Commitment to Community Health Workers is Essential for Achieving Universal Health Coverage

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The atmosphere was electric last month at the African Health Agenda International Conference in Kigali, Rwanda, sparked by a renewed sense of commitment to community health with the African launch of the World Health Organization (WHO) community health guidelines. Placing community health at the center of the Universal Health Coverage (UHC) movement is a global commitment to equity in ensuring that women, men and children living in rural and hard-to-reach areas have access to quality, primary health care (PHC) services first, disrupting the status quo of the last few decades.

When governments invest in national quality community health programs, they make a commitment to prioritize the care of their most rural populations. Importantly, they also make a commitment to support community health workers (CHWs) as formal members of the workforce and provide necessary training, supervision and payment to allow them to deliver quality PHC services to their communities.

As the WHO community health guidelines and evidence from the past several decades indicate, there are several quality components that must be strengthened to support optimal performance for CHWs. Ethiopia and Liberia, as champions in the community health movement, serve as examples in building CHW programs that drive high-quality performance by focusing on five core systems drivers: skills, supervision, salaries, strategy and supplies.

Skills: In Ethiopia, lauded for the rapid expansion, coverage and comprehensiveness of its community health program, there is a renewed commitment to strengthening and revitalizing the Health Extension Worker (HEW) Program. The Ministry of Health is up-skilling HEWs (Ethiopia's CHWs) to augment the level of care they can provide at the community level. By recognizing the value of the HEWs in improving delivery of PHC services to their own communities, the Ministry has identified an opportunity to upgrade the careers of HEWs from level III to level IV and expand upon the set of services they deliver. Currently, nearly 60 percent of HEWs have been upgraded to level IV among the more than 39,000 HEWs. Level IV certification means training the HEWs in new services, such as prevention and control of noncommunicable diseases and neglected tropical diseases. This will support Ethiopia's UHC goals by offering a more comprehensive set of health care services for rural populations.

Committing to training HEWs in a new set of responsibilities requires investment in the corresponding support systems as well. Ethiopia is working with partners to optimize the health extension program by accelerating the career development of HEWs, upgrading health posts and improving basic utilities. The Ministry of Health is also strengthening and digitizing the curriculum and training systems that will support HEWs as they expand their skillset.

Supervision: In Liberia, the National Community Health Assistant (CHA) Program continues to progress toward full national coverage. The program is currently at 70 percent scale, serving rural communities in 14 of Liberia's 15 counties. The National CHA Program has deployed over 3,000 CHAs (Liberia's CHWs) and nurse supervisors to provide integrated community-based PHC services to Liberia's hardest-to-reach communities, many of which have never had access to care. In Liberia, supporting CHAs means ensuring they have access to regular supportive supervision services. A cadre of 327 clinical supervisors spends 80 percent of their time in the field providing mentorship and supervision opportunities to CHAs, while also tightly linking them

and their patients to facilities. Clinical supervisors are trained to coach and monitor the CHAs and provide ongoing refresher trainings and mentorship. Supportive supervision has been key to improving CHA performance and job satisfaction.

Salaries: In both Ethiopia and Liberia, a critical feature of their programs is remuneration, an evidence-based method for improving CHW satisfaction, motivation, retention and performance. It is also a recognition of the moral obligation to provide the right to work for rural populations and an opportunity for female economic empowerment. It's impossible to support health workers without also supporting their payment. Adequate financing backed by political commitment has been necessary to ensure that Liberia's and Ethiopia's CHW cadres are recognized as paid health workers.

Strategies: Both Liberia and Ethiopia developed comprehensive, costed strategies and mobilized diverse resources for program execution. Liberia's program, for example, was informed by detailed costing and analysis, robust stakeholder engagement and Ministry of Health leadership to transform a fragmented patchwork of programs into a critical PHC component. The country's strategy of mobilizing significant, multiyear funding commitments to drive scale—even before the program's policy was finalized—enabled strong coordination across government, donors, partners and communities. In Ethiopia, the Health Extension Program was conceived as a flagship government program to deepen community health care access and embed HEWs within the formal health system. The high-level political support for the Health Extension Program led to buy-in across ministries and necessary budgetary allocations.

Supplies: Strong community health programs require standardized preventive and curative supplies for CHW and clinical supervisors. Supply chain is a key component of Ethiopia's and Liberia's programs, with significant investments in "last-mile" or "last-10-kilometer" distribution. Both countries recognize that strengthening the supply chain for community health cadres means strengthening the overall PHC supply chain, particularly the PHC facilities used for referrals. In Ethiopia, a current focus for strengthening the HEW Program is strengthening the health posts, with emphasis on improving supply chain and decreasing stock-outs. In Liberia, the National CHA Program has a standardized list of commodities and supplies to support CHAs in providing life-saving services in their communities. Each month, these supplies travel from the supply chain warehouse in the capital, Monrovia. From there, a local supply chain team works to deliver these supplies, including zinc, oral rehydration solution, amoxicillin and treatment for malaria, to the clinical supervisor who then ensures these reach the CHA each month.

In the coming months as the world defines its commitment to UHC, keeping CHWs central to the movement will be critical to achieve equitable UHC. It's not enough to commit to CHWs as delivery agents for community-based PHC services, governments and partners must recognize them as individuals that deserve access to strong support systems to enable them to deliver quality care to their communities.