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Policy brief for Bangladesh

Evaluation of South Asia's Current Community Health Worker Policies and System Support and their Readiness for Community Health Workers' Expanding Roles and Responsibilities within Post-Astana National Health Care Strengthening Plans

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Acronyms

BRAC	Bangladesh Rehabilitation Assistance Committee
CHW	Community Health Worker
CSG	Community Support Groups
CSBA	Community Skilled Birth Attendant
CG	Community Group
CHCP	Community Health Care Provider
DGHS	Directorate General of Health Services
DGFP	Directorate General of Family Planning
FWA	Family Welfare Assistant
FPIs	Family Planning Inspectors
GoB	Government of Bangladesh
HA	Health Assistant
HNPSP	Health, Nutrition and Population Sector Programme
HMIS	Health Management and Information System
HPNSP	Health, Population and Nutrition Sector Program
MNH	Maternal, newborn and child health
MPHV	Multi-Purpose Health Volunteer
NGOs	Non-Governmental Organizations
OP	Operational Plan
PHC	Primary Health Care
RCHCIB	Revitalization of the Community Health Care Initiatives in Bangladesh
PHC	Primary Health Care
RMNCAH	Reproductive maternal, newborn, child and adolescent health
SACMO	Sub Assistant Community Medical Officers
SDG	Sustainable Development Goals
SS	Shanthy Shebika
SK	Shasthya Karmi
UHC	Universal Health Coverage
WHO	World Health Organization

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Introduction and background

The Astana Declaration of 2018 reaffirmed the importance of Primary Health Care (PHC) towards achieving Universal Health Coverage and the health-related Sustainable Development Goals (SDGs). It reiterated the urgent need to build sustainable PHC systems that are people-centred, responsive to community needs, holistic in scope, and able to engender socio-cultural changes among communities and providers to promote and preserve good health and well-being.

Community Health Workers (CHW) are the backbone of Primary Health Care systems. Evidence highlights the effectiveness of CHWs in delivering a range of preventive, promotive and curative services related to reproductive, maternal, newborn and child health, Maternal and Infant & Young Child Nutrition (MIYCN), infectious diseases, non-communicable diseases, and neglected tropical diseases. However, CHW programmes often face several challenges including lack of clarity in roles, inadequate pre and in-service training, lack of clear career pathways, poor supervision mechanisms, and poor linkages with both the health system and communities.

> We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals.
>
> **Astana Declaration 2018**

South Asia has a rich history of vibrant CHW programmes and CHWs in the region continue to play a substantive role in Primary Health Care and act as bridges between the community and the health system. Simultaneously, countries in the region are witnessing demographic and epidemiologic transitions with increasingly ageing and urbanized populations and a rising burden of non-communicable diseases.

In such a scenario, there is an urgent need to enhance the contribution of CHW programmes to PHC strengthening and achieving the post-Astana goals and commitments in the region.

> CHWs are health workers based in communities (i.e. conducting outreach beyond PHC facilities or based at peripheral health posts that are not staffed by doctors or nurses), who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours.
> **World Health Organization**

Evaluation of Community Health Worker programmes in the South Asia region

- Formative evaluation in seven countries – Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan and Sri Lanka
- Objectives
    - o To understand the CHW policies and system support that are currently in place to support the effective functioning of CHW programmes
    - o To determine the key policy adjustments and interventions needed to address any gaps
    - o To assess the readiness of CHW programmes for their expanding or changing roles and responsibilities within the post-Astana national health care strengthening plans
- Desk review and key informant interviews at the national level in seven countries
- Analysis frameworks
    - o WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programs, 2018
    - o WHO health systems building blocks
    - o Operational framework for Primary health Care by WHO and UNICEF
    - o WHO gender responsiveness assessment scale

This policy brief presents the key findings from a formative evaluation of CHW programmes in the South Asia region conducted by the Centre for Maternal and Newborn Health, Liverpool School of Tropical Medicine, with support from UNICEF Regional office for South Asia. It details the policy and system support available for diverse cadres of CHWs in the region and measures to optimize the contribution of CHWs to PHC. It also highlights the reforms needed in CHW programmes and will be useful to inform the design of a set of feasibility and prioritization criteria that will support countries to develop an action plan aimed at optimizing the contribution of CHWs to Reproductive maternal, newborn, child and adolescent health (RMNCAH) and and Maternal and Infant & Young Child Nutrition (MIYCN) and to the strengthening of PHC. This brief is intended for policy makers at national and sub-national level in the South Asian region.

Bangladesh - country context

The health system of Bangladesh is a pluralistic system with four key actors: government, private sector, non-governmental organizations (NGOs) and donor agencies. It has gone through a number of reforms in recent years, an extensive health infrastructure has been established in the public and private sectors, and there have been significant improvements in a number of health indicators including under-five mortality, immunization coverage, maternal mortality and total fertility. Women's education, economic conditions and life expectancy have also improved.

However, despite recent economic growth, poverty and income inequality remain persistent challenges for the country. The health system continues to face challenges to achieving universal health coverage (UHC). These include a lack of coordination between the two ministries – the Ministry of Health and Family Welfare and the Ministry of Local Government, Rural Development and Cooperatives implementing primary health care (PHC) service delivery in rural and urban areas, a critical shortage of trained health providers and skill-mix imbalances in the public sector, and inequitable access to health services between urban and rural areas.

Community Health Worker programmes in Bangladesh

Bangladesh has a long history of CHW programmes effectively contributing to the attainment of public health goals. The principal CHW programmes of the Government of Bangladesh (GoB) are under the two

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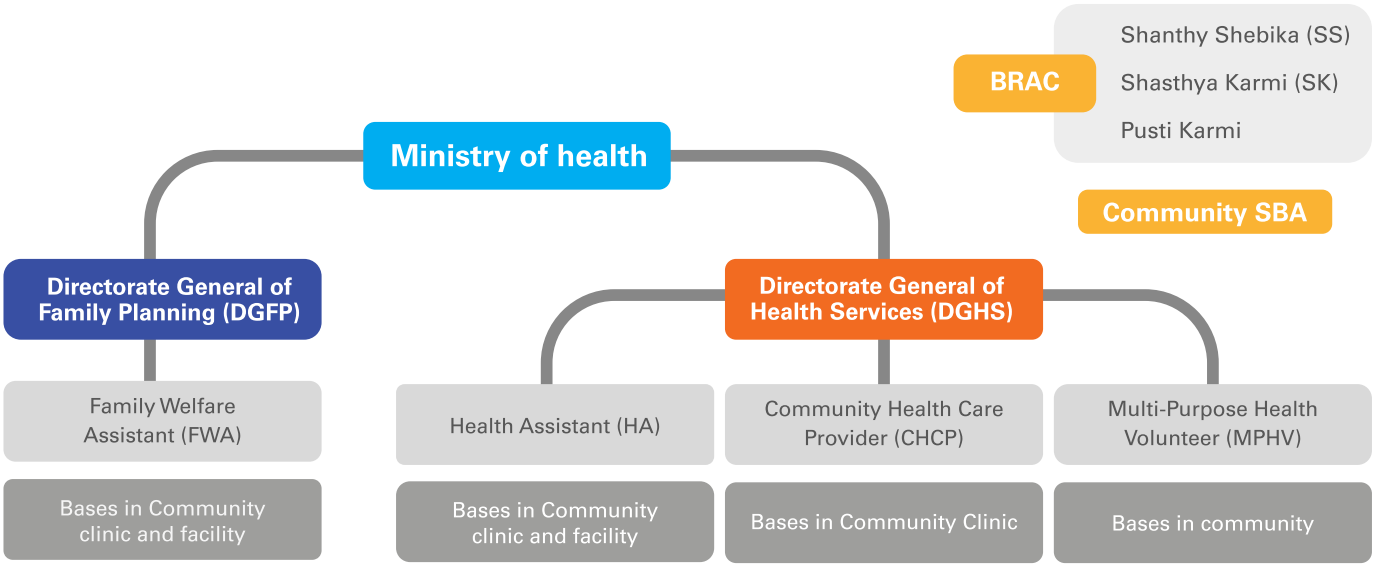
directorates within the Ministry of Health and Family Welfare which employ CHWs as part of their health workforce, as depicted in Figure 1.
There are other CHWs active in the country who are either recruited by NGOs or other agencies. The largest programme amongst these is that managed by Bangladesh Rehabilitation Assistance Committee (BRAC), a local Bangladesh NGO. The Community Skilled Birth Attendant (CSBA) is another cadre produced and providing community based Maternal, newborn and child health (MNH) services. They are being phased out and the current policy focus is to develop a professional midwifery cadre.

A CHW is a permanent resident of a particular community, assigned by government/ non-government organization, who provides promotive, preventive, limited curative care, rehabilitative, palliative and referral services in relation to maternal, neonatal, child and adolescent health, family planning, nutrition, communicable and non-communicable diseases to his/her community and shall be held accountable for the non-performance of these services.

MoHFW 2019

Figure 1: Community Health Workers in Bangladesh



A profile of the government CHWs is presented below.

	FWA	HA	CHCP	MPHV
Total number	19,583	15,213	12,293	21,056
Vacancy rate	17%	27%	19%	NA
Population covered	One per ward	One per ward	One per 6,000 population	One per 250-300 households
Gender	All women	Men and women	Both men and women	All women
Sector located in	Completely in the public sector	Completely in the public sector	Completely in the public sector	Completely in the public sector
Place of location	Community and facility	Community and facility	Facility	Community
Payment structure	Salaried staff paid by government	Salaried staff paid by government	Project staff paid by development fund	Performance-based incentives

There are close to 185,000 CHWs in the country currently, with 70,000 of these employed by the government. This translates to 3.8 CHWs per 10,000 population. In 2011, there were approximately 91,000 of the BRAC Shasthya Shebika cadre active across the country.

Health policy and system support for Community Health Worker programmes

Bangladesh introduced the CBHC programme in 1998, and the **Revitalization of the Community Health Care Initiatives in Bangladesh (RCHCIB)** was introduced in 2009. Under this programme, over 13,000 **Community Clinics** were established to extend Primary Health Care (PHC) to the door steps of rural people, enabling access for all to essential primary health services, and ensuring no one is left behind. This community-based health care programme is incorporated into mainstream health sector programme, with its own Operational Plan (OP) and budget under the current 4th Health, Nutrition and Population Sector Programme (HNPSP).

The GoB has formulated a number of policy documents related to the health workforce in the public sector in recent years.

- An **Action Plan of Bangladesh Health Workforce Strategy** was drafted in 2015, which reaffirms the GOB's commitment to the achievement of the SDGs.
- A supplementary document to the National Health Workforce Strategy, a **National Strategy for Community Health Workers,** was prepared in 2019. This strategy affirms Bangladesh's commitment to the Primary Health Care approach, as spelt out in Alma Ata and reiterated in the Astana Declaration, and the key role envisaged for CHWs in the delivery of PHC services.

The CBHC and CHW programmes in the country fall under the Ministry of Health, under the two Directorates- Health Services and Family Planning. The CBHC programme, especially the Community Clinic component, is seen to have political commitment at the highest level.

While the CBHC approach remains very relevant, its effectiveness has been constrained by the fact that the leadership of the government CHW programmes is provided through two separate Directorates in the Ministry. There are concerns that this is affecting coordination on the ground between different health officials and providers, as they operate in vertical silos.

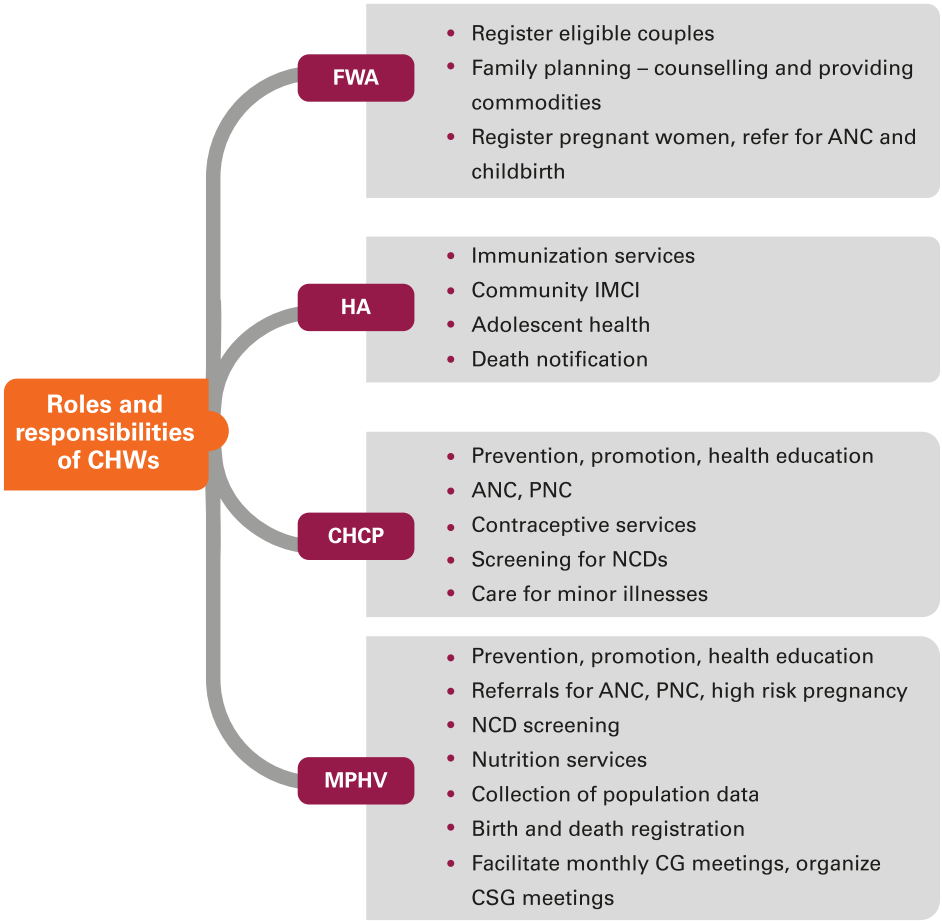
Roles and responsibilities of Community Health Workers

The focus of CHWs' roles and responsibilities has always been on different aspects of RMNCAH and MIYCN service provision.

- **Community Clinics (CC)** are the lowest level of facility providing primary care services and are served by three cadres of CHWs posted there – the CHCP, HA and Family Welfare Assistant (FWA). Each Community Clinic, with one CHCP, is expected to cover a population of 6000. CHCPs also offer screening for Non-Communicable Diseases (NCDs) such as hypertension and diabetes and refer clients to higher level facilities for further treatment.
- **HAs and FWAs** complement these CC based services through the provision of domiciliary and community-based care. There is supposed to be one FWA and one HA in each ward, with nine such units in each Union.
- The **MPHV** cadre is primarily at the community and domiciliary levels. Each CC is expected to have five MPHVs, with each MPHV assigned to 250–300 households.

The Government of Bangladesh (GOB) is obligated to ensure that all citizens enjoy a quality of life assured with basic healthcare and adequate nutrition as stated in the Article 15a of the Constitution. The Government is also committed to achieving the globally accepted goals such as SDG to be achieved by 2030.
Bangladesh Health Workforce Strategy

Figure 2: Roles and responsibilities of different Community Health Workers



While BRAC's CHWs focus largely on Reproductive, Maternal, Newborn and Child Health (RMCAH) services, NCDs are also a key focus area.

Several challenges affecting the ability of these CHWs to effectively carry out their roles and responsibilities were identified.

- **Overburdening of FWAs and HAs:** Over the course of time, additional responsibilities have continuously been added to FWAs' and HAs' scope of work. This was seen to have a negative impact on community and domiciliary activities.
- **Coverage of a larger population:** Because of staffing shortages and the fact that coverage areas have not been redefined to match population growth, the CC and CHWs often cover a larger population than they are mandated to, and FWAs and HAs can be assigned to more than one CC. This affects the provision and quality of both facility and community-based primary health care services.
- **Lack of focus on preventive and promotive care:** There is a disproportionate focus on curative care in the CCs to the detriment of preventive and promotive care- curative services represented 86% of services provided by CCs in past evaluations, and there was low demand for promotive and preventive services.
- **Lack of accountability mechanisms:** FWAs and HAs frequently do not perform all the tasks assigned to them and are often not found in either the CC or in the community. This was attributed to the absence of robust monitoring and accountability mechanisms.
- **NCDs as an emerging burden:** NCDs are emerging as a major problem in the country and therefore will be a key area of focus for CHWs in the future. However, the country was lagging behind in achieving key RMNCAH indicators and therefore this needs to be a continued focus area for CHWs.

- **Continued commitment to Community-Based Health Services:** Whether there will be sustained investment and commitment to CBHS in government policy as knowledge of family planning and uptake of immunization and other services improves, and with more sophisticated means of communication, is a concern. This is reflected in the MoHFW's decision to post FWAs and HAs to the CC, shortening their community presence, to improve staffing levels in these facilities. The MPHV has been introduced to address the gap in community-based health services, to improve demand, and to increase access to and utilization of health services at the grassroots level.
- **Lack of coordination between different cadres:** Structural issues affect the integration and reach of the services provided by these CHW. These include lack of harmonisation of field areas and administrative control by different Directorates. Inadequate coordination between these CHW cadres results in missed opportunities to increase coverage of promotive, preventive and curative services, and to reduce duplication and inefficiencies. The effective utilisation of the newly introduced MPHV is also at risk unless coordination is improved amongst the various cadres working at the CC. There is also lack of coordination between government CHW programmes and those run by the NGOs, which run parallel to each other.

Selection, education and certification

Figure 3: Selection and training pathways of Community Health Workers

Selection

- FWA, HA and CHCP recruited through formal government recruitment processes
- Educational criteria: FWAs and HAs- eighth grade, CHCP- 12th grade
- Gender criteria: FWAs-Women, HAs- Men and women, CHCP- Both men and women, MPHV-Women
- No community involvement in selection process. MPHV preferably from CSG or CG, but no community involvement in selection

Pre service education

- FWAs- 3 weeks focusing on FP
- HAs- 3 weeks focusing on immunization
- CHCP- 12 weeks
- MPHV- 3 days

Certification

- No formal mechanism of registering or certifying

In-service training

- No regular government refresher training provided by UN agencies and NGOs based on different project needs

While educational qualifications are specified as above, CHWs are often much better educated than that specified. The current CHW positions are attractive as they are perceived to be secure government jobs in an economy where employment is scarce and job security uncertain. In the case of CHCPs, the training and recognition they receive as clinical service providers also enhances their social status as well as provide them with private practice opportunities.

Challenges were reported in the selection and training process.

- **Administrative constraints:** FWAs and HAs, recruited several decades ago have now retired, leaving almost a third of these posts vacant. However, recruitment to replace these cadres has been hampered by various ongoing court cases and legal proceedings, which need to be settled before recruitment can take place.

- **Lack of integration of NGO programmes into the government system:** In contrast to government CHW programmes, the CHW programmes run by NGOs reported engaging communities in the selection of their CHWs. The CHWs of NGOs are however project-based and are functional only for the lifetime of the project. Though they receive training during the project and could potentially be valuable skilled resources for government programmes, there is no transfer mechanism to enable them to move between programmes.

- **Need for a comprehensive and refresher training:** More refresher training is needed for the CC CHW cadres. While the refresher training provided responded to health programme needs, it was not always based on the capacity development needs of these cadres.

Management and supervision

Job description

The CHCP's job descriptions are not fully aligned with the CC concept, and job descriptions for HAs and FWAs did not include their work at the CC. This makes supervision difficult when supervisors are not clear about roles and responsibilities they are expected to perform.

Remuneration

Government FWAs and HAs are permanent staffs. They are on the government payroll, receive regular government salaries and are eligible to receive benefits, like annual increments, as well as a pension after retirement. However, pay is low for these cadres and is a source of low morale.

The CHCPs are considered project staff and receive their salaries from the development budget. They are employed through a Trust created for the CBHC programme and are not permanent government employees, a source of dissatisfaction among them. The MPHVs are contracted on an annual basis and receive monthly performance-based incentives after successful completion of the specified work and targets.

Career progression

There is a lack of a career ladder for all government CHWs. While in theory, FWAs could become Family Planning Inspectors (FPIs), and HAs could become Assistant Health Inspectors (AHIs) or Health Inspectors (HIs), there are few vacancies within these higher-level posts and therefore, promotions are rare. Similarly, no career path is available for CHCPs either.

Supervision

There is a clear hierarchal supervisory system, with FPIs, AHIs and HIs supervising FWAs and HAs respectively. These are in turn supervised by Union level officials. CHCPs are also supervised by Upazilla level authorities on administrative issues and by Sub Assistant Community Medical Officers (SACMO) and medical officers on technical issues.

However, several challenges related to supervision were identified.

- **Quality of supportive supervision:** Supervision is often carried out for administrative and reporting purposes only and does not provide technical support and/or mentoring. Supervisors' lack of technical knowledge also affects the quality of supervision. Also, coordination between the FWA and HA, and their programmes of work is often lacking because they have different supervisors.

- **Lack of support for supervisors:** While supervisors receive training, they often lack the resources and motivation to provide effective supervision. There are no accountability mechanisms linked to supportive supervision. Often, lack of transport is a constraint to the provision of supervision. The availability of monetary and human resources to provide effective support to the large number of Community Clinics that are across the country was seen as a barrier.

- **Gender disparities:** Some female cadres are supervised by male supervisors, for example the FWA, who are all women, have male supervisors, which may affect the quality and depth of the supervision provided.

Integration into and support by the health system and the community

CHWs are well integrated in the health system through the network of community clinics all over the country. However, the complete exclusion of urban areas from the CHW programmes is a major challenge. Historically, health in urban areas has been under the Ministry of Local Government, not the Ministry of Health. No government CHWs are present in urban areas.

> CHWs are the community terminal of the health care organization of Bangladesh.
>
> **National Strategy for CHWs**

Availability of medicines and supplies

Individual CHWs receive supplies of medicines and commodities from the Upazilla level, which in turn are supplied through a streamlined government procurement and supply system. Buffer stock are reportedly available at the regional level and are supplied based on need. Supply is usually adequate and stockouts are infrequent and minimal.

Data collection and use

All CHWs collect data to feed into different levels of the HMIS. FWAs collect paper-based data in registers. CHCPs have been provided with laptops and are contributing data to the DHIS-2.

However, there are several challenges with the data management system.

- **Electricity issues:** Power scarcity in rural areas means that CHWs have to sometimes travel to nearby urban centres to charge their electronic devices.

- **Lack of integration:** One key challenge is that the data systems between the DGFP and the DGHS are not integrated or interoperable, resulting in parallel reporting systems. Also, reporting is not based on individual unique IDs, thus making aggregates unreliable and causing difficulties in making sense of the data. NGOs like BRAC also have a parallel system that does not feed into the government HMIS.

Community integration and engagement

In addition to interfacing with the formal health system, CHWs also interface and engage with communities. However, the deployment of HAs and FWAs, historically domiciliary service providers, to the Community Clinic, seems to be compromising community-based service provision, especially in hard to reach areas where these populations have less access to facility-based care.

While there does not seem to be any formal community engagement mechanisms or spaces for FWAs and HAs, such mechanisms have been set up for the Community Clinics. Each Community Clinic is supported by a Community Group (CG), which is in turn supported by three Community Support Groups (CSG). These groups are intended to be the bridge between the community and CC.

Community Clinics have mechanisms to mobilize resources from the community. Community Groups can set nominal charges for services to be paid by clients on a voluntary basis. These funds are then used for local

expenses like the maintenance of the clinic.

Fulfilment of World Health Organisation recommendations by the Community Health Worker programmes

The following table lists the recommendations by WHO on the policy areas around CHW programmes and depicts the fulfilments of these recommendations by the CHW programme in Bangladesh using a colour code. (Green – complete fulfilment of all dimensions of the recommendation, Yellow – Partial fulfilment of some dimensions, but not others, Red – All or almost all dimensions of the recommendation not fulfilled).

Only the government CHW programmes are

Policy area	WHO recommendation	Fulfilment	Remarks
Selection	Specify minimum educational levels		
	Require community membership and acceptance		No community involvement in selection
	Consider personal capacities and skills		Not considered for FWA and HA, but considered for MPHV
	Apply appropriate gender equity to context		Not considered for CHCPs
Pre-service training duration	Based on scope of work, roles and responsibilities		
	Consider competencies required		
	Consider pre-existing knowledge and skills		
	Social economic and geographic circumstances of trainees		Not considered
	Institutional capacity to provide training		
	Expected conditions of practice		
Competencies in pre-service training curriculum	Include core competencies domains-preventive & promotive, diagnostic, integration with wider health system, interpersonal skills, social determinants of health, personal safety		
	Include additional competency domains- treatment and care services - if required		
Training Modalities	Balance theory and practice		
	Use face-to-face and e-learning		
	Conduct training in or near the community		
	Consider interprofessional training approaches where relevant		
Competency based certification	Use competency based formal certification for CHWs who have successfully completed pre-service training		No certification
Supportive supervision	Establish appropriate supervisor – CHW ratios		Shortage of supervisory cadres
	Train supervisors		
	Coach and mentor CHWs		Supervision not always supportive
	Use of observation of service delivery, performance data and community feedback		Community feedback not included
	Prioritise improving quality of supervision		Part of national strategy
Remuneration	Remunerate practising CHW with a financial package commensurate with job demands, complexity, number of hours, training and roles		CHWs remunerated, but package considered low. MPHV given performance-based incentives
Contracting Agreements	For paid CHWs provide written agreements specifying roles, responsibilities, working conditions, remuneration and workers' rights.		Scope of work provided, but not clear
Career Ladder	Offer career ladder to practising CHWs		Very few supervisory positions,
	Further education and career development linked to selection criteria, duration and contents of pre-service education, duration of service and performance review		No career pathway

Policy area	WHO recommendation	Fulfilment	Remarks
Target population size	Expected workload		Defined target population, but high workload
	Frequency of contacts		
	Local geography		Not considered
	Nature and time requirements of the services provided		FWAs and HAs spend half of their time in facility and only half in community
Collection and use of data	CHWs document the services they provide		
	CHWs collect, collate and use health data on routine activities		
	Train CHWs and provide feedback on performance based on data		
	Minimize reporting burden, harmonize requirements		High burden, no harmonization
Type of CHWs	Adopt service delivery models comprising CHWs with general tasks as part of integrated primary health care teams		
	CHWs with more selective/specific tasks to play a complementary role based on population health needs, cultural context and workforce configuration		
Community Engagement	Involve communities in selecting & monitoring CHWs & in priority setting of CHW activities		No community involvement
	Support to community-based structures		
	Engage relevant community representatives in decision making, planning, budgeting & problem-solving		
Mobilization of Community Resources	CHWs to identify priority health and social problems and action plans		
	Community needs and develop required responses		
	CHWs mobilise and coordinate local resources		
	CHWs to facilitate community participation and links to health facilities.		
Availability of supplies	Ensure CHWs have adequate and quality-assured commodities and consumables through the integration in overall health supply chain;		
	Adequate reporting, supervision, management, training, and mHealth to support supply chain functions		

included in this.

Private sector involvement in Community Health Worker programmes

The for-profit private sector had grown tremendously in the country in recent years. However, this sector is unorganized and largely unregulated. It does not provide any preventive and /or promotive services, focusing on curative services. The not-for-profit private sector, such as NGOs run their own CHW programmes.

Financing for Community Health Worker programmes

Financing for the government community-based programmes comes largely from domestic resources, with development partners providing funding for the overall health sector through the Health, Population and Nutrition Sector Programme 2017-2020 (HPNSP). Government financing for the CBHC programme and the CCs almost doubled between 2012.
The recruitment of additional CHWs to fill existing CHW vacancies and address shortages in the community clinics will need additional finances.

Prioritized measures to optimize the contribution of Community Health Workers to respond to post-Astana requirements and Primary Health Care strengthening

This section identifies measures that could be prioritized to optimize the contribution of CHWs to Primary Health Care and help the country meet Post Astana requirements. The section is organised into two sub-sections – policy support measures and system support measures.

Policy support measures

While Bangladesh has not articulated any specific post Astana commitments, its health policies and strategies are focused on achieving UHC and the SDGs. The optimization, harmonization and re-envisioning of CHW programmes and the role CHWs can play in achieving these goals are a key focuses of ongoing health policy discourse at the highest level and is articulated in the recently developed National Strategy for Community

Health Workers.

- **Harmonization at policy and programme level:** There is an urgent need to harmonize the existing CHW workforce especially at policy level. This includes the harmonization of the different CHW cadres across government and NGO programmes. Mapping the different CHWs and their roles and responsibilities in service provision would be useful and would help identify the areas covered and the gaps that need to be addressed. Promoting communication and coordination between the FWA and the HA themselves and institutionalising the collaborative relationships that have been built between these cadres will improve functional integrations and harmonisation. Towards this, the National Strategy for Community Health Workers recommends the creation of uniform geographic catchment areas for the different CHW programmes and teaming up male and female CHWs cadres, so that CHWs working in the same area can provide complementary and integrated services.

- **Recognition for CHW contributions:** Including CHW cadres in human resources for health plans and budgets will recognise and enhance the potential contributions of CHW programmes to the overall health system and primary health care in particular. Collaborative and collective action is needed to assess the health system and the health workforce as a whole, from the tertiary to the community level, and to create a more functional health system at all levels that responds to the needs of the population and to achieve UHC.

- **Strengthening comprehensive primary health care:** In order to achieve the SDGs, the government needs to re-envision the health system to create a comprehensive primary health system. Such re-envisioning would focus on an essential services package and the human resources required to deliver such a package, rather than organising the health system and the health workforce around specific diseases or programmes.

- **Addressing diverse and differential needs:** A one-size-fits-all policy approach is not appropriate for Bangladesh, given its geographical, contextual and cultural diversity. In some areas where there are geographical constraints and cultural and social barriers to accessing and utilising facility-based services, a continued focus on domiciliary care will be required. In others where access and utilization are better, strengthening facility-based care would be more appropriate.

However, the provision of community-based health services across the country remains critical, especially for promotive and preventive services, and to safeguard the gains made in improving access and health seeking behaviour and to ensure that no one is left behind.

- **Establish urban health systems:** Reaching all populations with community health programmes will require a focus on establishing urban health structures and services and ensuring the availability and deployment of CHWs with the appropriate skills mix to these areas.

- **Coordination with NGO programmes:** NGOs and development partners should support evidence based community based programme that are aligned and integrated with government CHW programmes. Innovative, high impact, quality maternal and newborn health interventions would reach populations in the hard to reach areas and lead to improvements in MNH outcomes over the medium to long term.

- **Ensure adequate financial commitment and expenditures:** Ongoing initiatives, such as the introduction of MPHVs, require long term commitment and investment. This level of commitment will also be required to mobilise and invest the necessary financial and human resources to implement the National Strategy for CHWs over the long term.

- **Strengthen political commitment to address gaps:** There is a need to acknowledge the weaknesses in the current PHC system, especially around governance, efficiency, accountability, and then make the necessary political commitment to reform the system and address these constraints.

System support improvements to optimise Community Health Worker cadres

- **Optimizing CHW workload:** One area that needs immediate attention is the current CHW workload and the need to mitigate the effect this is having on effective coverage and the quality of services. In order to reduce the burden on CHWs, action on a number of areas are required, including addressing the high level of CHW vacancies, revisiting the mandated target populations that CHWs are expected to cover and using the MPHVs to increase coverage. The MPHV cadre, currently being piloted in 19 sub-districts, could be scaled up. The 2019 National Strategy for Community Health Workers, based on the projected increase in population and revised norms for household coverage (500 HH/CHW), recommends that an estimated 124,000 CHWs will be needed by 2030.

- **Strengthen supportive supervision:** Measures to improve supervision, including appropriate supervisor-supervisee ratios, adequate training for supervisors, and the use of observation, performance data and community feedback are needed to strengthen supportive supervision. The National Strategy also spells out a clearer

supervisory structure for CHWs.

- **Strengthen community engagement and ownership:** Stronger community engagement would serve to strengthen local accountability systems with the use of community representatives to monitor service provision and CHW performance. Given the importance of community engagement, the expectation for clinic time versus time in the community for FWAs and HAs needs to be reviewed. Greater community participation in the selection of CHWs, involvement in priority setting for CHW activities, the monitoring of CHWs, and in planning and budgetary processes would also be critical.

- **Improve accountability:** Accountability was identified as a key area affecting CHW performance, and while community-based mechanisms could lead to improvements in this area, lack of accountability is also a larger organizational culture issue, and needs to be tackled through interventions at multiple levels. Improving management, monitoring and supervision, as well as recognising and rewarding good performance are some of the suggested interventions.

- **Harmonizing information systems:** The lack of coordination between the multiple information systems used by the different CHW cadres and the resultant double counting and duplication of data is another challenge. The development of a system where each woman/client is given a unique ID is a way to more effectively track individual clients and harmonise the data collected.

Making the Community Health Worker programmes gender transformative

Aspects of the CHW programme in Bangladesh along the WHO gender responsiveness scale.

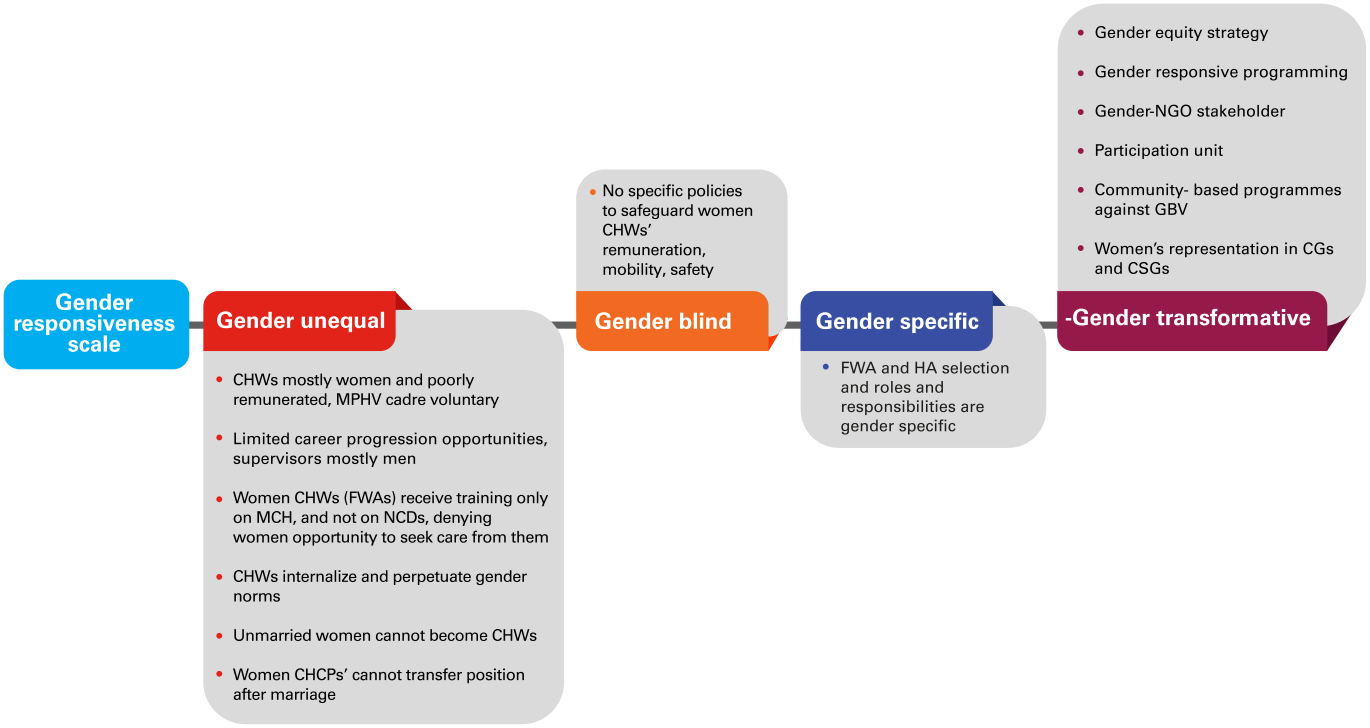


Figure 4: Gender responsiveness of the Community Health Worker programmes

A few key prioritized measures to improve gender responsiveness of the CHW programme include the following:

- **Integration of gender into all programmes:** While gender figures at a macro level in policy documents, it needs to be further integrated into programmes, spelt out in operational plans, with a gender focus incorporated into each stage of the project cycle, and gender specific indicators developed to monitor outputs and outcomes, and evaluate effectiveness and impact.
- **Gender training for CHWs:** Given the key role they play in PHC strengthening and their acceptance and position within the community, CHWs need to be given appropriate gender training to enable them address gender and social inclusion issues in their communities and promote equal access to all services for all individuals, irrespective of factors such as gender, location, ethnicity, disability or age.

- **Ensure health and safety:** Laws and policies that

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protect women who are working as CHWs are of paramount importance. Workplace safety is not very evident in the policies, but safety concerns are often used to underestimate what women can do. Ensuring safety of this cadre is important for realizing universal health coverage and supporting female empowerment. Sexual harassment policies should be developed and implemented.

- **Consider gender pay gap and equitable renumeration:** By paying female CHWs a rate that is not deemed 'acceptable' for men, CHW programmes are further perpetuating the inequalities that exist. Women's unpaid caring work needs to be formally recognized and valued to break the harmful gender norms that assume women are easier and cheaper to hire.

- **Provide CHWs with career progression opportunities:** Women and men have competing gendered responsibilities which often affects their ability to take up training opportunities. Policies need to consider how gendered responsibilities may make it difficult for women to relocate, for e.g. childcare and patrilocality, which affects their career trajectory. Career development opportunities need to be built into the system of CHW programming to encourage women to progress into higher levels of the health system and leadership positions if they so desire, and to provide the opportunity for women to input into health systems policy development.

- **Representation in leadership positions and roles:** Male and female CHWs are leaders within their own community. However, female CHWs and generally, women are less represented in leadership positions. Affirmative action to address this is needed. Giving CHWs a platform to input into policy development, including HR reforms and HR planning processes, would not only contribute to their empowerment, but also promote their role as agents of social change.

- **Ensure gendered needs of women are considered:** Workplace policies need to be put in place that support women in balancing paid employment and the domestic roles that disproportionately fall upon their shoulders. Recommendations that only married women can be CHWs reinforce normative gendered roles. In addition, measures like maternity leave and sickness pay can assist female CHWs in remaining in employment.

- **Gender-sensitive health data:** Health management information systems can identify and highlight the gendered dimensions of health outcomes. Gender-sensitive HR data should be collected and analysed. Health information systems should ensure the rapid collection, collation, analysis and use of these data to address inequities related to gender, social inclusion and disability.

Conclusions

Bangladesh has a large network of CHWs under both government and NGO programmes, and a large number of Community Clinics providing community-based primary health care through these CHWs. In order to strengthen CHW programmes in the country, there is a need to harmonize CHW programmes across different cadres, across government and NGO programmes, and across different levels of the health system. In order to achieve UHC and the post-Astana commitments and provide Comprehensive Primary Health Care (CPHC), CHW programmes have a key role in improving the provision and take up of quality RMNCAH services, especially among unreached and marginalised populations, in both rural and urban areas.

While the country has taken proactive steps in drafting a National Strategy for CHWs, sustained commitment and resources will be required to implement it over the long term.

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Policy brief for Bangladesh

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