CHAPTER 1. Introduction

Many countries are striving to achieve health for all. The concept of universal health coverage – ensuring that everyone in need is able to receive good quality health services without undue financial hardship – has been growing across the globe (WHO 2010). However, in many parts of the world, equitable access to health care services is still not achieved (Barros et al. 2012; Neal et al. 2015). Health systems, in particular those in low- and middle-income countries (LMICs), are struggling to serve poor and vulnerable communities that bear the brunt of the burden of disease. Globally, child mortality has dropped nearly 50% since the 1990s (Wang et al. 2014). Maternal mortality dropped 1.3% per year since 1990 (Kassebaum et al. 2014). Despite this progress, 17,000 children are still dying every day from preventable causes, stillbirth rates have not measurably changed, and numerous women are dying (289,000 in 2013) or suffering from acute or chronic illnesses as a result of childbirth (Requejo and Bhutta 2015).

Many LMICs will not have achieved the millennium development goals on the reduction of maternal mortality and preventable deaths of newborns and under five children by the end of 2015. New targets have been set in the recently developed sustainable development goals, which also contain a broader target on universal health coverage. The target reads:

“To achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.” (UN 2014: target 3.8)

Improving equitable access to quality health care services needs global and national investments in close-to-client primary health care (Rao and Pilot 2014; WHO 2008). Basic but essential health care services need to be available close to individuals, families and communities, close to where people live and work, and should constitute the first element of a continuous health care process (Rao and Pilot 2014).

Community health workers (CHWs) are an instrumental group of health workers who provide these health care services at the community level (Bhuitta et al. 2010). Evidence shows that CHWs can be effective in improving population health in LMICs (Gilmore and McAuliffe 2013; Perry, Zulliger, and Rogers 2014). CHWs are extensively involved in the provision of promotive, preventive and some basic curative health care services, often substituting for professional health workers as a result of task shifting in a context of constrained human resources for health (Chopra et al. 2008). Thereby, CHWs extend services to hard-to-reach groups and areas, delivering health interventions right in their communities, which tends to be more equitable than services delivered at health facilities (Barros et al. 2012).
Over the past years, many LMICs have made efforts to strengthen their CHW programmes as one of the elements contributing to achieving universal health coverage (Tulenko et al. 2013). CHWs work at the complex interface of communities and the health sector, have increasing tasks and responsibilities, limited training and face numerous resource constraints. Policy makers and programme managers who aim to optimize and scale-up CHW programmes are in search of strategies that could support the performance of CHWs (Glenton et al. 2013).

The aim of this thesis is to gain insight into how performance of CHWs in LMICs can be improved, in order to contribute to the realization of better informed, more effective and sustainable CHW programmes and ultimately improved health status of poor and rural communities.