Written evidence submitted by the REACHOUT Consortium

REACHOUT is a research programme, funded by the European Commission which is exploring the close-to-community (CTC) health programmes in 6 African and Asian countries (www.reachoutconsortium.org). Key learning which is emerging from this work that are of relevance to the International Development Select Committee's hearing include:

- ✓ That CTC programmes are increasingly being initiated and scaled up in response to the human resources for health crisis. These programmes are providing an array of services which respond to health priorities at local level. They are often reliant on volunteer labour or employ staff who are poorly remunerated.
- ✓ These programmes have the potential to provide health interventions which are responsive to community level needs and CTC providers are uniquely situated to understand and react to gender and other equity-related issues.
- ✓ Yet they face challenges in relation to remuneration, sustainability and performance and workload management.
- ✓ To improve the function and the impact of CTC programmes investment is needed in creating an evidence base on supportive management of programmes, the equity impact of CTC programmes, the relationship between CTC programmes and the broader health system in priority setting, and the cost effectiveness of these interventions.
- ✓ Existing evidence from different settings should be translated and shared across countries and between academics, policy makers and implementers in order to improve the function of these programmes. This requires funding for multi-stakeholder learning platforms.

1. REACHOUT is a European Commission-financed programme which is researching the role of close-to-community (CTC) providers of health care (often known as community health workers) in Ethiopia, Malawi, Kenya, Bangladesh, Mozambique and Indonesia. REACHOUT is led by the Liverpool School of Tropical Medicine. Further details of all the partners involved and outputs to date can be found on our website www.reachoutconsortium.org. Our evidence focuses on DFID's role in understanding and supporting CTC providers of health services as part of the push to strengthen health systems, achieve universal health coverage and reach broader development goals (including women's health and equity targets).

2. The call for universal health coverage is gaining momentum and is likely to form a core element of the post-Millennium Development Goal agenda [1] . Human resources are a key health systems building block that underpin the expansion of health services. Most countries in the global south have a shortage of formal health workers and are increasingly looking to a range of CTC health services to fill the gap, in order to reach the poorest and most marginalised individuals, households and communities. In the past decade, there has been a growing recognition of the contribution and potential of CTC providers to health system strengthening [2] and the need to develop CHW "Principles of Practice" [3])

3. We note and applaud DFID's previous and ongoing commitments to human resources for health. For example, initiatives like "Making it Happen", a programme in 11 countries that is supporting capacity building for doctors, midwives and nurses to manage complications of pregnancy and childbirth and promote quality of care. The Global Health Workforce Alliance are also recipients

of support. DFID are supporting the Ethiopian Health Extension Worker programme and Lady Health Workers in Pakistan. Through their financing to the European Commission they are indirectly supporting research programmes like our own which seeks to understand and inform the way that CTC programmes function.

4. We recommend that DFID continues and intensifies this support with a particular focus on: (1) investing in local evidence generation to provide improved information about the challenges faced by CTC programmes in different contexts and so that this can inform policy development; and (2) assisting researchers, policy makers and implementers in learning from different programmes and geographical contexts to better harmonise action at the international level.

5. There are many types of CTC providers, including community health workers (CHWs), village midwives, traditional birth attendants (TBAs), community based drug distributors (CDDs) and lay counsellors, who deliver a wide range of services in different contexts. What they have in common is that they are embedded in communities and are strategically placed to understand intra household gender and power dynamics and how social determinants shape health and well-being.

6. CTC providers are sometimes a formal employed cadre who are remunerated and seen as a key part of the health system; but they can also be a more temporary cadre of volunteers who are brought on board for certain health activities at particular times. Most (70% globally) CHWs are women [4]. In some contexts they are all women by policy (e.g. health extension workers in Ethiopia).

7. CTC providers' current roles include: education; health promotion, immunisation; management of outbreaks, community mobilization; counselling; screening and point-of-care diagnostics; treatment; follow-up; and data collection. Their scope of work ranges from maternal and child health, to sexual and reproductive health, HIV counselling and testing and TB diagnosis.

8. The REACHOUT literature review [5] looked at evidence from systematic reviews of the effect of intervention design and contextual factors on CTC provider performance. There is evidence for the effectiveness of the implementation promotional activities and specific service delivery interventions by CHWs, such as the provision of continuous support for women during labour in the presence of a skilled birth attendant and administration of misoprostol to prevent post-partum haemorrhage. There is evidence from systematic reviews that CTC interventions for intra-partum and newborn-care preparedness, specifically those based on building community support groups, community mobilization activities and home visits by community-based workers are effective in reducing neonatal deaths.

9. Tuberculosis (TB) control is one of the areas in which CHWs have been recognized as making a valuable contribution. To date this contribution has primarily focused on direct observation of treatment [6]. The REACHOUT literature review [3] identified evidence of moderate quality (when comparing Lay Health Worker (LHW) programs with usual care) that LHWs improve pulmonary Tuberculosis (TB) cure rates. Involvement of CHWs and other community members to facilitate DOTS can substantially increase treatment completion rates and reduce patient and societal costs, relative to facility-based services. "Studies are now appearing concerning the cost-effectiveness of CHWs for TB programmes. With rare

exception, the studies available to date all indicate that interventions implemented by CHWs are highly cost-effective by international standards" [7].

10. The TB REACH project in Ethiopia demonstrated the effectiveness of partnership with Health Extension Workers (HEWs) (who collect sputum at community level either at the household or the health post and liaised with supervisors for laboratory follow up). Through the community intervention significantly more women were diagnosed with TB at community level than in the health facility programme. The proportions of children and elderly among symptomatic and PTB+ cases also increased during the TB REACH implementation period, This shows how a community based approach to TB involving HEWs in TB diagnosis can increase access amongst women, children and elderly [8].

11. In the past decade been an increased international focus on Neglected Tropical Diseases (NTDs) [9]. One of the key distinctions between the different NTDs is whether prevention and ultimately eradication of the disease is possible through chemotherapy to the entire at risk population, or Mass Drug Administration (MDA). Involvement of endemic communities has been central to the success of MDA programmes. The African Programme for Onchocerciasis control (APOC) was one of the first programmes within NTD to adopt a community directed approach treatment with ivermectin (CDTI) [10, 11]. In the CDTI approach local community volunteers (often referred to as CDDs) distribute the drugs. CDDs are often used to deliver other health and development activities [12] including the distribution of malaria treatment, polio immunisation, guinea worm eradication and water protection [13, 14, 15].

12. Some have described CHWs as social change agents, functioning as social and cultural intermediaries between the existing health system and the community [16, 17, 18]. As change agents, they are strategically placed to facilitate community participation, stimulate critical thinking and act as a catalyst to social action to address the social and cultural determinants poor health status. At the micro-level, CTC providers are in a unique position to observe and understand many of the socio-cultural and gender factors that influence health and healthcare use within households and communities. This is due to their socio-cultural embeddedness and frequent contact with individuals in their household and community settings, as compared with relatively infrequent and brief consultations in health facilities away from their social context.

13. This is recognised in some international literature, and in some national CHW policy and strategy strategies. For example in India, ASHAs, are expected to play the role of a 'social change agent' [19] as described in the ASHA guidelines: "ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services" [20] although they face challenges in realising this role.

14. **Remuneration and sustainability**. Some CTC providers are paid a regular salary and are seen as part of the formal health system (e.g. Health Surveillance Assistants in Malawi); others are paid incentives in relation to performance e.g. numbers of women referred/supported (e.g. Shasta shabikas in Bangladesh) and others are "volunteers" in the true sense although they may receive transport allowances or meeting attendance (e.g. CDDs for NTDs). The management strategies for attracting, retaining and supporting the performance of people working on a voluntary basis or without formal contract are more delicate as intrinsic motivation is likely to have greater importance. There is therefore a real

need to understand what motivates CTC providers - particularly volunteers – in different contexts and the challenges and opportunities they face in their work.

15. CTC volunteer providers are often women from poor rural communities who may be motivated by improved community status, career opportunities, or altruism. This is likely to vary according to context, by gender and by community, and there is evidence that programmes can fail to attract the (female/male) workers they require. Incentives (both intrinsic and extrinsic) are key to performance, sustainability and career path choices and an area that requires further research. Looking critically at how best to support and enable CTC providers is arguably an important opportunity to drive forward the agenda on women's empowerment.

16. **Performance and workload management.** There is no consensus as to the optimal package that CTC providers can deliver on and what training and resources this requires. In many contexts health managers struggle to plan and manage their human resources resulting in high staff attrition and poor effectiveness and the quality and supervision of services varies widely. The situation is further complicated by the fact that vertical, health topic-specific programmes that use CTCs for service delivery are often fragmented, lack stewardship and coordination, and tend to give limited consideration to the multiple workloads and competing priorities they face.

17. In many contexts supervision focuses on reaching targets rather than empowering and supporting community health worker needs. CTC services often lack monitoring and evaluation systems and referral mechanisms to formal health facilities are poorly tracked or recorded. In summary there is need for strategies to motivate, strengthen and support CTC providers and link these critical services to realise their potential.

18. **Gender and power.** CTC providers themselves are subject to gender and power dynamics and this can limit their opportunities for influence. Research in Pakistan demonstrates that the interplay of gender, class and hierarchy means that female workers like the women they seek to serve, are likely to be marginalized and disadvantaged by the male dominated context within which they live. There is need to better understand the working experiences and realities of different CTC providers and the room for manoeuvre they occupy to feed their experiences into health systems structures and processes. [21].

Recommendations

19. There is a need for greater investment in locally owned, context specific research into CTC programmes which are designed to support and facilitate improved policy making and implementation. DFID has a strong track record of financing health systems research, through the Research Programme Consortia and other models, which prioritise and take seriously: (1) the need for capacity building at different levels within academic organisations in implementing countries to ensure sustainability and local relevance and ownership; (2) meaningful partnership between and across countries for the purposes of learning; and (3) the need for research communications and uptake work with stakeholders outside academia. We suggest that DFID consider applying this model to research on CTC programming.

20. Enabling close to community health providers to realise their potential requires health systems support and human resource management at multiple levels. There is a need to better understand the multiple demands CHWs can face

(especially when working across different programmes) and develop supportive supervision strategies. There is also need to better understand the ways in which communities select and support CTC providers and how they can be involved in supporting these programmes and fostering accountability.

21. Four global meetings regarding CHWs were held in 2012. All identified the importance of equity focused approaches to strengthen systems and overcome barriers to access that the poor face in hard to reach areas. However, the equity impact of community health programmes is seldom measured [2].

22. There is also limited literature on extent to which CHWs are able to feed into health systems priority setting and bring their embedded knowledge to health systems debates. This is an area that requires more understanding to inform debates and policy around community accountability and community based statistics. Mhealth approaches have potential in this regard and can enable CHWs to collect, analyse and use information from their communities. This arguably has transformational potential to support CHW's stronger participation in generating data, feeding into the health system and informing decision making processes.

23. Further research is required to understand the opportunities for CTC providers to support health systems and inter-sectoral collaboration to better address the social determinants of health at community level and gender and power relations. This also requires better understanding and implementation research to assess how can health system decision making processes and structures be better organised to enable CTC providers to inform priority setting.

24. Although DFID has recently financed some research which sought to explore the cost effectiveness of CTC programmes the evidence base in this area remains thin.

25. A Thematic Working Group on Community Health Workers has recently been convened as part of Health Systems Global as a way of strengthening the evidence base in this area and extending research knowledge to policy makers and practitioners. However this group is unfunded and therefore opportunities for dialogue are constrained. Learning platforms which enable cross-country collaborations should be supported.

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The text draws on a paper to be presented at the Centre for Applied Health Research and Delivery consultation in Liverpool – "Close to community health providers post 2015: Realising their role in responsive health systems and addressing social determinants of health" by *CAHRD health systems work stream (Sally Theobald, Eleanor MacPherson, Rosalind McCollum and Rachel Tolhurst in collaboration with REACHOUT)*

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