The Monrovia Call to Action

For investing in community health programs as an integral path to universal health coverage

We, the delegates of the 3rd International Community Health Workers (CHW) Symposium, gathered by the Government of Liberia from 22 to 24 March 2023 and inspired by progress of the exemplary Liberian National Community Health Program, reinforce our mutual commitment to fund, scale, and strengthen community health programs as an integral part of primary health care for the realization of universal health coverage.

We recognize that:

- CHWsa,[1] deliver primary health care, improve health outcomes, and save lives.[2]
- Community health is the equity arm of primary health care, and CHWs are leaders in providing an integrated package of services including in emerging areas, like non-communicable diseases and mental health.[3]
- CHWs are essential to global health security and play a critical role in pandemic preparedness and emergency response while helping to allay the health and economic shocks that follow.[4]
- Globally, seventy percent of CHWs are women.[5] They deliver health, nutrition, and social services for their communities, but they are often unpaid or underpaid for their work.
- Investing in a professional community health workforce can produce a 10 to 1 return on every dollar invested through healthier populations, increased productivity, and job creation, in particular for women.[6] A professional community health workforce is a 'public good' that should be financed from public dollars.
- Addressing the health workforce challenge is essential for progress towards all health- related sustainable development goals, universal health coverage, pandemic preparedness and response, and reducing the impacts of climate change.
- To be fully effective, CHWs need to be skilled, supervised, paid a living wage, and supplied by a well-functioning primary health care system coordinated at scale and integrated into broader public systems via data and financing.[7]

We are urgently concerned that:

- Domestic resource allocation to the health sector remains insufficient to meet the Abuja targets.[8] Fragmented and insufficient donor funding has worsened this situation.
- The global shortage of human resources for health is projected to be 18 million health workers by 2030.[9]
- Recent public health threats like Ebola and COVID-19 spread in part due to weak primary health systems that were not equipped to prevent, detect, and respond to outbreaks.[4]
- Over half of CHWs in low and middle income countries are unpaid.[10] CHWs are out of stock of key commodities one third of the time.[11] Many receive inconsistent supervision and continuous medical education is rarely available.[7] The failure to treat CHWs like professionals limits their ability to perform like professionals.[12]
- The majority of CHWs globally who are women face unique barriers accessing safe and decent work and leadership opportunities.[13] Women CHWs are at risk of sexual exploitation, abuse, and harassment and have limited access to the same legal and other protections extended to formal health workers. These and other barriers are also experienced by CHWs that are youths or people living with disabilities.
- Despite advances in healthcare systems, more than 800 million people lack access to healthcare and 54 countries are off track to reach SDG 3.[14]

We call on the highest level of leadership including Heads of State, Ministers of Health, Ministers of Finance, and other line Ministries, the African Union, Africa CDC, bilateral and multilateral partners, the United Nations system, civil society, and the private sector, to:

1. **Invest in country-led community health strategies.** Coordinate funding toward clear, costed, and prioritized national and sub-national community health strategies. Include core indicators on access, equity, and quality of an essential package of health services. Appropriately and incrementally increase domestic budget allocations and private sector financing for primary health care and CHWs, while decreasing out-of-pocket spending for patients. With recognition of the contributions CHWs make to disease-specific outcomes, affirm an integrated approach to service delivery and strengthen the health system to ensure they are adequately stocked with the required medicines and supplies. Create a budget line in all national budgets dedicated to financing CHWs. There should be one plan, one budget, and one implementation approach.

2. **Make professional CHWs the norm.** In line with the WHO Guidelines,[7] ensure formalizedb CHWs are paid a fair wage, skilled, supervised, and supplied to deliver the highest quality care, leveraging digital tools, and offered opportunities for career progression. This must be a just transition, undertaken with consideration for gender equity and social inclusion, to protect quality jobs for women and other marginalized groups. As valued workers, CHWs must be protected from health risks, violence, and sexual harassment.

3. **Integrate CHWs into human resource and health sector plans.** Recognize CHWs as a core part of strong primary health care systems. This starts with counting and accrediting CHWs at national and subnational levels and mapping coverage. CHWs must be included in health sector planning including national disease strategies, implementation, technology, governance, and program monitoring. CHWs themselves must be included in decision making. Policies should be designed to promote women's leadership and CHW career progression.

4. **Galvanize political support.** Continue positioning community health on the political agenda, cultivate champions and key influencers, and develop investment cases to elevate the community health agenda at global, regional, and national levels.

5. **Track progress of CHW programs.** Adopt an accountability framework ratified by countries in consultation with stakeholders including milestones, shared indicators, transparent investments by funding partners, and gender disaggregated data.

The evidence is clear. Protected, paid, trained, supervised, and supplied CHWs must be the rule and not the exception. As the CHWs of Liberia have repeatedly noted, "We are here for change." The time to act is now. We must urgently fund, scale, and strengthen community health programs for the realization of universal health coverage and global health security.

[a] *CHWs, whether formally recognized or not, go by different names in different countries.*

[b] *CHW formalization refers to the process by which CHWs are integrated into a formal health workforce, this involves pre-service training, contracting them with a written agreement specifying role and responsibilities, supervision, remunerate them for their work with a financial package commensurate with the job demands, and offer them with career advancement opportunities. While this is a government-led process, informed by national context, all countries are encouraged to formalize and remunerate at least one cadre of CHWs that is engaged in health service delivery.*

Endorsed by:

COMMUNITY HEALTH IMPACT COALITION

Community Health Roadmap
Investment priorities to scale primary care at the community level

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Healthy Life

LAST MILE HEALTH

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Context for the development of the Monrovia Call to Action

At the onset of the CHW Symposium, Dr. Wilhemina Jallah, the Minister of Health of Liberia, proposed that the participating stakeholders conclude the symposium by issuing a declaration. In consultation with Minister Jallah, USAID convened key partners, including UNICEF, the Community Health Roadmap, Last Mile Health, Community Health Impact Coalition (CHIC), Global Fund, country representatives, and CHWs to draft the Monrovia declaration. The drafting process commenced by considering the existing calls for action in the field of community health and attentively listening to the unique and pressing insights shared during the symposium.

The team actively sought input from CHW leaders and 10 to 15 country delegations participating in the event, incorporating their feedback into the initial draft. Subsequently, they opened the opportunity for feedback to all participants, distributing copies of the draft among the symposium's country delegations and other attendees. Additionally, the team engaged in focus group consultations with all community health workers (CHWs) present at the conference to gather their input.

All of the lead organizing institutions, including the Africa Center for Disease Control (A-CDC), provided feedback and edits on the draft. While some were able to promptly affirm their endorsement, others expressed support but indicated that their endorsement process requires additional steps and time. In all cases, the feedback received resulted in changes to the document. Often, the feedback aligned with the existing content but provided additional details. However, certain detailed suggestions were omitted to maintain a more streamlined Call to Action.

Following the symposium, all participants were invited via email to provide feedback on the published draft of the Monrovia Call to Action. The final version, incorporating revisions, is presented above on this page.