW-led health delivery.<sup>20</sup> Together these efforts can transform the current design and implementation challenges of CHW programs, and have important impact for patients globally.

A WHO report once declared: “there is no longer any question of whether CHWs can be key agents in improving health; the question is how their potential may be realized;” the report however, was written two decades ago.<sup>21</sup> Prompted by the recent failure to meet the health-related Millennium Development Goals<sup>22</sup> and a continuing global health worker shortage that imperils progress toward the new Sustainable Development Goals (SDGs),<sup>23</sup> there is mounting pressure to

avoid repeating the mistakes of the past. In the words of Skoll's James Nardella, “Universal global health coverage is a lofty goal, and it demands radical cooperation”.<sup>24</sup> While CHW programs require immense effort to design, implement, scale and maintain, they simultaneously offer significant opportunity to improve healthcare services. The current literature, complemented by the experience of implementers, offer us important insight to capture this opportunity.

### Conflicts of interest

Dr. Madeleine Ballard and Dr. Ryan Schwarz declare they have no conflicts of interest.

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