COMMITTEE

WORLD HEALTH ORGANISATION

TOPIC

COMMUNITY HEALTH CARE WORKERS: CHALLENGES AND OPPORTUNITIES

TABLE OF CONTENTS

HISTORY OF WHO

The World Health Organization was created in 1948 to coordinate health affairs within the United Nations system. Its initial priorities were malaria, and other communicable diseases, plus women and children's health, nutrition, and sanitation. From the beginning, it worked with member countries to spot and address public health issues, support health research and issue guidelines. It also classified diseases. Additionally, to governments, WHO coordinated with other UN agencies, donors, non-governmental organizations (NGOs) and therefore the private sector. Investigating and managing disease outbreaks was the responsibility of every individual country, although under the International Health Regulations, governments were expected to report cases of a couple of contagious diseases like plague and cholera. WHO had no authority to police what member countries did. By 2003 WHO, headquartered in Geneva, was organized into 141 country offices which reported to 6 regional offices. It had 192 member countries and employed about 8,000 doctors, scientists, epidemiologists, managers, and administrators.
The First World Health Assembly met in Geneva within the summer of 1948 and established priorities for the organization: malaria, tuberculosis, venereal diseases, maternal and child health, sanitary engineering, and nutrition. The organization had a budget of US$5 million in 1948. additionally, the Organization was involved in wide-ranging disease prevention and control efforts including mass campaigns against yaws, endemic syphilis, leprosy, and trachoma.

INTRODUCTION

1) Community Healthcare Workers

Community health worker (CHW) is an umbrella term describing public health and/or social service workers who are close to and serve members of the community by helping them to adopt healthy behaviors. CHWs duties are diverse because of the communities they serve. They form a trusting relationship which helps them to serve as a liaison/link/intermediary between health/social services and the community and allow access to services and improve the quality and cultural competence of service delivery.

Community health workers are also known to help build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities. That is done via outreach, community education, informal counseling, social support, and advocacy.

Therefore, to sum it up, CHWs are:

- Trusted members of the community they serve,
- Responsive to the needs of community members,
- Trained in the context of health interventions,
- Recognized by health services and certification authorities, and
- Not necessarily certified as professionals or paraprofessionals.

CHWs go by many titles, depending on where they work, who they work for and what they do. The role of the community health worker started as a societal position, appointed by and responsible to the community's members.

IN DEPTH OF TOPIC:

1) The history of community health worker programs

The concept of community members for basic health services, have a 50-year history at least. The Chinese barefoot doctor program is the best known of the early programs, But Thailand, for example, they have also made use of village health volunteers and communicators from the 1950s

Old documents present and emphasize the role of the village health workers (VHWs), as a healthcare provider and advocate for the community and an agent of social change. They were trained to fight against inequities and advocate for community rights. Therefore, they came to be known as a "liberator" rather than "lackey". This view is reflected in the Alma Ata Declaration (A Declaration which was adopted at the International Conference on Primary Health Care in Kazakhstan. Which expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all people) and identified CHWs as one of the cornerstones of comprehensive primary health care.

It was only during the economic recession of the 1980s, which jeopardized the economies of developing countries, leading to major shifts in the policy environment as the focus on liberation, decolonization as the "basic needs" and approach to development was changed by World Bank-driven policies of structural adjustment.

Working Conditions

CHWs often live in the community they serve. Which means that they spend a lot of their time traveling within the community, speaking to groups, visiting homes and health care facilities, Some CHWs also provide case management, client education, interpretation, and follow-up care all while working in the health facilities. Some CHWs are also employed by government agencies and nonprofit groups to provide community organizing, health education, and preventive care services in the field.

Community health workers are hired by health care agencies often have a population-based focus, such as promoting the health of pregnant women or children, improving nutrition, promoting immunization, or providing education around a specific health issue, such as diabetes or HIV/AIDS.

Roles of Community Health Workers

The roles and activities of community health workers (CHWs) meet the unique needs of the communities they serve. Their role depends on factors such their education, training, lived experience, and experience. CHWs may perform the following roles:

- Create connections between vulnerable populations and healthcare providers,
- Help patients navigate healthcare and social service systems,
- Manage care and care transitions for vulnerable populations,
- Reduce social isolation among patients,
- Determine eligibility and enroll individuals in health insurance plans,
- Ensure cultural competence among healthcare providers serving vulnerable populations,
- Educate healthcare providers and stakeholders about community health needs,
- Provide culturally appropriate health education on topics related to chronic disease prevention, physical activity, and nutrition,
- Advocate for underserved individuals or communities to receive services and resources to address health needs,
- Collect data and relay information to stakeholders to inform programs and policies,
- Provide informal counseling, health screenings, and referrals,
- Build community capacity to address health issues, and
- Address social determinants of health.

Role of community workers in COVID 19

Community health workers are medical professionals who operate in a non-clinical capacity. And who usually do not have medical degrees but have experiences shared with traditionally

underserved communities, have proven effective for consulting about and meeting patient social needs.

The data has shown that community health workers are effective in pursuing patient-centered care. One study published in *JAMA Oncology*, shows community health workers and patient care navigators improved clinical quality metrics while keeping healthcare costs down.

Patients in a community care program utilized certain clinical services less frequently than patients without community support. Emergency department visits declined by 6 percent, hospitalizations by 7.9 percent, and ICU admissions by 10.6 percent.

2) Challenges

The demand for timely, accurate information about CHWs is increasing as the profession gains recognition for its ability to improve health outcomes and reduce costs. Although numerous surveys of CHWs have been conducted, the field lacks methods for gaining access to this hard-to-identify workforce.

The profession is expected to expand in coming years, which leads to creating a critical need for more information about the workforce. Currently, in state health departments often lack information to answer basic questions about CHWs in their regions. This information includes workforce demographics, job titles, scope of practice, employer types, supervision, wages, and benefits offered by employers as well as training requirements and continuing education needs.

For decades, different stakeholder groups have collaborated to locate and survey various segments of the CHW workforce. These attempts have occurred independently and were led by various entities, including CHW professional organizations, employers, academics, state public health departments, payers, and policymakers. These surveys have employed many techniques and some have met with success.

In 1998, for example, and before the use of online surveys, the landmark National Community Health Advisor Study (NCHAS) was the first to engage CHWs and their employers across the United States in defining CHW workforce.

Structural and Contextual Barriers

Even when CHWs possess the necessary knowledge and skills, they are often challenged by the health system of which they are a part of . Structural and Contextual deficiencies can pose significant barriers to CHWs, with the added frustration because these barriers are often out of

their control. Contextual barriers resulting from the characteristics of the community itself can be equally problematic, with geographical and societal obstacles in the community interfering with CHWs' effectiveness.

CHWs operation on the peripheries of formalized health care

CHWs' position as informal, unsalaried health workers can jeopardize their ability to provide health services. Furthermore, CHWs' position within the health care sector can lead to difficult relationships between them and professional health workers, mostly due to not well- defined roles and responsibilities.

A study in Zambia found that community health assistants were omitted from meetings and staff lists, delegated the most undesirable tasks, and discriminated against in sharing financial and even pharmaceutical resources (Zulu, Kinsman, Michelo, & Hurtig, 2014). These tensions, however, can be avoided through engagement with health workers and CHWs throughout the planning process.

CHWs commonly cite a lack of supervision and support as a barrier in performing their responsibilities.

Weak internal systems

Community health care workers work within health systems that are weak, underfunded or exhibit visible problems in functionality. Because CHWs' effectiveness is in large part reliant upon the systems with which they are associated with, problems within these systems can leave CHWs unable to perform their responsibilities or cause the work that they do accomplish to fall short of desired outcomes.

in South Africa It was found that even when CHWs did perform the necessary outreach to encourage TB patients to get tested for HIV, the health facilities 11 themselves lacked the infrastructure to encourage, monitor and deliver the counseling and testing.

High workload

Since Community Health care workers work within under-supported health systems that have a shortage of personnel, they can be burdened with a lot more than anticipated workload. This heavy workload can lead to mistakes in patient care and poor quality of services. A high workload can also result from unrealistic expectations of what CHWs can reasonably accomplish within their work schedule. High workloads and expanding responsibilities can also detract from CHWs' primary objectives or can cause confusion regarding priorities.

Lack of necessary supplies and resources

It has been observed that often CHWs lack the materials and equipment to properly serve the community. Research consistently shows that shortages of necessary supplies are considered by CHWs to be a significant barrier to their work.

Attitudinal Barriers

CHWs' attitudes toward their work, regarding health topics, or individuals or groups within their community can prevent CHWs from providing health services.

Motivation

Constantly Maintaining the motivation of CHWs to consistently conduct their responsibilities is challenging and crucial. Simple appreciation or recognition to CHWs has been shown to impact their attitudes toward their positions and responsibilities. In a case study of a community-based health extension program in Ethiopia, researchers concluded that incentives and recognition of contributions could help to improve motivation and retention.

Stigma

This attitudinal barrier is pervasive among CHWs and renders them unwilling to provide services to their clients. Several studies found that despite training, CHWs continued having negative attitudes toward certain health topics that they usually perceived as controversial or taboo. This is especially true among CHWs whose responsibilities include family planning education and services.

Differences in socio-economic status can also influence the services health workers provide. A study of the knowledge, attitudes and practices of health workers who provided medical abortions in India found that 74 percent of health workers felt medical abortion was appropriate for well-educated women, while only 39 percent felt it was appropriate for women with no education.

3) Opportunities

CHWs or other additions to the workforce of a primary care office need to raise revenues or reduce costs to add value within a fee-for-service environment. Already mentioned was one CHW role in primary care. For chronic patients, CHWs/health coaches add value by improving patient self-management, along with other things. improved two-way communication and better compliance with recommendations may be very helpful to patients and to overall health spending. Providing some physicians and nursing tasks to CHWs can also improve productivity. Where less-trained and lower-waged people substitute directly for physician or nursing time, there can be a clear fiscal benefit to a practice, even if paid on a fee-for-service basis.

Since CHWs are often members of the communities they serve, and rural communities typically have strong community connections, CHWs have an opportunity to:

- Develop trusting, one-on-one relationships with patients,
- Act as a liaison between the healthcare system, patients, and families/caregivers,
- Gain support from other organizations serving the community,
- Strengthen care coordination by connecting patients with available healthcare and social support services,
- Extend the reach of healthcare providers and services, which is particularly helpful in areas with shortages of providers,
- Deliver services that are appropriate based on the patient's language and culture, and

- Give back to their communities.

They represent niches an especially important issue is how fast and in what ways payers move This may include global or local capitalization or some form of risk-sharing by providers.
These less-defined opportunities include:
• helping primary care practices become more productive by undertaking non-clinical tasks, such as helping patients navigate the health system,
• helping the responsible provider (such as hospital or clinic) or payer (e.g., health plan, self-insured employment group) reduce utilization by promoting effective prevention and primary care, especially for chronic care and other high-cost patients,
• helping medical and health homes promote more effective diagnosis and treatment by improving knowledge about and approaches to addressing the social determinants of health, especially for chronic conditions and among disadvantaged subpopulations,
• helping avoid inappropriate utilization, especially by unusually high users of care, notably at hospital emergency departments and inpatient settings, and
• helping patients to manage their chronic conditions themselves, in line with some version of the chronic care model. As the following types of shift occur, there will be more scope for primary prevention, better health literacy, improved two-way communication between caregivers and patients:

- The focus of care management shifts from individual patients to patient panels and population-based health care, through medical home or health home models or otherwise.
- The unit for payment shifts from individual procedure codes to episodes of care encompassing comprehensive services both within and outside the clinic walls.
- Covered services expand from clinical locales into community locales including workplaces, schools, churches, and other community-based organizations.
- Employers move from simply paying for services or insurance to paying for employee wellness through programs and even aspects of community prevention.
- In the realm of public health and primary prevention, our environmental scan suggests that the full range of potential roles is already in use. At least three major issues might affect CHW employment going forward.

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