



GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

**BANGLADESH NATIONAL STRATEGY
FOR
COMMUNITY HEALTH WORKERS**

(A complimentary document of Bangladesh Health Workforce Strategy 2015)

Ministry of Health and Family Welfare

July 2019

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List of Acronyms

AHI	Assistant Health Inspector
BHW	Basic Health Worker
BNHWS	Bangladesh National Health Workforce Strategy
CC	Community Clinic
CD	Communicable disease
CG	Community Group
CHCP	Community Health Care Provider
CHW	Community Health Worker
C-IMCI	Community Integrated Management of Childhood Illness
CMH	Combined Military Hospital
CS	Civil Surgeon
DD	Deputy Director
DH	District Hospital
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DM	Diabetes Mellitus
EPI	Expanded Program on Immunization
ESP	Essential Services Package
FP	Family Planning
FPI	Family Planning Inspector
FW	Field Worker
FWA	Family Welfare Assistant
FY	Fiscal Year
GAP	Good Agricultural Practices
GHP	Good Hygienic Practices
GM	Growth Monitoring
GMP	Good Manufacturing Practices
HA	Health Assistant
HTN	Hypertension
HI	Health Inspector
HNP	Health, Nutrition and Population
HRD	Human Resource Development
HRM	Human Resource Management
ICHW	Integrated Community Health Worker
MCH	Maternal and Child Health
MCWC	Maternal and Child Welfare Center
MH	Maternal Health
MHM	Menstrual Hygiene Management
MOHFW	Ministry of Health and Family Welfare
NCD	Non-communicable Disease
NGO	Nongovernmental Organization
OGTT	Oral Glucose Tolerance Test
PHC	Primary Health Care
PW	Pregnant Women
SACMO	Sub-assistant Community Medical Officers
SDG	Sustainable Development Goal
UHC	Universal Health Coverage
UHC	Upazila Health Complex
UH&FPO	Upazila Health and Family Planning Officer
UH&FWC	Union Health and Family Welfare Center
UFPO	Upazila Family Planning Officer
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Forward

Acknowledgments

1 Introduction

In 1978, health experts and world leaders gathered in Almaty, Kazakhstan, towards committing to health for all. Endorsed at that conference, the declaration formed the foundation for the last 40 years of global primary health care efforts.

The Global Conference on Primary Health Care (PHC) in Astana, Kazakhstan in October 2018 endorsed a new declaration emphasizing the critical role of primary health care around the world. The declaration aims to refocus efforts on primary health care to ensure that everyone everywhere is able to enjoy the highest possible attainable standard of health. The PHC approach is foundational to achieving shared global goals in Universal Health Coverage (UHC) and the health-related Sustainable Development Goals (SDGs). The new declaration has renewed political commitment to primary health care from Governments, non-governmental organizations, professional organizations, academia and global health and development organizations.

The 2015 National Health Policy of Bangladesh (draft) reiterates assurance of universal availability of free, comprehensive primary health care services, as an entitlement, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable and non-communicable diseases in the population.

The PHC model emphasizes Community Health workers (CHW) as fore front workforce to bring about changes through community health programs to national level. In 1978 Declaration of Alma –Ata and subsequently in the 2018 Astana declaration recognized CHWs as a vital component of primary health care and the countries engaged CHWs at different health care actions at community level. In 2018 World Health Organization (WHO) released the CHW engagement guideline to address the immediate and pressing needs of the health care in the context of evolving health system. The WHO Global Strategy on Human Resources for Health: Workforce 2030 (resolution WHA 69.19 (2016)) presents a range of policy options for Member States to maximize benefits from health workforce investments. The Global Strategy acknowledges that community health workers are effective in the delivery of a range of preventive, promotive and curative health services, and that they can contribute to reducing inequities in access to care (annex-1).

2 Background

The health system in Bangladesh can be characterized as “pluralistic” in that community-level and facility-based services are delivered by the government, non-governmental organizations (NGOs), and private for-profit providers. This pluralism is thought to have contributed to Bangladesh’s successes in improving health outcomes. This system has achieved high coverage of several key interventions, which is illustrated by service utilization data. Each part of the system has largely distinct sources of financing: private providers are mostly financed by household out-of-pocket payments, NGO providers are supported by international funding as well as out-of-pocket payments, and government services depend on the government budget, including on-budget international financing. Nonetheless, the bulk of government financing and attention are focused on the government service delivery system. In addition this system is perhaps the most important instrument for the government to work towards its development goals in the Health, Nutrition and Population (HPN) sector, encompassing around 225,000 staff, 18,000 primary health care facilities, 481 Upazila facilities offering inpatient care, and 130 secondary and tertiary hospitals across the country.

The entities within the Ministry of Health and Family Welfare (MOHFW) include among others the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP).

Service delivery is managed by both DGHS and DGFP, operating structure at different levels. The lowest level facility is Community Clinic (CC), each for 6,000 population that serve as the first point of contact for PHC services, including immunization, family planning (FP) services, and health education. Services are delivered by domiciliary workers of both the departments. Health Assistants (HA) provides domiciliary services at the ward or village level, supervised by Assistant Health Inspector (AHI) from union level and Health Inspector (HI) from upazila level (DGHS) and Family Welfare Assistants (FWA) provides domiciliary services/satellite clinics at the ward or village level, supervised by Family Planning Inspector (FPI) from union level (DGFP). The domiciliary staffs of DGHS and DGFP along with the community healthcare providers (CHCPs) are responsible for providing services through the CCs.

At union level, facility exist from both health and family planning departments. Three kinds of health facilities provide outpatient care: rural health centers, union sub-centers, and Union Health and Family Welfare Centers (UHFWCs) for every 24,000-30,000 population. Each union-level health facility is staffed with a graduate physician among other staff. All union facilities have sub-assistant community medical officers to provide health services to the people. The family planning department through UHFWC's provides MCH and FP services staffed with paramedics.

At the sub-district level the health department provides preventive, promotive and curative services through Upazila health complexes (UHCs) for every 250,000 population, usually with in-patient capacity of 31 to 50 beds. Some of these facilities also provide secondary care including comprehensive emergency obstetrical care. Family planning department also has separate maternal and child health (MCH) unit at sub-district level physically located mostly in the same building of UHC.

At district level for every 2,500,000 population, health department provides secondary care through district/general hospitals of varied bed strengths (100-250). Some districts also have medical colleges with hospitals providing tertiary care along with primary and secondary. At some districts there are other facilities from health department facilities such as school health clinics, chest clinics/chest hospitals, leprosy hospitals and infectious diseases hospitals. The FP department operates 10-20 beds Maternal and Child Welfare Center (MCWC) at districts which along with FP services also provide emergency obstetrical care services.

Tertiary level services are provided by the health department through teaching hospitals and specialized hospitals based in divisional headquarters. At the national level, there are institutions for pre-service education as well as for postgraduate medical education/training along with specialized treatment of patients. Most of the specialized institutes (cardiovascular, traumatology, kidney, mental health, cancer, neuroscience, ear-nose-throat, ophthalmology, chest diseases etc.) that provide tertiary care (along with secondary and primary) are located at Dhaka, the capital city and operate under health department. There are two 100 beds maternal and child health hospitals and infertility clinic operated by the family planning department and are at Dhaka.

Management structures of the above mentioned service delivery mechanisms of health and family planning departments are also separate. Upazila Health and Family Planning Officer (UH&FPO) is the manager at the sub-district from health department and manage hospital, union level facility, community clinics and domiciliary services along with all preventive and promotive health interventions. Upazila Family Planning Officer (UFPO) and Medical Officer (maternal child health-family planning) jointly manages sub-district level MCH unit and union level facilities along with domiciliary services. At the district level Civil Surgeon (district medical Chief) is the representative of health department and manages facilities at district and below including sub-districts. The district hospital is managed by superintendent of varied grade depending upon the bed strength of the hospital and in some places Civil Surgeon holds the ex-officio position of the superintendent. Deputy Director is the district manager from the FP department and manages facilities (MCWC etc.) and other

operations with the district. Both the departments have Divisional Director at divisional level to supervise, monitor facilities and programs within the division. Medical College has separate Principal. Directors manage Medical College Hospitals and specialized institutions.

MOHFW regarded Community Clinics as the first-step for delivery of 'Essential Services Package'. A standard and quality integrated health and family welfare services is being provided free of cost from these centres (which is treated as one-stop service centre) according to the demand/need of the rural people. It is envisaged that even after the Community Clinics are in operation, domiciliary services would continue on a temporary basis. Domiciliary services would also be provided at regular intervals to those living at distant places. Apart from this, delivery of services for some special group of clients (e.g., post-natal cases, advanced pregnancy, dropouts) through home visits would continue. After the Community Clinics are in full operation the existing satellite clinics and EPI outreach centres would be gradually phased out in a planned way.

Other public sectors providing services, mostly curative, for their own employees and in some instances for communities within the catchment area includes, CMH (Ministry of Defense), Police Hospitals (Ministry of Home Affairs), Railway Hospitals (Ministry of Railways), Jail Hospitals (Ministry of Home Affairs), Biman (Ministry of Civil Aviation) etc. PHC services in urban areas are provided by the MOLGRD&C.

3 CHW as Key Health Workforce

3.1. Community Health Workers

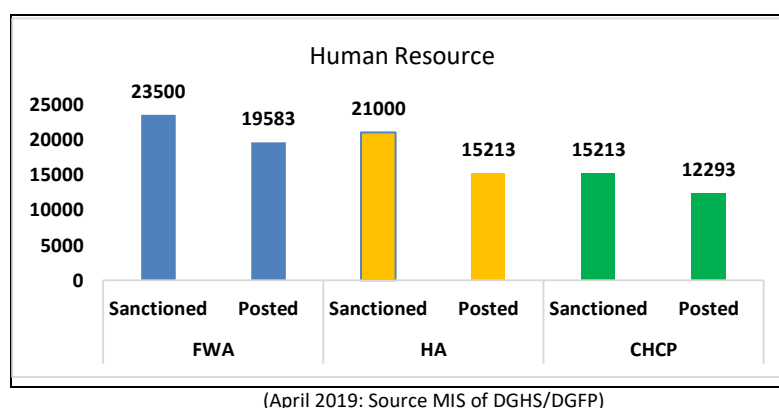
The community terminal of the health care organization of Bangladesh is a large fleet of community health workers (CHW) who are mandated to provide a range of domiciliary and community-based services that includes promotion, education, and screening, provision of essential care and commodities, and data collection.

The 4th meeting of the National Steering Committee on Community Health, MOHFW approved the definition of CHW (annex-2) as follows: ***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 nonperformance of these services.***

Bangladesh has more than 185,000 CHWs, with approximately 70,000 employed by the GOB and the remainder by NGOs. CHWs have diverse scopes of work and many have been involved with pioneering innovations that have subsequently been scaled up. GOB CHWs include Family Welfare Assistants (FWAs), who provide community-based family planning services under the DGFP; Health Assistants (HAs), who provide immunization and other primary health care services under the DGHS; and Community Health Care Providers (CHCPs), who are managed under a special project to provide a range of preventive and primary curative care at CCs. Currently there is 19,583 FWAs working against sanctioned post of 23,500. These FWAs are being supervised by 3,965 FPIs against a sanctioned post of 4,500. A total number of 15,213 HAs is currently working against the sanctioned post of 21,000. 12,293 CHCP is currently working against the sanctioned post of 15,213. The first two categories of GOB CHWs operate at household and outreach levels, and while the third is located at the lowest level of health care facilities—the CCs. Under a recent government directive, FWAs and HAs are also working at CCs for 3 days a week. Under the Ministry of Health and Family Welfare (MOH&FW), there

are approximately 3.8 CHWs per 10,000 population¹. The profiles of CHWs supported by NGOs vary widely, ranging from paid full-time workers (e.g., Shasthya Karmi of BRAC) to volunteers who sell health commodities (e.g., Shasthya Shebika of BRAC), to NGO-supported private Community Skilled Birth Attendants (pCSBAs), and depot holders and volunteers who receive no monetary benefits (e.g., Community Volunteers of the MaMoni project).

Figure 1: Existing Strength of CHWs



Bangladesh Government developed Health Workforce Strategy (BNHWS) in 2015 to support achieving health goal of the country. The strategy provides a framework, which includes strategic interventions and supportive actions in order to address priority health workforce management issues and challenges. It is focused on five key areas: health workforce planning, capacity building, deployment, managing high performance and information system. This strategy recognized the engagement of CHWs in the definition of Health Workforce in the beginning of the document, which set a tone to elaborate the scope and engagement in details. Bangladesh government planned to revitalize Community Clinics (initially launched in 1999) through a project “Revitalization of Community Health Care Initiatives in Bangladesh” (RCHCIB) as priority intervention from 2009-2014. This project was mainstreamed in the third health sector program’s operational plan titled “Community Based Health Care” (CBHC). However, the translation of the BHWS into action poses a challenge in recruitment, deployment and retention (equitable distribution) of adequate number of CHWs.

Bangladesh has it enormous learning to engage CHWs. Stellar successes of at least three national programs—Control of Diarrheal Disease (CDD), Expanded Program on Immunization (EPI) and Family Planning (FP)—is widely to effective CHW components with extensive community penetration and engagement. Historically in public sector of Bangladesh, CHWs were employed with a certain task, which evolved over years with substantial additions of new tasks. On the other hand, a number of CHWs involved in community health care from NGOs/Private sector where the coordination/collaboration with government system is absent in major cases. Realizing the potential health system contributions of CHWs requires including them in human resources for health planning and budgeting.

3.2. Auxiliary Community Health Workers

The Directorate of Health has recently initiated a program to engage Multi-Purpose Health Volunteer (auxiliary CHWs) within the catchment area of each CC. MHV are volunteers from the same community

¹ Improving CHW Program Performance through Harmonization and Community Engagement to Sustain Effective Coverage at Scale: Project Proposal; Save the Children, 2018

who support the CC in disease prevention, improvement of health standards and rehabilitation and in any emergencies. MHV receives short training and work as i) community motivator ii) change maker iii) linker between community and health centre, iv) planner and v) friend and fact finder. In general five MHV has been planned to be engaged as auxiliary volunteer for each CC. They receive performance based remuneration and are accountable to the community.

The Directorate of Family Planning also initiated a program to engage Paid Peer Volunteers (PPV) (auxiliary CHWs) on ward basis to cover the gap due to shortage of FWAs as an interim arrangement (already 3,500 has been recruited). PPVs are passed Secondary School Certificate (SSC) exam and trained to provide delivery, nutrition and FP services as well as promoting delaying marriage for adolescent health care. They work for 22 days a month and receive a remuneration of Tk.500.00/day for HTR areas and Tk. 400/day for plain lands.

4 CHW Strategy Development

Considering the current need and upcoming priority (in context of UHC), MOHFW felt the need to focus on the development of a CHW strategy for Bangladesh, in line with the BNHWS 2015 as a supplementary document and NOT as a new policy document. Rather the CHW strategy would be a collation of discussed solutions and directions to address previously identified system challenges.

4.1 Process

Save the Children, Bangladesh with the support from USAID is working with CHWs through its Improving Community Health Workers' Project where a number of issues have been identified (service & system) through rigorous consultation with UNICEF, UNFPA, WHO and other stakeholders. UNICEF is a technical partner of this project. A national Steering Committee (annex-3) headed by the Additional Secretary, HRM at MOHFW oversee the major project deliverables. The ICHW project supported development of CHWs' definition in line with WHO's guideline, CHW's profile and harmonized job description (JD) along with capacity building plan in context of the need.

The 5th meeting of the National Steering Committee on Community Health in its meeting of 26 February, 2019 gave the following directives:

- ☐ National CHW strategy will have three major domains which are i). Selection, education and certification, ii). Management and supervision and Integration into and iii). support by health system and communities
- ☐ The new WHO guideline for CHW will be considered while developing the National CHW strategy
- ☐ CHW document will be a supplement document of National Health Workforce Strategy 2015 as an annex.
- ☐ Save the Children, Bangladesh will provide technical and secretarial support in developing a draft of the National Strategy for CHWs in Bangladesh in collaboration with Line Director, CBHC, DGHS under the guidance of LD-HRD, MOHFW.
- ☐ HRD will share the draft of the National Strategy for endorsement of National Steering Committee on Community Health, MOHFW
- ☐ The Position paper for the National CHW strategy is approved

Minutes of the 5th meeting of the National Steering Committee on Community Health and the approved position paper are in annex-4.

By working with MOHFW through CBHC Program, the project facilitated the strategy development process. A national Consultant worked with CBHC and other stakeholders throughout the strategy

development process. As first step, a stakeholder's consultation meeting steered by Line Director, CBHC formed three working groups to work on the process of development. The groups hold several rounds of meetings and worked on three major domains, which include i). **Selection, education, certification, recruitment and deployment**, ii). **Management and supervision**; and iii). **Support by health system and communities** (ToR and list of working group members is in annex-5). A guideline was prepared and the groups after several meetings prepared the draft CWH strategy. Subsequently the draft CHW strategy was shared at five divisional level workshops at Barishal, Rangpur, Khulna, Shylhet and Chottogram. Divisional, district, upazila, union and field level health and family planning workers as well as LG officials (Divisional Directors (Health and Family Planning), Civil Surgeons, Deputy Director's Family Planning, Deputy Director's Local Government, UH&FPOs, UFPOs, MOMCHs, Health Assistants, Family Welfare Assistants, Assistant Health Inspectors, Family Planning Inspectors, Community Health Care Providers, Health Inspectors, NGO representatives and UN Partners) attended the workshops. The inputs provided to the draft strategy by the participants were duly incorporated. Further one-to-one discussion was carried out with Dr. Selina Ahmed (DfID), Dr. Edwin Ceniza Salvador and his team (WHO), Dr. Kazi Mustafa Sarwar, Director General of Family Planning and DG-HS and the draft final version was prepared. The draft final version was again shared with a broader audience through a national level workshop chaired by Mr. Md. Habibur Rahman Khan, Additional Secretary, Admin and LD (HRD), HSD, MOHFW and attended among others by Mr. Asadul Islam, Secretary, HSD, MOHFW, Prof. Abul Kalam Azad, DG-HS, Mr. Kazi A.K.M. Mohiul Islam, DG-FP, Prof. Dr. Abul Kashem Khan, LD, CBHC, DGHS, senior MOHFW officials, divisional and district level managers from both DGHS and DGFP, Development and NGO partners and professional organizations. Incorporating all the suggestions and inputs from the stemmed audience, the final report has been prepared. Schematic diagram reflecting the strategy development process, which took almost seven months, is at annex - 6.

5 Community Health Worker's Strategy

5.1 Mission²

Ensure quality community health promotion and essential services for all by developing and deploying skilled, motivated and responsive community health workers in adequate numbers and available equitably across the country.

5.2 Vision

Competent community health workers deployed for the health and wellbeing of the people of Bangladesh.

5.3 Goal

Improved health promotion and essential service delivery through an adequately trained and motivated Community Health Workers for achieving SDGs in Bangladesh

² CHW document will be a supplement document of Bangladesh National Health Workforce Strategy 2015 as an annex. Hence the mission, vision and goal statement follows the original mission, vision and goal statement of BNHWS-2015 emphasizing the community component only.

5.4 Strategic Objectives

- 1) To provide policy guidance and framework for selection, education, certification, recruitment and deployment of CHWs
- 2) To strengthen management and supervision structure and ensure system in place for CHWs
- 3) To establish systems for integration into and support by health systems and communities

5.5 Outputs

SO 1: Provide policy guidance and framework for selection, education, certification, recruitment and deployment of CHWs

- Output 1.1: Comprehensive framework developed for selection, recruitment and deployment of CHWs
- Output 1.2: System developed and functioning for skill development, training, mentoring etc. (Pre-service and on-the-job) and certification³ of CHWs.

SO 2: Strengthen management and supervision structure and ensure system in place for CHWs

- Output 2.1: System developed for supervision and monitoring of CHWs
- Output 2.2: System established for provision of appropriate financial package/remuneration and contracting/appointment letter of CHWs

SO 3: Establish systems for integration into and support by health systems and communities

- Output 3.1: Systems established on integration and health system support for effective functioning of CHWs
- Output 3.2: Guideline developed on effective community engagement for improving CHW performance and utilization

5.6 Strategic Actions

Output 1.1: Comprehensive framework developed for selection, recruitment and deployment of CHWs

- 1.1.1. Define job-description of CHW in the broader context of health system aligning with approved country context of CHW definition
- 1.1.2. Develop selection guidelines for CHWs (with gender balance) and integrate in health workforce strategy
- 1.1.3. Project CHW requirement, deployment guidelines and integrate within human resources for health planning

Output 1.2: System developed and functioning for skill development training, mentoring etc. (Pre-service and on-the-job) and certification of CHWs

- 1.2.1. Identify skills required for CHW based on roles and responsibilities (as per job description)
- 1.2.2. Develop capacity building package for CHWs
- 1.2.3. Institutionalize certification of CHWs
- 1.2.4. Develop principles for harmonization of CHW roles across health system needs

Output 2.1: System developed for supervision and monitoring of CHWs

- 2.1.1. Strengthen management systems and strategies for CHWs
- 2.1.2. Develop functional linkage of CHWs with primary health care structures

³ Certification include accreditation or approval of CHWs who meet agreed standards

- 2.1.3. Formalize supervision and monitoring system along with performance evaluation and feedback
- 2.1.4. Institutionalize e-record keeping, e-reporting system and effective use of technologies for services provided by CHWs.

Output 2.2: System established for provision of appropriate financial package/remuneration and contracting/appointment letter of CHWs

- 2.2.1. Develop appropriate financial package commensurate with the job demands, complexity, training and roles of CHWs
- 2.2.2. Include financial resources for CHW programs in health system resource planning
- 2.2.3. Identify provision of conditions specifying roles, responsibilities, working environment, remuneration.
- 2.2.4. Retain and motivate CHWs by linking performance with opportunities

Output 3.1: Systems established on integration and health system support for effective functioning of CHWs

- 3.1.1. Identify potentials of CHWs to strengthen primary health care and relevant services.
- 3.1.2. Identify service delivery models for specific emerging problems services like DM, HTN, Obesity, safe food etc. to be delivered by CHWs
- 3.1.3. Identify complementary role for CHW with more selective services

Output 3.2: Guideline developed on effective community engagement for improving CHW performance and utilization

- 3.2.1. Develop effective local government support plan with community engagement approaches
- 3.2.2. Develop functional GO-NGO coordination and public private partnership (PPP) mechanism
- 3.2.3. Identify community role and responsibilities for promotion and demand generation of services, service management, resource mobilization and accountability of service providers and users.
- 3.2.4. Develop and utilize client based tools for supervision, monitoring, accountability and community engagement.

Logframe is in annex-7.

6 Community Health Worker's Strategy: Strategic Actions

6.1 Comprehensive framework developed for selection, recruitment and deployment of CHWs

6.1.1 Job-description of CHW in the broader context of health system aligning with approved country context of CHW definition

According to the approved definition of CHWs, task/activities for CHWs includes promotive, preventive, limited curative, rehabilitative, palliative and referral services in relation to maternal, neonatal, child, adolescent health, family planning, nutrition, communicable and non-communicable disease to the community. CHWs needs to be oriented on certain basic principles to boost up their commitment and empowered to serve the communities which should be well-defined and specific. Some major functions are outlined below (not exhaustive):

- i). **Planning & Implementation:** Appropriate distribution of activities narrated in the JD, prepare advance work plan, perform activities according to the work plan
- ii). **Technical:** Support effective coverage of selected interventions (Reproductive, Maternal, Neonatal, Child, Adolescent, FP, Nutrition, Non-Communicable Diseases (NCDs) and Communicable Diseases (CDs) including menstrual hygiene and conduction of safe delivery) and maintain quality of care. Some specific and common tasks for all types of CHWs including referral system need to be incorporated.
- iii). **Limited Curative Care:** Provide screening (Growth Monitoring (GMP), Severe Acute Malnutrition (SAM), Diabetes Mellitus (DM). Hypertension (HTN)) and referral services including provision of first aid.
- iv). **Counseling:** Counseling of in-laws, family members, pregnant women and care givers by using government approved existing communication materials to improve the knowledge and demand creation on RMNCAHFP and nutrition, NCD/CD services and improving WASH situation and environmental health.
- v). **Communication:** Detail communication plan with Community Group (CG)/Community Support Group (CSG)/ Community leader/ UP/ Religious leader/NGO and Community Support Organizations (CSO) to ensure community awareness, demand creation for services and effective program implementation of Reproductive, Maternal, Neonatal, Child, Adolescent, FP, Nutrition and WASH.
- vi). **Record keeping & Reporting:** Collection of information according to supplied format (Aligned with DHIS2), ensure monthly completeness and timeliness of reporting, individual tracking of pregnant women, newborn and under five children and gradual shifting to e- recording and reporting
- vii). **Adaptability:** Engaging with community as member of the community not only on health and family planning related activities but also relate nutrition, WASH and on social development activities, social safety net, during disaster and humanitarian aspects of the community.
- viii). **Coordination:** Working closely and establish effective and functional cooperation and networking with relevant stakeholders – GO including Local Government Institutes (LGI), NGO and private sectors working on health, FP, nutrition and WASH for harmonization and effective coordination.
- ix). **Mentoring:** Provide mentoring, coaching and supervision of all Volunteers working in the same community

6.1.2 Selection guidelines for CHWs (with gender balance) and integrate in health workforce strategy

6.1.2.1 Selection Criteria

Selection of the most appropriate people as CHWs is crucial to the success of a community health intervention. CHWs should be selected based on the below criteria:

- CHWs minimum educational levels should be passed H.S.C (Higher Secondary Certificate) exam or equivalent (Educational qualification may be relaxed upto S.S.C. exam or equivalent in case of female candidate living in remote and hard to reach areas i.e., hill tracts region, coastal area, islands and areas with ethnic diversity).
- Must be from the same community and accepted by communities. Acceptance from communities means community members trust and respect them and feel a sense of ownership over the program. The community's acceptance of CHWs and their sense that the CHW program is locally appropriate and "owned" is associated with increased CHW retention, motivation, performance, accountability and support.
- Employing married girls from a community is encouraged for retention and continuation of services.

- CHW should be physically fit having tested good IQ, basic knowledge on health, FP and good communication skills. Cognitive abilities, integrity, motivation, interpersonal skills, and demonstrated commitment to community service should be considered in the selection process.
- Preference should be given for Information Technology (IT) skilled person and for female

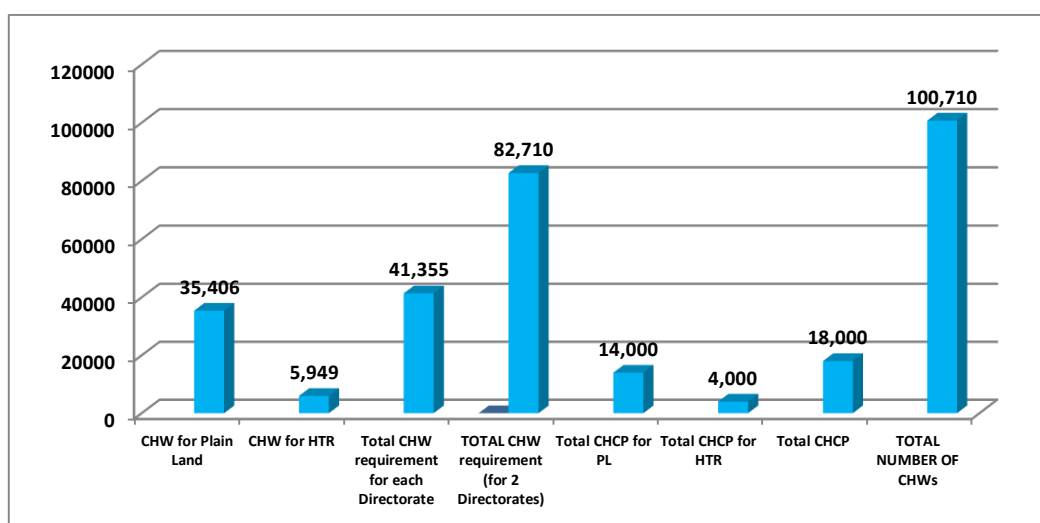
6.1.3 CHW projection, deployment guidelines and integration within human resources for health planning

Optimal population size for CHWs is ambiguous⁴. An excessive workload could result in decreased motivation and ultimately lower performance by CHWs, with the CHW–population ratio identified as an influence on CHW performance. Although some evidence suggests that small population coverage was preferable, however evidence also suggests that an additional workload could be integrated into existing CHW duties without significantly impacting performance. Furthermore, increasing the workload of CHWs was found to be cost-effective if coupled with sufficient support and supervision. Decisions about catchment area population should be based on a variety of considerations: frequency of contact required; nature of the services provided; expected weekly time commitment from the CHW; and local geography (including proximity of households), weather and transport availability. Estimate of population projection till 2030 is in annex-8.

6.1.3.1 Scenario 1: Requirement of Rural CHWs based on Ward

According to BBS, total Upazilla of the country is 481 with 4595 unions. Out of those, EPI of DGHS earmarks 661 unions that fall under category of hard to reach and 3934 unions under plain land. Estimating coverage of new ward (nine ward in each union) with 1 CHW/Ward/Directorate, a total number of 82,710 CHWs would be required by 2030 to achieve SDGs (41,355 HA from Health Directorate and 41,355 FWA from Family Planning Directorate). If the CC is considered constant (18,000 CC), the required CHCP by 2030 would be 18,000. Cumulating the **total required CHWs would be 100,710** (41,355 HA from Health Directorate, 41,355 FWA from FP Directorate and 18,000 CHCP).

Figure 2: CHW Projection – 2030 (Based on Ward): Scenario - 1

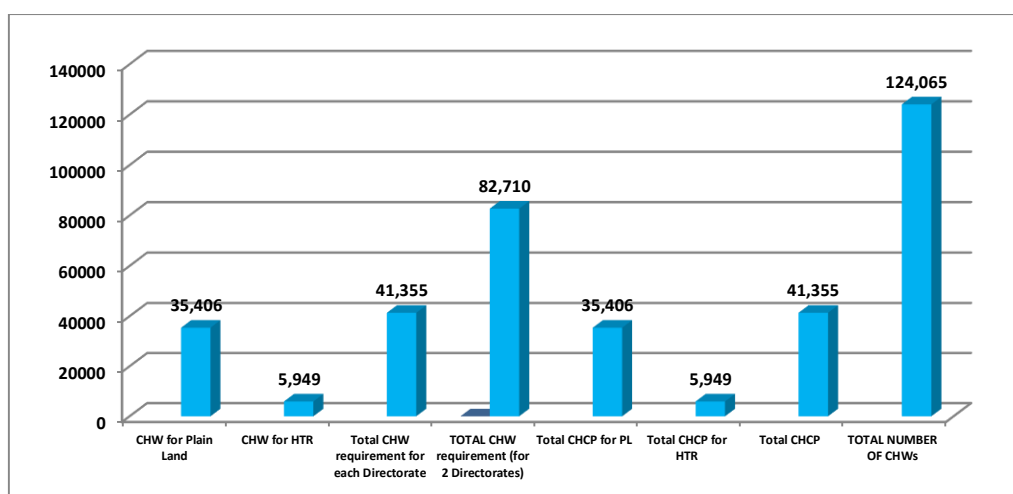


⁴ WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programs, ISBN 978-92-4-155036-9; © World Health Organization 2018

6.1.3.2 Scenario 2: Requirement of Rural CHWs based on Ward

Based on number of ward coverage estimates with 1 CHW/Ward/Directorate a total of 82,710 CHWs would be required by 2030 to achieve SDGs (41,355 HA from Health Directorate and 41,355 FWA from Family Planning Directorate). However, with increasing demand at community level for CCs, there might be plan to have 1 CC at each new ward. In such case the total number of CC would be 41,355 (35,406 for Plain Land and 5,945 for HTR areas) and the number of required CHCP needs to be 41,355). Cumulating the **total required CHWs would be 124,065** (41,355 HA from Health Directorate, 41,355 FWA from FP Directorate and 41,355 CHCP).

Figure 3: CHW Projection – 2030 (Based on Ward) - Scenario - 2



6.1.3.3 Phased Deployment

Recruitment of projected CHWs can be hired in three phases- short term (within two years), mid-term (within five years), and long term (by 2030). The short-term deployment will be considered for highly densely populated unions, mid-term deployment to be for densely populated union, and the long-term can be deployed for remaining unions.

6.1.3.4 Deployment Criteria

6.1.3.4.1 CHW: Household Coverage Approach

Based on coverage analysis, it is proposed that the deployment of CHWs should be based on population (household) size as below:

- a) Household visits:
 - 450 - 550 Household/one CHW for Plain Land
 - 200 - 250 Household/one CHW for Hard to Reach Areas and char areas⁵
- b) Fixed facility:
 - i). EPI Outreach Site/Satellite Clinics
 - The CHWs during household visits should also complete EPI Outreach and Satellite Clinic Sessions

⁵ According to EPI, hard to reach area is defined as Unions requiring 2 hours for a porter to transport vaccine from Upazila EPI store to the vaccine distribution point

- ii). Community Clinic:
 - 6000-8000 Population/one CHW for plain land
 - 4000 Population/one CHW for Hard to Reach Areas⁶

However, for an equity-advancing strategy a differential approach needs to be pursued. Example could be of Khulna division which doesn't require the same level of domiciliary services that will be needed for Sylhet division.

6.1.3.4.2 CHW: Ward Coverage Approach

Each ward (nine wards in each union) should have two CHWs – one from Health Directorate (HA) and the other from Family Planning Directorate (FWA). Both the CHWs in each ward should be given a demarcated geographical boundary to cover the proposed households. In identification of the earmarked area, following guidelines should be adhered:

- Crossing of rivers/canals/hoars/hills is not required
- From the same community

6.1.3.4.3 Community Clinic: Ward Coverage Approach

The other option could be one facility (Community Clinic) for each ward (nine wards) with 3 CHWs (one CHCP for CC and HA and FWA for household coverage).

6.1.3.4.4 CHWs responsible for households visits and fixed facilities

Each CHW should work 6 days a week and cover the followings:

- Fixed Facility (CC)
 - ☐ Community Clinic at village level and Community Clinic Corner at Union/Upazilla level will be considered as 1st line of contact for each client to receive PHC services. In case of Sadar Upazila, District Hospital would be considered as 1st line of contact for each client to receive PHC services. One Community Health Care Provider will be based at each Community Clinic/Community Clinic Corner and will provide services 6 days a week
 - ☐ One CHCP based at each Community Clinic/Community Clinic Corner (6days/week)
 - ☐ Two days/week (to be decided by the upazilla managers) HA/FWAs would work based in the Community Clinic within his/her working jurisdiction and provide services as stipulated in the job description⁷
- Household coverage (including EPI outreach/Satellite Clinic)
 - ☐ One HA, and
 - ☐ One FWA
 - ☐ Coverage includes all household and postnatal visits, drop outs and monthly visits of all pregnant mothers (the frequency can be more based on need).

A monthly meeting with all CHWs of GO (including MPHVs and PPVs) and NGO should be organized to prepare plan, analyze accomplishment and resolve problems/issues prevailing in CC catchment areas.

6.1.3.4.5 Supervisory personnel:

For three CHWs, there should be one direct supervisor. As each union will have nine CHWs, there should be three immediate supervisors. Similarly, for each three unions there should be one 2nd supervisor.

⁶ However, this figure may vary based on geographical barriers, population distribution to form villages, pocket populations etc.

⁷ For MOHFW CHWs only

For Health Directorate it translates to:

- 3 HAs to be supervised by 1 AHI
- 3 AHI to be supervised by 1 HI

For Family Planning Directorate it translates to:

- 3 FWAs to be supervised by 1 AFPI (new post)
- 3 AFPI to be supervised by 1 FPI

For CHCP it translates to:

- CHCP to be supervised by AHI/HI (would depend on the projected number of CHCPs)

6.1.3.5 CHWs of Non-Government Organizations

NGOs should follow the same guidelines as of MOHFWs CHWs. NGOs planning to deliver CHW program should also follow the same guiding principle linking with CC. Each ward (nine wards in each union) should have one CHW and be given a demarcated geographical boundary to cover the proposed households. In identification of the earmarked area, following guidelines should be adhered:

- Crossing of rivers/canals/hoars/hills is not required
- From the same community
- For hard to reach areas instead of wards CHWs should be deployed by households:
- 200 - 250 Household/one CHW for Hard to Reach Areas & Char area

A monthly meeting with all CHWs of GO (including MPHVs and PPVs) and NGO should be organized to prepare plan, analyze accomplishment and resolve problems/issues prevailing in CC catchment areas.

6.1.3.6 Urban CHWs

The urban health landscape is rapidly evolving in Bangladesh demanding clarity on how the health system should work in city corporations and municipalities. The urban health care scenario needs to better reflect changes in the operating environment, including increased rural-urban migration and shifts in the epidemiological and demographic profiles of urban areas. The community component of the urban primary health care is being catered mostly by the NGOs. For maximizing efficiency, long-term strategy for CHWs employed by different NGOs in urban area should consider:

- ☐ selection and deployment of CHWs should follow the MOHFW approved definition with harmonized job description
- ☐ creating effective interface between rural and urban health systems for CHWs including standardization and synchronization of the service delivery and reporting system
- ☐ using single competency module used by MOHFW for CHWs
- ☐ ensuring mandatory certification system for CHW

6.2 System developed and functioning for skill development training, mentoring etc. (Pre-service and on-the-job) and certification of CHWs

6.2.1 Skills requirement for CHW based on roles and responsibilities (as per job description)

Harmonized job description for CHWs emphasized on **quality and coordinated service delivery** aligned with UHC requires area allocation, task shift, skill development on ESP, harmonization among GO-NGOs, coordination with local government authorities, community engagement, supportive supervision and mentoring. The following competency domains are proposed in the curriculum for capacity development of CHWs:

A. Core areas:

- a) promotive and preventive services, aligned with ESP, including other priority primary health care services tailored to the community requirements;
- b) integration within the wider health care system in relation to the range of tasks to be performed in accordance with CHW role, including screening and referral, collaborative relation with other health workers, patient tracking, disease surveillance, monitoring and data collection, analysis and their use;
- c) social and environmental factors affecting health;
- d) gender based violence
- e) injury prevention and first aid
- f) skills related to confidentiality, communication, community engagement and mobilization;
- g) personal hygiene, infection prevention and safety

B. Additional areas

- a) diagnostic, limited curative care in alignment with planned agreed expected role(s) and applicable regulations on scope of practice;
- b) providing psychosocial support

6.2.2 Capacity building package for CHWs

6.2.2.1 Contents

Contents need to cover CHWs' overall knowledge enhancement on ESP delivery, communication skill and administrative job performance; facility management skills, planning and managing WASH services, infection prevention and waste management. Alongside the facilitation approach need to adapt the ways that will have impact not only CHWs knowledge and skill development but also expansion of professional attitude towards service delivery. Contents should include but not limited to the following areas:

6.2.2.2 Overall knowledge and skill enhancement

1. Country context & Community Situation
 - Maternal, Neonatal and Child Health, Nutrition status, Family Planning, Adolescent Reproductive Health, Water, Sanitation and Hygiene (WASH) and environmental health;
2. Health delivery structure
3. knowledge on services (Focus on service delivery including prevention and promotion)
 - Maternal, Neonatal, Child and Adolescent health
 - Reproductive health and Family Planning
 - Maternal, Child, Adolescent nutrition and nurturing care for young children,
 - WASH including food hygiene, personal and environmental hygiene
 - Communicable & Non-Communicable Diseases (CD-NCD), Public health
 - Rehabilitative service, Referrals services
4. Work Policies and Principles
5. Understanding about community-geography and norms
 - Community engagement and resource mobilization
 - Functions of different community platform (Union Education, Health and FP Standing Committee (UEHFPSC), Community Clinic Management Committee (CCMC), CG/CSG etc.) and integration of MPHV
 - Communication, Coordination and Relation Mapping
6. Job Descriptions
 - Existing Job descriptions
 - Harmonized Existing Job descriptions

- Role of Supervisors – Union/ Upazila/ District

6.2.2.3 Communication & Counseling Skill

Communication skill (IPC, Negotiated Counseling and Group session facilitation) & Social Mobilization, advocacy, awareness campaign Skill

6.2.2.4 Recording and Reporting Skill

- Skill on IT Device
- Data entry, compilation and Reporting

6.2.2.5 Attitude

- Community values, culture & practices
- Client Rights
- Service providers' motivation and attitudinal shifting towards health service

6.2.2.6 Other Skills

- Logistic Management
- Service Quality Improvement (Setting indicators such as service access, service utilization, service arrangement, etc.)

6.2.3 Certification of CHWs

A key component of quality health care delivery is CHW standards. This implies defining professional roles, scope of work, responsibilities and tasks, along with educational standards and minimum competency requirements for different health service positions. It is proposed that after successful completion of training the CHWs (both in public and NGO/private sector) are provided with a certification. The certification process should entail verifying and attesting that the CHWs have not only successfully completed their pre-service education, but have also demonstrated possessing the technical and soft skills required to practice according to their role. Certification provides a formal recognition awarded to those meeting predetermined standards. It is expected that certification may increase their motivation and sense of self-esteem. Certification can be used as part of admission criteria for further education as an evidence. CHWs in the NGO sector will only receive the certification after successful completion of the training/refresher's training package from the accredited enlisted institute (formal accreditation of institute to be provided by MOHFW). The certificate may be issued either by the recognized training institutes or anyone designated by MOHFW. In the short term NIPORT as National Training Institute with its Regional Training Centers may act as the focal training institute. However, in the longer term steps should be initiated to form a body/council responsible for providing certification to CHWs.

The Upazila and District Health/Family Planning Manager would only allocate areas and provide logistical support to the NGOs who submit copies of the course certificate of the CHWs from an accredited institute.

6.2.4 Principles for harmonization of CHW roles across health system needs

CHWs in both government and non-government organizations (NGOs) would work collaboratively in the community in a synergistic manner with the view of achieving the relevant goals of SDG and Universal Health Coverage. CHWs working in the community collaborating with the existing referral facility/ies would provide services to the community through a common plan of action developed and led by the government service providers to ensure quality of care. The purpose of collaboration and harmonization among CHWs is to ensure full coverage of the community without duplicative effort, analysis of data and reports at local level and developing local level plan to resolve issues, ensure

quality services, and avoid duplication and to maximize utilization of resources. At the community level, community clinic (CC) will act as coordination hub for CHWs and their services.

The principles for harmonization of CHW should emphasize on:

- i. **Accountability:** refers to self, community, team mates and administrative authority
- ii. **Quality of Care:** refers to timeliness, maintaining asepsis, complete information, and delivery of standard services and client satisfaction.
- iii. **Spirit of Team Work:** refers to nurturing a TEAM spirit and being mutually responsive and supportive. Should work in a coordinated way with other community health support systems. CC to be used as coordination hub for CHWs.
- iv. **Community Engagement:** refers to involve communities in different forums related to HNP activities and services and with recognition.
- v. **Harmonized reporting:** refers to systematic record keeping, analysis of data and reports at local level, sharing amongst them and formulate a joint report.
- vi. **Learning & Development Attitude:** refers to being open to learn from experiences and others to improve the service volume and quality.

6.3 Systems developed for supervision and monitoring of CHWs

6.3.1 Management systems and strategies for CHWs

Management of CHWs requires sustainable support by and integration into local and national health systems and plans. It also requires supportive supervision that solves problems and improves skills. The CHW works within the context of a program, a community, and health system which are interconnected, nonlinear, self-organizing, and dynamic. The organization of services, the system provisions to ensure effective delivery and linkages with the beneficiary population, consists of elements and relationships within a dynamic system. Overall performance of the system (i.e., how well it actually meet the needs of the population it is meant to serve) depends on the effective functioning of all of its parts, as they interact. As a result, design choices or the performance of particular elements can have very important consequences.

Careful planning during the design and early implementation of interventions through CHWs is essential for a context-appropriate program that successfully trains, supervises, and retains CHWs, while simultaneously improving the health service delivery on the community level.

Supportive supervision needs to be established for sustainable CHW functioning with supervisors having required skills. Follow-up supervisory visits should be built in and should be supported by a strong data system with well-trained users. For an improved management system program organogram can be designed to understand the hierarchy.

6.3.2 Functional linkage of CHWs with primary health care structures

CHWs of various designations through training and supervision within the health system structure are able to successfully identify, screen, in some instance manage diseases and refer complicated cases to formal health facilities (union and Upazila level). The following focus areas needs to be addressed in setting up a strong link between CHWs and PHC structures:

- Coaching and mentoring
- Encouraging and supporting career building
- Ensuring uninterrupted supply chain
- Functioning of effective referral system through organized means
- Attending meetings regularly of the Union and Upazila Health, FP and Nutrition Coordination committee, WASH standing committee.

6.3.3 Supervision and monitoring system along with performance evaluation and feedback

Supportive supervision that targets and measures knowledge and skills, motivation, and adherence to correct practices provide incentive that positively impact performance. It is essential to streamline the supervision process by identifying effective strategies and including them in the implementation of interventions. Supportive supervision strategies includes coaching, observation at community and facility, community feedback, and supervision. In addition to providing administrative and clinical oversight, psychosocial support to frontline CHWs must be included who face a wide range of challenges on their own.

Supervision approaches, using guidelines/checklist, should include group supervision, peer supervision, and community supervision to distribute the supervision tasks and increase support to CHWs. An effective supervisory and monitoring tool needs to be developed and utilized through regular analysis and providing structured feedback.

6.3.4 E-record keeping, e-reporting system and effective use of technologies for services provided by CHWs

Community health information system should be a combination of paper, software, hardware, people and process which seeks to support informed decision making and action taking of CHWs. Use of technologies will reduce workload of CHWs which will increase time and efficiency of CHWs for providing services. These include:

- **Recording** of basic demographic data, service data, stock and resource availability
- **Tracking and taking action** on individual program-based needs such as maternal and child health services, mortality and morbidity and NCDs.
- **Reporting and feedback** including routine upward reports, feedback reports, ad hoc reports and specific reports for different stakeholders.
- **Administrative functions** including approval of tour program, leave approval, on line report return, electronic salary system etc.

While designing the information system for the CHWs, the followings should be pursued:

- a. Design to strengthen government ownership and sustainability.
- b. Enable and strengthen community engagement.
- c. Build a balance between reporting burden and provision of care.
- d. Strengthening capacity of CHWs and other stakeholders as a team.
- e. Follow incremental and evolutionary principles of system design and development.

In each month, the facilities must conduct data analysis and mapping, system configuration, and reflections on the observed assessment challenges. Findings obtained by supervisor should be presented and feedback should be given based on performance. Minimum data needs to be feed to the system for documentation at higher level. Local information should be used at the community and health facility level. Standard practice of identifying follow up cases should be used by the supervisors. Simple statistics calculation needs to be introduced for the CHWs to understand the local situation. A dash board from ward/union to upazila and upper levels be introduced for micro monitoring of local managers.

6.4 System established for provision of appropriate financial package/remuneration and contracting/appointment letter of CHWs

6.4.1 Appropriate financial package commensurate with the job demands, complexity, training and roles of CHWs

Adequate resources should be duly budgeted in health system resource planning for remuneration of CHWs to provide financial package commensurate with the job demands, complexity, number of hours, training and roles that CHWs undertake. For facilitation of service provision, CHWs working under DGHS and DGFP (HA, FWA, CHCP) be brought under uniform National grade scale. Similarly, supervisors under DGHS and DGFP (AHI and FPI) be brought under uniform National grade scale

6.4.2 Financial resources for CHW programs in health system resource planning

CHWs are essential service providers at the forefront of the health system. Their inclusion into formal health systems signifies that they need to be recognized and paid. The provision of a financial package to CHWs could take different forms (salary, honorarium, monetary incentives), in accordance with the employment status and applicable recruitment laws and regulations.

Financial package to remunerate CHWs should be done as a part of the overall health and FP sector planning, and adequate resources should be made available to implement this recommendation through the mobilization and prioritization of the required resources.

6.4.3 Provision of conditions specifying roles, responsibilities, working environment, remuneration

During appointment specific job responsibilities, duration of employment, working conditions and remuneration terms should be clarified. Monetary remuneration (such as salaries or financial incentives, insurances and compensated to cover expenses incurred in delivering services) and non-monetary incentives (such as respect, trust, recognition, and opportunities for personal growth, learning, social protection for families and career advancement) are important motivators for CHWs retention.

A career ladder should be offered to CHWs, promoting that further education and career development are linked to next grade promotion subject to duration of service and performance review.

6.5 Systems established on integration and health system support for effective functioning of CHWs

6.5.1 Potentials of CHWs to strengthen Primary Health Care and relevant services

CHWs have the potential to strengthen PHC and relevant services as they function as a link between the community and the health care system. It is envisioned that, at the transitional phase CHWs will spend 60% of their time at a static centre (EPI outreach site/Satellite Clinic/CC) and 40% of their time for domiciliary services. CHWs should be accountable to the health system and to their communities, and they should be supported by the Local Health Committees (CG and Union Education, Health and FP Standing Committee). To strengthen the PHC towards achieving SDGs, CHWs role must encompasses the followings:

1. Community empowerment for:

- a) Identifying health-related problems including disease outbreaks, poor environmental hygiene,
- b) Prioritizing community health problems,
- c) Determining actions for solving problems, including mobilization of resources at local levels

- d) Mobilizing the community for local health, nutrition and FP activities to sensitize through different events,
- 2. Serving as a liaison between health facility staff and the community.
- 3. Implementation of promotive and preventive health activities including good hygiene message to improve WASH situation with behavior change
- 4. Taking effective measures for referral cases for further management at the health centre or hospital,
- 5. Creating depot holders for ORS, including condoms and contraceptives.
- 6. Provision of follow-up care including home visits for patients with chronic conditions such as Tuberculosis (TB), DM, HPT, pregnant and post-natal mothers, awareness creation for environmental health practice like improve toilet, hand washing, waste management and defaulter tracing for malnourished children and immunizations etc.
- 7. Liaising and networking with other community-based workers
- 8. Collaboration with the community, other agencies working for the same community

6.5.2 Service delivery models for specific services like DM, HTN, Mental Health, Obesity, safe food etc. to be delivered by CHWs

Service delivery models must be developed with general tasks for specific services for DM, HTN and obesity. In addition other tasks should be developed for safe food including food hygiene, safe water and water safety, safe sanitation including safe disposal of child faeces, promotion of hand washing with soap at critical times and improved practice of menstrual hygiene practice etc. to be delivered by CHWs. Health facility support plan including adequate, inclusive water, sanitation and hygiene facilities should be developed.

CHWs need to prepare annual planning and plan for special situations like- flood, cyclone, humanitarian situation, Road Traffic Accident (RTA), and/or any other catastrophe arise in their catchment areas, work and provide services in collaboration with local administration and community. Differential program interventions should be pursued and planned based on geographic patterns.

6.5.3 Complementary role for CHWs with selective services

Due to demographic and epidemiological transition there has been shift of disease pattern which demands engagement of CHWs to complementary role with more selective services like HA for NCD and FP services; FWA for Immunization, nutrition etc. It is recommended that CHWs perform general tasks as part of integrated primary health care aligning with ESP, however, some CHWs will be assigned with more selective and specific tasks playing a complementary role when and where required.

6.6 Guideline developed on effective community engagement for improving CHW performance and utilization

6.6.1 Effective local government support plan with community engagement approaches

A. Community engagement: following community engagement approaches be undertaken:

- i. Consultation with community leaders including CG/CSG; Meetings to sensitize community to an imminent intervention, led by community leaders or community members. UP Chairman and women UP member of respective CC cluster in rural area/Ward Councilor in urban area, should play the lead role in this consultation process.

- ii. Monitoring of CHWs; Community leaders including CG/CSG should be involved in supervision and monitoring.
- iii. Selection and priority setting of CHW activities; In addition to program needs, local need should be addressed in the JD.
- iv. Support to community-based structures; CHWs should be coopted in Community Group/Community Support Group and UEH&FPSC. Should attend regular meetings of the committees and contribute to the mandate of the committees within the scope of CHW.
- v. Involving existing community based structures; engaging community representatives in decision-making, problem solving, planning and budgeting processes.

B. CHW project evaluation and oversight

- I. Involving community members, CG/CSG in decision-making, quality improvement and evaluation, e.g. participatory evaluation meetings
- II. Establishment of a village/para health committee for project and CHW oversight

6.6.2 Functional GO-NGO coordination and public private partnership (PPP) mechanism

Principles of these coordination mechanisms should be:

- Both the GO and NGO officials have to develop a positive attitude towards the collaboration.
- Openness, welcoming the ideas and opinions, and giving recognition of the work for both counterparts become helpful to solve the behavioral problem and also to increase mutual understanding.
- Transparencies and openness about the project objectives, policies and strategies would ensure better understanding between the two partners.
- Impartial and perfect situation analysis is to be recommended.
- Introduction of proper follow-up and monitoring system is necessary which would ensure the feedback of the programs and also help to remove the structural barriers of the system.

A monthly meeting with all CHWs of GO (including MPHVs and PPVs) and NGO should be organized to prepare plan, analyze accomplishment and resolve problems/issues prevailing in CC catchment areas.

6.6.3 Community role and responsibilities for promotion and demand generation of services, resource mobilization and accountability of service providers and users

The long-term goal of community participation is to develop sustainable processes that lead to organize communities working in partnership with the Government for the achievement of common goals for the sector.

Local level planning, as well as quality of facilities, such as whether there is adequate supply, infrastructure and WASH services; community involvement in implementation, and monitoring for the ESP should be used as entry points for such partnerships between Government and communities and will thereby serve as testing ground towards strengthening local self-government and community empowerment. Local communities should be involved in supervising the low performing areas.

To develop the necessary competencies and foster needed attitudinal changes, local communities require orientation for the adoption and utilization of existing tools and techniques for participatory appraisals, planning and monitoring. Government functionaries and program managers likewise require training to prepare them for the attitudinal changes that are required for working in a team and for going into partnership with local community. External facilitators as well as peer-group

motivators would be needed for such processes. NGOs could act as trainers for facilitators and motivators, as community-organized processes take shape.

CHWs may contribute to mobilizing wider community resources for health by:

- identifying priority health, nutrition, FP, environment, WASH and social problems and developing and implementing corresponding action plans with the communities;
- mobilizing and helping coordinate relevant local resources representing different stakeholders, CG, sectors and civil society organizations to address priority health problems;
- facilitating community participation in transparent evaluation and dissemination of routine community data and outcomes of interventions;
- Strengthening linkages between the community and health facilities.

6.6.4 Client based tools for supervision, monitoring, accountability and community engagement

It is imperative that, clients need to be capacitated to ask for effective and respectful care, irrespective of their ability to pay. It stipulates accountability through monitoring and regular, inclusive, transparent reviews of progress and performance at the household, facility, subnational and national level services, linked to the health-related SDGs.

Functioning user friendly accountability tools and mechanism should produce regular reports and holding reviews using those reports to assess the quality and progress of the health care services at community to upper level facilities should be institutionalized. Beyond the traditional accountability tools, some globally used tools are- community score card, citizen report card, public hearing, social audit, complain/suggestion box, WASH FIT etc. are recognized. These tools should be used to ensure active and meaningful participation of community in the reviews of accountability, progress and performances of facilities served by CHWs and other health care providers. This level of performance visibility also has profound motivating effects in terms of recognition of excellence.

7 Cross Cutting Issues

7.1 Gender

Women constitute almost half of the Bangladesh population. But because of widespread illiteracy among the population as a whole and women in particular, inadequate female participation in development activities and above all, the age old sex discrimination, it is difficult to ensure their active participation in health and health related development activities.

Organization of gender specific services and focusing on them would be required to ensure gender-based equity in service inputs. Privacy, confidentiality and sensitive care are often missing in health systems depleted of human and financial resources. Poor provider practices that deny women and their families respect and dignity discourage women and the family gatekeepers that control many women's access, from using health services. Attention should be provided to discrimination in the delivery of services, and should address the discriminatory attitudes and practices of CHWs, both towards clients and fellow providers.

Gender equity should be taken care of in design of delivery of different services. Steps will be taken to render gender friendly services and alleviate provider insensitivity to gender concerns. On the supply side, mechanisms should be developed to identify and assess gaps – in both financial resource and its allocation, and human resource – in service delivery that impact negatively on gender equity. On the demand side, service accessibility by women and girl children should be monitored, deterrence and disincentive to service and facility utilization by them should be identified and addressed.

The financial information system should include mechanism to identify budget allocations for community centered facilities based on gender priorities, so as to reduce gender gaps in health service utilization due to out-of pocket expenditure including accessibility and status. Data gathered from both supply and demand sides should be used to develop gender impact indicators – focusing on utilization of service and health status. Sex disaggregated data based indicator would create more gender impact on health status as well as services. Therefore, data at all levels should be gathered and maintained on the basis of gender, so as to provide useable information.

7.2 Sectors beyond Health

7.2.1 Food and Agriculture

CHWs can orient households on food safety practices, sanitation and how to improve household dietary diversity through homestead gardening. They can link households to Assistant Agriculture Officer or Sub Assistant Agriculture Officer for further support on homestead gardening to improve dietary diversity of household members.

Assurance of safe and quality food is an important determinant for nutrition security for all age groups. In addition to strengthening Good Agricultural Practices (GAPs) (including aquaculture and veterinary), Good Hygienic Practices (GHPs) and Good Manufacturing Practices (GMPs) along the food chain/value chain, risk-based food inspection, risk based food standards formulation, monitoring of food contaminants and adulterants, and conduction of food borne disease surveillance supported by laboratory analysis; campaign for good hygienic practices, support for the food businesses operators are needed to be ensured. To achieve SDGs it is important to work all together to improve the nutrition indicators, so that we can achieve the vision 2041.

7.2.2 Local Government Institutes

Urbanization is occurring at a rapid pace in Bangladesh. In 2011, 28 percent of the population lived in urban areas. From 2001 to 2011, the country's urban population expanded by 35 percent, at an annualized growth rate of three percent. Urban health service in Bangladesh falls under the responsibility of the Ministry of Health and Family Welfare (MOHFW) and the Ministry of Local Government, Rural Development and Co-operatives (MOLGRD&C). MOHFW is the designated ministry for all matters related to health and for ensuring or arranging health services for the entire country, urban and rural. It is responsible for national health-related policy, planning, and decision making on all health issues, which are then implemented by different executing and regulatory authorities. MOHFW also has the stewardship functions of setting technical standards, regulating the sector, and developing policy. In urban areas, it is responsible for providing policy and technical guidance; setting standards of services; and licensing of private and nongovernmental organization (NGO) health providers (including diagnostic centers, laboratories, and pharmacies) as well as provision of medical supplies, inspections, monitoring, evaluation, and coordination. It is also responsible for the direct provision of urban secondary and tertiary health services. As for MOLGRD&C, through its Local Government Division (LGD) is responsible for providing primary health and public health services specifically in urban areas. The LG/City Corporation Act of 2009 and the Paurashava Act of 2009 clearly mandate that LGD deliver and maintain all social services, including education and basic health services (provision of preventive and promotive health as well as limited curative care and services) in urban areas. Urban governments, as local administrative units governed by elected representatives, have been mandated since the 1960s to provide a wide range of public services to citizens within their jurisdictions and are responsible for the provision and maintenance of basic services and infrastructure in cities and towns. The Paurashava and City Corporation Acts of 2009 delegate to urban

governments many responsibilities that go beyond the basic public health function. In the health sphere alone, these include the maintenance of health systems; the establishment and maintenance of hospitals and dispensaries, health centers, maternity centers, and centers for the welfare of women, infants, and children; provision of training for dais (traditional birth attendants); promotion of family planning; adoption of such other measures as may be necessary to promote the health and welfare of women, infants, and children; and provision of annual registration to private hospitals, clinics, diagnostic centers, and paramedical institutes in their jurisdiction based on the prior approval (No Objection Certificate) from MOHFW's Directorate General of Health Services (DGHS). Moreover, these mandated responsibilities include waste removal, drain management, road sweeping, control of wild dogs considered dangerous to humans, removal of the carcasses of dead animals, mosquito control, birth and death registration, provision of different certificates, control of food adulteration, sanitation, Expanded Programme on Immunization (EPI) activities, and medical waste management (licensing and renewals to those who collect, transport, and dispose of medical waste). LGD provides urban governments with budgetary and management support from the central government, with little participation of urban governments in the planning process. Finally, urban governments receive block grants from LGD for the discharge of their functions, but the grants are not earmarked for health (or any other) services. Nor have clear monitoring and accountability structures been established for the use of these funds

Union Parishads has 12 standing committees – one of them being *Union Education, Sanitation, Health and Family planning standing committee (UEH&FPSC)*. Union and Upazilla Parishads has earmarked 15% of their annual budgets allocated for health. CHWs can activate these UEH&FPSC and can also put on leverage for effective use of the earmarked funds for HNP related activities.

7.2.3 Education Sector

CHWs can deliver health education in schools and community for adolescents through discussing issues on SRHR including menstrual hygiene management, importance of TT, HPV vaccination, nutrition, deworming and availability of services.

CHWs can administer EPI, Deworming tablets, IFA supplements and support mental health screening and referrals. At the same premise, they can orient teachers on deworming, importance of taking IFA supplements, importance of TT and HPV (when it becomes available) vaccination.

7.3 Social Protection/ Financing

Despite policies of the GOB directed at reduction of poverty, extreme poverty remains a reality in the villages and the urban slums of Bangladesh. Although available data are inconsistent on the trend of poverty in recent years, there is agreement that poverty is widespread in both rural and urban areas. Recent surveys suggest that higher morbidity and mortality are prevalent among the poorest households with 72% difference in severe illness (self-reported) rates between the highest and lowest income quintiles. Illness-related expenditure is estimated to account for more than one fifth of the slippage of non-poor families into the poverty group, where they then are exposed to the higher illness rates associated with poverty. According to economists, this can lead to downward movement to poverty, the 'poverty spiral', especially in cases of hospitalization or chronic illnesses. This warrants the provision of effective health care at low costs in poverty alleviation schemes.

Measures should be planned to ensure the access of the disadvantaged groups (poor) of the population to client-centred quality services. Several NGOs and GOB facilities have experience of providing health care with cost-recovery while keeping the safety net for the poor. The services incorporated into ESP are quite comprehensive and thus address most of the health needs of the poor.

Nevertheless, following the process of identification of the poor and health consequences of poverty based on local epidemiological trend, it is needed to adjust by mixing the services and the method of delivery in such a manner that it meets the need of the poorest households. There is a tremendous difference between illness and risk patterns in the poorest sections of society compared to the more affluent. Thus, the poor people quantitatively need more health services. The three most important issues which will be addressed in ensuring that households most in need do in fact receive timely care of sufficient quality are:

- Identification of vulnerable groups
- Creation of delivery mechanisms
- Verification

Various modalities using several indicators and combination thereof, e.g. direct calorie intake, food energy intake, cost of basic needs, cash income, landholding, various indices based on housing etc. have been used on identification of poverty. The Health Poverty Interface may be used for developing a methodology to identify the most vulnerable people who need focused health care.

7.4 WASH Sector

CHW can act as the gateway for the community education and awareness on WASH and broader hygiene issues. Hygiene though has a notion only around hand washing but dimension of hygiene theme encompasses around some other important behavior and practices; i.e. menstrual hygiene management, food hygiene, oral hygiene etc. Of them, as the CHW have scope to make home visits, they can come in closeness with the women, adolescent girls and family heads and thus can orient and train them on healthy hygiene behaviors and practices on healthy menstrual management.

CHW can play a vital role to promote WASH at community level, during house visit; they can also observe overall environmental health issues in relation with WASH like improved latrine, waste management, child faeces management etc. and can motivate people to improve the wash related benefit of overall health and nutrition status improvement. CHWs can play a strong role to orient households on use of improved sanitation including safe disposal of child excreta, safe drinking water including water safety, hand washing with soap at critical times and improved practice of menstrual hygiene.

CHWs have opportunities to disseminate WASH information during EPI and outreach sessions. CHWs need to orient teachers about importance of consistent use of improved sanitation, safe drinking water and both hand washing with soap at five critical times specially before taking food and after defecation at house hold level.

At institutional level, CHW can conduct session for students on overall health, nutrition, hygiene specially hand washing and menstrual hygiene management collaborating with other development workers and school authority. During patient counseling at health centre, they can also incorporate WASH as content related with overall health and nutrition

They can augment through home visits to share the theme and importance of the different global and national day's celebration and create mass awareness among communities; particularly on world toilet day, menstrual hygiene day, world water day, world health day etc.

7.5 Social Welfare and other Social Sector

The Government is aware that without health financing reforms and adequacy of supply side interventions in health, education, water supply and sanitation, the cash transfers from the life cycle scheme alone will not achieve the desired results. The Government has already adopted a long-term comprehensive health financing reform strategy, which will be fully implemented.

A child's health is intimately linked with the mother at the pregnancy stage. The Government will build on the positive experiences of the Maternal Health Voucher Scheme (MHVS) and expand coverage to all women who need this service, undertaking it in a phased manner based on evidenced effectiveness of the scheme. MoHFW could coordinate supply-side interventions to ensure that the demand for the service financed through MHVS does not go unmet.

CHWs can be made part of the governments' maternal voucher scheme in the sense that if they refer (or bring) clients to the public hospital, then the CHWs can be given x% from the voucher incentive budget (that the public hospitals receives from the government).

Social Security Fund (SSF) is under the Ministry of Social Welfare. A SSF Officer (SSFO) at field level maintains a budget allocated by the Ministry to provide financial or in kind support to the admitted disadvantaged population who are admitted to government hospitals. In addition, to having the allocation from the Ministry, the SSFOs can raise fund from local sources (e.g. local elite people's contribution or private sectors'). Therefore, it would be good if the CHWs enagage with the local SSFOs, and given a small training on the SSF and how to facilitate access by the disadvantaged population. Although this linkage will not benefit the CHWs financially, however, it would work towards their advantage.

7.6 Private Sector

The contribution of the private sector to the provision of health care services in Bangladesh has progressively increased during last 20 years. This rapid development has improved access by the population to medical care, especially in the urban areas. The 1982 Private Clinic & Laboratory Act provided some guidelines for regulating the private sector. Other than the MOHFW's regulations, trade licensing procedures, taxation systems, regulation of recruitment of manpower and staff development, access to bank credit, procedures for utility connections, procurement of equipment & supplies and adopting medical ethics etc. all together affect the private sector and have significant impact on it.

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Annex – 1

Universal health coverage: Community health workers delivering primary health care: opportunities and challenges; Report by the Director-General (Seventy-second World Health Assembly, A72/13, Provisional agenda item 11.5, 25 March 2019)

(PLEASE INSERT PDF FILE OF THE DOCUMENT)

**Minutes of the 4th National Steering Committee on Community Health,
MOHFW**

(PLEASE INSERT PDF FILE OF THE DOCUMENT)

National Steering Committee

<i>Sl. No</i>	<i>Name</i>	<i>Designation</i>
1.	Additional Secretary (Admin) & Line Director HRM, MOFFW	Chair
2.	Line Director, MNCAH, DGHS, Mohakhali	Member
3.	Line Director, CBHC, DGHS, Mohakhali	Member
4.	Md. Abdur Rouf Mia, Deputy Secretary, Local Government Division, Ministry of Local Government, Rural Development & Cooperative	Member
5.	Md. Saiful Hassan Badal, Director (MIS), DGFP, Kawran bazaar, Dhaka	Member
6.	Chief, Health & Nutrition, UNICEF, BSL Office Complex, Minto Road, Dhaka	Member
7.	Director, Health, Nutrition & HIV-AIDs, Save The Children, Gulshan, Dhaka	Member
8.	Nahid Sultana Mallik, Deputy Chief, HRM, MOIIFW	Member-Secretary

Terms of Reference

- To influence national policy
- To provide strategic d directions in improving community health workers program performances.
- To endorse the decisions of the stake holders forum

Minutes of the 5th meeting of the National Steering Committee on Community Health and the approved position paper

(PLEASE INSERT PDF FILE OF THE DOCUMENT)

ToR and list of working group members

Introduction

To ensure quality of care at community level to improve the status of Maternal, New born and Child health, Family Planning and Nutrition services.

Aim or Expected Results:

The Working group will review the existing policies and guidelines and will be developed National CHW strategy considering the following domain.

1. **Selection, education and certification**
 - CHW needs - Projections for next 12 years – link with SDGs
 - Equitable allocation
 - Balance of male and female CHWs
 - Capacity building
2. **Management and supervision**
 - Principles for harmonization
 - Community Clinic as hub – attachment of HA/FWA
 - Use of technology
 - Supervision, monitoring, record keeping and reporting
3. **Integration into and support by health system and communities**
 - Geographic focus – differential program approach
 - GO-NGO coordination and complementary approaches – partner engagement
 - Community engagement approach and plan
 - Local government support plan

Tasks:

1. Conduct situation analysis by collecting contextual information and reviewing, prioritizing and documenting evidences of national and international on CHW and community health programs for selecting interventions that are most appropriate to national needs.

Lists of documents need to review:

- WHO CHW Global Guideline
 - National Health workforce strategy 2015 (Bangladesh)
 - National Health workforce strategy (India)
 - Document on SDG on UHC
 - Indicators from different OP like MIS, MNCAH, CBHC, NNS, CCSDP, MRCAH etc.
 - Document on Health insurance
 - Document on 7th 5s plan
 - In alignment with digital Bangladesh (Technology use)
 - ESP document
 - 4th HNPSD document and PIP with deferential program specially sylhet and chattagram division.
 - National Health policy 2012
 - National Nutrition policy 2015
 - National Population Policy 2013
 - JD of HA,AHI,HI,FWA, FPI etc.
2. Prepare draft Strategy by reviewing the existing document and incorporating current issues
 3. Develop matrices for the implementation

Time Frame: Working group will meet preferably in fortnightly and complete the work between 1st February 2019– 31st March 2019

Proposed Committee:

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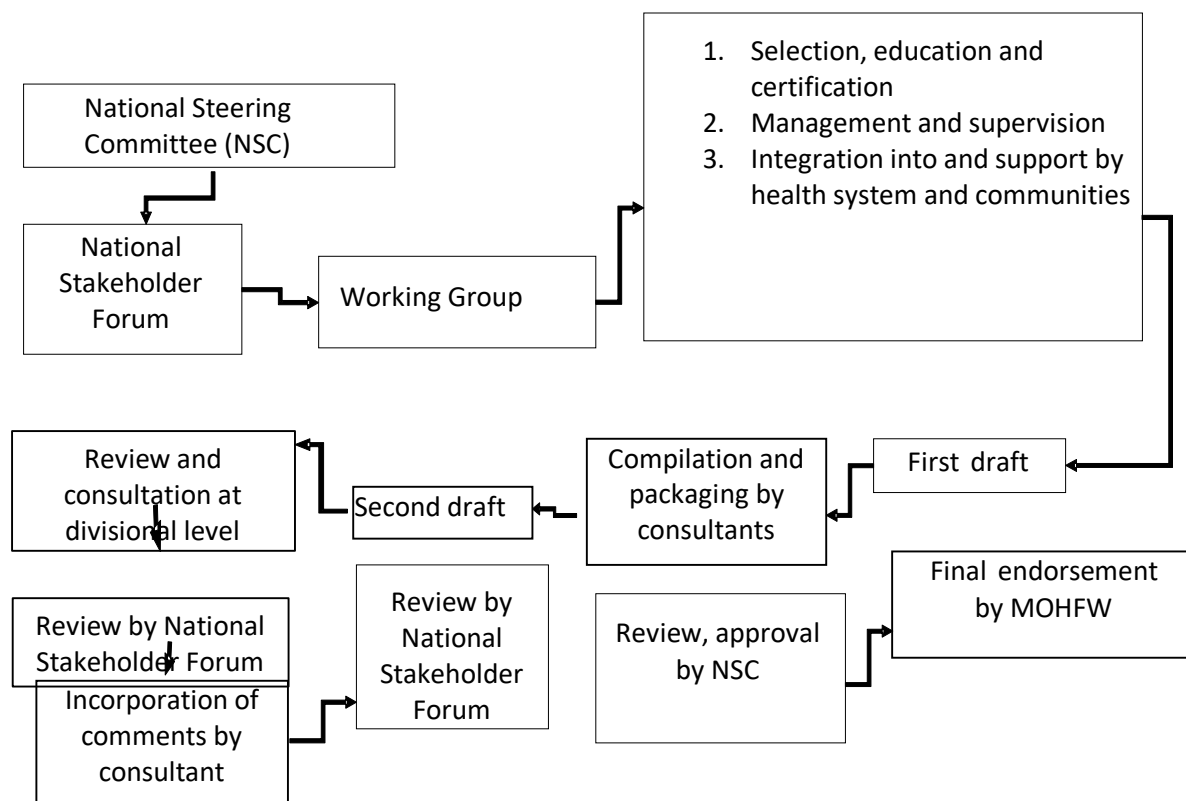
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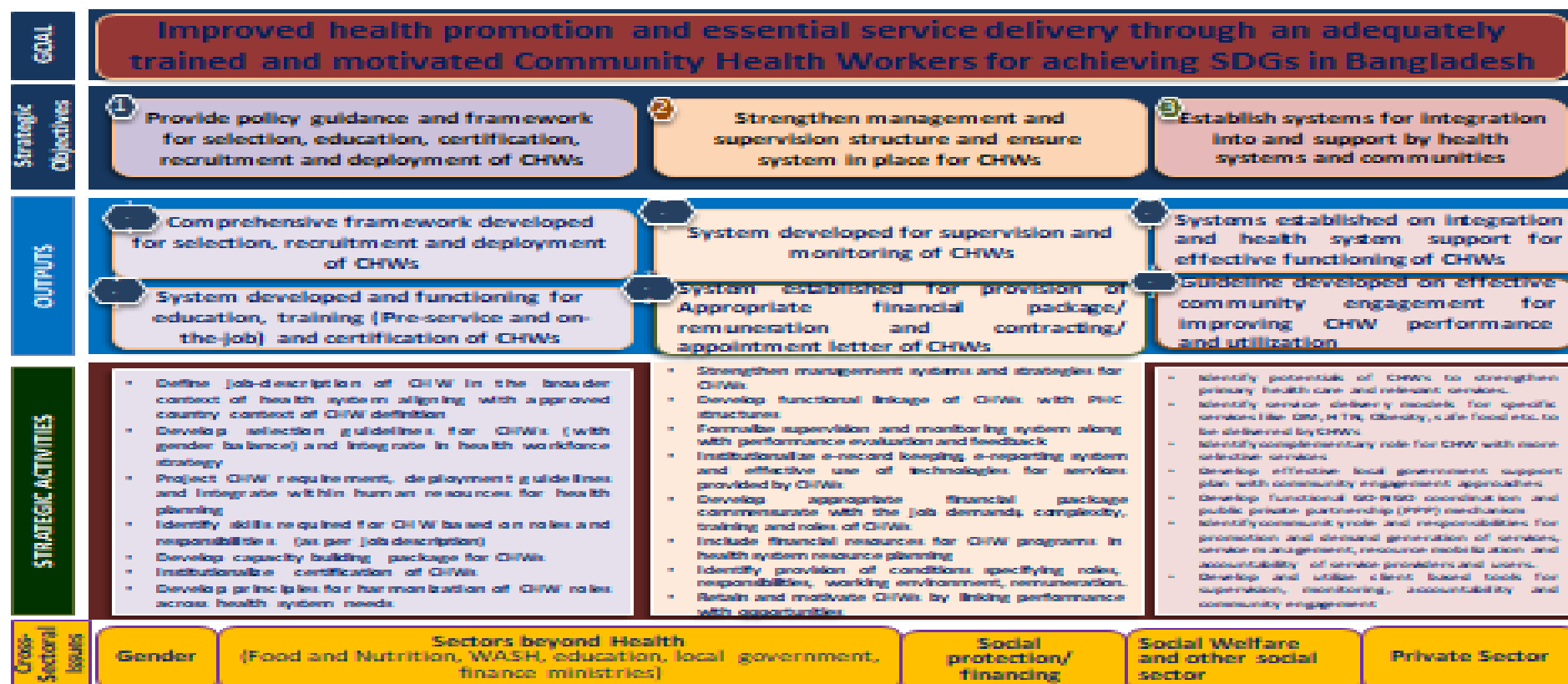
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Process of Strategy Development



Logical Framework for CHW Strategy in Bangladesh



CHW requirement and integration within human resources for health planning

The fifth Population and Housing Census, 2011 conducted by BBS and the 2017 Revision of World Population Prospects (twenty-fifth round of official United Nations population estimates and projections) prepared by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat has been used to estimate the population projections of Bangladesh. In estimating the CHW projection the following principles/assumptions has been made:

- The fifth Population and Housing Census, 2011 and subsequent estimated population projection through Bangladesh Sample Vital Statistics is close to proximity with the United Nations population estimates. Hence, the population projections of Bangladesh are estimated using the United Nations population estimates.
- Since MOHFW is responsible for ensuring HPN services for rural population the projections are based on rural population estimates
- The national household composition size of Bangladesh in 2017 is estimated as 4.2 per HH (4.3 HH in rural area and 4.2 for urban areas)
- Analyzing the trend it is expected that the rural household composition would gradually decrease from 4.2 HH (in 2019) to 3.8 HH (in 2030)
- Intercensal Growth Rate will remain between 1.37 to 1.36
- The rural In-migration rate will be within the range of 37.8 (per thousand) to 40 (per thousand)
- The rural out-migration rate will be within the range of 43.5 (per thousand) to 45 (per thousand)
- Fifth Population and Housing Census, 2011 estimated 4569 Union across the country. However, the EPI vaccination estimates 4595 unions (2019) out of which 661 unions falls under hard to reach category. This calculation considers the EPI vaccination estimates of Union.

Figure 4: BBS Estimation of Population Trends in Bangladesh (in millions)

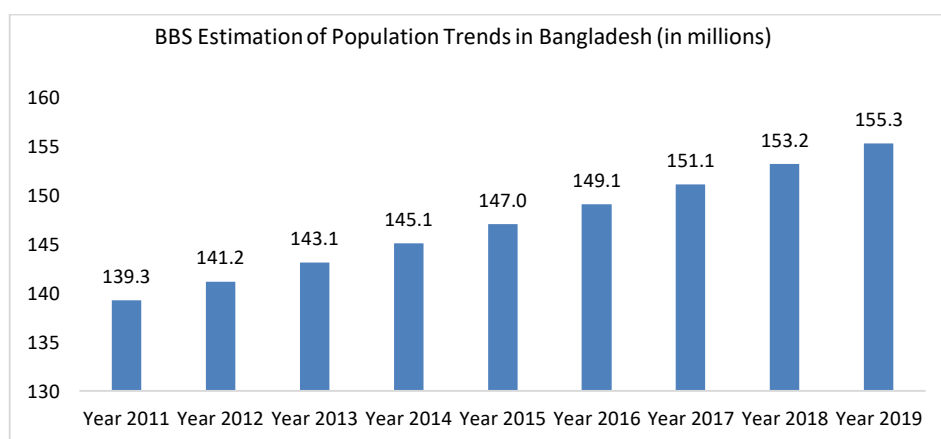


Figure 5: Projected Population of Bangladesh (in millions)

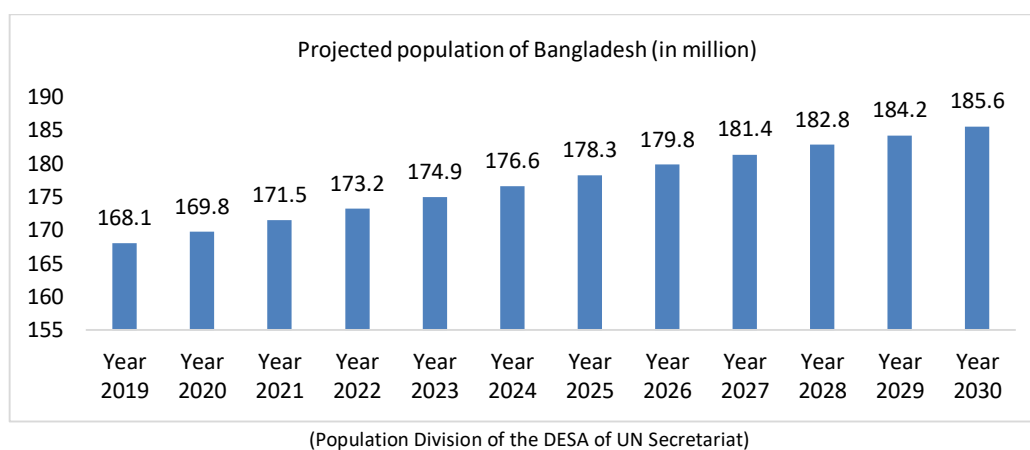


Figure 6: CHW Projection - 2030 (Based on HH Coverage)

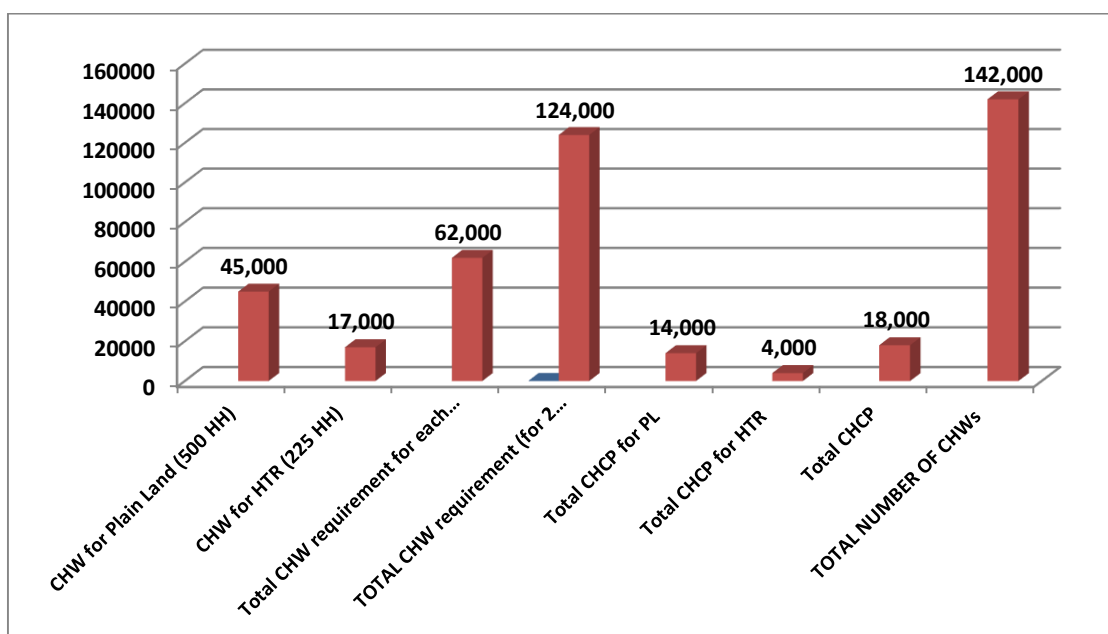


Figure 7: CHW Projection till 2030

Year	Total Pop.in Plain Land (in '000)	Total HH in Plain Land (in '000)	Total Pop.in HTR Area (in '000)	Total HH in HTR (in '000)	CHW for Plain Land (500 HH) (in '000) ⁸	CHW for HTR (225 HH) (in '000) ⁹	TOTAL CHW ((in '000) ¹⁰	CHW for Plain Land ¹¹	CHW for HTR ¹²	TOTAL CHW ¹³	Total CHCP for PL ((in '000)	Total CHCP for HTR (in '000)	Total CHCP ((in '000)	Total CC
	Population Projections				Estimated CHW requirement based on HH coverage			Estimated CHW requirement based on ward calculation			Estimated CHCP requirement based on HH coverage			
1	2	3	4	5	9	10	11	12	13	14	12	13	14	15
2019	90,067	21,444	15,133	3,603	43	16	118	35,406	5,949	82,710	15	4	19	19,000
2020	89,861	21,396	15,099	3,595	43	16	118	35,406	5,949	82,710	15	4	19	19,000
2021	89,646	25,539	15,062	3,674	51	16	134	35,406	5,949	82,710	15	4	19	19,000
2022	89,414	21,808	15,023	3,664	44	16	120	35,406	5,949	82,710	15	4	19	19,000
2023	89,160	21,746	14,981	3,654	43	16	118	35,406	5,949	82,710	15	4	19	19,000
2024	88,873	22,218	14,933	3,733	44	17	122	35,406	5,949	82,710	15	4	19	19,000
2025	88,547	22,137	14,878	3,719	44	17	122	35,406	5,949	82,710	15	4	19	19,000
2026	88,181	22,045	14,816	3,704	44	16	120	35,406	5,949	82,710	15	4	19	19,000
2027	87,777	22,507	14,749	3,782	45	17	124	35,406	5,949	82,710	15	4	19	19,000
2028	87,342	22,395	14,675	3,763	45	17	124	35,406	5,949	82,710	15	4	19	19,000
2029	86,874	22,862	14,597	3,841	46	17	126	35,406	5,949	82,710	14	4	18	18,000
2030	86,382	22,732	14,514	3,819	45	17	124	35,406	5,949	82,710	14	4	18	18,000

⁸⁻⁶ Calculation based on population distribution: 1 CHW for 450-550 HHs (average 500 HHs)

⁷⁻⁹ Calculation based on geographical distribution: 1 CHW in each ward of nine wards in a Union